Gender relations, livelihood security and reproductive health among women refugees in Uganda

The case of Sudanese women in Rhino Camp and Kiryandongo Refugee Settlements

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To Stanley and Joel Matthew

List of Tables

List of Figures

List of Charts

List of Diagrams

List of Boxes

Acronyms and Abbreviations

ADF	Allied Democratic Force
ADRA	Adventist Development and Relief Agency
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
AU	African Union
BAT	British American Tobacco
CAO	Chief Administrative Officer
CARA	NGO named after Irish name
CBDA	Community Based Distribution Agents.
CBO	Community Based Organization
CSDR	Chid Survival and Development Revolution
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CRLP	Centre for Reproductive law and Policy
DDHS	District Director For Health Services
DED	Germany Development Service
DHSPDM	District Health Service Pilot Project and Demonstration Project
DISO	District Internal Security officer
DMO	District Medical Officer
DP	Depo Provera
DRC	Democratic Republic of Congo
ECF	Equatoria Civic fund
EU	European Union
EVI	Extremely Vulnerable Individual
FAO	Food Agricultural Organization
FGDs	Focus Group Discussions
FGM	Female Genital Infibulation
FWCW	Fourth World Conference on Women
GTZ	Germany Technical Services
HIV	Human Immune Virus
HRO	Human Rights Organization
HRW	Human Rights Watch.
HSD	Health Sub-District
IASC	Inter-Agency Standing Committee
ICPD	International Conference on Population and Development
ICRC	International Committee of the Red Cross
IDP	Internally Displaced Person
IMF	International Monetary Fund
LRA	Lords Resistance Army
MCH	Maternal and Child Health
MDG	Millenium Development Goals
MoH	Ministry of Health
MSF	Medicines sans Frontieres
NRA/M	National Resistance Army/Movement

OCHA	Office of the Coordination of Humanitarian Aid
OPM	Office of the Prime Minister
PHC	Primary Health Care
PGN	Practical Gender Needs
PNC	Post Natal Care
POP	People-Oriented Planning
PTA	Parent and Teachers Association
RAA	Refugee Affected Area
REC	Refugee Eligibility Committee
RPF	Rwandese Patriotic Front
RWC	Refugee Welfare Committee
SIDA	Swedish International Development Agency
SMI	Safe Motherhood Initiative
SPLA	Sudan People's Liberation Army
SPLM	Sudan People's Liberation Movement
SPSS	Statistical Package of Social Service
SRH	Sexual and Reproductive Health
SRS	Self-Reliance Strategy
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBA	Traditional Birth Attendant
TT	Tetanus Toxoide
UDHS	Uganda Demographic and Health Survey
UNEPI	Uganda National Expanded Program for Immunization
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children Fund
UPC	Uganda People's Congress
UPDA	Uganda People's Democratic Army
UPDF	Uganda People Defence Force
UPE	Universal Primary Education
WB	World Bank
WCED	World Commission on Environment Development
WFP	World Food Program.
WHO	World Health Organization
WID.	Women in Development
WOTRO	Wetenschappelijk Onderzoek Van de Tropen [Netherlands Foundation For the Advancement of Tropical Research] .

GLOSSARY

Achuathialwei	Dinka word for anti fever medicine
Achitak	Dinka word for eggplant (used for constipation)
Ajon	Local Brew made from cassava and sorghum
Agwek	Dinka word for frog
Boda Boda	Motorbike or bicycle used to transport passengers for money
Dawa ya Kienyegi	Swahili for local (traditional) medicine
Ingumba	Kinyarwanda word for childless women
Jua Kali	Swahili for short-term income-generating activities performed under strenuous conditions
Kabalagala	Pancakes made out of cassava or maize flour
Kigaji	Luganda word for *Aloe ferox*
Komo tree	Used as a source of medicine for massaging the abdomen for proper positioning of baby in uterus by the Dinka
Konya Odira	Communal Work
Kwete	Local Brew made from millet
Njaga	Luganda for *Cannabis Sativa*
Lalur	Acholi word for infertile woman
Leja Leja	Piecework usually in form of digging for money
Lira Lira	Local spirit distilled from maize
Malakwang	Acholi for Green vegetables
Malaya	Swahili for prostitute
Mandiet	Dinka word for twins
Mululuza	Luganda word for the scientific *vernonia amygdalina*

Patana	Swahili for striking a deal normally associated with digging
Posho	Maize flour
Shamba	Garden/plot
Reer	Neem tree used for anti fever preparations
Ruat	Similar to okrah and used for skin diseases by the Dinka
Rwot	Acholi word for Chief
Rwodi	Acholi word for Chiefs
Ugali	Mingled maize or sorghum
Ugonjwa wa Kienyegi	Disease that does not respond to western medicine

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Deborah Mulumba
Wageningen, The Netherlands, 26 October 2005

Map of Uganda indicating the districts of Arua and Masindi

1

Background and Rationale for the Study

1.0 Introduction

This work is the result of an actor-oriented[1] and gender-based analysis of humanitarian assistance in refugee settlements in Uganda. Specifically, the study examines how power and gender relations affect the livelihood security and reproductive health of the Sudanese refugees in Kiryandongo and Rhino Camp refugee settlements[2] in Uganda. The study is pertinent because conditions related to or resulting from reproductive health problems, such as poorly-managed pregnancy, abortion, anaemia, sexually transmitted diseases (STDs) and HIV / AIDS, are among the top killer diseases in sub Saharan Africa (UNAIDS, 2003; WHO, 2003). In general, women's subordination and gender inequality have attracted a great deal of scholarship (for example, Obbo, 1990; Mies, 1986, Moore, 1988; Longwe, 1991). However, the analysis of gender with respect to their livelihoods and reproductive health of women refugees has only received limited scholarship. Moreover, few humanitarian aid programmes have been subjected to actor-oriented and interface analysis.

The primary focus of the study was therefore to investigate and analyse how power and gender relations affect the livelihood security and reproductive health of refugees and how refugees respond to these processes. I set out to investigate and document how the gender inequalities were reproduced and perpetuated at the interface with humanitarian aid programmes. The motivation for doing this study was prompted by the protracted nature of armed conflict in the Great Lakes Region of Eastern Africa; second, by my own past experience with refugees, and third, by academic inquisitiveness and interest.

The study also stems from my past gender study experiences and observations that the reproductive health process, apart from being a function of physiology, is a social process that hinges on several other factors. I had for example observed that gender ideology in most African communities prescribes the social position of men and women, including specific gender roles.

1.1 The Research Motivation

My motivation in undertaking this study stemmed from several factors. First, it is the many years of working with and for refugees at UNHCR, Kampala Uganda and later with a community based organization (CBO) which was charged with implementing two refugee projects – one, an urban based project and the other a rural based emergency project in Mbarara district in 1990. Secondly, my own concern about the relevance of some aspects (i.e. contraception) of reproductive health projects for a population such as the southern Sudanese that had suffered immense human loss from the effects of war plus their high illiteracy rates. Thirdly, even though my earlier professional training as a registered nurse/midwife had equipped me with the skills of handling reproductive health care, it did not expose me to analytical skills critical in the mastery of appreciation of the relationships between the socio-cultural, economic, political as well as gender and power relations dynamics that are so instrumental in the reproductive health process. The final motivating factor was the desire to explore further the difference over the definition of reproductive health as understood by the refugees and the 'official' definition by the United Nations (UN, 1994). This discrepancy in meaning was recognized during the pilot study before the fieldwork research. This, I concluded, was in part caused by the implementers' failure to understand what the 'beneficiaries' want and prefer. In the next sub-section, I briefly discuss two short examples arising out of my work experience with refugees and one short case-study arising out of the field work for the present study to illustrate my point and to show why I have decided to study the notion of power and gender relations in refugee situations.

Example 1: The UNHCR Representative and Augustine[3]

As I mention in chapter 4 below, the early 1980s were particularly insecure for the Banyarwanda[4] refugees in Uganda for two main reasons: 1) they were suspected of supporting Yoweri Museveni's guerilla war which he launched in the early 1980s to fight Obote's government for allegedly having rigged the general elections that brought him and his party, the Uganda People's Congress (UPC) to power for the second time in 1980; 2) The Banyarwanda were further suspected of having supported the Democratic Party (DP) during the 1980 election and this was used as a good reason by Obote to chase them away.

The ensuing confusion made the Banyarwanda refugees insecure and many of them sought assistance at the UNHCR office in Kampala. The UNHCR representative at the time (himself having been a Hungarian refugee in Britain at a young age) had a very paternalistic attitude towards the refugees and tried his level best to assist them. Augustine, a Munyarwanda refugee in his mid-thirties, visited the UNHCR office on a daily basis with money requests. On most occasions, the requests were granted. In addition, we were directed to open a file for Augustine's wife so that she looks after their children. Furthermore the Representative secured a job for Augustine at the Silver Springs Hotel in one of the Kampala suburbs. However, the first day Augustine took up his job was the last day he worked. He returned to the UNHCR complaining that the job was below his standards. I actually remember him saying that "*how will*

they hear that I am washing plates at Silver Springs? It appears he considered washing plates a 'woman's job' even though the job would have helped him a lot financially in his refugee environment.

Example 2: Fortunate, the Psychiatric Nurse

On one of the counselling days, we were approached by Fortunate, a twenty-year old student nurse at Butabika Hospital School of Psychiatric Nursing. She informed us that she was a registered refugee from one of the settlements, but currently a student nurse and had documents to prove both statuses. We wondered how she could have been admitted for a nursing course without any inquiry at the UNHCR (normally the UNHCR paid fees for such courses for refugees). A verification visit to the hospital indicated that she 'passed' for a Munyankore[5] and as there are no proper personal identification registration modalities in the country it was difficult to prove whether she was a Ugandan or not. At the counselling office this doubt was raised and she was told she could not get the 'requirements' she had asked for because according to the records at the hospital, she was a Ugandan. Yet the UNHCR records showed she was a refugee. After lengthy arguments and counter arguments and pleas and appeals to the Representative, it was agreed that she would be facilitated with a mattress, blanket and bed sheets which she had asked for. No sooner had she gotten the items than she sold them to the next person right outside of the UNHCR office. On inquiring why she had done so, she said that she needed the money to look after her siblings who needed money to go school and had been chased away for being Banyarwanda. She was the first born and they all looked to her to provide for them.

Example 3: Susanna and Husband Fight and She Finds a Way of Protecting Him

Susanna is a married woman refugee from the Sudan, about 35 years old and with six live children having lost three in their infancy. She is Kuku by tribe and was married according to local custom. By the time they fled to Uganda, the husband Michel had not finished paying all the bride wealth. She is one of two wives. The other wife is in another cluster in the same settlement and is younger with four children. Michel married the second wife while in the settlement and has never paid any bride wealth, although he has promised to pay when they return to Sudan. According to Susanna, since the man married the other wife she has had seen no peace. He always comes and beats her for no reason and accuses her of bewitching the younger wife. On the day in question, he came home drunk and found that Susanna had gone to the market to sell her pots so that she could buy some second hand clothes for her children. There was therefore no one to give him food. As soon as she came back home, he pounced on her asking her for cooked food. She tried to explain to him that she was not aware he was coming to eat in her house that day but all to no avail. He got hold of a big stick, and while accusing her of having been with other men he hit and cracked her leg. The neighbours took her to the health centre at Olujobo where she was given painkillers and had plaster applied to the leg. The settlement authorities were informed and later came to see her

> at home. When they arrived, she categorically denied that the husband had beaten her. She informed them she had tripped and fallen down as she took the goats out to feed. Later, I understood that she confessed that her husband had vowed he would kill her if she ever reported him to the authorities. She feared to tell the truth because she had nowhere to go in case her husband chased her away and in which case her children would suffer (several sources, Olujobo 1 February 2002).

The initial ideas I had about factors influencing reproductive health vanished after reflecting on the above short stories. In one way or another they all show the complexity of the refugee situations and how any one factor is related to the others in that setting. The above three illustrations serve to show the interfacing dynamics in dealing with people particularly those who, on the surface, might exhibit signs of hopelessness, but who in adverse situations use their agency to achieve what they have set out to do with few compromises. Augustine's case is particularly illustrative. He may have been a refugee but he saw himself as a Rwandese Tutsi with set standards beyond which he could not descend. He presents himself to the UNHCR as a totally hopeless man in need of help and manages to convince the UNHCR Representative to 'open' a file for his wife so that she can continue to get assistance for their children. During the encounter with his new employers at the hotel, he also presents himself as a superior man 'above' washing dishes.

The question I pose is: "how many times do those charged with humanitarian assistance encounter such situations?" In many instances, humanitarian assistance is packaged without the slightest idea of how the beneficiaries will perceive it. For instance, Fortunate needed money and not the mattresses and blankets she asked for. When she pleaded with the UNHCR Representative, she exercised room for manoeuvre. She knew the only way she could get the money is by selling the items. One can see how she tries to cope when she registers as a Ugandan to be able to get into the nursing school. And yet, in retrospect, I must admit that as counsellors doing 'our' work, we must have been hard on her especially when we learnt that she was applying dubious means to get what she wanted. Susanna's case is yet another case that would puzzle an outsider, but which, within the actor-oriented perspective, was a conscious human action taken after weighing the consequences between reporting her husband and losing him. It also shows the type of struggles that are embedded in gender relations and the seemingly hopeless situation women are caught up in. These three examples raise notions of power relations, which are embedded in the social relations fabric at every point of human interaction.

Indeed, during the years I have worked with refugees in Uganda, I have come to learn that survival for refugees is a complex matter. The major factors, which have influence on women's reproductive health, are of a socio-cultural, economic and political nature and usually include issues of survival, prestige, honour as well as guilt and shame. Even in refugee situations, refugees do not necessarily maintain homogeneous perceptions about issues of reproductive health and tend to approach it in several and divergent ways. It is therefore crucial to understand the effect refugee situations have on the reproductive health process and the divergent ways, which refugees employ as coping

strategies to mitigate the problems.

Thus, focusing on the individual refugee woman as the unit of analysis and the household as a social arena, I examine the processes in the household and the wider community, which are likely to influence the coping and survival strategies in general and reproductive health in particular. Such processes within the socio-cultural, socio-economic and geo-political institutions include social and gender relations, gender-based violence, livelihoods including land and food security and reproductive health programmes.

1.2 Official definition of reproductive health

According to the United Nations, reproductive health is defined as:
"the state of complete physical, mental and social well-being and not merely the absence of disease as infirmity in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (International Conference on Population and Development – Cairo 1994; *Plan of Action*, para 7.2).

Reproductive health is an issue because it is the anchor for the existence of humankind. Women by virtue of their sex are prone to sexual abuse through acts of rape and violence in situations of armed conflict. The vulnerability and hopelessness of these women exposes them to sexual encounters which may not necessarily be violent but in which they get infected with STIs and HIV / AIDS. However, it is important that reproductive health should be addressed from a holistic perspective. During periods of crises and calamity, a woman, desperate for her own survival and that of her family, may be forced to prostitute to survive (Jiggins, 1986).

1.3 Refugee women perception of reproductive health

During the fieldwork for this study, refugees were asked what reproductive health meant to them. Several responses were given, which I summarize here;

- For the adult women refugees, reproductive health was: "a healthy reproductive system, which is free from disease and capable of having children that do not die".
- The men were more concerned with the avoidance of sexually transmitted infections (STIs) and having money for school fees.
- The adolescents on the other hand had a different view in general and theirs was the capacity to avoid pregnancy and, for the girls in particular, it meant being able to

get sanitary towels to enable them attend school during menstruation.

It can therefore be seen that I started off with several and varied definitional approaches of reproductive health at variance with the official UN definition. Hence, using the refugees' views of reproductive health in conjunction with the above broad UN definition of reproductive health, I studied the following aspects of reproductive health: safe motherhood, contraception and family planning, sexually transmitted infections including HIV / AIDS, sexual and gender based violence and adolescent sexuality. Although the study initially targeted women refugees, during the pilot study, we established that the inclusion of men and the adolescents was inevitable and pertinent.

I wanted to study issues to do with power in gender relations and, as these can best be studied as relational variables I had to situate them in the context of human relationships through the actor-oriented approach and gender analysis. I decided to choose a topic that would enable me study the relationships of power at the micro and meso intersections during the process of refugee settlement; and what better topic than ''livelihood security and reproductive health in refugee situations''? I started off with the assumption that the subordination of women is further reproduced and perpetuated by the refugee experience. Within the household, the social relations processes included marriage, bride wealth, gender roles, gender division of labour and livelihood strategies, including coping mechanisms. The interface analysis at the project implementation level considered the relationships of the social actors and how these shaped social practice and were in turn reshaped. Interface analysis focuses on the linkages and networks that develop between individuals or parties at points where different, and often conflicting life-worlds or social fields intersect (Long 1999:1).

For many years, health issues of a general nature and reproductive health issues in particular were addressed from a medical perspective with reproductive health sector targeting women within the childbearing age and their children. This jeopardized the fact that reproductive health is a function of the totality of the well being of individuals as per the UN definition of health (UN, 1994). The approach ignored the reproductive health needs of many who did not fall in that category. Most importantly, the problems of men, non-childbearing women and the adolescents were overlooked. Another reason why I chose to focus on reproductive health is that armed conflict and involuntary migration assume untold dimensions of violence which result from a breakdown of traditional structures and the limited protection from sexual and gender violence. The extensive and brutal use of rape of women as a weapon of war, including ethnic cleansing, continues as has been reported in many wars including Chechnya, East Timor, Rwanda, Sierra Leone, Democratic Republic of Congo, to mention but a few. The action taken against the perpetrators as per Resolution 1325 (UN, 2002) is yet to be understood.

It is worth noting that the well being (or lack of it) of reproductive health is not an issue of concern only during armed conflict and refugee situations. It should be seen as an urgent and important health issue in the lives of individuals in the developing countries today, particularly when the HIV / AIDS pandemic is threatening to wipe significant parts of Third World populations from the globe. As if the HIV / AIDS is not bad enough, the majority of countries in Sub-Saharan Africa have very high maternal mortality rates and yet many of the causes of such deaths are preventable (UDHS, 2001). General trends in reproductive health in

the developing countries indicate that a healthy reproductive life is far from being achieved as depicted by the following statistical indicators:

- 585,000 women die each year –one every minute-from pregnancy – related causes. Ninety-nine per cent of these deaths occur in developing countries (UNFPA, 2002).
- Girls aged 15-19 are twice as likely to die from childbirth as women in their twenties. Those under 15 are five times as likely to die from childbirth (UN Report, 1999).
- More than 330 million new cases of sexually transmitted diseases (STDs) occur every year, affecting 1 of every 20 adolescents (UNAIDS, 2002).
- 120 million women say they do not want to become pregnant, but are not using any methods of family planning (WHO, 1991).
- 20 million unsafe abortions occur every year – 55,000 each day- resulting in some 80,000 deaths and hundreds of thousands of disabilities (UNHCR, 1999 citing WHO, 1998).

The above indicators pertain to a non-refugee situation. There are hardly any statistics to indicate maternal and infant deaths in refugee situations. Goyen *et al.,* (1996) gives strikingly high death rates of Rwandese refugees in Goma in Democratic Republic of Congo (DRC). On the other hand maternal mortality rates might reduce as a result of the health system provided by organizations like UNHCR in the refugee camps. This area needs further research.

1.4 Women refugees

Women refugees constitute the majority of the displaced persons of the contemporary world (UNHCR, 2000) and form the basis of this study. They raise particular interest because of the gender-specific problems they face and the mechanisms they devise for survival amidst the daunting challenges of refugee situations and their own position in society. Refugees generally do not have an automatic claim to basic needs and income generation. But even among these fragile groups can be found others that are even more deprived; ie unaccompanied women, children, the handicapped and the aged. Women refugees, who also care for the other vulnerable household members, are in this respect exposed in a multifaceted fashion. First, they have to find their place among the various power relations, which exist in all societies, but are more poignant in refugee situations. Secondly, they also have to deal with the gender roles, directly related to the power structures in their communities and in the new refugee situation, that are related to their reproductive, productive and community roles in society. In the face of these challenges of refugee life, the choices women make concerning their health can highlight how they rank their own livelihood and health concerns and exercise their options. Such choices may include self-medication, use of medicinal herbs, consulting a relative or traditional birth attendant, or a health care provider. Similarly during food shortages they may resort to rationing meals, going without eating and feeding children on raw mangoes as was the case in this study. Thirdly, upon the phasing out of humanitarian aid programmes to refugees such as was the case in Kiryandongo, women are faced with the challenges of survival for their families including their health. Nevertheless, the above processes are intertwined with the daily social relations at

the household level, the community and wider structures. Within these levels, are deeply embedded gender ideologies, which are detrimental to the enhancement of women capacities (Kabeer *et al.*, 1999).

The problem has further been exacerbated by globalization, the existence of 'economies of violence' and state collapse or failure, the weakening of the State in service delivery through structural adjustment programmes (SAPs) which have affected the development discourse and policies. It is interesting to note that while the International Monetary Fund and the World Bank (IMF/WB) dictate budget cuts for social spending in the indebted countries, SAPs have not targeted military spending, which in the Third World countries has continued to increase immensely. Furthermore, the social impact of SAPs has been recognized: poverty has increased both in the rural and urban areas; real salaries earnings in many countries have plummeted by more than 60% since the beginning of the 1980s, while the situation is much worse in the informal sector (Adedeji, 1999). In line with Chambers' conceptualization of vulnerability, it can be argued that these reforms have garnered defencelessness, insecurity and exposure to risk, shocks and stress and difficulty to cope (Chambers, 1989:1). This formidable set of factors has rendered millions of individuals displaced within their countries as internally displaced persons (IDPs) and over the borders as refugees (Korn, 1999). By January 2003, the UNHCR (2003) estimated a total of 20,556,781 persons who fall under the mandate of the UNHCR.

1.5 The problem statement and objectives of the research

There is substantial scholarly work done on several refugee issues in Africa including relief, repatriation, resettlement, aid and development, humanitarianism, refugee integration, transnationalism, (Horst, 2003; Turner, 2002; Hyndman, 1997; Kibraeb, 1993; Daley, 1991; Wijbrandi, 1988; Harrell-Bond, 1986, etc,). In addition, studies that focus on health in general and reproductive health of refugees in particular abound (Packer, 1995; van Damme, 1998; Simonds, 1983; Dick and Simonds, 1983). However, none of the above mentioned studies has addressed notions of power and gender relations, livelihood security and reproductive health in refugee situations together. Moreover, the above health studies are inclined more towards a medical perspective than a social science perspective. The study of reproductive health issues in refugee situations is quite pertinent not only because of the very high maternal and infant mortality rates, but also because of gender biases that result in the poor access to health care services. The obvious paucity of research work on gender and reproductive health in refugee situations, makes the research project relevant. While the provision of essential health care services is a priority in any refugee situation, reproductive health care has often received little attention. Yet, refugee women, as do all other women, require basic care for safe births, family planning, the treatment of STIs and HIV/AIDS and other facets of reproductive health. The Handbook on Emergencies (UNHCR, 1983: 72) specifies that after the emergency phase is over, UNHCR and her implementing partners should assume the health policies of the country of asylum. This would, for Uganda, mean that health services in refugee settlements should follow the Primary Health Care (PHC) strategy, which is enshrined in the Health Policy of the Uganda government. The PHC strategy as a long-term strategy emphasizes participation as an important pillar in people's health. However, the study established that refugees were recipients of short-term health programmes. This, despite

the International Labour Organisation (ILO) observation that participation is itself a basic need of the people and it must be included as a critical consideration in any development strategy, proved problematic in refugee situations where most of the refugee programs have already been designed and only await implementation. It is against this backdrop that this research project focuses on the empirical reality of the rural refugee women in Uganda. Through an actor-oriented and gender analysis of the actors at the household level and at the interface of program implementation, it is hoped that the study has unearthed the *intra* as well as *inter* household dynamics and other important variables within the wider structures, which are significant to refugee women and the way they access reproductive health care.

The main objective of the study is to gain insight into how women cope with reproductive health needs in refugee situations. This has been achieved by focusing on gender and power relations in two refugee settlements in Uganda as well as through a study of the substantive and institutional characteristics of reproductive health care programs.
The specific objectives of the study are:

1. To assess the nature and magnitude of patterns of vulnerability of women refugees in general and with regard to reproductive health problems in particular;
2. To provide an in-depth description and analysis of the reproductive health problems encountered;
3. To identify the coping mechanisms of refugee households in issues related to reproductive health; and
4. To identify the factors that impinge on the provision of reproductive health care, especially the role of gender and power relations.

1.6 Outline of the thesis

The following Chapter 2 discusses the conceptual and theoretical perspectives based on the existing literature. The main concepts discussed include: the subordination of women and the evolution of the second women's movement, the actor oriented approach, the gender analytical tools, armed conflict in contemporary world, the international refugee and institutional framework, the household, and vulnerability.

Chapter 3 presents the research questions and discusses the methodology of the study including the research design, the phases and activities undertaken in each of the phases. The chapter also gives the justification for the methods used in the collection of data and explains in detail how the sample was selected, the instruments used, how the case studies were done and how data were handled and analyzed. Finally, the limitations encountered and how these were overcome are highlighted.

Chapter 4 discusses forced migration in and out of Uganda. The chapter is in two main parts. The first part gives a detailed account of refugee movements into Uganda since the 1940s, how they were managed and, their role in the internal politics of Uganda. It also discusses the nature of settlement and the various types of humanitarian assistance. The second part describes the political problems that have characterized Uganda since the 1960s and which have been responsible for internal displacement of Ugandans. A

table summarizing the events and effects of human displacement is also included in the chapter.

In Chapter 5, I discuss the international and national health policies and approaches, which have guided health care provision in Uganda for the last forty years. These include the health care policies of the 1950s-1960s and the primary health care (PHC) strategy. In addition, I discuss the new concept of 'reproductive health', which assumed centre stage after the 1994 conference in Cairo on population and development (ICPD) and its implementation nationally. Further, the discussion elaborates on the Bamako Initiative as a further strategy consolidating PHC. The structural adjustment programmes (SAPs) and their influence on health care provision and the condition of women are also discussed. I end the chapter with a discussion of the Uganda reproductive health policy.

Chapter 6 discusses the national health care delivery system focusing mainly on reproductive health care programmes. It is divided into four main sections. The first section is an overview of health care in Uganda. This is followed by a discussion on the current context in which health care is provided. I then proceed to discuss the training of the human resource for the health sector. This is followed by a discussion of the post-ICPD programs. Last, I discuss the implementation of the programmes mentioned above.

Chapter 7 describes the context of the study area and 'host environment'. A brief discussion of Uganda as a country hosting refugees is presented. I also provide a brief discussion of the health delivery system in the refugee settlements that are part of this study.

I discuss the findings for Rhino Camp refugee settlement in Chapter 8 along the following themes: social organization, livelihood security, refugee education and reproductive health programs, and violence and vulnerability. The section on social organization describes the socio-cultural arrangements of the Madi including the gender patterns, marriage, division of labour, noting the changes which have occurred as a result of the refugee experience. In the section on livelihood security, I discuss the income generating activities that refugees engage in. I also discuss how they obtain food and their coping strategies in the face of food shortages. The discussion on refugee education highlights the gender imbalances in enrolment and the causes of which the issue of power relations was frequently mentioned. The discussion of reproductive health constitutes an interface analysis of the reproductive health project funded by the United Nations Population Fund (UNFPA). Lastly, the chapter discusses the vulnerable situations in which girls find themselves.

Chapter 9 discusses the findings of the study in Kiryandongo refugee settlement in Masindi district. Like in Rhino Camp, I start by describing the social organization of the Acholi, noting any changes that might have occurred due to the refugee experience and how the changes affect the social relations. Making particular reference to Bweyale trading centre, I discuss the livelihood strategies of the refugees including the coping strategies during food shortages. The discussion on education addresses primary and secondary school education and adult literacy and points the specific problems associated with accessing education. I do not dwell much on reproductive health in Kiryandongo.

Instead, I undertake interface analysis of the social actors in the initial implementation of the health care project. Lastly, through the presentation of two case studies I present the vulnerability and show the resilience of two unaccompanied girls.

Chapter 10 presents the main empirical findings and final conclusions of the study.

[1] A detailed discussion of the actor-oriented approach and gender analysis will be found in Chapter 2
[2] The term settlement is used throughout the thesis to refer to rural villages created by the Uganda government for refugees. It refers to a plot of land allocated to a refugee where (s)he is expected to till the land and grow own food crops and surplus for sale.
[3] Please note that for confidentiality purposes all names are fictitious.
[4] Munyarwanda is singular for a national of Rwanda. Banyarwanda is plural.
[5] Munyakore refers to a native of Ankore, a region in western Uganda. Banyankore is plural.

2

Theoretical and Conceptual Perspectives

2.0 Introduction

This chapter discusses the theories and concepts used in the analysis of the data. In particular, it examines the interrelationships of the concepts and the influence this has on the gender relations in refugee households and the wider community. The main aim of the study is to describe how power embedded in the social-cultural, economic and political processes influence gender relations in a refugee settlement in Uganda. Taking reproductive health as an entry point, the study examines in detail some relevant humanitarian programmes and the interfaces of the various actors in its implementation and utilization. In addition the study examines the adaptations and coping strategies for survival in new host surroundings that are characterized by new environments and restrictive 'encampment' policies. My main argument is that refugees will maximize the use of the projects they deem beneficial to their survival irrespective of the impending constraints. Applying the actor-oriented approach[1] and a gender perspective for a conceptual analysis, I focus on women refugees (and men) as social actors who actively shape their lifeworlds through the social construction of gender and power relations within their social networks and the wider structures that may seem remote and yet crucial for the decisions they make.

In this chapter, I explore the main themes and concepts on which the study is anchored: women and the development process, armed conflict and forced migration, reproductive health and humanitarian assistance. The chapter further illustrates the basic concepts within the actor-oriented approach and gender analysis that form the basic analytical framework. This provides a basis for a presentation of the arguments that are usually advanced to support the existence of gender inequalities on the one hand and on the other to dispel the argument that women are passive victims in post conflict situations. It should be noted that I did not use one single consistent, systematic and ready-made available theory; rather, like Frerks (1991:24-25), the approach I followed in formulating this framework has been eclectic. In the next section (2.2), I introduce the notion of women and development and in section (2.3), the second women movement is discussed. The analytical framework perspectives are contained in the fourth section (2.4) where I elaborate on the actor-oriented approach and gender analysis. In the fifth section (2.5), I discuss contemporary violent conflict. Section six (2.6) discusses the household. In

section seven (2.7), I discuss the concepts of vulnerability, capacity and coping. Finally, in section eight (2.8), I discuss the international legal and institutional framework for refugees. I make concluding remarks in section 2.9.

2.1 Women and the development process

This study is mainly about women in refugee situations. However, it is fitting to give an overall background of the position of women in 'normal settings' and its relation to the development process and then try and situate the arguments into a post-conflict situation. The role of African women in the development process prior to colonisation is obscured partly because of the viricentric writings about women and partly because of the current marginalization of women. For instance, part of the available literature on women in Eastern Africa depicts women as a 'means of production to be owned, exchanged and distributed', captured as slaves, as having helped kings through polygyny to expand their kingdoms, *et cetera* (Tamale, 1999:5). These perceptions of women in precolonial times originated from the ethnographies of early Western anthropologists and missionaries who 'fossilized African societies through the bifocal lens of sexism and Eurocentricism (Tamale, 1999:5 citing Ashe 1894; Johnson 1902; Roscoe, 1911). Their attention to the perceived negative aspects of women obscured their search for power-wielding women such as Nyabingi of Kigezi (Mulindwa, 1994) or Nambi of Buganda (Nakanyike Musisi, 1991). However, to the best of my knowledge there has been no study about Alice Lakwena who led an insurgent army that waged war against the government of Yoweri Museveni from 1987 to 1993.

Since the second women's movement that began in the 1960s, there has been a great deal of feminist writing concerning the roots of the subordination of women. One of the main contributions is the revelation by Ester Boserup (1970) of women's participation in the economies of Sub-Sahara African countries. She established that in the hoe-farming societies in Africa, women contributed at least 70 per cent of the food for those communities. Despite this revelation, the work women do is neither validated nor accounted for in the national accounting systems. Much of the earlier feminist writing pointed to patriarchy as the root cause of subordination of women (Millett, 1972; Gittins, 1993; Carby, 1982). However, recent studies and evidence have showed that patriarchy was negotiable, as indeed some women had managed to transcend it (Mbilinyi 1992; Mohammed, 1995). But even if this were the case, how many women are in this category? This argument extends to the example above concerning the role of women movements in Eastern Africa and the power they have wielded; how representative is it? How much can one judge from this example that women are not oppressed? Why is it that today female foeticide in India is at its peak? And despite the United Nations campaigns to promote the girl child, why is it that the majority of the 120 million children not attending school are girls?[2] Why do the communities place less appreciation on women and the work they do? These and other questions concerning women's subordination and gender inequalities have been at the forefront of the women movement struggles.

The two UN Decades for Women (UN, 1985; UN 1995) have underscored the pivotal role of women in the development process. Resulting from the deliberations of the

conferences to which the United Nations, International Agencies and several countries are signatories, there have been deliberate efforts to implement gender sensitive policies. Affirmative action policies to enhance women development have been initiated, even though these have been challenged by some feminists (see, for instance, Tamale, 1999). After having replaced Women in Development (WID), Gender and Development (GAD) is the developmental approach being pursued by the UN and most countries in Sub-Saharan Africa.

The process of modernizing the South and the policies used to achieve this have come under attack by many scholars (Long, 2001; Booth, 1994; Moser, 1993; Schuurman, 1993). The modernization policies targeting women and children comprised of the top-down handouts of food aid, measures against malnutrition and family planning. Women during this phase of development (the 1950s and 1960s) were targeted for their reproductive roles. As such, the welfare approach is the earliest policy concerned with women in developing countries (Moser, 1993; Kabeer and Subrahmanian, 2000). Women were part of 'relief aid' while 'economic aid' went to men. Women were passive recipients; mothers who had to be reached for the sake of their children. Women received handouts, food aid, programmes against malnutrition, programmes for family planning. They were a delivery channel for welfare and their work in producing wealth was ignored (Townsend, 1995:170). I argue that there are several women who fall outside the parameters of these welfare approaches. Such women include the menopausing and post-menopaused, the young, the spinsters and those who are within child bearing age but who are not mothers. This social development policy, which is still quite popular within humanitarian aid circles, as it is non-challenging, reflects its colonial origins, which were by and large based on the private versus public dichotomy; where men were expected to go out, work, and fend for their families, while the women remained at home to nurture the family. However, this method did not improve the overall status of the targeted beneficiaries. This alienation of women from the productive arena even in countries whose women have been known to participate actively in both reproductive and productive work, has been effected through discriminatory policies (Moser, 1993; Rogers; 1980).

The dominant ideas of development are constructed on the enlightenment-based ideas of scientific and technological progress (Braidotti et al., 1994). Various critical standpoints view these development paradigms as structural models of development, tainted by linear, determinist and externalist views of social change. In addition, the ethnocentric positioning of the industrialized world as the universal model of development has been disputed just as the rooting of those development models in the discourses of intellectual modernism, and therefore seeking to provide singular universal explanations of poverty and development and prescriptions for overcoming them (Long, 1992; Scott, 1995). For feminists, the production of knowledge is best described as a social activity embedded in a certain culture and worldview. Science aims to explain reality but one's perception of the experience of this reality is a product of human thought determined by culture (Braidotti et al., 1994:30). Feminist critics of science have pointed out that the Western worldview and Western science as they have developed since the enlightenment period are "over determined by political, economic, and social

conditions which can be explained by reference to a patriarchal order. Thus, women were not only systematically excluded from the actual activity of doing science, but patriarchal scientists declared them to be unfit for the usage of reason" (Ibid: 30). But such views are changing and many more women are doing science, thanks to the women's movement.

A number of authors have argued that these same welfare policies in the form of emergency relief programmes are widely used to target especially the 'vulnerable groups' in refugee situations (Black, 1994; Moser, 1993; Harrell-Bond, 1986), although even in refugee situations, women's managerial and reproductive roles are critical (Townsend 1995:171). Women in Development (WID) advocates rejected the narrow view of women's roles (as mothers and wives) underlying much of the development policy concerning women. Thus, according to Moser, projects implemented by the UNHCR and NGOs, most often focus on women in their reproductive role, with special attention given to the pregnant and the lactating. These are identified as a 'vulnerable group' in the same category as the elderly, orphans and the handicapped (Moser, 1993:60). Welfare provision for the family was targeted at women who, along with the disabled and the sick, were identified as 'vulnerable' groups, and remained the responsibility of the marginalized ministry of social welfare (ibid, 1993). These policies fail to view women as producers but rather label them as vulnerable and victims. This strategy had serious implications for women. While the productive sector dominated by men focused on financial aid for economic growth, relief aid for socially deprived groups, targeted the reproductive sector supposedly dominated by women. The approach further meant that international economic aid prioritized government support for capital intensive, industrial and agricultural production in the formal sector, for the acceleration of growth focused on increasing the productive capacity of the male labour force. As we shall see in Chapter 8, in Rhino Camp refugee settlement, all farmer extensionists were men and it was only men refugees who received awards for having been the best farmers.

Even after the welfare programmes have been criticized for creating dependency because of their top-down structure, they nevertheless remain popular, precisely because they are "politically safe, not questioning or challenging the traditionally accepted role of women within the gender division of labour" (Moser, 1993; Kabeer and Subrahmanian, 1999). This observation is particularly important. In refugee situations, not everyone is capable of productive work, especially with many children and older dependants and broken down social networks. Some of the findings emerging from the study indicate that such policies were counter productive for birth control. For many women, it was '*UNHCR would look after us*'. This study identified that UNHCR follows the same pattern of categorization of 'beneficiaries'. The categories - the vulnerable and the extremely vulnerable individuals (EVIs) meant that these refugees, unlike the general refugee population, needed special attention. My problem with this, is the point at which a vulnerable individual moves out of the vulnerable category or descends to the extremely vulnerable and vice versa. The tendency is for refugees in these categories to remain in those clusters for long periods and it creates a need for adaptation. The example I can readily give here concerns the high birth rate in the refugee settlements (pregnant and

lactating mothers are in the 'vulnerable' category). Although an interplay of factors was mentioned, the refugees' perception of UNHCR as being there for them seems to have played as a motivating factor for getting more babies.

The national governments adopted and maintained the traditional policies that view women for their reproductive attributes. For example, since the 1970s, maternal and child health and family planning policies have dominated the provision of reproductive health services and are linked together on the assumption that their effective implementation and utilization will make better mothers. According to Hardon (1996), in population control programs aimed at poverty reduction, women are identified as the primary targets through the widespread dissemination of contraceptive knowledge and use; accordingly " this lets men off the hook in terms of their responsibility for birth control, while increasingly placing the burden on women" (citing DAWN, 1985). For effective birth control programmes, it is better to target both men and women, hence the inclusion of 'participation of men in reproductive health' in the *ICPD* (UN, 1994) and *Beijing Platform of Action* (UN, 1995). But as we shall see in Chapter 8, refugee men do not participate in birth control programmes, in fact, they even stop their women from participating. However, there are many women who, despite the opposition by their husbands**,** have used birth control methods surreptitiously.

2.2 The Second women's movement

Women in Development (WID)

This section of the chapter discusses the evolution of the second women's movement. The term "women and development" was coined in the early 1970s by an American based network of female development professionals (Tinker, 1990:30). Based on their own experiences, they had begun to challenge "trickle down" theories of development arguing that modernisation was impacting differently on men and women. Instead of improving women's rights and status, the development process appeared to be contributing to a deterioration of their position (Shahrashoub Razavi and Carol Miller 1995:2). This move coincided with a resurgence of the women's movement in the North at this time as they advocated for equal employment opportunities. Turning to the developing countries, WID gave primacy to women's productive roles and integration into the economy as a means of improving their status. Another impetus was the emerging body of research on women in developing countries, such as that by Boserup in 1970. From the perspective of the WID movement, the importance of Boserup's *Women's Role in Economic Development* was that it brought out clearly the dimension and importance of gender within the process of development and challenged the myth that a family income would be equally available to all members of the household. Even though Boserup's work has come under criticism (Whitehead, 1990), Tinker observes that one reason why Boserup's work was taken up so enthusiastically by WID advocates was that it legitimised efforts to influence development policy with a combined argument for justice and efficiency. (Tinker, 1990:30). Ten years later, Barbara Rogers**,** in her book *The Domestication of Women, Discrimination in Developing Societies* (1980)**,** brought to the surface the disastrous consequences of the imposition of western values and norms on

the position of women in developing countries. Having said that, the WID approach is not without shortcomings. The approach is non-confrontational; it does not challenge the causes of women's subordination and fails to address the social and historical roots of gender inequality. It focuses only on the productive side of women's lives, ignoring women's reproductive roles. Furthermore, it overlooks the influence of class, race, education, as if there are no differences among women (Mohanty, 1988). It fails to challenge a paradigm, which has continually proven its bias against women. In addition, the WID approach tended to conceal the diversity of the situation of women. Lastly, it adopts the same unilinear, growth-oriented model as earlier development strategies (Rathgeber 1990: 491), which assume that once women are economically empowered, equality will naturally follow.

Talking of women as a category conceals the complexity of women's lives and the differences in their living situations (Moore, 1994). While the media has used the images of women to publicise the plight of African women as poor, landless, overworked, illiterate and so on, there are differences among women of Africa. My point of view is that refugee women, though deprived of their resources in the process of displacement, they do hold their households together by ensuring that there is sufficient food and that the sick are catered for, even though this is not without problems. As I discuss in the later chapters women refugees devised several coping strategies for survival. Kibreab (1995) in a study of Eritrean women refugees in Khartoum found them resilient. Callamard (1992) shows how Mozambican refugee women in Malawi divorced their refugee husbands and opted to marry local men for survival. Finally, Daley (1991) in her study of Barundi refugees in Tanzania noted that women refugees attached themselves to 'well off' families for survival.

It is now twenty-three years since Rogers' (1980) revelations about the effects of imposing western values and norms on women in developing countries. A lot has changed. Notions like gender literacy, gender analysis and gender mainstreaming have assumed centre stage in the gender and development discourse. The UNHCR and the Uganda government are both signatories to the deliberations of the UN Decades for Women. But what has this meant for the rural woman in post-conflict situations, in refugee settlements viewed as a temporary phenomenon and yet in which she must devise coping strategies for her self and her family? How gender sensitive are the programs in the settlement? Responses to these questions will be discussed in later chapters.

Gender and Development (GAD)

The 1990s saw the term gender and development (GAD) gaining prominence over women in development (WID) with respect to developmental strategies in the Third World countries. By the late 1970s, some of those working in the field of development were questioning the adequacy of focusing on women in isolation, which seemed to be a dominant feature of the WID approach. Although an analysis of women's subordination was at the heart of the WID approach, the essentially relational nature of their subordination had been left largely unexplored (Shaharashoub Ravi and Carol

Miller, 1995:12). Besides, when WID identified women's lack of access to resources as the key to their subordination, it ignored the role of gender relations in restricting women's access to resources in the first place.

As Amartya Sen notes:

> "Conflicts of interest between men and women are unlike other conflicts, such as class conflicts. A worker and a capitalist do not typically live together under the same roof-sharing concerns and experiences and acting jointly. This aspect of 'togetherness' gives gender conflict some very special characteristics" (Amartya Sen, 1990:147).

A shift from WID was spearheaded in 1978 by the coming together of a number of feminists to form the *Subordination of Women Workshop* at the Institute of Development Studies, University of Sussex, at which several papers on women's position were presented culminating in a collected volume, *Of Marriage and the Market, Women's Subordination Internationally and its Lessons* edited by Kate Young *et al*. (1981). This publication marked a significant watershed in the evolution of the thinking on feminism and development. The contributors to this book were critical of the WID literature, which, they contended, seemed to isolate women as a separate and often homogeneous category. It was also felt the WID literature was 'predominantly descriptive' as well as being 'equivocal in its identification and analysis of women's subordination' (Pearson *et al*, 1981).

GAD, for the moment, is the international approach of choice for it is gender specific. It looks at both men and women as key players but with different roles, needs and entitlements in the development process. It attempts to fill another lacuna; one that had emerged from applying the economic categories of traditional Marxist theories to the analysis of gender relations (Pearson *et al*, 1984:x). GAD links the relations of production with relations of reproduction since it takes into consideration all aspects of women's lives based on social construction of production and reproduction as the basis of women's subordination. Furthermore, it questions the validity of gender roles as ascribed to both women and men in different societies; it examines the systematic discrimination of assigning women inferior roles in societies. This approach also assumes that male privilege makes most men less likely to ally themselves to the cause of women's advancement. It therefore sees women as agents of change who within the GAD approach can self-organize to increase their negotiating power within the economic system. Furthermore, the approach also emphasizes the necessary role of the state in enabling the acquisition of advancement opportunities, such as education, employment, health to women and girls. It is also worth noting that GAD is not concerned with women *per se* but with the social construction of gender, assigning of roles, responsibilities and expectations. Unlike WID, GAD by focusing on the social construction of gender as the root of women's subordination, is a holistic approach claiming that oppression, gender subordination, capitalism and patriarchy are interrelated (Bandarage, 1984: 506). Despite the fact that GAD was born out of what appeared to be a lacuna in the WID approach, the two are not mutually exclusive, hence the continuum in the development process. While WID focuses on the condition of women and GAD on the position of women, the two approaches focus on the situation of women.

Third World Women Feminism

A number of Third World feminists (Afshar and Agarwal, 1989; Braidotti *et al.*, 1994; Mohanty, 1991) have argued that in as much as women's communality stems from the biological reproductive role women experience, they are less cohesive in their experiences of domesticity and the extent to which the double burden of nurturing and productivity comes into daily conflict. Theirs is a struggle against both poverty and subordination, for survival and respect. Like Johnson-Odim (1991:320), I argue that 'gender oppression cannot be the single leg on which [Third World] feminism rests. It should not be limited to merely achieving equal treatment of women *vis-a-viz* men'. As proposed by Tamale (1999:31) "attention must therefore be paid to the nuances of gender relations, which manifest variable factors in different societies and may in turn inform gender discourses in different contexts". I subscribe to this strand of feminism thinking, not because I am a woman of the South, but because of the diversified nature of the causes of oppression of women in the Third World, which makes homogeneity of women subordination an understatement. The majority of women in the Third World countries are economically marginalized and poor. Their work pattern has common features all over the world: they are mostly engaged in subsistence food production, and / or work in the informal sector; for their activities, they utilize few modern tools and skills; their activities entail little or no capital investment; and, women more than men lack access to and control over productive resources, such as land and capital, both of which might increase the economic returns on their labour and their productivity. Women fall more in the vicious circle of poverty because they cannot access technology and credit which resources they would need for improving their productivity, which would improve their income and would make them in turn eligible for credit. Women become powerless when they cannot address these aspects in a positive way. During the fieldwork for this study, it was surprising that even in the freely available primary education (provided by the UNHCR) in the refugee settlements, there were more boys attending school than there were girls. These are some of the issues that must be tackled by the Third World Women movement. Despite recognizing some of the common features of women's experiences in the Third World, we have simultaneously to move beyond such a universalizing approach in order to appreciate the prevailing differentiation.

After a careful analysis of contemporary feminist theories and their suitability to the situations of marginalized women, Third World Women's feminism is emerging through a critique of hegemonic 'Western' feminism and the formulation of autonomous, geographically, historically and culturally grounded feminists' concerns and strategies (Mohanty, 1991). It tries to recognize and analytically explore the links among the histories and struggles of Third World women against racism, sexism, colonialism, imperialism and monopoly capital. Mohanty suggests that we call Third World women and politics of feminism the "…communities (political and not essentialist definition) of women with divergent histories and social locations, woven together by the political threads of opposition to forms of domination that are not only pervasive but also systematic" (Mohanty, 1991:4 in Mohanty *et al*., 1991). Many Third World feminists assert their belief in international coalitions among Third World women in contemporary capitalist societies, particularly on the basis of a socialist-feminist vision,

while others posit the empowerment of Third World women based on the demystification of ideologies of gender and sexuality that affect women's daily lives across the globe. Mohanty (1991:5-7) cautions us against our definitions and interpretations of the third world women in terms of their 'problems' or their 'achievements' as they do not form a constituency; to do so would be to freeze them in time and space". Geographically, the nation states of Latin America, the Caribean, the Arab World, Sub-Sahara Africa, South and Eastern Asia, China, and Oceania constitute the parameters of the non-European Third World. In addition, Black, Latino, Asian, and indigenous peoples in the U.S, Europe and Australia, some of whom have historical links with the geographically defined Third World, also refer to themselves as Third World peoples. With such a broad canvas, racial, sexual, national, economic and cultural borders are difficult to demarcate, shaped politically as they are in individual and collective practice. Moreover what seems to constitute 'Third World Women' is a viable oppositional alliance in a common context of struggle rather than color or racial identifications. Similarly, it is Third World women's oppositional political relations to sexist, racist, and imperialist structures that constitute our potential commonality. Thus, it is the common context of struggles against specific exploitative structures and systems that determines our potential political alliances.

Fundamental differences between Third World feminism and Western feminism have been highlighted. Third World women's writing on feminism have consistently focused on (1) the idea of the simultaneity of oppression as fundamental to the experience of social and political marginality and the grounding of feminist politics in the histories of racism and imperialism; (2) the crucial role of a hegemonic state in circumscribing their daily lives and survival struggles; (3) the significance of memory and writing in the creation of oppositional agency; and (4) the differences, conflicts and contradictions internal to Third World women's organizations and communities; (5) In addition, they have insisted on the complex interrelationships between feminist, antiracist and national struggles. In fact, Black, White and other Third World women have very different histories with respect to the particular inheritance of slavery, forced migration, plantation and indentured labour, colonialism, imperial conquest and genocide. Sivanandan (1990) challenges the rewriting of history and questions the use of 'discourse' as an adequate terrain of struggle and suggests that while discursive categories are clearly sites of potential contestation, they must be grounded in and informed by the material politics of everyday life, especially the daily life struggles for survival of poor people – those written out of history. With this we set out to examine how women are caught up in refugee situations and relate to the every day issues of poverty, reproduction and production. Findings indicate that women employ coping and survival strategies. The above section presents a discussion about the ongoing debates about the status of women. From the discussion, we can see that the debate is not about to end. However, one of the things we learn is that feminism is viewed from several perspectives, depending on which side of the globe one is. Western feminism has yielded most of the theories, which are now being challenged by the Third World feminism. This Being as it may, we in the Third World, in as much as we try to get to grips with our plight, it is important to take note that our colonial heritage and experiences with 'modernization' and religious ideologies, to a great deal, shape the

way we think and determine our actions. It may be difficult to completely rid ourselves of this 'embeddedness' of attitudes and perceptions. The next section discusses the analytical perspectives and concepts used in the study.

2.3 Analytical Framework

An Actor-oriented Approach

The study aims at unearthing how the refugee experience affects the coping strategies of women refugees towards their daily survival in general and to the reproductive health needs in particular. In addition, it is the aim of the study to contextualise the nature of the changes in the survival and coping strategies as a response to the changing circumstances in the wider geopolitical arena. For a proper grasp of the complexities of the processes that influence the everyday lives of individual women, I have combined two perspectives, namely; the actor-oriented approach and a gender analytical approach. Each of the perspectives implies various notions, although several concepts overlap, which I find most suitable for understanding the everyday lifeworlds, actions and strategies of women. I have used the actor-oriented approach proposed by Long (2001).

The use of an actor-oriented approach stresses the importance of how women themselves actively shape the patterns of their livelihood strategies. One way to recognize characteristics of diversity and inequality, is to focus on the actors. Like other actors, women devise different ways of dealing with problematic situations and changing circumstances, and they creatively organize their resources to find solutions to these situations. Long's interest in social actors is the conviction that although it may be true that important structural changes result from the impact of outside forces, it is theoretically unsatisfactory to base one's analysis on the concept of external determination. All forms of external intervention necessarily enter the existing lifeworlds of the individuals and social groups affected, and in this way, they are mediated and transformed by these same actors and structures. Also to the extent that large-scale and 'remote' social forces do alter the life chances and behaviour of individuals, they can only do so by directly or indirectly shaping the everyday life experiences and perceptions of the individuals and groups concerned. Let us now look at the concepts that arise within the approach.

Social Actors

The notion of 'social actors' implies that it is difficult or impossible to predict impacts of innovations without a thorough knowledge of the socio-cultural context where the innovation is going to be adopted. The actor-oriented approach does not mean that it is the individual *per se* that is the focus of analysis, but the individual acting in social situations, where the conduct of one influences the conduct of others and vice versa. Thus, even if one focuses on decision-making by the individual woman (or man), this does not imply that their actions can be explained simply by reference to her own dispositions and beliefs. We have to take into account the various relationships in which s/he is embedded, both within and outside the family, and not only those present

in face-to-face situations, but also all those who are absent, but influential both for the action and its outcome. Long (2001:13) cautions us against viewing local actors as 'simply disembodied social categories (….) or passive recipients of intervention, but as active participants who process information and strategize in their dealings with various local actors as well as with outside institutions and personnel'.

In this thesis, I contend that women experience the effects of displacement and exile differently and, while some may adapt to the new changes easily and others with difficulty, each has the capability to devise ways of coping with their needs. How they choose to go about this results from a social process. Hence the application of an analytical approach, which is neither linear nor deterministic, helps to elucidate the diversity and complexity of the practices that people engage in. This study therefore looks into the practices, which refugees engage in to generate survival and coping strategies.

A number of feminists have applied this analytical tool to research. Stolen (1991) notes that gender studies carried out with such a framework would depict women as active shapers of their lives, whether they exploit new opportunities or resist them, or whether they succeed in their pursuits or not (however, emphasizing that this view does not imply a disregard of the fact that the constraints on women's action may be overwhelming and that women are often exploited by or subordinated to men).

Agency

At the centre of an actor-oriented approach is the concept of *human agency.* The concept of human agency attributes to the actor (individual or social group) the capacity to process social experience and to devise ways of coping with life, even under the most extreme forms of coercion (Long and Villarreal, 1996: 155). It is important to stress that 'agency' is not simply an attribute of the individual actor. Agency is composed of social relations and can only be effective through them; it requires organizing capacities.

According to Long (1992:23 citing Giddens, 1984), the notion of agency presupposes that actors are knowledgeable' and 'capable' and:

"[t]hey attempt to solve problems, learn how to intervene in the flow of social events around them and monitor continuously their own actions, observing how others react to their behaviour and taking note of the various contingent circumstances" .

I therefore looked at, and tried to understand the ways in which people interpreted their experiences and their perceptions. For instance, the use of family planning was an intervention that attracted several responses within the refugee community, and yet the women who dared to use it 'monitored continuously their own actions, observing how others reacted to their behaviour …..'.(Long 1992: 22). They used discursive means to reach decisions and justify them. This tool was most applicable. Women refugees, through the networks they maintained, are active not only in shaping their lifeworlds but also in choosing the course of action to adopt. The formal and informal networks, which women make, are crucial for the exercise of agency, as agency is effectuated through social relations. Furthermore, agency (and power) depend crucially upon

the emergence of a network of actors who become partially, though hardly ever completely, enrolled in the 'project' of some other person or persons' (Long, 1992: 23). This involves the emergence of social networks that enroll others in their own 'projects' and become enrolled in others' 'projects'. The enrolment is only partial and never complete, as they must leave 'room for manouvre'. Room for manouvre refers to the social space, which actors have to pursue their projects. Effective agency then calls for strategic manipulation of a network of social relations and the channeling of specific items such as claims, orders, goods and instruments. This strategic bargaining character of refugee women's networks may give also them *group agency***.** This could be seen with women refugees in refugee settlements. They actively and consciously organized themselves into a body that interacted with other organs in the process of transforming their lives. These women did not take all the advice from the health providers as given, rather they negotiated with other actors about their life situations and did this in spite of the differences among themselves since they were not a homogeneous group.

Interface analysis

Social interface is defined as " a critical juncture of intersection or linkage between different social systems, fields or levels of social order where structural discontinuities, based upon differences of normative value and social interest are most likely to be found" (Long, 1989:2). The interface concept implies some kind of face-to-face encounter where the parties involved represent different interests and are backed by different resources. Interface studies are essentially concerned with the analysis of discontinuities in social life. Such discontinuities are characterized by discrepancies in values, interests, knowledge and power. Interfaces typically occur at points where different and often conflicting, lifeworlds or social fields intersect. Such discrepancies arise in all kinds of social contexts. Discrepancies become particularly evident in situations of development interventions where external, sometimes expatriate 'agents of change' are present locally. The kinds of discontinuities created and negotiated in interface encounters are multifaceted and vary from one socio-cultural context to another. Since societies are gendered, the way local actors relate to interventions will be gender specific, even when interventions, as such, are conceived as 'gender neutral' and not directed particularly towards men or women. Thus, in this study, I am especially interested with discrepancies at two levels: the household level and the level of humanitarian intervention.

Stolen (1991) argues that if men dominate the area where technology is going to be used, they will normally be the ones to appropriate it. For example, new agricultural technology has often been directed towards men, also in cases where women play the main role in agriculture. This was evidently the case in Rhino camp discussed in Chapter 8 where agricultural extensionists targeted men in agricultural improvement practices and actually gave out presents to men as the 'best refugee farmers' while at the same time acknowledging that women did extensive farming more than men. Interestingly, in the course of this study, we established that the reproductive health project purposely implemented so as to lure men's participation, instead ended up being taken over by women. One can argue that its effective implementation failed as a

result of the 'gendered notions' of who should use family planning contraceptives. In addition, it originated from up with no input from the supposedly would-be users.

A gender perspective

The defection from the term WID to GAD was because it created a false reality. It isolated 'women's problems' from the general discourse in mainstream development planning. The problems women are experiencing with regard to access and control of resources is a result of the social construction of gender identity and are created by society. The social construction of an individual's gender identity is a central concern within the feminist discourse. Through institutions such as the clan and family and in schools and places of worship, individuals are socialized into values, norms, beliefs, attitudes and practices that are appropriate for men and women. The socialization process eventually determines the way people are expected to behave and how others perceive them as much as they perceive themselves. Gender relations are therefore shaped by ascribed relations and are based on the ascribed position of an individual according to sex, age and other attributes like level of education, etc. (Webster, 1989). Thus, in order to analyze actors and human agency as socially constructed, I have adopted a gender perspective because individuals have socially constructed identities. These identities influence the position and the kind of strategies open to individuals in the various hierarchies, which they occupy (Webster, 1989). The meaning of and differences between sex and gender have preoccupied much of the feminist writing (Oakley, 1972; Lorber, 1994; Butler, 1990; Scott, 1995), and I do not intend to repeat them here. However, suffice it to note that in feminist studies, *gender* is the central concept while gender *relations* is the focus of research. Hence, my focus on gender relations among refugees.

As used in this study, gender can best be understood when placed within the context of sex, inequality and culture. I am in agreement with Kabeer's (1999:4) definition of gender: "[g]ender is taken to refer to the full ensemble of norms, values, customs and practices by which the biological differences between the male and female of the human species is transformed and exaggerated into a very much wider social difference". There has been a tendency, and this has been subject to intense debate, to assign social and cultural roles to men and women based on the biological imperatives of sex (Roger, 1980; Ortner and Whitehead, 1981). But Kabeer (ibid) reiterates that the tendency to conflate *sexual difference* which is biological ,with *gender difference* which is social, gives rise to a view that all observed differences in the roles, capacities and aptitudes attributed to men and women within a given context are rooted in their biology and cannot change. Moreover gender is only one aspect of social relations and is not the only form of inequality in the lives of men and women. According to Kabeer (1995:65), "while gender is never absent, it is never present in pure form". This more comprehensive aspect of the gender concept also coincides with the Third World feminism's emphasis on the simultaneity of several forms of oppression. Besides, for the purpose of the present discussion, it would not be sufficient to look at gender just as a social construct; instead we should look at it from the possible angles of potential transformation. By so doing we shall be in a position to advocate for the reduction or elimination of the

'naturalness of gender' from the dominant ideologies.

The negotiation of gender relations

In this section, we dwell mostly on the arguments raised by Patricia Mohammed in her article *"Writing Gender into History: The Negotiations of Gender Relations Among Indian Men in Pre- Indenture Trinidad Society, 1917-47"* (1995: 20-47) concerning the negotiation of gender relations. The negotiation of gender relations incorporates several dimensions. First is the idea that the negotiations are never static, but are always ongoing. Given that these negotiations are about gender relations and the construction of gender identity, they invariably start from basic premises about masculine and feminine roles in a specific class and culture and from the knowledge of a system of gender relations.

Thus, one can theorize that negotiations in gender relations involve collusion, compromise and accommodation as part of the construction of gender identities, retaining many of the features from a gender system with which people are familiar. Some of these may seem oppressive to those outside a particular class or ethnic group, but have their own internal rationale. For instance, the practice of polygyny among some tribes in Africa may appear abhorrent to adherents of Christianity who promote monogamy.

These negotiations can take place at the individual (micro) level where men and women, men and men or women and women, work out their own gender boundaries and norms in the privacy of their homes or in their workplaces or in social gatherings. Another level for negotiations is the cultural or aggregate level, where what is being negotiated are new components in the existing system of gender relations. This level of negotiation involves a macro-level institution of the state, which often reflects the prevailing dominant ideology- and therefore the cultural structures which provide the accepted framework for masculinity and femininity (Mohammed, 1995:29). According to Mohammed (Ibid), the sources of power in the two levels of negotiations are differently allocated to men and women. Thus, for example, within the household and family, women may appear to have more power, and negotiate within the frame of reference provided by the household relations. As child bearers and child-rearers, their knowledge of children may give them greater bargaining power for themselves and for benefits on behalf of their children. On matters pertaining to religion, politics, and a wider social interaction with society, which has not been expected to be in women's knowledge, men have greater influence and through institutionalized frameworks such as religion and politics they have historically made decisions about women's well being. My own study reveals that women had a substantive amount of decision making when it came to health seeking behaviour for their children. This was principally because it is they who seemed to know more about the medicinal plants in the ecosystem. I witnessed that before women sought medical treatment for fever at the health centre, to mention but one example, they would first grind some leaves from a tree (*mululuuza*) and the liquid would be given to the patient, the remaining crushed leaves would be mixed with water and the solution used to sponge the child so as to lower the temperature. But we also noted the limitation to such negotiation particularly with issues to do with

sexuality and fertility. Women may have and indeed do have their bodies, but issues to do with child bearing were highly sensitive and quite honestly I do not know if couples ever discussed them. I got the impression that certain matters were taken for granted and were never discussed; married women were expected to produce. The question 'have you stopped breastfeeding?' was constantly asked in reference to the fact that if the baby is not suckling then why is one not pregnant!

Gender division of roles

That women and men undertake different tasks and activities is not in doubt. What is at stake here are the perceptions and attitudes of the policy makers, the humanitarian aid regime and the implementers concerning the role of men and women and the effect this is likely to have on the beneficiaries of the programme. We also note the fact that disruption creates discontinuities that are likely to 'disorganize' the *status quo* of gender roles. When humanitarian aid programmes which are tailored and packaged in the West where the assumptions of the family (household), the status of women, and the position and power and authority of men differ with the reality in Africa, how does this affect the gender division of roles? This has significant implications on how the gender responses are undertaken. For instance, regarding the issue of non-food requirements, the assumption is that a male head of household would distribute the requirements to the dependants in the household equally. And yet I met many women who complained how their husbands had sold the non-food requirements such as saucepans, blankets and jerricans. In this respect I prefer to argue that gender relations may only in part and in specific contexts cause the (female) individual actor the capacity to devise ways of coping with life, even under the most extreme forms of coercion**,** as Long argues.

A number of authors have documented changes in gender roles (Payne, 1998; Thirkell, 1995; Callamard, 1993). Women acquire headship due to the absence of men who may have joined the warring factions, or may be dead or who might have travelled elsewhere to seek employment. The UNHCR in a bid to improve its services, distributes humanitarian assistance in a way that focuses on women as heads of households, which in my view is fair. In particular, food is distributed to women irrespective of gender of headship. In the process, however, gender relations are thrown into imbalance. Makanya (1990) observes that the disempowerment of men in refugee camps and their loss of status through assistance policies which fail to provide meaningful employment, exposes men to the risk of greater psychiatric disorders and reinforces family violence as a means of asserting their male role. Payne (1998) notes that men refugees were in some sense 'vulnerable' as they had lost their previous roles (and authority) as cultivators. This argument is further endorsed by Turner (2002) who asserts that the Barundi refugee men in Tanzania accuse UNHCR of being 'husband' to their women by giving them too much autonomy. In a slightly different but related argument, the unaccompanied male Sudanese refugees in Kakuma suffered malnutrition, not because there was no food, but because it needed cooking and they were not accustomed to cooking, and since cooking represented a compromise to their societal role (Kathina-Juma, 1998). The reproductive roles associated with the nurturing by women which proved time consuming and laborious in Kiryandongo were firewood and water

collection. Viewing the gender roles within a dynamic and all-embracing perspective in refugee contexts is important and quite crucial if we are to reduce on the potential negative consequences and improve the quality of life of refugees.

Gender needs

The recognition that women and men have different needs as defined by their gender roles must be acted upon by offering opportunities to raise women's position and condition. Moser (1993), building on Molyneux's gender framework, has identified two needs, which have to be addressed in order to transform the position of women. First, are the practical gender needs, which are needs called for to make society work. They are not women's needs per se, but they are associated with women because, like water, though used by everybody, society has made it **a** women's problem. Every body needs water, food, health, and income; women are just a delivery mechanism, expressing a need they feel on behalf of other people (Townsend, 1996:173). These are linked to the gender roles assigned to women by culture. Addressing these does not challenge the gender division of labour; rather they are a response to the basic needs. Second are the strategic gender needs, which arise as a result of the subordinate position of women in society (Moser, 1993:39). They vary according to particular contexts. They relate to gender divisions of labour, power and control and may include such issues like legal rights, domestic violence, and women's control over their bodies and equal wages. Meeting these strategic gender needs would bring about transformation in women's lives and a reduction in their subordination and hence enhance the achievement of equality. Strategic gender needs are those needs that are formulated from the analysis of women's subordination to men. Deriving out of this analysis strategic gender interests necessary for an alternative, more equal and satisfactory organization of society than that which exists at present can be identified. According to Moser (1993), this relates to the structure and nature of relationships between men and women. It was interesting to note that the Uganda government, the UNHCR as well as other agencies attempted to satisfy the practical gender needs of women; in doing so, they helped to reproduce and perpetuate gender inequalities. As argued above, it is changing the access to resources such as education, skills and credit that can make structural changes in women's lives. The question as to whether these structural needs are catered for in refugee settings will be discussed in this study.

Power

Gender focuses on inequality between men and women, but gender differences on their own do not indicate the reasons for the inequalities. Hence the need to analyse the concept of power. In social research, power has been used in the Weberian sense of 'having power over somebody' emphasizing the notion of domination and subjugation. It gives the impression that power is something you gain or possess. However, as I indicate, power has several dimensions.

A number of authors have described power with varied meanings such as repressive (Radke and Stam, 1994). Others see it as productive and enabling, wielding and yielding

(Giddens, 1984; Villarreal, 1994). Power, like gender, is a relational concept; it does not exist outside relations and it is not something a person simply possesses. Giddens (1984) refers to power as being integral at all levels of society within primary groups as well as institutions, and intrinsic to human agency. This integral nature of power and human agency enables us to contextualize the social behaviour of refugees. We are able to look at how women refugees process information, how they strategize their involvement and their interplay in these practices. Thus, within a gender perspective, the question is not whether women or men have or do not have power, but how power comes about in relationships between them.

For a long time, and especially in women studies, power has been considered in repressive terms only. Women were claimed to be victims of the exercise of power by men. Nonetheless, a view on power as simply repressive conceals the fact that it may also be constructive and enabling**.** Women will always have 'room for manouvre' where they can use their creativity. Recent studies have shown that women are not just passive victims. Villarreal (1992: 256) asserts that even though power is fluid and difficult to measure, it is not only the amount of power but also the possibility of gaining edge and pressing it home. 'The scope of power, commonly defined as the capacity of an individual to impose his or her will upon others must be unpacked to allow for an understanding that includes the probability of achieving only part of one's project, of accepting compromises, but then pressing home one's moderate gains in an attempt to dominate as big a part of a situation as possible so that one can consider one's aspirations consummated'. She later explains: " I have defined power as of a fluid quality, as embedded in social relations, in strategies, discourses and forms of organization. Power is not inherent to institutions, actors and social positions, but is socially constructed. It is wielded through complex processes which involve diverse forms of agency, whether we are speaking of power as being wielded or as capacity to wield" (Villarreal 1994: 223). In this respect then, we should look at power in a distinct and defined space. Both women and men refugees had power but the magnitude and its application was influenced by the social context within which they were placed. This therefore makes the assumption of 'powerless refugee women' problematic. Take, for instance, her dominance over indigenous knowledge with respect to medicinal plants, soils, et cetera. This tantamount to power in what Long and Villarreal seem to imply when they argue that: " Knowledge processes are embedded in social processes that imply aspects of power, authority and legitimation; and they are just as likely to reflect and contribute to the conflict between social groups as they are to lead to the establishment of common perceptions and interests" (Long and Villerreal, 1995:158).

Giddens at a later date (1993:257) defines power as the "capacity to achieve outcomes"; whether or not these are connected to purely sectional interests is not germane to its definition. He argues, "the existence of power presumes structures of domination whereby power that 'flows smoothly' in processes of social reproduction (and is, as it were 'unseen') operates". Hollway (1995: 253) in a gender study of the Tanzania civil service observes that gender equality is undermined in practice by the gendered power relations (i.e. the structure of authority, control and coercion) of the organization and its wider context; arguing that the wider culture is manifest in conjunction with the

power relations of hierarchy. This thesis therefore draws, for its conceptual analysis, from the above theoretical arguments on the several concepts raised, weaknesses notwithstanding.

2.4 Contemporary violent conflict

In the First World War, only 5 per cent of the casualties were civilians. By the Second World War, the percentage had risen to 50 and in recent current major conflicts, it is estimated that around 95 per cent of the casualties are civilians (Byrne, 1995). Armed conflict may occur as high technology (such as the recent war in Iraq), war of attrition (such as the recent conflict in Bosnia), army in occupation (such as that in Palestine), war of suppression (in Burma, East Timor), and wars of insurgency involving untrained rebels like what we see in Uganda, Sierra Leone, Sudan and Democratic Republic of Congo (El-Bushra and Lopez, 1999). What is mainly at stake is the use of deadly weapons during these conflicts.

Conflict refers to a state of disagreement or argument between opposing groups (Longman's Dictionary). We shall not go into the typology of conflict here, but the context within which we are discussing conflict in Eastern Africa concerns the use of armed violence between opposing groups and the resultant effects. Wars of this nature have been characteristic of contemporary Africa. First, they were fought as liberation wars in search for independence during the 1960s and early 1970s. Secondly, they were fought on ideological fronts during the Cold War. But now the armed conflict seems to be fought along many fronts, some of which include authoritarian dictatorship, ethnic rivalry and access to resources. Only in Africa, the 1990s witnessed wars in Sierra Leone, Liberia, Guinea, Sudan, Uganda, Democratic Republic of Congo, Congo (Brazaville), Mozambique, Angola, Rwanda, Burundi, Somalia, Ethiopia and Eritrea, the list is endless. In many of the countries just mentioned, wars are still waging on while in others such as Eritrea, Ethiopia, Rwanda and Liberia, although war has come to a truce, there is no guarantee that we shall not witness war again in the near future. As a result of armed conflict therefore, we find ourselves with approximately 3,014,000 African refugees and 10,310,000 internally displaced individuals (US Committee for Refugees, 2002). The statistics do not include self-settled refugees. Armed conflict forcibly displaces people from their habitual residences.

Causes of such wars are many and we shall not go through them as they have been sufficiently discussed elsewhere (Johnson, 2003; El Bushra and E. Lopez, 1993) and would require a separate chapter. Our main concern is the effect of these wars on people. Wars have a high toll on human life. The war in Rwanda left almost one million people dead (Prunier, 1995). The actual number of the dead resulting from armed conflict in Africa will never be known. However, what is likely to get acknowledged statistically is an estimated number of displaced, both, within their countries of origin as internally displaced persons (IDPs), and beyond national boundaries as refugees.

Civilians caught up in war suffer untold atrocities committed by combatants and in many cases even government soldiers who are supposed to offer protection. Many

young men are conscripted against their will, women and girls are abducted and raped and/or taken as sex slaves. In quite nasty instances of armed conflict, adults and even babies have been mutilated; their limbs get chopped off like what happened in Sierra Leone[3]. In northern Uganda, women had ears, noses, and lips cut off, while both men and women have had legs and arms amputated for disobeying the orders of the rebels.

This was a continuous occurrence (ISIS-WICCE, 2002). For many women these acts have been scarring and disfiguring; many have lost their limbs, which they depend on to fulfil their daily roles, others have contracted STDs and HIV/AIDS through rape. This is not to speak of the psychosocial trauma resulting from rape and other forms of violence including loss of dear ones. In yet other situations, they have been ostracized; this was the case for many Somali refugees in Kenya in the early 1990s (Africa Watch, 1993; Musse, 1996). Another very important aspect of displacement concerns the loss of the environment they depend on for survival (Kibraeb, 1995). Women depend on the environment for the application of indigenous knowledge, for instance, as a source of food, medicines, grass, and fuel. Therefore, displacement seriously affects the survival strategies of the displaced people.

Because of the different roles men and women perform, men stand a higher risk of dying during war than women because they are more likely to engage in fighting. The high death toll especially of men has gender and reproductive implications. The absence of men, for whatever reason, is likely to bear heavily on the women who may assume new roles such as heads of households. So one is likely to end up with many female headed households during armed conflict and soon thereafter. In addition women are expected to replenish the tribes by bearing as many children as possible. Sudanese refugees pointed out the need to replenish their stock as "*many Sudanese have died in the war*". This was the perception in the Kiryandongo and Rhino Camp refugee settlements.

Wars in Africa are protracted and repetitive. An example is the war in southern Sudan which has gone on since 1982, before that it had raged on from 1955 to 1972 with the signing of the Addis Ababa Peace Accord (Africa Watch, 1990), so the truce was to last only ten years. Similarly, the civil war in northern Uganda is seventeen years old. The displacement process is likely to affect people's identity. People depend on socio-cultural symbols for their identity. The cattle, for the Dinka and the Nuer, symbolize a number of meanings to reinforce their identity. Cattle for these groups and several others are necessary for bride wealth, for rituals and ceremonies. As such, without them their identity becomes disorganized, hence, their recourse to violence.

The social divisions along ethnic, cultural, religious, linguistic or national lines, which underlie conflict situations, are cross cut by gender divisions. The militarization of a society leads to shifting definitions of masculinity and femininity and to shifting responsibilities for men and women (El Bushra and Lopez, 1993). Conflict centres on struggles over power and resources. A gendered analysis can illuminate how men and women are caught up in different ways in this struggle, through different identities, differential access and control over resources, and through changes in gender ideologies and identities. Gendered analysis contributes to the study of power relations by pointing

out the way in which power finds expression in the symbolic and socio-cultural relations between men and women.

Since the end of the Cold War, Africa seems to have lost its strategic importance[4] . The role of the UNHCR and its functions of protection and humanitarian assistance to refugees have also been affected. The prevailing donor fatigue has led to cuts in refugee project budgets, spearheading aggressively repatriation and, the integration of the parallel refugee social services into the national system[5] . For the hosting countries, it may imply spending more of the meagre resources[6] to absorb the extra population load. On the other hand, refugees are aggressively encouraged to repatriate[7] or to find other sources other than UNHCR for survival. Other measures, though not pursued aggressively in Africa, include the creation of 'safe havens' for IDPs to prevent them from crossing borders and seeking asylum. On a number of occasions, the UNHCR has been criticized that this might be a contravention of the legal protection to be provided to refugees and the principle of non-refoulement (Hyndman, 1997). Moreover, the tightened migration policies in Europe have made it next to impossible for Africans to seek asylum in European countries.

2.5 Understanding the household

This section discusses some of the theories advanced to define the household and the conceptual difficulties they pose when we try to apply them to the African household. The household is a fairly common form of social organization and often represents the primary site for the structuring of gender relations. Planners, humanitarian agencies, economists and researchers have used the household as an entry point and unit of analysis. In spite of the fact that the concept of household is universal, it has no standard definition. Several definitions have been advanced regarding the concept of household.

Chant (1997) notes a major consensus in defining households in developing countries as spatial units where members live in the same dwelling and share basic domestic and/or reproductive activities such as cooking and eating. However, she finds this definition problematic. Households mean different things to different people in different places and there is a growing debate on desirability (or otherwise) of generating definitions which might be universally acceptable. Households may be understood as kinship units or economic units, than as housing units. She recommends that it is important to acknowledge that even households' reproduction may not depend entirely (or even predominantly) on those who live in it. In the context of refugees, the role of diasporic remoteness is an evident issue. The other problem identified is that there is fluidity of household boundaries and as such, a large share of domestic functions is performed outside of the residential unit. Another problem with the conventional definition of households is the notion that co-resident household members function on the basis of shared participation in survival activities. A final factor in need of emphasis is that while households often consist of individuals related by blood or marriage, they are by no means always family based entities, but may comprise unrelated persons such as colleagues, friends, lodgers or indeed lone individuals (Chant, 1997:5-6). Another definition by Rudie refers to a household as a co-residential unit, usually

family based in some way, which takes care of resource management and primary needs of its members (Rudie, 1995; 228). In a refugee setting however, such a definition needs to be complemented due to the fact that refugee households were observed to be scattered in several refugee settlements and the members of those households did not have to be resident in a household. During my fieldwork, it was, for example, common to see men eating their meals in one of their wives' houses and spending the night in the house of another.

For Lehman (1986), the household is where people 'eat from one pot' and live together 'under one roof'. Within households, people 'pool' resources to provide the household members' needs. Brydon and Chant (1993) define the household as a residential unit whose members share domestic functions and activities, a group of people who eat from the same pot. Furthermore, Ellis (1998) refers to a household as a social unit defined by the sharing of the same abode. While the above definitions do not allude to any conflicts and antagonisms likely to take place within the household, several authors have diverse views over the way the concept of household is perceived. It is these held opinions over the term household, which influence relief and development policies and programs in Africa (Moser 1993). What these definitions do not mention, but what I observed in refugee households is the dependency on neighbours for resources (even when they are not related). Women refugees go to neighbours to ask for salt, fire or firewood. This happens all the time. Women have digging groups, baby minding groups and even trading groups. It is important for the planners to be aware of these attributes to be able to plan properly.

Nuijten (2001) argues that while a household represents an important form of organisation, it should not be reduced to a unit of strategic economic action in which members share a collective project and common interest. Besides, feminist studies have convincingly cut through romantic assumptions about family and household unity, arguing that there exist instead multiple voices, gendered interests and an unequal distribution of resources within families and households. That dynamics within households are likely to bring about gender inequalities in access to and control of resources in a household, is not disputed as evidenced by several authors (Adepoju and Oppong, 1994; and Brydon and Chant, 1993; Moser, 1993; Creighton and Omari, 1995) who argue that although members of a household often share the same residence and by implication a minimal degree of interaction with others in the unit, it cannot be assumed that such interaction entails equality or even cooperation among the individuals. Often, there are considerable disparities in terms of inputs, benefits and activities of various household members with age and sex often being critical variables in the equation.

Creighton and Omari (1995) observe that the household strategy approach downplays the constraints under which individuals and households make decisions and while it focuses on couples, it ignores other subordinate members of the household or men and women living alone. Another pertinent issue is that membership in the household is internally differentiated by material constraints, which may strongly influence access to and control over resources (Kabeer, 1991). This has implications for the behavior of

the household and the coping mechanisms devised for survival. But for the present study, the household, being the focal point for the provision of humanitarian aid, is critical for understanding the interrelationships between gender roles, antagonisms and power relations surviving in refugee households. Changes that occur in household form or functions in the event of forced migration have implications on access to resources (tangible and non-tangible), the gender division of labor and power relations of refugees. Guyer (1981) has argued that the household, far from being a discrete entity, its boundaries are often very permeable since the units are embedded within wider structures. Furthermore, the household encompasses the domestic sphere as a contributor to and product of wider cultural and social processes (Guyer and Peters, 1987). It is however argued that whereas a household denotes common residence and economic cooperation for production, consumption and reproduction, due to the several transformations that have taken place, households members now include those present and those physically absent (Netting and Wilk, 1984). Consequently the most important members of many households could be those who are not in residence at all, but supply such households with vital cash remittances, goods and services. In my study, I established that individuals outside the household mattered as much some times even, more than those inside it, when it came to survival and decision-making. Remittances from relatives (refugees who had resettled in the West) and those outside the settlements were crucial in sustaining refugees' survival in refugee settlements. Therefore, this dispels the view that a household necessarily implies co-residence.

In spite of the conceptual weaknesses in the household models, the household remains pertinent to understanding patterns of gender and power relations in refugee settings. As a unit, it provides a locus with discernable though permeable boundaries and in the case of this study to access resources and their subsequent utilization are closely related to the establishment of a household in a rural refugee settlement in Uganda. Hence, although much of the survival strategies that I discuss centre on individual refugee women, they can be connected to the wider spectrum composed of household members and related networks. Accordingly therefore, the concept household shall refer to an individual or group of individuals living together or not, who may be related by blood or through other avenues, but who depend on each other for their socio-cultural and economic wellbeing. Hence, in order to transcend the static component of the physical aspects of the household as a unit, I also look at what happens inside and outside the households. Beyond each household are several networks that enable the households to survive. I studied these networks of activities beyond the boundaries of the household in as far as they contributed to the survival of the households. Focusing on the household as a social arena, I examined the inter-household and intra-household dynamics including their constant struggles and negotiations for survival.

The African household and women-headed households

A number of authors have expressed difficulties in defining the African household because of a myriad of differences in a number of general indicators of economic development, kinship systems, women activities and colonial heritage (Brydon and Chant, 1993:36; Whitehead and Bloom, 1992; Omari, 1995). In addition to the influences

of colonial rule, Islam has had its influences south of the Sahara and in most cases predated Christianity. Traditional religions also have had a bearing on the structure of the household. In many parts of West Africa, the tradition of women living with their female kin persists. In southern African countries, such as Botswana and Lesotho, women are *de- facto* heads of households because their husbands are forced to migrate to South Africa to look for work. In parts of East Africa, such as Mafia in Tanzania, families are fairly fluid and women have a great deal of autonomy because of their traditional rights to own land (Creighton and Omari 1995). High numbers of women-headed households on the East African coast are also attributable to local high divorce rates (Kaplan, 1984). According to Verma, *de facto* women-headed households are defined as those where husbands have migrated, or where husbands and wives reside together but their marriage exists in 'name only', while *de jure* women-headed households are defined as those where women are responsible for the livelihood needs of all residing in the household and have the power to make major decisions (Verma 2001: 134-136). In Kiryandongo and Rhino Camp, women refugees refer to their husbands as roving husbands because they have wives in many settlements. They therefore spend most of the time moving from one settlement to another. This contributes to many *de facto* female-headed households. The other important observation we made was the fact that humanitarian aid is tied to heads of households irrespective of sex. In this regard, women deny being married even when they are. Divorce is also common in West Africa. The above evidence indicates that the patriarchal household is by no means the norm in Sub Saharan Africa. It has been noted that the nuclear family is only likely to be found in large numbers in urban areas, which have been subject to intense colonial pressures, development and the penetration of capitalism (Brydon and Chant, 1993: 36). Rogers notes that in many cases where women are officially classified as 'dependants' of a household head, it is clear that in fact they play a crucial part in the maintenance of individuals in that grouping, and that, in some cases, the man classified as the 'head' might accurately be described as dependant from the point of view of productive activity (Rogers, 1980:65). This is an important observation in refugee settings. It is likely that UNHCR by virtue of focusing on heads of household irrespective of sex, would miss out on the vulnerability of women dependants in male-headed households. It has been reported that even in cases where men are the heads of households, responsibilities to feed the family fall on to the women.

Having said that, it is worth noting that even within the diversity of the African household, the superiority of the status of men in Africa is based on much more than productive activity. Men in Africa, through patriarchy, assume a higher status and take the authority as God-given. While we note criticisms advanced against measuring women's status through sets of externally imposed Western criteria (Moser, 1993; Mohanty, 1988; Tamale, 1999), we have to take cognizance of the fact that the last one hundred and fifty years have been influenced by introduction of religion, the experiences of colonial rule, and incorporation into the world's capitalist system. Since all of the above entail patriarchal ideologies, women's status is therefore generally subordinate. Thus, whatever women's status was, in pre-colonial societies, it has changed and women in these societies have been incorporated into the new Third World nation-states in travestied ways (Brydon and Chant, 1993: 63). I am also of the opinion that

Africa is not only part of a global process of inquiry, but has also already embraced some of the externally formulated models. Thus, whereas there is need to analyze these concepts locally for a deeper understanding, their application in a study like this one is quite relevant and pertinent.

2.6 Vulnerability, capacity, coping and adapting

We are giving special treatment to the concepts vulnerability, capacity, coping and adapting for two main reasons. First, the four concepts are quite inter-related in that attempts to make structural improvement of refugees in situations of vulnerability are likely to enhance their capacities and improve their coping and adaptive strategies. Second, short term emphasis on coping (like is common in refugee settings) may not be beneficial in the long term as such emphasis would most likely not address the capacities of individuals and their vulnerability to the processes which reinforced the status. To this end, refugee households are likely not to transcend the shocks and stresses if we do not address the structural causes of gender biases. When populations are forced to migrate, they suffer a reduction in capacity to cope with the challenges of new experiences. Women in particular are at loss with their environment and try to devise ways and means of survival of their households. Coping is a direct human adaptive response to stressors. It refers to short –term survival response while adaptation refers to the response developed over time (Davies, 1993).

The ongoing vulnerability debate has attracted much contribution (Chambers, 1989; Lewis 1999; IFRC 1999; Anderson and Woodrow 1993; Frerks *et al*., 1999). Lewis defines vulnerability as the degree of susceptibility to a natural hazard. He sees the vulnerable state of populations and settlements being as much a contributor to the cause of natural disasters as are the physical phenomena with which they are associated. He proposes that vulnerability has to be addressed therefore, not only by post-disaster concern and response, but also as part of the day to day management of change – whether or not that change is called development (Lewis, 1999:5). Similarly, the International Federation of the Red Cross (IFRC) refers to vulnerability as "the characteristics of a person or a group in terms of their capacity to anticipate, cope with, resist, and recover from the impact of a natural or man made hazards" (1999:11).

In their book, *Mapping Vulnerability: Disasters, Development and People,* Bankoff, Frerks and Hilhorst (2004) situate the concept 'vulnerability' in a complexity of inter-related processes. They argue, for instance, that although vulnerability may be seen as simple, it is complex and that to understand it better one has to take account of people's perceptions and experiences. They advance the view that vulnerability is about people's perception and knowledge and underscore the importance of 'local knowledge' based on grass-roots experience. This they call power. However, when viewed by outsiders, this power is referred to as people's capacity to deal with vulnerability and their resilience to withstand disasters. It was noted how refugees' local knowledge did not feature during the provision of health care. If anything, at times it was shunned. However, refugee women treasured their own local knowledge and that of the TBAs in the treatment of their children and during the delivery of their babies.

Conditions of war are known to contribute to social disintegration and the weakening of traditional structures. Ellis (2000) describes the most vulnerable households as those that are both highly prone to adverse external events and lack assets that could carry them through periods of adversity. Vulnerability, according to Chambers (1989), is characterized by long-term factors that weaken people's ability to cope with the sudden onset of shocks and stresses, exposure to risks, risks and leaves them defenceless. He further argues that the understanding of vulnerability must take into account the context-specific nature of risks and shocks, and the capacity of households to manage such risks. In our fieldwork we established that people depend a great deal on their local knowledge to yield power in stressful situations.

The capacities of communities, that is the resources of individuals, households, communities and institutions to resist the impact of a hazard need to be explored. However, in the course of doing so, we are cautioned by Frerks *et al* (1999:14) against the uncritical celebration of people's capacities, urging the consideration of power differences and the inequalities that lead to unjust distribution at the expense of the poor or otherwise more vulnerable people. They further note that disasters can strengthen or generate power relations and mechanisms that consolidate social inequalities, allowing some people to benefit from economic opportunities presented in emergencies. Vulnerability should not be seen only in terms of individual harm, but linked to the broader context of crises, including the differentiated nature of responses across households and communities. In some cases the refugee situation was found to be empowering. For instance, the allocation of land to women as heads of households, gave them room to make choices related to what they planted for consumption and for sale, thus increasing their incomes and making them somewhat autonomous.

Vulnerability and refugees

External factors influencing vulnerability also relate to the extent to which particular groups are perceived and treated by the wider society. For example, scholars of refugee studies make the observation that by the very virtue of being a refugee[8], refugees are from the outset deemed vulnerable in a sense that they require protection. However, they also argue that humanitarian policies (Harrell-Bond, 1986; Anderson and Woodrow, 1993) for the management of refugees perpetuated refugee vulnerability. They observe that refugee assistance regimes themselves promote dependency by usurping the decision-making and organizational capacity of refugee individuals and communities. By giving several examples that allude to the dependency-creating policies of the UNHCR, Harrell-Bond (1986) highlights the role that humanitarian policies actually play in perpetuating vulnerability and dependency of refugees.

In his study of refugee vulnerability in Greece, Black (1994) defines vulnerability as the inability by the infirm, the children, the elderly to sustain a livelihood, or to respond to threats to their well-being suggesting further that it is possible also to see vulnerability as deriving from circumstances external to the individual concerned. In one sense, this relates to the division between the coping abilities (resistance and resilience) of individuals, and their level of exposure to risk, making vulnerability a relational

concept. Black (Ibid) identifies two aspects of vulnerability: socio-economic and legal / political vulnerability in his study. He argues further that a case can be made that all refugees are vulnerable in terms of problems over legal status and lack of basic rights, such as the right to work and permanent residence. He therefore proposes that if the purpose of targeting public action is seen as removing or reducing vulnerability, rather than assisting the most vulnerable, attention needs to be switched away from the internal characteristics of households, and towards what might be described as the underlying causes of vulnerability. As I have already remarked, within the UNHCR policies and programmes, there is a lack of mechanisms to addressing the underlying causes of vulnerability.

The notion of vulnerability therefore, to a great extent, has been applied by international agencies to special groups of refugees that face special problems in refuge due to their identity e.g. the female, the unaccompanied and the disabled. Africa Rights Watch (1994) argues that UNHCR policies to protect and assist victims of sexual violence are still not being adequately integrated into UNHCR programs and services in the field. Furthermore, protection efforts that do address the issue of sexual violence, such as the vulnerable women and children's programme (formerly the victims of violence project) in Somali refugee camps in north-eastern Kenya, continue to remain the exception rather than the rule. The vulnerability of women should be assessed within the context of changes in the social relations resulting from forceful displacement. My study indicates that the lay out of the settlement, the gender roles of women – gathering fuel wood and collecting were some of the areas where women suffered violence most. Moreover the fact that men are redundant encouraged over drinking and violence.

Sex and gender-based violence

In recent years UNHCR has begun to focus on the need to address the issue of violence against women refugees as a precursor to women's vulnerability. This has been institutionalized by the definition of sexual violence in 1987 (UNHCR, 1991). This having been said, womanhood and the vulnerability of women in conflict situations do not entitle women to refugee status per se. Even when sexually violent actions, such as rape and other forms of sexual assault, have been inflicted upon women in conflict and post conflict situations, they have not been sufficient enough to meet the "persecutory fear' required for refugee mandate. Despite this, the International Criminal Court (ICC) statute recognizes a range of acts of sexual and gender violence as among the most serious crimes under humanitarian law. It criminalizes these acts in Article 7 of the ICC statute (Bouta and Frerks, 2002:304) as crimes against humanity and in article 8 as war crimes. Included on the list are rape, sexual slavery, enforced prostitution, enforced pregnancy, enforced sterilization, or any form of sexual violence also constituting a grave breach of the 1949 Geneva Convention (Bouta and Frerks, 2002).

2.7 International legal and institutional framework

Definition of Refugees

This discussion sheds light on the legal and institutional framework for refugees that guides the UNHCR and hosting countries in the determination of refugee status and the subsequent management of refugees. Before the 'refugee problem' descended to the South, the issue of humanitarian assistance received attention on two occasions only in 1956 (the Hungarian refugees) and 1957 (the Chinese refugees in Hong Kong). Before that time, any (Western) European country receiving refugees[9] would ensure that refugees in their jurisdiction were assimilated in the mainstream economy (Holborn, 1975). The office of the UNHCR then played a protection role. Refugees fleeing from Eastern Europe after the Second World War, were seen as an economic opportunity and also a failure for Communism (Horst, 2003). However during the 1960s, the UNHCR in addition to its protection role, assumed the role of providing humanitarian aid when the refugee problem descended to Africa, starting with refugees in Morocco (Holborn, 1975) and has done so ever since. The 52-year UNHCR with headquarters in

Geneva maintains branch and sub-branch offices in several countries in the world. For its operations, the UNHCR depends on fundraising. The main binding principles are the refugee instruments for refugees and asylum seekers in African countries, namely, the 1951 UN Refugee Convention, the 1967 Protocol and the 1969 OAU Refugee Convention.

The 1951 Convention

The 1951 UN Convention Relating to the Status of Refugees defines a refugee as some one who:

> As a result of events occurring before 1 January 1951 and owing to a well-founded fear of being persecuted for reasons of race, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country, or who not having a nationality and being outside of his former habitual residence as a result of such events, is unable or owing to such fear, is unwilling to return to it (UNHCR Handbook 1988: 253-254).

The above definition is narrow in focus and uses gender blind language omitting female specific factors that constitute 'fear of persecution'. For instance, Sharia laws that denigrate the dignity, self-esteem and human rights of women are ignored by this Convention. During September 2002[10] we witnessed the sentencing to death of Amina Lawil a 30-year old Nigerian woman (upon weaning of her child) because she got pregnant outside wedlock. It is quite doubtful that without special amendments to the existing 1951 refugee instrument such a case can be considered to warrant "fear of persecution". But even if she were let free, there is no guarantee that such stringent measures would not be applied to another woman in similar circumstances. Thus, the Convention needs to be amended to address the women-specific needs that constitute 'fear of persecution'.

This study established that the Convention only applies to individual refugees who seek asylum in Uganda. As for the refugees who move *en masse,* such as those from the Sudan and other neighbouring countries, the Uganda government applied *prima facie* recognition. The refugees were therefore not subjected to individual determination of refugee status. According to Zolberg, *et al.,* (1988) given the seemingly large numbers of African refugees during the 1960s, the illiteracy of many of them and the inaccessibility to several of the areas they were at, adaptations had to be made. Goodwin-Gill (in Zolberg *et al*.,1989) reports that conditions of underdevelopment in Africa made individual assessments of refugee status impractical and that people should benefit from refugee status when there was no doubt that 'political conditions' had compelled the flight of the entire group in question. African refugees seeking asylum in groups are not subjected to individual interviews; rather they are accorded *prima facie* status. However, this treatment renders asylum seekers in Africa 'second hand refugees' for having omitted the use of the Convention in establishing their claim to refugee status, for in the event that they were subjected to individual determination interviews, they would be unable to justify their 'fear of persecution'

The 1967 Protocol and the OAU definition

Realizing that the 1951 UN Convention was Eurocentric with geographical limitations, the UN amended it to cover refugees elsewhere other than Europe and to also do away with the geographical limitations. The discrepancy between the domains of the UNHCR and of the Convention was corrected in 1967 when a protocol, the 1967 Protocol, was enacted to eliminate time and space limits from the Convention (Zolberg *et al*., 1989:25). The 1960s and the early 1970s witnessed many liberation wars for independence from colonialists. At the same time, armed conflicts in the Great Lakes region in Eastern Africa had started displacing thousands of refugees. It was imperative that the Organization of African Unity (now called African Union-AU) formalized in 1969, the Convention on Refugee Problems in Africa. Keeping within the provisions of the 1967 Protocol, the OAU added the following section to the definition:

> "(t)he term 'refugee' shall also apply to every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to seek refugee in another place outside his country of origin or nationality" (UNHCR Handbook 1988: 254).

Again, the language used in all these instruments is not gender sensitive. However, the above OAU definition has a friendlier usage of the term *refugee* because one does not have to actually prove that her/his life is being persecuted. In the early 1970s the UNHCR mandate was extended further to include people in 'refugee –like situations' if no other agencies were available to provide relief.

Further guidelines on refugee women

As a further step towards the protection of women refugees, the UNHCR has initiated policy guidelines to ensure equality of women refugees, integration and mainstreaming of gender issues into main refugee policies. Some of these initiatives include: the *Policy on Refugee Women* (UNHCR 1990*); Guidelines on the Protection of Refugee Women* (UNHCR 1991); *The People –Oriented Planning (POP) Process* (UNHCR 1994); *Sexual Violence against Refugees: Guidelines on Prevention and Response* (UNHCR 1995); and the creation of the post of Senior Co-ordinator for Refugee Women in 1989. The Guidelines also suggest a range of preventive and remedial measures that can and should be taken to combat sexual violence. The UNHCR, in conjunction with the World Health Organization (WHO) and UNFPA has further distributed an *Inter-agency Field Manual on Reproductive Health in Refugee Situations.* This manual highlights reproductive health concerns including reproductive health of adolescents, the prevention and treatment of STIs especially HIV/AIDS and sexual and gender based violence. Furthermore, the Five-Year Reviews of the Beijing Women Conference and International Conference on Population and Development are equally concerned about the poor performance at the implementation of the resolutions that concern exploitation, abuse and violence against refugee women and children. They call for the provision of sufficient resources to address the needs of women and children including training personnel dealing with specific programmes that address the healing of women from trauma (CRLP, 2001).

Security Council Resolution 1325

Security Council Resolution 1325 was adopted unanimously on 31 October 2000. This resolution (S/RES/1325) is the first resolution ever passed by the Security Council that specifically addresses the impact of war on women, and women's contribution to conflict resolution and sustainable peace. It recounts the evolution of the Resolution and how the various UN Conferences of women have had a bearing on its formation. It mentions for instance, the commitments of the Beijing Declaration and Plan of Action, the Windhoek Declaration and the Namibia Plan of Action and the principles of the Charter of the United Nations and the primary responsibility of the Security Council and expresses concern over the plight of women in armed conflict (www.peacewomen.org/un/sc/1325.html).

The Security Council Resolution could not have been adopted at a better time than now when Africa is riddled with armed conflict. The onus now rests on the implementation of the Resolution and will depend on the combined and concerted efforts of the UN, the member states and the people including warring factions. In addition, this should be spearheaded by the women movement as a way of improving women and girls well-being in armed conflict.

Humanitarian Assistance

International debates over humanitarian interventions have preoccupied NGO discourses and governments. Conflict is about power. Material resources represent, buttress and are essential to power. Thus, when NGOs introduce resources such as food, cash and equipment, they become foci of struggle (Anderson, 2001). There have been many debates as to whether humanitarian aid does not actually fuel war. There is also a question as to what extent to which it contributes to development (De Waal, 1989; Duffield, 2002). At the same time, the benefits to NGOs and the local staff and improvement to the infrastructure of hosting areas have been mentioned (Goyen *et al*., 1996). However, Anderson (2001) discusses how humanitarian intervention may worsen conflict. She mentions that this can be done through the payment of tariffs and taxes by NGOs, which money is then used to propel the conflict. In addition, she argues that NGO intervention can reinforce and worsen inter-group tensions by affecting the distribution of resources (e.g. employment of some people and rejecting others); these can spark off jealousies, inequalities and fuel separate group identities. Furthermore, NGOs' presence affects wages, prices and profits. Through interaction with some officials they legitimate some actors and delegitimate others. Moreover, NGOs use of horror pictures may serve to dehumanize war perpetrators in the minds of the wider public and reinforce their alienation in peace efforts. The continuation of the war on south Sudan has been blamed on several factors, the key being humanitarian aid (Duffield, 1998; Keen, 2000). The foregoing discussion has dwelt mostly on ongoing conflict. But my study also concerns issues in post conflict situations. However, it can be argued that what happens during conflict is quite likely to influence the post conflict rehabilitation.

Much as the UNHCR has the mandate to offer protection and assistance to refugees, it is not usually the practice that it also implements its projects. It rarely does so, normally only during the emergency phase of a refuge influx while scouting around for implementing partners. The interventions refer to programmes and services, which are rendered to the population in need of survival in the short-term (in disaster and emergency situations) and, in longer term as a way of decreasing the vulnerabilities of the communities and building up their capacities. In refugee situations, such interventions also depend on the refugee policies of the hosting countries. To give but one example, refugees in Kakuma refugee camp in Kenya have been there for over 10 years, however, they are maintained on short-term (yet permanent) humanitarian assistance which include 100 per cent food ration while in the Uganda case which maintains agricultural settlements, refugees are expected to till the land and start living off it in the shortest time possible. Immediate short-term humanitarian interventions include the addressing of basic needs: shelter, food, clothing, health, water, and sanitation. The long-term include, but are not limited to, allocation of land plots, farm implements – hoes, sickles, seeds and education facilities.

Several factors influence who gets humanitarian aid and who does not. Moreover, in the Ugandan case, there are conditions in place which refugees must satisfy before they can access such aid. First, one has to be a recognized refugee by the hosting

government and the UNHCR. This spells out certain notions, such as areas of settlement, registered versus non registered. The Uganda refugee policy (see a detailed account in chapter 4) consists of rural agricultural settlements in government gazzetted land. These settlements are managed by settlement commandants recruited by the Office of the Prime Minister (OPM)[11] which office is also responsible for refugee matters nationally. Hence, refugee administration is centrally done in contrast with the decentralization policy. However, that is not to say that local governments do not have a say in refugee matters; they do but decisions are heavily influenced by the OPM. The choice of settlement is decided by the OPM and refugees have little say in that. As has been the practice in the past, the OPM makes an effort to settle refugees in areas that are akin to their ethnicity, for example, southern Sudanese are normally settled in northern Uganda, and refugees from Rwanda and Congo are accommodated in the refugee settlements in the west. But exceptions occur. For many years now there have been a small number of Sudanese refugees in Ibuga settlement in Kasese having been resettled there on grounds that they suffered from leprosy (personal communication with Matovu 2002). Similarly, there are about 1000 Somali refugees in Nakivale refugee settlement in Mbarara district (UNHCR Branch office, 2002).

Reasons behind settlements have been discussed (Harrell-Bond, 1986). Perhaps another important aspect that goes with settlements is that of recognition. After the relevant authorities have recognized people seeking asylum, they are then referred to as refugees. In other words, they assume a label. The term 'refugee' is further disaggregated to contain the male heads and female heads and the single heads of households, the 'vulnerables', a social and medical construct which is further broken down into further classes as the unaccompanied minors, the pregnant and lactating, the disabled, the aged and so on. An individual refugee normally bears no name but is called '*individual case* (*IC*). For UNHCR, the disaggregation is for planning purposes and proper provision of assistance. A number of authors have expressed their views on the negative aspects of labelling (Zetter, 1991; Harell-Bond, 1999; Horst, 2003). The negative aspects notwithstanding, in our study we established that the label(s) were gainfully used to access resources. In this respect, refugees in the category of extremely vulnerable individuals (EVIs) were quite happy to stay in the category as long as aid for them was available. Pregnant and lactating women received extra vitamins, and supplementary food in Imvepi (Mulumba, 1998) and Palorinya in Moyo[12] . In a discussion with some refugees in Kiryandongo, I was asked the use of their being called EVIs was if no assistance was coming. In yet another incident, it was important to be a recognized refugee before one is considered for scholarship, for resettlement or even for a loan. Thus, it can be argued that the refugees used their agency to maximize the benefits within the aid system. That was inside the settlement. Outside, refugees did not want to be recognized as such. In fact, men refugees in Kiryandongo paid tax so as to 'pass' as Ugandans. But as we shall see in the case of Tereza (case 9.5), her friends at school thought she was pretending to be a refugee so as to get free things. We can also recall the highly publicized unaccompanied minors in Kakuma who have since been resettled to the USA. In a way, the 'label' has succeeded in meeting, to a great extent, their strategic needs. I am not in any way suggesting that labelling is a good thing. I am only pointing out the positives that have accrued to refugees as a result of it. Therefore,

UNHCR, NGOs and hosting nations set the category and conceptualization of a refugee within which a refugee is perceived and receives his/her entitlements. Operating outside of these parameters would lead to exclusion and denial of resources – this means therefore that there is constant production and reproduction of the labelling by refugees and the institutional framework.

Having discussed the conditions that govern humanitarian aid, what are some of the experiences of those who receive aid? My study revealed ambiguous findings. On the one hand, refugees yearn for it and, on the other, would prefer not to get it at all. As one man in Rhino Camp said " *it is too small and comes too late*". Harrell-Bond discusses several aspects of humanitarian aid that negatively affect refugees in the process of seeking or utilizing it. She mentions among other things, the stress that is associated with the experience of empowerment through being helped "so characteristic of the process of becoming refugees" (1999:137), the gender differentials in experiences, constant swoops by the police as refugees wait for aid, and the lack of dignity in the humanitarian assistance planned for refugees in the South (*ibid*: 140) (*Bosnian aid was better but not perfect –added emphasis*).

For Somali refugees, the experience of headcount that requires refugees to be rounded up inside fenced lots does 'not respect basic human rights'. For them, this experience common to refugees in most camps 'reminded them of the slavery under Arab rule" (Hyndman, 1996:101).

It has been argued that not all is negative about crisis situations and disasters. Cuny (1983) asserts how communities and areas having undergone calamities and disasters are rehabilitated. Daley (1991) notes how the refugee experience is liberating to the youth from the confines of patriarchal control. Kibreab[13] believes that some times the refugee experience is an empowering one for women. The case study about Tereza in this study attests to the fact that there are some (albeit few) who gain from the refugee experience. Besides, many women were quite happy that their newborn babies were not dying as they used to in the Sudan because of the availability of health services. In addition, the Sudanese refugees who resettled in the West keep sending 'home' money to their parents and other relatives. Cindy Horst (2003) identified remittances in Daadab as key to the livelihoods of the Somali refugees in Kenya.

Non Governmental Organizations (NGOs)

The role of non-governmental organizations (NGOs) in disasters and complex emergencies and development has received considerable attention (Hilhorst, 2003; Hulme and Edwards, 1999; Zetter, 1999). Hilhorst (2003) argues that despite the vast numbers of NGOs, there is no single answer to the questions of what an NGO is, what it wants and what it does. NGOs are many things at the same time and it is difficult to determine their boundaries. Accordingly, to understand NGOs, she argues " we have to take on board a more dynamic approach to organizations, pay more attention to the working of discourse within them and, above all, accord more importance to the question of how actors in and around NGOs deal with the local, international and global

complexities that affect NGOs' shapes, values and practices.

Such an approach to organizations and organizational discourse will provide a vehicle to comprehend otherwise unresolved questions about the diversity among NGOs and the discrepancies observed in their histories, ideologies and practices" (Hilhorst, 2003:4). On a pragmatic note, Zetter discusses the important role played by NGOs working with grassroot communities, who normally are the first to report and to respond to the arrival of refugees. He notes that depending on the capacity of local agencies and the scale of influx, locally based responses are likely to be more in sympathy with the needs and coping mechanisms of refugees than dependency –creating, fully mobilized international programmes (Zetter 1999:62). However, he notes that the more complex large-scale emergencies of recent years have shaped a rather different NGO response. He shows the advantages of this response such as ability to act speedily, to collaborate with UNHCR in assessment missions and programme design and to conduct own assessments leading to very rapid deployments in advance of the main programme. Goyen *et al.,* (1996) discuss the positive elements of the NGOs response in Goma in the mid 1990s. These include reduction of mortality and morbidity by ensuring that the basic human needs are met. Such needs include shelter, water, sanitation, medical care and public health care. However, they also point to the harm that NGOs cause the local structures by making them devoid of the best staff because of their attractive salaries and allowances (even though short lived). This was witnessed in Rhino Camp when UNHCR cut its budget. This move forced many health personnel to resign their posts. The first to leave was the Medical Coordinator followed by all the Medical Assistants and the registered nurses.

According to Zetter (1999), evidence from a number of refugee emergencies across the world suggests that international NGOs, both before and after, 'take over' the programme. This practice marginalizes the indigenous community based organizations (CBOs). In the present study we identified two local NGOs, Inter Aid and the Uganda Red Cross[14] as implementing partners to the UNHCR. In Rhino Camp, one of the implementing partners during the emergency phase, the German Development Services (DED) eventually took over the programme. As for Kiryandongo, the withdrawal of Inter Aid left a gap (for a discussion of UNHCR withdrawal see Kaiser, 2000), which was filled by the OPM. The temporary relocation of Sudanese refugees from Achol Pii in 2002 due to insecurity in the north meant that the International Rescue Committee (IRC), which was implementing in Achol Pii moved to Kiryandongo[15]. Our own observation was that the geopolitical climate in the region affects the NGO time and financial input in the operational activities. NGO work in Uganda in the mid-1990s declined as the attention focused on Rwanda. The duration of stay influenced the type of activities to be implemented. At various times during the setting up of the settlements, there were very many NGOs implementing sectoral activities; only to disappear all of a sudden.

The expansion of humanitarian aid over the recent years has gone hand in hand with an increase in the number of NGOs. This situation has received criticism from several corners. Excesses were noted in duplication, such as the one in Sudan, that attracted

the participation of over 150 NGOs and in Rwanda with over 200 NGOs. With such numbers, operational coordination can become more difficult (Bennet, 1995; Rey, 2001). Although a moral yearning to help those in need has been said to be the cornerstone of NGOs, Rudolf van Bernuth thinks otherwise when he states: "(T)he reasons involved were staggering. The UN Consolidated Appeal for Rwanda in 1994 alone raised more than $1 billion. Probably another $500 million was raised directly by NGOs from the general public. This was big business, and the competition, between humanitarian NGOs and between human rights organisations, was intense" (Bernuth, 1996: 283). Many NGOs rely heavily, if not entirely, on funds from UNHCR for their overseas operations. Such heavy reliance on funding through UNHCR has led to enormous competition among NGOs for contracts (Harrell-Bond, 1986; Zetter, 1996). It is no wonder then that the local NGOs are marginalized. My own observations of NGOs in refugee work regard their dependency on UNHCR for funding. The NGOs who have solicited money from other sources such as American Refugee Committee (ARC) and UNFPA have implemented only short-term reproductive health projects whose impact is difficult to measure. Furthermore, the dependency on specialization by NGOs (e.g. nutrition experts, immunization experts, water, and environmentalists) renders the implementation of refugee projects cumbersome and unsustainable. The failure by UNHCR to identify local NGOs to implement refugee programmes makes the agenda rather questionable.

2.9 Concluding remarks

The foregoing discussion is about the subordination of women in sub Saharan Africa and how they are entangled in a web of both internal and external processes that affect the way they respond to new situations. I have discussed the rationale of employing the actor-oriented approach and gender analysis as the more dynamic approach to the understanding of social change, because it stresses the interplay and mutual determination of 'internal' and 'external' factors and relationships and recognizes the central role played by human action and consciousness (Long, 2001: 13). I argue in the above chapter that women start off at a subdued level into refugeehood; that despite the several feminists' debates concerning the needs of women and how these should be addressed, the UNHCR and the NGOs only partly satisfy on short-term basis the practical gender needs. This hardly makes any structural changes in the lives of women. I further argue that instead of viewing power as repressive *per se*, we should as well examine those aspects where women use subtle power to effect changes through their agency. I have also extended my observation regarding the tendency for UNHCR to view 'vulnerability' from the perspective of individuals' inherent and exhibited characteristics, for instance, 'pregnant and lactating', 'disabled', 'unaccompanied minor', 'female heads of households', et cetera, totally ignoring the vulnerability of the structures and institutions, which arguably should constitute part of the focus of attention. This perspective ignores the role of human action and consciousness. It is by considering, among other things, the role of actors, their knowledge and capabilities (the internally-generated strategies and processes of change (Long, 2001:15) that we can effectively address vulnerability. In the next chapter, I shall introduce the research questions and the methodology of the study.

[1] For analysis, I used the actor-oriented approach by Norman Long, see chapter 2, In: Norman Long (2001) *Development Sociology: Actor perspectives*. London: Routledge. Regarding the gender perspective I draw on Lorber and Farrell (1991) *The Social Construction of Gender*. Sage Publications. " Doing gender" as expressed by West and Zimmerman is a concept I rely on to explain some of the behaviour of the women and men refugees (see, Candace West and Don Zimmerman in Lorber and Farell 1991).

[2] According to the BBC news of 11 December 2003, the UNICEF in its Annual Report indicates that there are still gender inequalities in school attendance in Sub Saharan Africa and South East Asia.

[3] The BBC 20 June 2001

[4] This view may be changing in light of the war against terrorism.

[5] Since 1990, the UNHCR and Uganda government are implementing a Self Reliance Project for Sudanese refugees in northern Uganda. This among other things means that refugees should not be equal to and not above nationals.

[6] I found this a problem with the health services resulting from the failure to budget for the extra numbers. The medicine/drug kits were always running out before the mandatory three months. (I am not suggesting that this is the only reason, but it could be one of the many reasons).

[7] We saw this with Mme Sadako Ogata in 1998 with Rwandan refugees in Tanzania. Similarly, the United Nations High Commissioner for Refugees, Mr Lubbers travelled to Khartoum in November 2003 to discuss modalities of repatriating the thousands of Sudanese refugees in exile (BBC 15 November 2003).

[8] Several people including two government ministers I talked to hold this perception. They said refugees by virtue of having become stateless have no rights!

[9] It also happens that refugees seeking asylum in Europe at this time were White fleeing the Communist Block.

[10] The BBC 5 September 2002

[11] Under OPM there is the Ministry of Refugees and Disaster Preparedness.

[12] Reproductive health quarterly report by Africa Hilfe, implementing partner for UNHCR in Palorinya in 1999

[13] In a seminar paper on 10 November 2003 at Wageningen University, Dr. Gaim Kibraeb noted how in many cases women refugees had become empowered through skills
training, employment and the ability to make own decisions.

[14] The Uganda Red Cross has affiliation with the International Federation of Red Cross and Red Crescent Societies, as such it is not quite appropriate to call it a local NGO and Inter Aid was purposely created to implement the care and maintenance project for the urban caseload. The organization depends on UNHCR for all its costs.

[15] Towards the end of 2003, it was practically impossible to access Kiryandongo even when the Sudanese refugees from Achol Pii had been transferred to the districts of Nebbi and Arua in West Nile region.

3

Research Questions and Methodology

3.1 Introducing the Research Questions

Based on the theoretical and conceptual discussions in chapter 2, the following central research question has guided this study. "How do gender and power affect the livelihood security and reproductive health of refugees in Uganda and how do women refugees respond to these processes?" The specific research questions are:

1. What are the international and national approaches and policies to health in general and reproductive health in particular?
2. What are the institutional and organizational characteristics and practices of the health care aid programmes in Uganda and the refugee settlements?
3. What are the major social, cultural, economic and political features of the local environment?
4. How do refugees perceive reproductive health and how has the new situation of refuge changed their socio-cultural expectations, practices and coping mechanisms?
5. What is the role of power/gender relations at household and community level in influencing the utilization of reproductive health services in refugee contexts?
6. What factors contribute to 'gender-neutral' planning and implementation of reproductive health programmes in refugee situations and how can these be changed?

3.2 Methodology

This section sets out to show the research approach employed by the study and to explain the methods used in the collection of data in the attempt to answer the above research questions. This discussion proceeds as follows; I first discuss the research design. This is followed by the different phases of the fieldwork undertaken, and the methods and techniques used in the data collection. I proceed to specify the units of analysis and the sampling techniques used and elaborate on issues of representativeness, validity and reliability. I conclude with data management and analysis, and the problems and limitations encountered.

3.3 Research Design

The study is descriptive and exploratory in nature and the methodology employed was primarily qualitative and took the form of field observation and in depth interviews. Qualitative ethnographic methods were best suited for this study because they provided for close interaction, empathy as well as personal experience, which were crucial for the research questions raised (Fonow and Cook, 1991). Furthermore, through triangulation of methods (Tashokkori and Teddie, 1998), it was possible within a gender perspective, to explore the processes in a refugee situation, that impact the quality of reproductive health of refugees and how refugees devise coping mechanisms to deal with those needs. In addition, it was possible to advance the experiences, perceptions and interests of women refugees and to understand their behaviour towards their predicament, in a refugee situation in general and their reproductive health in particular. It was therefore important to pay special attention to the meanings women give to their experiences. Rather than maintain a subject–object relationship with the respondents, I adopted a strategy, which allowed for feelings, emotions and non-verbal information (Reinharz, 1992: 18-45). In addition, paying attention to the interpretations of respondents highlighted the role of socio cultural processes and structural contradictions in humanitarian aid, which shape gender dynamics in a refugee settlement. Moreover, through observations and interviews, it was possible to enlist the power relations at play within the several hierarchical layers of stakeholders in the refugee settlements. Although the research methodology included a survey, this was used solely for descriptive purposes and not for 'theory testing'. Supplementary data was drawn from an analysis of documentary research. The principal advantage of employing this methodological approach lay in its potential to elicit from the respondents rich, detailed material on several topics, which could be used in qualitative analysis (Lofland and Lofland, 1984).

A more comprehensive analysis of the interview transcripts and field notes was done through induction following the Grounded Theory approach advanced by Strauss and Corbin (1990) and Miller (2000). The basic principle of this approach is that a theory must emerge from the data; in other words, a theory must be grounded in the data. Hence the approach is inductive rather than deductive. This approach has been recommended (Frerks, 1991: 65 citing Swanborn) because I was not able to identify a sufficiently developed theory pertaining to the study at hand that could be tested and also because of its flexibility in responding to the complexity of the context. Furthermore, it was important to follow an approach, which was likely to optimize the pluralistic nature of the actors involved working on diverse findings and suggestions. Information collected through taking life or family histories was used to further contribute to an understanding of the social phenomena at stake. The aim of this research approach is the use of inductive, grounded theory strategies in order to work from empirical observations to the generation of concepts, taking great caution 'not to rediscover the conceptual wheel and ignore all work that preceded them' (Strauss and Corbin, 1990:11). According to Crabtree and Miller (1992:10), this kind of knowledge is informed by qualitative methods. In the case of refugee studies, the choice of an exploratory approach is a suitable one. A qualitative approach is suitable in refugee settings where one aims

at in-depth understanding of a social phenomenon and its concomitant variables in a holistic manner and understanding their mutual relationships. Several proponents of qualitative research, (Crabtree and Miller, 1992; Miller, 2000; Strauss and Corbin, 1990) have provided the justification for qualitative approach to research thus: qualitative data preserves the chronological flow, assesses local causality and derives fruitful explanations. Qualitative data are more likely to lead to serendipitous findings and to new theoretical integration as well as helping the researchers to go beyond initial preconceptions and frameworks. Lastly, qualitative data produces findings not arrived at by means of statistical procedures or other means of quantification. I also would like to add that research on such sensitive issues like reproductive health in a very dynamic and complex surrounding could only be done feasibly by adopting a qualitative and ethnographic approach.

The various forms of empirical inquiry as indicated below were engaged so as to embrace the pluralism of actors involved. These assisted me to explore what it means to be a woman refugee and the daily contestations and negotiations that are undertaken to ensure survival. Moreover, the research examined, within a gender perspective, the social relations between men and women as well as adolescents and how this affected the gender division of labour, time use and access to resources in the household, and those in the settlement, as well as the wider society as a whole. Refugees' coping and survival mechanisms were also subjected to inquiry, as to which means they used to access humanitarian assistance. The aspect of forced migration and humanitarian assistance brings an element of a change in the situation that obtained before the displacement, as compared to the new situation after the displacement. It was therefore important to establish the general situation including livelihoods, social services, and social relationships of the Sudanese refugees before being displaced and after displacement. In addition, refugees' perceptions, attitudes and behaviour towards reproductive programmes such as antenatal, hospital deliveries, contraceptive use and condom use were solicited. The perceptions of the health providers involved in the refugee aid system have been investigated as well. Given the above, it was necessary that an initial household survey be done to facilitate the determination of the general situation and the criteria for selection of case respondents and further issues of inquiry.

The Case Study Approach

Yin (1994:12-14), describes the case study approach as an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. This approach zooms in on social units as a whole and is suitable to answer the 'how' and 'why' questions about events because it provides better circumstances for creating mutual trust between informants and the investigator. It embraces multiple forms of information gathering and makes it possible to pay a number of visits to the household. Frerks (1991:70), refers to case study as a method of studying phenomena through *the thorough analysis of an individual case.* Miller (2000:7) associates the case study approach with more 'breadth' and its non-limitation to only a small number of variables in their analyses. Moreover, it is much more exploratory and less constrained by predetermined

protocols. Sociologists use life stories (life case studies) to understand and define relationships and group interactions and memberships (Atkinson, 1998:6 citing Linde, 1993). A life story can help the researcher define an individual's place in the social order of things and the process used to achieve that fit. It can help explain an individual's understanding of social events, movements, and political causes or how individual members of a group, generation or cohort see certain events or movements and how they see, experience, or interpret those social events that link to their individual development (Atkinson, 1998:14 citing Stewart, 1994). According to Crabtree and Miller (1992:5-6), case studies examine most if not all the potential aspects of a particular distinctly bound unit or case (or series of cases). They argue that qualitative description explores meanings, variations and perceptual experiences of phenomena and seeks to discover relationships, associations, and patterns based on personal experience of the phenomenon under question.

However, the case study approach is not without limitations. It can allow for unlimited scope to the inquiry, thereby posing danger to over accumulation of data (Mula, 1999:41 citing Campilan, 1995). In similar vein, Frerks observes that the often-quoted problems with case studies are lack of rigor in research method and analysis, lack of generalization, long duration and massive documentation in a narrative way. To counteract this he proposes a thought out selection of the units of analysis and observation and not to use any kind of information-sources at different levels' (Frerks, 1991:70). In the present study, I tried to avoid the limitations through a very careful selection pattern of the case respondents. I found this approach most suitable particularly in situations where women had experienced sexual and gender based violence a few years before the research. Surely, these experiences would not have been captured had I only employed an interview schedule. Moreover, a case study approach enabled me to probe further, to visit the relevant sites and to make observations as I went along. This yielded richer data. The study's overall approach having been largely exploratory and qualitative means that there has been no attempt at testing any hypotheses. After a purposive selection of the cases with the assistance of TBAs, women leaders and camp commandants, in-depth interviews were undertaken. They constituted asking one or two questions and letting the woman express herself in whichever way she felt worthwhile. At times she would call upon her relatives to remind her of the dates and names of things she could not quite recollect. In situations such as these, it was difficult to ensure confidentiality. In any case it appeared that the misery and experiences was not an individual thing, rather it was shared and felt by all concerned (except by the perpetrators of violence in cases of gender-based violence). I was reminded that it was an African custom to suffer with the suffering, to empathize with those in pain and to jubilate with those in happiness. Furthermore, refugees always hoped that research of this nature would produce results for the improvement of their situation. Needless to say, it took time to convince refugees that case studies interviewed on individual basis were what I looked for. However, I must say that in situations where the particular refugee was mentally retarded or an imbecile, I interviewed the members of the household particularly the parents as well. The majority of the case studies in this report took a minimum of three days to complete. A final concern was of course to select enough female cases. I do not have to argue that this was paramount to my study. In

this connection, I would like to quote Atkinson (1998:18-19) who asserts that more life histories need to be recorded of women on their cultural groups.

> "The feminine voice needs to be given opportunities to be heard, analyzed, and theorized about, at least to see if there might be a female equivalent to the monomyth, so that researchers will be able to determine more effectively the similarities and differences between the male and female experience and to seek a synthesis that would expand life story options for all and benefit both genders". (Citing Gergen and Gergen, 1993).

3.4 The different phases of the fieldwork

Fieldwork for this study was undertaken in two refugee settlements, namely, Rhino Camp in Arua district and Kiryandongo in Masindi district in Uganda. It was implemented in four distinct phases, namely, the preparatory phase, the household survey phase including focus group discussions and selection of the case respondents. The third phase included the case studies and key informants' interviews. The fourth phase included revisiting the study areas with the aim of verifying some issues that appeared not to be so clear during the analysis.

The first phase (November 2000 and January / February 2001) of the research was an exploration of the study areas in the districts of Arua and Masindi. Several activities were accomplished during this phase. These included the introduction of the intended study to the Office of the Prime Minister (OPM) and the district and refugee settlement officials, the UNHCR and the German Development Services (DED) - the implementing partner; obtaining research clearance by OPM; establishing rapport with refugee leaders and agency staff at the settlement level; and planning the logistics such as accommodation, transport and recruitment of interpreters.

Phase Two (July 2001 – February 2002) consisted of the household survey, focus group discussions and selection of the case studies. Some of the activities undertaken included:

- Selection of and training research assistants,
- Designing a semi-structured questionnaire,
- Pre-testing of the questionnaire [for content and clarity of questions, time length of each interview (the pre-testing the questionnaire was done on the Sudanese refugees in Kampala)],
- Making adjustments to the questionnaire,
- Conducting a household survey,
- Conducting focus group discussions,
- Key informant interviews,
- Selection of case studies

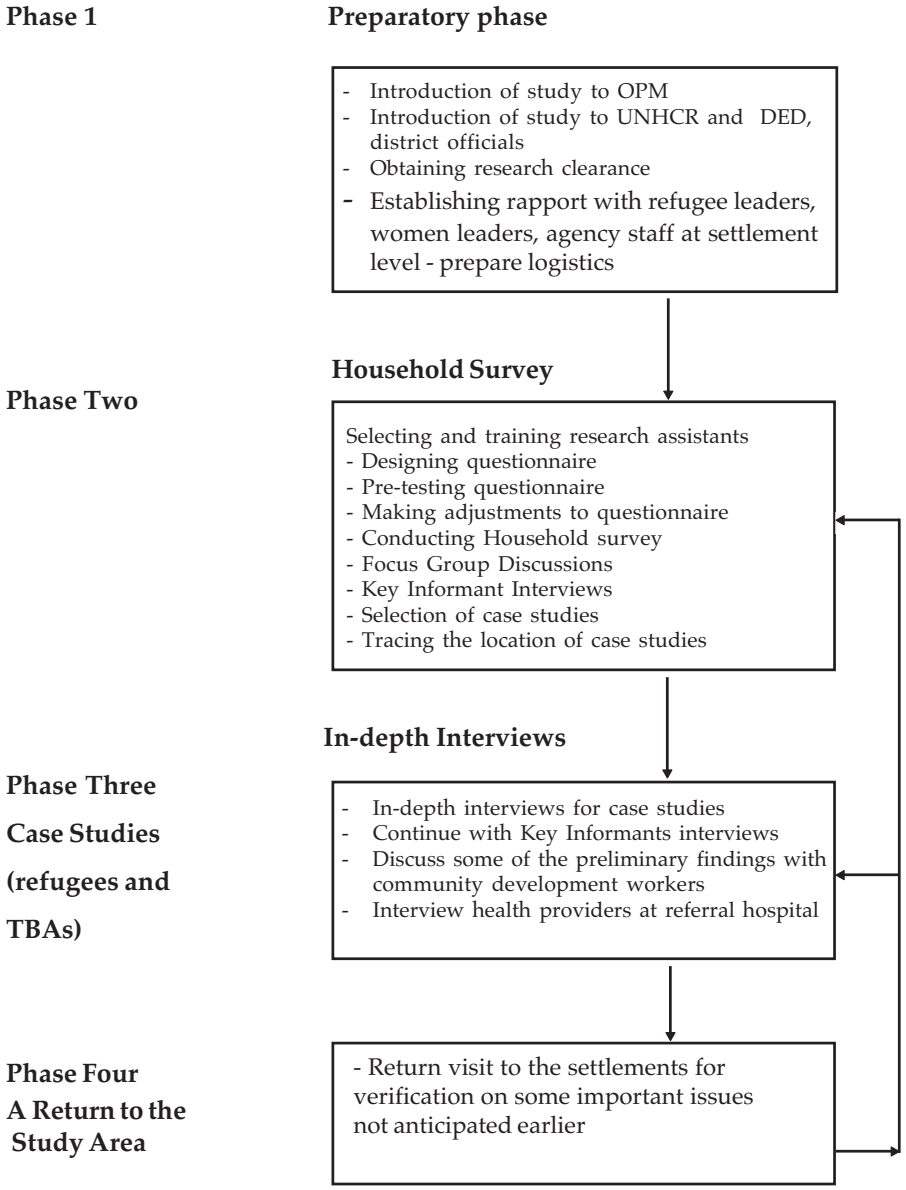
The activities were the same for the two refugee settlements except for one difference; the questionnaire for Rhino Camp included a section pertaining to knowledge, attitudes and practice of reproductive health interventions. This was because DED had just ended the implementation of UNFPA funded reproductive health project (1997-1999) which targeted both men and women refugees. The household survey as well as the

focus group discussions were done jointly with the research assistants. I personally conducted the interviews with key informants who included the settlement commandants, women and men refugee leaders, implementing Agency staff, UNHCR medical personnel, OPM staff, Local district authority staff, health providers including TBAs and a priest in the case of Kiryandongo.

In Phase Three (August 2002 – February 2002) of the fieldwork I conducted case study interviews. The case studies took long to complete as the respondents required considerable time to recollect events and the cooperation of some other concerned or related players such as parents. In one particular case of a deaf mute that had been raped, it was necessary to make return visits until I was able to get the mother for detailed explanation of her daughter's experience. As indicated above, it was almost impossible to guarantee confidentiality as information pertaining to many of the cases had to be solicited from different sources e.g. community workers, settlement commandants, refugee leaders, etc. In addition, we had to discuss some of the cases (after permission by the respondent) with the settlement officials for possible interventions. A few cases of rape, disability and unwanted pregnancies were discussed with staff of the implementing agency for possible assistance.

In Phase Four (October 2003) of the fieldwork, I returned to the study areas to verify certain aspects that had been missed. In particular, I visited Kuluva Mission Hospital once again to interview the health providers on the type of cases referred to them. I also used the opportunity to take some photographs of mothers who had undergone caesarian sections. In addition, I wanted to ascertain how the management of fistulae was done. In Kiryandongo, I followed up two case studies of interest and visited Bwayale, a market that has flourished due to the presence of refugees in the area.

Diagram 3.1: Showing the Phases of Fieldwork



3.5 Methods and Techniques for Data Collection

Data has been collected from secondary and primary sources.

Secondary Data

Raw data were obtained by a detailed content analysis of written records and documents, some of which included the following:

- Official government documents, national health policy documents, etc;
- UNHCR documents including guidelines and policies on the protection of women and reproductive health care service for refugees;
- Records at health units and hospitals;
- Tripartite agreements (Agency / GoU / UNHCR);
- Project reports by implementing agencies;
- Journals covering refugee issues, gray materials and published reports;
- Archival documents on refugees in Uganda;
- The Daily News Papers;
- The Media (in particular, the BBC);
- Books and publications on feminism and gender, sociological theory and methodology.

Primary Data

The techniques for collecting primary data included the following:

The Survey:

Surveys were undertaken in the two refugee settlements of Kiryandongo and Rhino Camp for descriptive purposes. The surveys included investigations of the pre-flight, refuge seeking and post-flight situations. They were administered through the use of a semi-structured interview schedule, which had been translated into Madi, Acholi, Juba Arabic and Swahili languages. It was important therefore that I got interpreters well conversant in those dialects. In most cases the questionnaire was administered on behalf of the respondents, as many of them could not write well. Caution was taken to ensure that the responses were written to represent what the respondent wished to say. At the end of each interview, we read out the responses to see if they reflected the real message. In cases where it did not, changes were made accordingly. In addition, focus group discussions were undertaken to get deeper insights into meanings that were portrayed. The surveys focused on the following data:

- Data related to the refugees' demographic profile of refugees: age, sex, education, religion, marital status, age at marriage, whether living with spouse or not, date of arrival in settlement, headship of household;
- Data related to gender roles, gender division of labour, access to resources including finance and social services, livelihood activities, time use and activity profiles;
- Data related to tangible and non tangible resources:
  size and productivity of land plot, accessibility to social services and other resources in the settlement, social support systems and pattern of settlement,

application of indigenous knowledge in health related matters, sources of income, mobility, education facilities;
- Data related to gender-based violence within the household and in the community;
- Data related to reproductive health profile: number of children ever born, Number of alive, attitudes towards health unit deliveries, attitudes towards family planning, home-assisted deliveries and TBA, indigenous remedies, accessing reproductive health services, such as antenatal and postnatal care, immunization, contraceptives, STIs including HIV / AIDS;
- Data related to the health providers;
- Constraints encountered and solutions to the constraints.

Interviews

An interview is a method of data collection that may be described as an interaction involving the interviewer and the interviewee, the purpose of which is to obtain valid and reliable information. Interviews may range from casual conversation or brief questioning to more formal, lengthy interactions (Marshall and Rossman 1995:82). We explained the purpose of the interviews and sought permission from the refugees for their participation after assuring them of confidentiality. However, while the promised confidentiality was maintained in the case of the survey research, it proved almost impossible with case studies.

According to Fontana & Frey (1994) there are a number of interview models that can be applied in a qualitative-oriented research approach. In general there are two main types, the formal and informal interviews. Their use depends largely on the aim of the study and the researcher. Formal interviews are employed in structured settings in order to standardize interview topics and general questions. In-depth interviewing is more suitable for qualitative (case study) research (Atkinson, 1998; Marshall and Rossman, 1995). Described as a "conversation with a purpose', in-depth interviews help to unfold a participant's perspective on the social phenomenon of interest as the participant views it, not as the researcher views it (Marshall and Rossman, 1995:82). However, the interview technique has weaknesses and limitations. According to Marshall and Rossman, interviews must involve people and their cooperation is necessary. Interviewees may not be willing to share all the information that is needed with the interviewer. The interviewer may not ask appropriate questions because of lack of expertise or familiarity with technical jargon; conversely, the interviewer may not properly comprehend the answers to the questions or, worse still, interviewees may not always be truthful (Marshall and Rossman, 1995:83).

To reduce this problem, I employed triangulation of research methods and did not entirely depend on interviews. "Designing a study in which multiple cases are used, multiple informants or more than one data gathering technique can greatly strengthen the study's usefulness for other settings" (Marshall and Rossman, 1995:146). In the present study, we conducted formal as well as informal interviews. In addition observations and focus group discussions were done to enrich the data. I employed a

semi-structured questionnaire for the refugees, a checklist for focus group discussions (FGDs) and question guide for the Key Informants, these can be viewed as annexes. A variety of people were interviewed:

- Refugee women, men and adolescents of both sexes were interviewed on several issues including among others; livelihoods, socio-economic activities, the relations within the household, the use of health facilities, their value of children, the reproductive health history including number of children ever born, sex and state of living children, knowledge and use of contraceptives, violence and STIs; the strategies the women refugees employ to manage their reproductive health needs; the constraints and obstacles they face; their relationship with the health providers, the TBAs, the settlement commandants; their role in refugee leadership in the settlements; issues of sexual and gender-based violence.
- TBAs were interviewed on matters concerning conducting deliveries, their use of indigenous knowledge and how equipped they were in case of emergency.
- Health providers in the refugee health centers were interviewed on their own professional capacity, and on reproductive health programs implemented and types of cases referred and the way they were managed.
- Health providers in referral hospitals were interviewed on the nature of complications referred to them by the refugee health units and how these were managed.
- UNHCR, UNFPA, OPM, District officials and Implementing Partners on the implementation of reproductive health programme in particular.
- Ministry of Health (reproductive health policies) and the degree of gender incorporation in reproductive health programs.

3.6 Units of Analysis and Observations

I selected several units of analysis because the study presented several entry points. Frerks asserts that the unit of analysis is the entity one wishes to explore, describe and explain through a sociological inquiry, while the unit of observation refers to the subject that one approaches by applying one's methods or techniques of data collection (Frerks, 1991:74). The main unit of analysis is the women refugees in the context of the households and the surroundings. Another entry point was the health program. Actors in these institutions were the health providers, staff of UNHCR and NGOs, the TBAs, the divine healers and male refugees.

3.7 Selection of the study area and Sampling

Selecting the Study Area

Selection of the research site is crucial to any attempts at qualitative research. Marshall and Rossman (1995:51) consider the ideal research site as the one where entry is possible; where there is a high probability that a rich mix of the processes, people, programs, interactions and structures of interest are present. Furthermore, the site should provide space for the researcher to be able to build trusting relations with the participants of the

study, and where data quality and credibility are reasonably assured. In the following sections I shall discuss the reasons why the districts and study areas were selected.

Masindi District

Masindi district was selected because it accommodates one of the oldest refugee settlements in Uganda, which still accommodates refugees in large numbers. Other older refugee settlements such as Oruchinga Valley Refugee Settlement established in the early 1960s have experienced a progressive reduction in numbers as the Banyarwanda refugees started repatriation back to Rwanda since 1995.

Although approximately 5,000 new Hutu (UNHCR, 2001) new refugees have sought refuge in Uganda after the genocide in Rwanda in 1994. Besides, Masindi district is renowned for accommodating all the 52 tribes in Uganda. There is also a historical perspective to the selection of the district. Polish refugees were hosted at Nyabyeya in Masindi in the 1940s, during and after the World War II. (Lwanga-Lunyiigo, 1998). Furthermore, the district is of special interest in that during the end of the 1990s humanitarian assistance was withdrawn on the assumption that refugees are self-reliant, except for some minor supplies for the vulnerable groups. The health programme was handed over to the district though the payment of staff is still done by UNHCR through OPM.

Kiryandongo Refugee Settlement

Kiryandongo was the only refugee settlement in Masindi district and as such there was not much of a choice. It was established in 1990 and is fairly accessible by road. More importantly, the refugees in this settlement were fairly homogeneous in that approximately 90 percent were Acholi by tribe. Currently, the distribution of food and non-food rations has stopped except for about 5 per cent of refugees in the settlement. The refugees are expected to produce their own subsistence food supplies, in addition to surplus for sale. Funding from UNHCR has been drastically reduced to just enough to cater for the salaries of health personnel, and supplementary medicines that may be lacking in the 3-monthly drug kits supplied by the district health authority. Furthermore, the armed conflict in northern Uganda which has persisted since 1986 has displaced many Ugandans, as well as refugees in those areas who have sought refuge in the areas surrounding Kiryandongo. It has been suggested that many actually reside in the refugee settlement. For example, when the LRA rebels hit the Achol Pii refugee settlement in the Pader district on two occasions in 2002 more than 120 refugees were killed, while many refugees were displaced,[1] as a short term measure, the government of Uganda and UNHCR relocated the refugees to Kiryandongo on temporary basis. The displaced refugees from Achol Pii were resettled in the districts of Nebbi and Arua in West Nile region in September 2003.

Sampling technique in Kiryandongo

Refugee statistics indicate that there are 1800 households with a refugee population of 10,250 in Kiryandongo (UNHCR, 2002). In addition Kiryandongo refugee settlement has three ranches named ranch No. 1, No. 37 and No. 18 and a total of thirty settlement clusters lettered AA to ZZ. Four settlement clusters were selected randomly in ranch 18 because it was a bigger ranch with the biggest number of refugees. It was also the last to be inhabited. Three clusters each were selected in ranches No. 37 and No.1 making it a total of 10 clusters from the three ranches. Using the existing lists at the commandant's office, a sampling frame for refugee women was constructed. From this new frame and using systematic sampling with a random start, we selected 120 women refugees. It was also necessary to include a few husbands of some of the women on the sample and a purposive sample of 50 men was selected. In addition, two schools out of four in the settlement were selected for inclusion of the adolescents. From each of the two schools we selected 15 boys and 15 girls making a total of thirty adolescents.

Another group purposively added to the sample were the key informants. They included health providers, agency personnel, refugee leaders, teachers, settlement commandants and religious leaders who also suggested names of case study respondents.

Table 3.1: Sample by sex and ethnic grouping in Kiryandongo

Tribe / Ethnic group	Adolescents		Women refugees	Men refugees	Total
	M	F			
Acholi	10	10	64	20	104
Baring	3	2	14	5	24
Didinga	1		4	4	9
Madi	1	2	25	10	38
Lotuka		1	10	6	17
Lango			3	5	8
Total	15	15	120	50	200

Source: compiled during fieldwork

Arua District

Arua district was selected for the following reasons: First of all, it forms part of West Nile region where in the early 1980s most of the population was displaced into Sudan, and north Democratic Republic of Congo (DRC). During the course of the war that got rid of Amin and his henchmen, the infrastructure including social services was destroyed, such that after the war the returnees and the Sudanese refugees were much in a similar situation of need. Secondary, Arua district has ethnic similarities with the

tribes of southern Sudan. Moreover, the West Nile region, like in most parts of northern Uganda, is quite marginalized in terms of infrastructure, economy, social services and is less developed than the south, and yet it hosts a big case load amounting to slightly over 180,000 registered refugees (UNHCR, 2002), excluding the self settled. Lastly, the choice of the district was based on occasional reports of insecurity caused by some LRA rebels fighting the Uganda government.

Rhino Camp Refugee Settlement

The selection of Rhino Camp refugee settlement was based on its physical and geographical isolation. It is located in one of the least developed regions in Uganda, where transport facilities hardly exist and where initially no Ugandan citizens wished to reside. Historically, Rhino Camp was a game reserve where many rhinos could be found. Unfortunately, they were hunted to extinction. Some parts of the settlements are non-strategically situated in the rain shadow, and this negatively affects some of the settlements. Insecurity in northern Uganda has not spared Rhino Camp settlements. For example, rebels attacked it[2] in 1998 and approximately 8 girls at Imvepi refugee settlement were kidnapped.

The Rhino Camp settlement, which was established in 1995, continues to receive new refugees. The programme in Rhino Camp is on 100 percent UNHCR assistance with fully funded, well-equipped and well-staffed health units. Almost 90 percent of the refugees are on food rations. However in July 1999, a new strategy called the Self Reliance Strategy (SRS) was implemented as a measure to wean refugees off aid. It was implemented in the Sudanese refugee affected areas in northern Uganda, and if successful, it was to act as a model for the remaining refugee settlements in Uganda. However, the recently concluded peace agreement on 8 January 2005 between the Sudan government and the SPLA could make a difference to the future of Rhino Camp (CNN.Com 9.1.05; BBC News, 9.1.05; VOA News; 9.1.05).

Selecting the Respondents

Forty-three clusters make up Rhino Camp refugee settlement. The refugee statistics indicate that there are 9,346 heads of families in the 43 clusters. It was not possible to cover the whole settlement, due to its very large size and the poor and unreliable transport at my disposal. Therefore, through a random sample of the sub-settlements, ten clusters were selected for the initial survey population. In addition, purposive selection of the sub-settlements was done located far away from the basic social services and including the ones accommodating the Dinkas who appeared to have been settled at the periphery of the settlement. The 10 sub-settlements / clusters selected included; Eden, Tika 1&2, Ariwa 3, Ngurua A, Katiku B, Olujobo, Simbili 1, Siripi, Yelulu. Using food distribution lists, it was possible to construct one sampling frame from which a sample of 130 women was selected using systematic sampling with a random start. A purposive sample of 50 men who had to be husbands of fifty of the women in the sample was selected. In any case where a particular selected woman was missing, another woman on the list was selected as a replacement. A list for the adolescents was

obtained from randomly selected schools of Tika, Eden, Siripi and Yelulu. A total of 60 adolescents were selected from primary four to seven and between the adolescent years of 10-19. Although initially the study targeted women refugees, our subsequent views and results from the pilot study made it imperative that the sample included adolescents and men as well. Details of the sample for Rhino Camp can be seen in Table below.

Table 3.2 sample by gender and tribe in Rhino Camp

Tribe Ethnicity	Adolescents		Women	Men	Total
	M	F			
Kakwa	8	8	35	15	66
Kuku	7	5	22	10	44
Madi	6	16	51	12	85
Pojulu	2		10	13	25
Zande		1	4		5
Dinka	1		3		4
Bari	6		4		10
Mutesi			1		1
Total	30	30	130	50	240

Participant Observation

Observation was a very important tool in the data collection exercise. Direct observation can be a valuable tool for the collection of data for it allows one to look at a situation through the eyes of a non-participant observer, noting exactly what is seen with little emotional involvement to what is being observed (Patton, 1990). Observation entails the systematic description of events, behaviour, and artefacts in the social setting chosen for the study. Participant observation is a special form of observation and demands first hand involvement in the social world chosen for the study. Immersion in the setting allows the researcher to hear, see, and begin to experience reality as the participants do (Marshall and Rossman, 1995: 79). I stayed in the settlements for long periods at a time. Through observation, I saw respondent's body language, body emaciation, scars, shouting at the health units, the endless queues at water points, repetitive daily food processing such as the grinding of sorghum and simsim; the borrowing of grinding stones, small 14 and 15-year mothers with babies on their backs, young girls selling alcohol, a mother breastfeeding her baby and her daughters, man fighting another man over queuing at water point on behalf of his wife, the long queues at the Settlements' Commandant's office, burial ceremony, and participation in the market place and several other activities.

Selecting the Case Studies

Although, in principle, I depended on the results of the survey to determine the criteria for the selection of the case studies, the final selection was guided and influenced by social and community workers, key informants, settlement commandant and health providers. The selection was also based on one or more of the following guiding factors:

- The majority of cases had to be women refugees within childbearing age;
- Had to be adolescents of either sex;
- Had to have undergone sexual and gender- based violence;
- Teenage mothers;
- Husbands of women refugees in sample

Eventually, 14 case studies were selected as the table below shows.

Table 3.3 case studies interviewed

Chapter 8	Country of origin	Settlement	Sex/age	Characteristics
8.1-Limo	Uganda	Self-settled	Male/55	Defying local norms and customs
8.2-12 year old	Sudan	Rhino Camp	Female/12	Lured into sex by 37 year old driver
8.3-Kiden	Sudan	Kampala	Female/40	Sex trade as coping mechanism
8.4-Nurse /Midwife	Uganda	Based in Rhino camp	Female/ Adult	Health / Hygiene lessons
8.5-Health	Uganda	Rhino camp		Health provider / provision patient encounter
8.6-Mariam	Sudan	Rhino Camp	Female/15	Under-age pregnancy negative attitude by health providers ceasarean section
8.7-Iyom	Sudan	Rhino Camp	Female/40	Traditional Birth Attendant
8.8-Shewla	Sudan	Rhino Camp	Female/17	Rape by camp driver Pregnancy, and Dissention
8.9-Esther	Sudan	Rhino Camp	Female/20	Post natal mental disturbance, child rejection
Chapter 9				
9.1-Anna	Sudan	Kiryandongo	Female/25	Gender roles, personal development and violence
9.2-Annen	Sudan	Kiryandongo	Female/12	Violence, Teenage pregnancy and death
9.3-Arach	Sudan	Kiryandongo	Female/30	Ex-rebel fighter, sexual abuse, violence and educational ambitions
9.4-Khasifa	Somalia	Nakivale	Female/23	Unaccompanied minor with siblings, access to resources
9.5-Tereza	Sudan	Kiryandongo	Female/27	Vulnerability, risk taking, coping strategy

A total of 14 case studies were recorded (9 in Rhino Camp, 1 in Nakivale and 4 in Kiryandongo).

In summary, we can say that the present study employing the case study approach has employed a combination of qualitative research methods including semi-structured interviews, in-depth interviews, and participant observation. The main aim has been to gain a deeper understanding of the complex nature and dynamics inherent in the various processes in a refugee settlement, particularly those concerning the provision

and utilization of reproductive health services and livelihood strategies. These will unfold in the coming chapters.

Employing Assistants

The services of a research assistant were necessary right from the beginning of the fieldwork because of the need to translate the questionnaire from English to Juba Arabic, Madi and Kakwa and Kuku. In addition, the fact that there had been insecurity in the survey areas made it necessary that some one indigenous and known in the community introduced us and explained about the field research in all parts of the settlements before the commencement of the survey. This activity was accomplished with the aid of two bicycles purchased. Four university graduates in social sciences with sound knowledge in research methods and interviewing skills were recruited as research assistants to help me with the surveys. One exceptionally good research assistant hailing from the district and fluent in the refugees' dialects as well as English was retained to assist with the case studies and to do some of the follow-ups.

Although the research assistants had a theoretical grasp of data collection, they lacked the practical 'hands on' expertise and it was therefore necessary to spend two weeks training them in methods of data collection. We went through the questionnaire and ensured that the translation carried the intended meaning. In order to evaluate its effectiveness, the questionnaire was first subjected to pre-testing on a number of Sudanese refugees in Kampala, testing especially for the importance of note taking, personal biases, rapport, observation and listening.

3.8 Data Management and Analysis

The data collected from the survey was edited in the field before being subjected to a statistical package (SPSS) for analysis by a statistician. The open-ended questions were coded and then entered into the computer.

Qualitative Data

The qualitative data, from focus group discussions and observations were transcribed from the tapes (the few that were taped) and from the notes taken and key themes, ideas and opinions identified. Analysis of qualitative data was done within the stages as proposed by Sarankos (2003:315) as follows:

Stage 1: Data reduction

This process involved a careful reading of the recorded material, identification of the main themes of the studied process, behaviour and so on, and categorisation of the material for the purpose of analysis. During the analysis, generalisations and interpretations were made. This process continued until the research was completed. In the case of participant observation or in-depth interviewing, data reduction occurred at the point of interaction with the respondent. Information was collected, processed,

analyzed and the process continued until the research was completed.

Data Organisation

This is the process of assembling information around certain themes and points, categorising information in more specific terms and presenting the results in some form. The present study has presented the findings mainly in text form.

Stage 3: Interpretation

This stage involves making decisions and drawing conclusions related to the research question. Identifying patterns and regularities, discovering trends and explanations are aspects of this process, which will allow the development of some firm view to guide the research further, namely more data collection and reduction, organisation and interpretation and so on. In the present study we followed the research process until the data collection yielded nothing new. In other words a saturation point had been reached, beyond, which we would be repeating ourselves (Miles and Huberman, 1994). The case studies and personal narratives were analysed in a similar manner.

The case studies were analyzed manually, carefully listening to the stories and making sense of them within the context of gender, age, marital status, access to and control of resources, vulnerability and gender division of labour and education. Additional qualitative data were categorized and attached to various topics for illustrative purposes and to enhance understanding of the other data.

3.9 Representativeness, validity and reliability

The analytical study of two refugee settlements on the basis of an exploratory and in-depth qualitative approach of two refugee settlements may not appear to be representative. I am also aware that although the sample for the general survey was randomly selected, the subsequent selection of the case studies may not have followed the normal rules of random sampling facilitating representativeness. But this is not to say that the research is not relevant. The case studies are quite detailed and reflect many ignored and isolated cases that are not so visible or are often overlooked due to the stereotypical perceptions of gender. Furthermore, the two settlements are sufficiently large with many diverse ethnic and socio-economic components to be regarded as sufficiently representative. The data from the survey and focus group discussions and observations are quite rich and augment the case studies quite well. Present factors and processes could be connected to the past and this was seen leading to particular outcomes and events.

The validity of the research stems from the research methods we employed in the collection of data. The adoption of qualitative procedures, the in-depth interviewing, the FGDs which required repeated visits allowed for extensive observation as well as probing and cross checking. In addition validation was realized by the triangulation made through the different methods employed to collect data and through the multiple

sources of information. The reliability of the study was enhanced through the use of: semi-structured questionnaires, in-depth interviews, rechecking the responses to questions, training of research assistants and use of a check list for in-depth and Key Informant interviews. Besides, we have adopted an explicit conceptual and theoretical framework in addition to a detailed methodological approach.

3.10 Problems and Limitations

This research has not been without problems. First of all, even though I am an African woman, my background was fairly different from that of the refugee women studied in terms of ethnicity, education and social standing. It appeared that I was operating in a social and cultural setting different from the one I was accustomed to. However this was soon overcome after a series of interactions with the refugees at a personal level and I decided to dress in a similar simple and 'culturally accepted' way, shared meals with them, fetched water at same bore hole, attended their burials and when I saluted them in their language. Another limitation I consider to have affected my study is the person-season (Chambers, 1983) field visits done during only a shorter period of time, which does not reflect the environmental conditions of the local area. Biases formed can influence the researcher to focus on issues that are misguiding. I tried to get over this problem by making several research visits during different seasons.

Qualitative interview methods require a lot of time. The significance of time then becomes an issue especially when such interviews interfere with people's daily activities. For women the work schedules seemed to occupy them all day. It was therefore more convenient to carry out the interviews during market, antenatal and immunization clinic days when the women had some time to spare. Exceptionally, visits to the borehole and drinking places were found to be useful.

The question of language proved a considerable handicap on several occasions due to the multiple ethnic backgrounds of the settlement population. This problem was however overcome by selecting mainly respondents conversant in Juba Arabic, Swahili and or a Ugandan language. This strategy may not have guaranteed representativeness, but fortunately, most refugees speak or have a fair grasp of Juba Arabic and I was also able to recruit an interpreter to simplify the problem. Another huddle I had to contend with was the issue of meanings of certain words. This was quite challenging in a social space that provided several cultural values and knowledge, which also provided room for different ways of interpretation. I also sensed, at times, that the interpreter tended to correct interviewees' responses for my understanding, which can easily influence the reliability and validity of the data.

Finally, I encountered many logistical problems during data collection. As already mentioned Rhino Camp refugee settlement is isolated geographically from other areas in Arua. There was no vehicular transport of any form in the settlement. Discarding the bicycle, which was the only transport available but which could hardly be ridden on sandy paths, I had to walk on foot to the scattered settlements. This took a lot of time and interfered with the time schedules I had worked out with the respondents.

Furthermore, the implementing partner, DED, observed the agreement rules to the full. As a non-UNHCR and non-DED staff, I was not allowed the benefit from their transport except on one occasion when I was allowed to accompany the Assistant Community Services Officer and thus the use of the vehicle. I also got to understand that the staff was under strict orders not to talk to me except with prior permission from the Program Coordinator. This proved cumbersome and I feel there is a lot of information I was not exposed to. This forced me to be more alert, to keep ears and eyes open just in case I miss out on something important or useful. However, the health providers were quite receptive and responded well to most of the questions.

The above notwithstanding, I must commend the efforts put in by the Implementing Partner in Rhino Camp to avail me with accommodation on the many occasions I visited the settlement and for the advice to hire a motorcycle from one of the casual workers. Unfortunately this arrangement worked only briefly before the motorbike broke down. Besides, fuel could not easily be obtained anywhere nearby. We had to send for it from Arua, which was 60 km away. This meant extra costs and waiting. The research assistants used the bicycles as they were used to the sandy roads, for Arua was their home district. For me, this meant doing most of the case studies and FGDs on foot. Fieldwork in Kiryandongo was much better as it was possible to hire a properly functioning motorbike any time it was needed.

Finally, there was always the ever-present apprehension that the settlements, especially Rhino Camp, could be attacked by LRA. Indeed the research process was disturbed in August 2002 when overnight the settlement received some 20,000 refugees displaced from Pader district as a result of rebel activities in northern Uganda. During this period, there was plenty of insecure activity, apprehension and excitement amongst the refugees in the settlement. We were forced to suspend the interviews and move out of the area and returned a month later when refugees were calmer and the new caseload better settled.

[1] The New Vision, 20 August 2002
[2] Personal communication with Dr, Clement Luluga of Imvepi health services November, 2000

4

The history and management of refugees and displacement in Uganda

4.0 Introduction

The aim of this chapter is to give a historical perspective of refugee movements within Eastern Africa in general and Uganda in particular during the last fifty years. Although armed conflict and refugees are not a new phenomenon, they pose special challenges given the typology of conflict, the weaponry used and the consequences to humans and their livelihoods and the changing international responses to refugees and asylum seekers. Moreover, the gender-based violence of conflict and health overtones coupled with the HIV/AIDS epidemics now appear to be transcending the physical and psychosocial ill-health and are threatening the actual existence of the African population. Besides, the protracted nature of armed conflicts retards socioeconomic development as most of the governments' energy is usurped in the process of counteracting the effects of the armed conflict and insurgency. Sadly, the majority of African countries south of the Sahara have been plunged into armed conflict at one time or the other during the last forty years. Causes of such conflicts are many and outside of the present discussion. However, suffice to mention that most of the armed conflicts have been waged as a result of annihilation due to ethnicity complexes, poor governance, inequitable distribution of resources, mineral squandering and so on. It has been documented (Pirouet, 1988) that since 1955 the Great Lakes region of eastern Africa has been plunged into endless armed conflict, which has resulted into among other things, mass exoduses and influxes of refugees into neighboring countries and beyond. The next section of this chapter gives an overview of pre-independence migration into Uganda and the influx of Second World War refugees. The third section is about refugees in Uganda. In the fourth section I discuss the effect of armed conflict in Uganda on forced internal displacement. In each section I shall indicate how the government at the time managed the internal conflict or NGOs dealt with the refugees or IDPs resulting from the conflicts in the Great Lakes region including Uganda itself. Finally the chapter ends with concluding remarks.

4.1 Pre-independence migration and Second World War Refugees

In the period before 1960 migration of people from one African country to another occurred mostly for economic reasons and colonial service. During the colonial rule in

Uganda and particularly after the 1884 partition of Africa, the immigrants in Uganda included the Asians brought by the British to construct the East African Railway line, the Nubians from Sudan who fought alongside the British, the Kenyans and Sudanese who worked in the sugar and rubber plantations (Pirouet, 1988). This period also includes the Kenyans who fled Kenya during the Mau Mau uprisings in the 1950s and settled in Masindi (Lunyiigo, 1998). Immigrants also included the Banyarwanda to whom we turn in the following section. A second major influx occurred during the Second World War and is dealt with after the description of the Banyarwanda migrants.

The Banyarwanda migrants

The issue of the Banyarwanda[1] in Uganda remains a contentious one mainly due to the difficulties in the definition process of a Ugandan Munyarwanda versus a Munyarwanda refugee. Historically the Banyarwanda in Uganda fall in three categories. The descendants of migrants who came to Uganda in search of better opportunities between 1920 and the late 1950s; the Banyarwanda (also known as Bafumbira) whose ancestral home can be referred to as an 'enclave of Kinyarwanda speakers' in Uganda on the south western border between Uganda and Rwanda, itself a creation of the definition of colonial boundaries in 1884; and, the third category consists of the Banyarwanda and their offspring who sought refuge in Uganda since the 1960s.

The introduction, in 1908, of cotton and sugarcane in Buganda in central Uganda attracted the Banyarwanda to migrate to Uganda. Although not much has been documented on the Barundi[2], from the oral interviews, I was made to understand that many of them migrated to Uganda alongside the Banyarwanda[3]. This was timely in Buganda, which had experienced a decline in population between 1870 and 1920 as a result of war and disease. Another factor likely to have induced the migration was the draconian forced labour introduced by the Belgians in Ruanda-Urundi. Literature reviewed indicates that as a result of inquisitions, "the people hardly had time to grow food, and famine threatened" (The U.S Committee for Refugees 1991:4). Life became unbearable for many Banyarwanda who, often afflicted by famine, migrated in hundreds of thousands to Uganda. The majority of these were Hutu who had become increasingly dominated and exploited by the Tutsi ruling majority partly as a result of Belgian policies (Pirouet 1988:240 citing Linden 1977). They migrated to escape labour dues and to find money to pay their taxes and mostly found work in agriculture in Buganda. Furthermore they had little contact with the Tutsi cattle keepers who had migrated to Ankole at the turn of the century. The pre-colonial period therefore can be said to have hosted many immigrants of various ethnic and racial backgrounds. The interviews revealed that the Hutu group of Banyarwanda and Barundi was assimilated in the areas they migrated to as many of them took on local names, customs and spoke the local languages.

Second World War Refugees

Many Europeans were displaced resulting from the Second World War (1939-1945). Some of the displaced who included civilian internees and prisoners of war from Poland,

Germans, Austrians, Romanians, Bulgarians, Yugoslavs, Hungarians and stateless Jews were brought to Uganda, Cyprus, Syria, Palestine, Egypt, Ethiopia, Eritrea and Somaliland (Lunyiigo, 1998). Approximately 7,000 Polish refugees comprising mainly women and children were hosted in the districts of Masindi and Mukono in Uganda while Italian prisoners of war and civilian internees were accommodated in Jinja and Entebbe respectively. The Arapai camps near Soroti accommodated civilian internees of the Axis powers brought to Uganda from Cyprus, Syria, Palestine and Egypt. By 1948, most of these refugees were resettled in Britain, Canada and Australia; the remaining taking up employment in Uganda and other British colonies of Eastern and Central Africa. As for the "difficult to resettle cases" such as the old, the infirm and those with a criminal record, they remained at Koja camp until 1952 when the camp was finally closed and they were relocated to Tanzania.[4]

Administration and welfare of refugees

Administration of refugees in East Africa was centralized with headquarters in Nairobi to take charge of refugees in the East and Central African colonies as well as in the Belgium territory of Ruanda-Urundi. In Ugandan refugee camps, Poles had much authority over the administration of refugees. Polish Camp leaders assisted by an all-refugee advisory council did camp administration. They took charge of all basic administration, including internal security, health, education, recreation, work and religious affairs. Camp buildings were largely constructed out of local materials by African labor. The welfare of refugees was ensured through the provision of piped water, primary schools, and vocational school in each of the camps, hospitals, churches, orphanages, recreation centres and cemeteries. At Kojja, electric lighting was installed and a guesthouse built in Kampala. Initially supplies such as wheels and looms came from Europe, clothing and other basic amenities, such as books and radios from the European community in East Africa while food stocks were purchased in Kenya. On the other hand refugees were encouraged to cultivate their own food and to make their own clothing. At Nyabyeya, weaving, spinning, tailoring, cobbling were taught at the vocational school. Not much is said in the literature on the Poles in Uganda about their social relations. However for the British the main concern was the unbecoming behavior of some refugees. One was that the men drunk a lot while some women had illicit intercourse with Africans. As a way of eliminating this contact, two notorious prostitutes were taken to the Polish Penitentiary of Makindu in Kenya. According to Lunyiigo (1998:27) "the official assumption was that if a white woman had sexual intercourse with either African, in particular, or non-Europeans in general, then that person was automatically a prostitute". Some of the literature reviewed indicates various racist attempts by the British to explain the behavior of some women. An incident in which some two women were found in the sleeping quarters of the African Askaris (guards) resulted in their description as having no 'compunction about contact with Africans' by the Camp Commandant, "feeble minded" and sexual perverts. Doctors recommended that a special home for the feeble minded" be found for them (Gaya, 1944:1)[5] . The apprehension the British had even before this had led to the introduction of very serious measures regulating contact with Africans. A pass was a necessity before entry to the camps and African housing were constructed outside the refugee perimeters.

4.2 Refugees in Uganda

The 1950s onwards signaled the period of liberation wars in Africa. For many African countries this period points to the beginning of the perpetual geopolitical and ethnical rivalries, conflicts and the marginalization that has contributed greatly to the instability in this region for the last forty-five years. The political and civil strife in Rwanda, Congo and Sudan has been responsible for mass influxes of refugees from those countries into Uganda. Soon after Britain and Egypt lifted their condominium over the Sudan in 1955, civil war broke out in the country between the Arabs in the North and the Southerners forcing thousands to flee into the neighboring countries including Uganda. When Belgium was about to relinquish its mandate for Ruanda-Urundi, the two dominant ethnic groupings - the Tutsi and Hutu rose against each other and Uganda received 80,000 more refugees (Kiapi, 1998). Meanwhile the former Belgian Congo also caught fire during the early 1960s. A breakdown of law and order forced 33,000 Congolese to flee to Uganda (Pinycwa, 1998). Uganda is host to refugees from all neighbouring countries except Tanzania. By 2003 there were 199,607 registered refugees in Uganda (UNHCR, 2003).

Rwandese Refugees

The Banyarwanda are East Africa's largest ethnic group; a Bantu people who live in Rwanda, eastern Congo, western Tanzania and south western Uganda. They speak Kinyarwanda and are close relatives of the Banyankore and Bakiga in Uganda, the Barundi in Burundi and other neighboring groups. The term Banyarwanda embraces three subgroups: Hutu, Tutsi and Twa. For several centuries, the society of Rwanda was stratified into castes. The royal family, nobles, army commanders, most chiefs and people who kept cattle were Tutsi. Some chiefs and soldiers and the people who grew crops were Hutu. A small group of hunters and gatherers were Twa. Censuses during the Belgian colonial era indicated that 84 per cent of Banyarwanda were Hutu, 14 percent Tutsi and 1 percent Twa. However it has been argued that very few Tutsi benefited from the caste system as social mobility and intermarriage blurred caste distinctions. Nevertheless the Tutsi maintained dominance over the Hutu through a "feudal" system based on cattle. This system ensured that the Hutus gave their labor or part of their crop to the Tutsi; in return for cows and protection in the 'client – patron' linkages. This clientage was oppressive to the Hutu and on the poor Tutsi. It was an advantageous means of social advancement for the Tutsi. It has been advanced that the advent of colonialism and the Church deepened ethnic divisions producing much bitterness that has followed up to this day by advancing the Tutsi at the expense of the Hutu for several decades. Where Hutu chiefs were ruling, the Belgians installed Tutsi. They sharpened class differences by reclassifying all Rwandese with less than 10 cows as Hutu and those with more as Tutsi. Until the late 1940s, they educated only Tutsi.

The real big challenge to the Belgian-sanctioned Tutsi supremacy came in March 1957 when the inauguration of the Bahutu Manifesto criticized the Tutsi monopoly in all sectors. It advocated the end of caste prejudice, the employment of Hutu in public offices and other steps for the 'promotion of Hutu'. The Belgians took little notice of

this. Then in 1959 things began to run out of control. Political activity started to take root with the establishment of political parties based on ethnic lines. The political tensions evolved into violence leading to the death of several hundreds Tutsi. The Belgians did little to contain the violence. When they finally did, they cracked down on the Tutsi, arresting 919 compared to 312 Hutu (The U.S committee for Refugees 1991:4). Unrest culminating into the death of at least 350 persons ensued. The Hutu continued to harass and burn Tutsi huts. By April 1960 about 22,000 Tutsi had been internally displaced. After the general elections in July 1960 in which the Hutu party recorded an overwhelming victory, the Hutu continued to persecute the Tutsi causing them to flee. By 1963 about 120,000 had fled to other countries. This period was the beginning of Rwandese refugees in Uganda. It is estimated that between 40 and 70 percent of Rwanda's Tutsi fled their country between 1959 and 1964. In Uganda, the refugees were settled with assistance of the UNHCR in large grazing areas in south western Uganda, which promoted cattle keeping. Literature reviewed indicates that the Tutsi in exile in Uganda attempted to go back to Rwanda in the early 1960s but failed. Under the umbrella of Rwandese Patriotic Front (RPF) the Rwandese refugees succeeded in taking over the Habyarimana government in April 1994 following one of the bloodiest genocides.

Banyarwanda refugees and local politics

The fortunes of the Banyarwanda refugees have seesawed with different political regimes in Uganda. When they came in the early 1960s, Uganda was prosperous, land plentiful and the mood among refugees was optimistic for a quick return. But in the late 1960s life soured. Exile began to seem permanent. The return had failed and Uganda's own stability was eroding. In 1969, President Obote ordered the removal of all non-skilled foreigners from public employment, including thousands of Banyarwanda. The same year he decided to move against the Banyarwanda of Ankole who were mostly Catholic and opposed to his Protestant–backed political party, the Uganda Peoples Congress (UPC). He ordered a census of ethnic Banyarwanda, reportedly with a view towards excluding both citizens and refugees from the political process and possibly even expelling them from Uganda (The US Committee for Refugees). The exercise was not completed when his Commander Idi Amin overthrew him in January 1971.

Banyarwanda during the Amin regime

Obote was suspicious of the Banyarwanda and thus tried all available means to frustrate and marginalize them. In an effort to consolidate himself to power, Obote promoted many of his ethnic Langi and Acholi soldiers. Amin had become suspicious of Obote's promotion of Langi soldiers and as such, when he took over power in a *coup d'etat* in January 1971, he recruited, heavily into the army, people of his choice including refugees (Nabuguzi, 1998: 74). During the Amin period (1971-1979) increasing numbers of refugees including Banyarwanda moved out of the settlements, which were becoming overgrazed and overcrowded. It is noted that after some initial help by UNHCR and other agencies by end of the 1970s refugees had become self-sufficient (Pirouet, 1988:

240 citing Clay, 1984). Amin had also become a personal friend of the Umwami[6], Kigeri IV, whom he invited to return to Uganda from Nairobi (he had been chased by Obote) and offered him state accommodation. As a result of these close ties with the Umwami, some Rwandese refugees were also employed in a number of state security organisations (Nabuguzi, 1998: 75).

The Sudanese in Uganda

Well before the 1950s, the people of southern Sudan used to migrate to Uganda for several reasons most importantly for economic purposes. In addition to their personal initiative to look for work (usually digging), southern Sudanese would be recruited by the Uganda government to work in sugar and rubber plantations in the south. After interviews at Kaya in the Sudan, they would be recruited for eighteen months after which they would be taken back to the Uganda/Sudan border from where they would find their way home. Their main economic motive was to save money for bride wealth and to purchase a bicycle. These migration patterns resulted in many Sudanese settling in the southern parts of Uganda, notably in the areas near the sugar plantations such as Busaana. It is actually quite difficult to delineate between the ethnic communities along the Uganda/Sudan border. Oral interviews with the older Sudanese indicated that during the 1940s many Sudanese in Uganda were recruited into the Kings Armed Rifles (KAR) by the British and fought in Burma. Upon return from World War II, many stayed on. Other Sudanese immigrants included the Muslim Nubians brought by Captain Lugard and were settled at Bombo, a few kilometers north of Kampala.

The eve of Sudan's independence in 1955 signified the first war in which southern Sudanese army soldiers at Torit Army Garrison mutinied. The fleeing that ensued initially involved only soldiers but was joined by the people of Kajokeji who feared for their lives. It is estimated that approximately 178,000 Sudanese nationals fled to Uganda in 1955 (Pirouet, 1988: 241 citing Morrison, 1971). The incoming soldiers were disarmed at the border and kept in a camp for a while after which they were let free. Some found work in the Kilembe Mines and on the Lugazi sugar plantations. The situation in southern Sudan sobered a little until 1958 when Esborn Mandiri formed a political party the 'Federal Party' for southerners only on whose ticket he stood and won but was barred by the government from attending parliament. What followed included, among others, his arrest and detention for seven years. However, this ignited the south and the Army Chief of Staff, General Farik Ibrahim Aboud took over government in November 1958. Parliament was dissolved. The students in southern Sudan became very active politically and moved to neighbouring countries including Uganda. According to available information[7] the Islamization of the south including the declaration of Sunday as a working day, and the building of mosques next to Christian churches ignited fire. John Lagu had by this time started the Anyanya I rebel movement and Latara single-handedly started another guerrilla movement in the East in 1962. Schools went on strike, were closed and many students fled to Uganda and Congo. It is understood that students were kept in Arua. However, the District Commissioner (DC) connived with the DC in Yei in southern Sudan and wanted to send the students back to Sudan. When they got wind of it they fled to Congo. They are estimated to have numbered about three hundred.

The remaining students were camped at Bombo by the government and benefited from the Teachers for East Africa (TEA) program sponsored by the governments of the UK, USA and Canada for students of the Post Graduate Diploma in Education in Uganda. The students insisted that Sudanese should be enrolled in the schools where they were doing teaching practice. In 1964/1965 the UNHCR wanted to build a special school for refugees, but the Uganda Government wanted the money for expanding the existing general facilities. Refugees meanwhile would contract the local Nubians for work in their gardens. It was reported, during the interviews, that records at Bombo hospital should be available that show how the Sudanese students suffered from poor eyesight due to poor feeding. During this time, there was Church interest. The Catholic Church took some boys to Gulu High School. A World Christian Council of Churches project for refugees started at Namirembe. Worth noting is the fact that in all the interviews I held regarding the Sudanese' quest for education there was not a single mention of girls seeking education.

In 1972, the warring parties signed a Peace Accord in Addis Ababa and the situation in the South improved. Some refugees repatriated, but this was a truce that was to last for only a decade. In 1983, the Sudan government ill-advisedly introduced Sharia Law in the country and the war resumed in the country on this score, with the Southerners accusing Moslem leaders of breaching the Addis Ababa Accord (International League for Human Rights, 1985). Warring activities of the Sudan People's Liberation Army (SPLA) and the counter-offensives of the Sudanese Government have characterized the period 1980 to date[8]. This has forced tens of thousands of refugees to flee to Uganda and her neighbors. In Uganda today there are approximately 155,932 Sudanese refugees (UNHCR 2002), excluding the self-settled, residing in twenty-eight settlements in the districts of Arua, Moyo and Adjumani in the West Nile region. The rebel activities by the Lords Resistance Army (LRA) in northern Uganda have inflicted harm, injury and death not only to the Acholi but also to the Sudanese refugees settled in Achol Pii refugee settlement in Pader district. The worst incidents involving rebels and refugees in northern Uganda so far have been the attack of Achol Pii refugee settlement in August 2002 by the LRA.[9] Many refugees including women and children were killed, women were raped, huts burnt, health units looted of medicines, staff abducted and refugees sent in disarray[10]. Many of the displaced were temporarily relocated to Kiryandongo refugee settlement on Masindi. At the beginning of September 2003, the government of Uganda relocated[11] the Achol Pii refugees from Kiryandongo to Yumbe district in West Nile region. In July 2001, the governments of Libya and Egypt initiated a peace package endorsed by the government of Sudan government and the SPLA as an initiative to put an end to the 18-year civil war in South Sudan. These peace talks have resulted in signing of a series of peace initiatives. The first, the Machakos Peace Initiative (December 2002) signalled the laying down of arms by the warring parties. The second, the Naivasha Peace Initiative signed on 6 January 2004 spells out the sharing of oil resources. According to a BBC and CNN report, the final peace agreement was signed by the SPLA/M and the Sudanese Government on 8 January 2005 in Nairobi. In the meantime the war in Darfur has complicated the situation considerably.

The management and subsequent integration of the first wave of Sudanese refugees into Uganda is not well documented. One of the reasons could be that UNHCR had not established its presence in Uganda until 1964. During this period, most refugees received assistance from the World Council of Churches and the ICRC. At the same time, there was a high mobility of Sudanese looking for work in the rubber and sugar cane plantations in Uganda where many Sudanese are still employed up to today. It is also a fact that many refugees coming in at that time were assimilated in the local areas; there are several of them in Mukono district. In my work with UNHCR, during the registration of incoming Sudanese refugees in Moyo in the early 1980s, there were earnest pleas by some Sudanese refugees to let them join their relatives in Kasana in Mukono District.

In 1986, the UNHCR funded a returnee program for the Ugandan refugees in Sudan and the DRC. These had fled Uganda during the war to topple Amin in the late seventies. This period coincided with the escalation of the armed conflict in south Sudan that forced thousands of Sudanese nationals to flee to Uganda at the same time the Ugandan refugees were returning home. It has also been advanced that the war in south Sudan prompted the Ugandan refugees to return. However the area the returnees and refugees were coming to had been totally destroyed during the war that toppled Amin. While the refugees were given substantial amounts of humanitarian assistance, the returnees received only the basics, which created inequalities in the general standard of living and access to resources. In the process many returnees registered as incoming refugees to access aid arguing that they were in exactly the same conditions as the refugees[12]. For refugees, the UNHCR assistance program has been implemented since the mid 1980s. The Sudanese refugees reside in refugee settlements in the districts of Adjumani, Arua, Hoima, Masindi, Moyo and Nebbi where they are allocated land and provided with services to meet their basic needs. Furthermore, the basic infrastructure comprising roads, water, health care services, and primary schools is in place. The refugees are expected to abide by the laws of the land, but specifically by the Refugee Act that controls where they stay and restricts their mobility.

The Congolese

The first refugees from the Congo arrived in the mid 1960s, and they continued to filter over the border during the next four to five years. It is estimated that there were about 33,000 of them who self-settled along the Uganda/Congo border (Pirouet, 1988:240). The failure to be settled was compounded by the absence of a UNHCR office in Uganda at the time. On the other hand, the group that sought asylum in 1964 was settled in Kyaka 1 in Kabarole District in western Uganda where they received humanitarian assistance and lived until they repatriated in 1998 and 1999. No sooner had they been repatriated than trouble erupted in Eastern Congo. During the past seven years comprising of rebel activities in Eastern Congo and Uganda's temporary "occupation" of some parts in Eastern Congo, many Congolese have sought asylum in Uganda many of whom are accommodated in refugee settlements. However, there is a big number who constitute predominantly young men and women who prefer to eke a living in the urban setting than to settle in refugee settlements. The main reasons they give for this

preference is the language barrier in the settlements and education opportunities in the urban areas. Currently, official statistics indicate that there are 14,774 Congolese refugees in Uganda without the self-settled (UNHCR 2002).

Other nationalities

Kenyan refugees of Somali ethnicity were forced into exile during 1988 and 1989 in particular due to anti Somali attitudes in Kenya at the time. Many found their way into Uganda. For some reason however, they were not granted Convention refugee status but were mandated by the UNHCR. The number of the Somali refugees in Uganda grew bigger after the overthrow of President Siad Barre in the early 1990s. They were later to form the bulk of the urban caseload in Kampala for many years. Beginning early 1995, UNHCR insisted that any Somali refugee requiring assistance had to reside in the refugee settlements. They were required to reside in Nakivale refugee settlement in Mbarara district. This policy, directed at the Somalis as it had already been enforced to other nationalities, reduced considerably the size of the urban caseload; those opting for urban living catered for themselves. At about the same time also, for the first time[13], Uganda received and accommodated non-Somali Kenyan refugees[14] in Nakivale refugee settlement in the early 1990s who have since repatriated. Furthermore, there are a few more Kenyan refugees scattered in the several settlements. Yet another smaller number of refugees also exists and comprises refugees from South Africa, Mozambique, Angola, Liberia, Chad, Cameroon, China and Iraq. Individual refugees and a few families make up the urban refugee caseload catered for by the UNHCR.

Durable Solutions

The UNHCR maintains three 'durable' solutions for African refugees, namely; resettlement in a third country, local settlement/integration into the host society and voluntary repatriation. It is within these 'solutions' that humanitarian assistance is contextualised.

Resettlement

Resettlement refers to relocation from the country of asylum to another country. It is mostly done for security considerations when the security of the refugee cannot be guaranteed by the state or under the guise of 'good neighborliness'. In addition, it has been the practice for resettlement to be (this was a common thing before the end of the Cold War during the 1980s when Ethiopian and Eritrean refugees and asylum seekers were resettled in fairly big numbers in the USA and Canada) extended on humanitarian grounds (medical/disability), particularly by the Western countries albeit in small numbers. Harrell-Bond (1986:1), decries the non-significance of resettlement in a third country for African refugees as a durable solution noting that even if they were to be accepted, there are very few refugees who, unless guaranteed employment would opt to be relocated in yet another poor African country; yet the mood of industrialized countries towards receiving African refugees was quite restrictive. In 2001, some single Sudanese (unaccompanied minors) in Kakuma Camp in Kenya were granted

resettlement opportunities in the USA. Similarly, according to available statistics the US accepted 3000 African refugees on its resettlement quota (U.S Committee for Refugees, 2002). However, when compared to the global refugee statistics, the figure above is quite miniscule and a drop in the ocean. Resettlement countries in the West subject visa applicants to very stiff and alienating conditions which refugees must satisfy before being accepted. Not many African refugees can satisfy the stiff conditions. Consequently, there are only two options left; local settlement and or voluntary repatriation. Let us now look at local integration.

Local Integration

Next to repatriation, local integration is the next most preferred solution for the refugees in Africa by UNHCR. The policy of local settlement dates back to the 1960s (Voutira and Harrell-Bond, 1997). Although integration in several African countries has been defined in varied forms, in the case of Uganda, it means subsisting on the land allocated by the government or the communities, as is the case in Adjumani district. It also means abiding by the strict rules obtaining in the settlements such as the 'labelling and regimented regime' that obtains in agricultural settlements, in which the identity of people transforms into the 'identity of refugees' (Horst, 2003). Moreover these settlements are normally situated in isolated and secluded areas. Harrell-Bond (1986) gives reasons for this. She argues that in order that UNHCR is seen to convince donors for support, refugees have to be counted. The one easy way of counting them is by isolating them. Second, having refugees in one area enhances easy administration and distribution of relief and other social services. The third reason concerns OAU's concern for the security of hosting countries; hence the removal away from the border – although the OAU does not come up explicitly with distance dimensions. On the other hand, Daley (1989:200), shares a different view when she asserts that "refugee settlements in Tanzania served two specific functions; firstly, to ensure regional security through containment thus preventing insurrection; secondly, and more importantly, to utilize the labour resource of a 'captive' peasantry to increase the exploitation of peripheral areas of the country ……'. Another view over local integration is the assumption that the allocation of land to refugees will make them self sufficient in food to enable UNHCR/WFP withdraw its food rations.

It is worth noting that the processes, which influence gender in refugee situations, were ignored when considering the issue of refugee settlements. Forbes Martin (1992) has consistently argued that women are not involved in the decision-making processes in refugee settlements. She is not alone. Many other authors have raised similar sentiments (Callamard, 1993; Makanya, 1990; Indra, 1999; Hyndman, 1997). In addition, the majority of women in refugee settlements in Africa are illiterate with rural backgrounds and have no concept of feminism (Makanya, 1990). Having said that, the policies themselves fail to recognize the strengths and role of women. For instance, it is common knowledge that women cater for the food needs of their families. And yet, until recently when UNHCR is taking remedies to correct this anomaly, men have been in charge of distributing food. The distribution of food by men puts them at an advantage over women.

Furthermore a recent study of the vulnerability of women to refugee situations indicates how some women are compromised to offer sex in return for food (Kathina Juma, 1998).

Voluntary Repatriation

Voluntary repatriation refers to un-coerced return to one's country of origin. For UNHCR, it is the most durable solution. This is detected in the nature of most refugee policies, which are designed to reflect the temporary nature of exile and imminent repatriation. Similarly, the Government of Uganda (the Directorate of Refugees, Office of the Prime Minister) in its Mission Statement (2003: para 4) states that " on the other hand, although government has put in place measures to ensure the self-sufficiency of refugees, it prefers the eventual repatriation of refugees to their home countries as the most durable solution." However, realizing that refugee situations are always not so temporary, there has been a deliberate effort by UNHCR to 'encourage' refugees to return home. For instance, not so long ago the repatriation of Rwandese refugees from Tanzania in which exercise high-level UNHCR officials participated did not seem to be so voluntary after all. In yet another earlier incident in Uganda in 1982, the Banyarwanda (nationals and refugees) suspected of supporting Museveni in his guerrilla war against Obote were forcibly pushed into Rwanda. In the process, refugees and nationals lost their lives, property and were uprooted from their homes. This episode of uncertainty for the refugees concretized their aspirations of returning to Rwanda. For Ugandans, however, it reinforced xenophobia against the Rwandese refugees (Kamukama, 1997).

The British Broadcasting Corporation (BBC) spent the days of 24, 25, 26 February 2001 informing the world about the "voluntary" repatriation to Ethiopia from Sudan of some 100,000 Ethiopian refugees claiming that the 3,000 who had remained in Sudan had ceased to be refugees. This was because in UNHCR's own opinion the conditions, which had forced them to flee Ethiopia, were no more. The BBC analysis went on to suggest that the refusal to repatriate by the 3,000 could be due to a dependency syndrome created over the years by humanitarian assistance. At about the same time also a search by UNHCR for Sierra Leone refugees believed to be stranded in a corridor in Guinea, found empty camps and concluded that a successful repatriation had taken place. In my own view the 'voluntary' nature of repatriation needs to be deconstructed and other processes likely to facilitate and or hinder the successful repatriation examined.

Humanitarian Protection and Assistance

Humanitarian intervention for refugees in Uganda is twofold; protection and assistance. Protection is rendered by the state as well as the UNHCR, while assistance can be said to be the role of the UNHCR, land allocation notwithstanding. As a member of the United Nations fraternity and in line with the international legal refugee framework, Uganda has hosted thousands of refugees since 1960. The majority of refugees seeking asylum in Uganda have done so *en masse* and their status determination is made by the government on *prima facie* basis under the OAU provision (1969) after which they are identified by the WFP ration card. The refugees are kept in rural settlements where humanitarian assistance, such as shelter, healthcare, food, water,

and primary education is given. In addition, plots of land for agricultural activities are given to the refugees. The refugees are expected to reside in the settlement; movement outside of the settlement requires prior permission from the settlement commandant. This forms an opportunity for many refugees to leave the settlement. In fact I learned that although in practice refugees should never leave the settlements without warrant, in practice they do.

Through the use of the 1951 UN Convention Refugee Instrument, the status determination of individual refugees takes a different mode. Status determination is done by the Refugee Eligibility Committee (REC) and includes interviews by the UNHCR, the OPM, the Special Branch of the Ministry of Internal Affairs through a process that includes the applicant's personality, reasons for flight, social identity, and a thorough knowledge of the political situation in the country of origin. This process assumes that the government or UNHCR official doing the interview has the skills in interviewing and evaluation, which may not be the case.

The motives behind refugee settlements (Harrell-Bond, 1986) notwithstanding, the overall Uganda government policy has been to accommodate refugees in rural agricultural settlements where each head of a refugee household is allocated land for the cultivation of food crops and surplus for sale. These settlements are located in the districts of Mbarara, Kabarole, Hoima, Nebbi, Masindi and Arua. Other settlements are situated in the northern districts of Adjumani and Moyo, having been donated by the communities in these areas. Several authors have challenged the wisdom behind the refugee settlement (Harrell- Bond, 1986; Nabuguzi, 1998; Wim Damme, 1999) arguing that in a developing country like Uganda, it would be more cost-effective if humanitarian aid was used to develop the refugee affected area. Nevertheless, even though all refugees in Uganda are required to reside in a rural environment irrespective of ones circumstances and professional skills, according to Nabuguzi (1998:60) self-settlement has been possible because of government's inability and ineffectiveness to fully implement the settlement policy. It is in the course of their stay in the settlements that the UNHCR extends the humanitarian assistance. The UNHCR responds to the specific protection and basic needs of refugees in both short and long-term assistance programs, some of which include education, health care, food and non-food, shelter, and income-generating activities.

Education

Each settlement is provided with primary schools and educational materials. On the basis of the refugee affected area (RAA)[15] approach, the nationals in the surrounding areas are expected to share the primary schools in the refugee settlements, the degree of which will be indicated in chapters 8 and 9 for the settlements included in this study. Primary education is free in Uganda. However, for the refugee children, education is paid for by the UNHCR. The teaching follows the national syllabus and curriculum. The teachers comprise of trained and untrained Ugandans and refugees. There are very few women teachers even though the schools are mixed schools. Salaries are paid by the UNHCR.

The available secondary schools are on a self-help basis and they are the initiative of the refugees themselves. The refugee secondary schools in the north are renown for excellent performance in school leaving exams, at least they do better than the national schools. The parents and or guardians of the students pay for the secondary education. This however, has gender implications; there are many more boys attending secondary school than girls. In addition, the assumption that refugees are in a position to meet the cost of secondary education is erroneous and leaves out genuine refugees in need of assistance. The Uganda government implements Affirmative Action policy in favour of girls where an extra 1.5 marks is given to any girl entering university after the 'A' level. Unfortunately, the fact that only very few girl refugees make it to the 'A' level renders the extra 1.5 marks a missed opportunity. It would therefore be in order if refugee girls were given opportunities at lower educational levels to ensure upward mobility into education.

Health care services for refugees

There are health facilities in each refugee settlement in Uganda funded by the UNHCR, an exception being immunizations, which are supplied by the Expanded Program of Immunization (UNEPI) section of the Ministry of Health (MoH). The implementation of the healthcare programs is done by several implementing partners and is not uniform. The health scheme also seems to lack proper supervision concerning standards. It is common to find in one settlement properly constructed buildings, equipment and a good supply of medicines, such as the ones at Rhino Camp refugee settlement in Arua and, in another, such as some settlements in Adjumani district to find poorly constructed grass thatched and poorly ventilated health units. This shows the lack of a standard policy regarding the construction of health units in refugee settlements or if it is there, it is simply was not being adhered to.

Refugee health centres should be registered as NGOs, but this was not the case with the health centres in many of the refugee settlements. Despite this anomaly however, the government district health officials[16] were quite helpful in making sure the health centres received the quarterly drug kits from the Ministry of Health. It was observed that there was at least one health centre in the refugee settlements in western Uganda. However, for the settlements in the West Nile region, the numbers of health centers did not commensurate with the population in the catchment area; their establishment seems to have been dictated by resources and implementers' competition. It also points to the lack of the Ministry of Health input with regards to the establishment and standards of health units in Uganda. Take for instance, the four health centres (2 at Grade II and 2 Grade III) in Rhino Camp with a refugee population of 25,000 and an estimated host population of 17,000 making a total population on the catchment area to be 42,000. Most refugee health units were equipped with ambulance vehicles essential for quick patient referral. Whereas the ambulance services were free for the refugees in Rhino Camp settlement, nationals were expected to contribute towards fuel for the ambulance. Nevertheless the ambulances at Kiryandongo and Moyo refugee schemes were strictly for refugees and could not be accessed by the nationals. This caused resentment as the host conditions prevailing were not better for the nationals.

The health providers include trained medical personnel and auxiliaries. The quality of recruited health providers appears to have been influenced by the salary package each refugee settlement programme was willing to give. Take Rhino Camp refugee settlement as an example, at the beginning of my field work for this report in 2001, the health programme was implemented by highly trained medical personnel including a medical doctor, Clinical Officers and Registered Nurses. However, three years later, mostly due to the cuts in UNHCR funding, a registered nurse, enrolled nurse/midwives and nurse auxiliaries operated the programme. It was not clear whether the change in the professional calibre of the health providers negatively affected the quality of healthcare being provided.

The majority of refugee health centres receive quarterly drug kits from the Ministry of Health through the office of the District Director of Health Services (DDHS). In case the prescribed drugs are not available in the kits, they are procured for the refugee patients. In addition, UNHCR commissioned GTZ to 'top up' the drug shortages in any of the refugee health units. Services rendered by the health centres include out-patient and in-patient consultations, maternity and child health including immunizations and family planning.

From the foregoing, it can be concluded that, a few constraints notwithstanding, refugees in Uganda receive better healthcare than the nationals in the districts accommodating the refugees.

Food and Non Food Requirements

Until such a time as refugees are deemed to be self sufficient in food, the World Food Program continues to supply food to refugees, although the duration and amounts may falter. Food for refugees in Uganda consists of maize, sorghum, beans and cooking oil and occasionally salt. There is clear lack of animal protein, fruits and green vegetables in the diet. Special categories of refugees requiring special feeding are attended to in a special way. Therapeutic and targeted feeding is implemented in many refugee settlements and is aimed at the young and old with protein malnutrition, the pregnant and lactating mothers, the disabled and the unaccompanied minors. I observed that purposive targeting of pregnant and lactating mothers for special feeding even when at times was uncalled for catapulted their wish to become pregnant (see chapter 8 for detailed discussion). The essence of rural settlement is to facilitate agriculture. In most refugee settlements, refugees grow their own food crops and supplement the monotony of the rations. They also grow vegetables for additional vitamins, which could be lacking in the WFP rations. But not all refugees were planting vegetables and neither did they plant any fruit trees. They seemed to depend solely on mangoes, which are so bountiful in the areas surrounding the settlements. Depending on the progress to self-sufficiency, WFP food rations are phased out gradually; such was the case in Kiryandongo. Non-food requirements refer to utensils, water jerricans, blankets, hoes, basins, machetes and saucepans. These were distributed once and were not distributed according to number of people in a household. For instance, in Rhino Camp each refugee household would receive one jerrican and one blanket.

Water storage was a problem as the jerrican could only store 10-20 litres and yet women needed much more water for daily chores. This meant that women had to fetch water many times a day to the detriment of other activities and their own development. The issue of one blanket is discussed in chapter 8. The fact that clothes, paraffin and sugar were not supplied and the monotony of the food rations forced refugees to sell part of their food rations to meet these otherwise pressing needs. Missing on the non-food list were sanitary towels, which women and girls need to use when they are menstruating.

The Self-Reliance Strategy (SRS)

The SRS was developed in the face of dwindling UN funds and protracted nature of refugee situations in the Great Lakes region of Eastern Africa. It was specifically designed for the Sudanese refugee population in the refugee-affected districts of the West Nile region; and, it was envisaged upon its successful implementation to be extended to other parts of Uganda and the region as a whole. The SRS was adopted by UNHCR and the Office of the Prime Minister (OPM) in 1998 and was supposedly based on the district partners and refugees' experiences and practices and in consultation with donors.

The overall goal of the SRS is to " improve the standard of living of the people including refugees in the districts of Moyo, Arua, and Adjumani. The main objectives of SRS were to: empower refugees and nationals in the area to the extent that they will be able to support themselves; establish mechanisms, which will ensure integration of services for the refugees with those for the nationals. This strategy has been implemented by the districts since July 1999 and it was hoped that by 2003 refugees would be able to grow or buy their own food, access and pay for basic services and maintain self-sustaining community structures. The present study did not set out to study SRS, however we feel this is a very interesting area requiring research. In 1999-2000 the UNHCR and the government of Uganda endorsed the self-reliance strategy (SRS) whose main aim was to wean the refugees off humanitarian assistance. The project was implemented in the refugee hosting districts of the West Nile region. Although the success or failure of this strategy has not been clearly evaluated and documented, a new approach – the Developmental Assistance is now being implemented in refugee-affected areas of West Nile. The gist of this approach is that development targeting refugees should be holistic and include the surrounding hosting areas including the local population (OPM, 2004). The sudden change in development approaches could mean that the implementation of SRS was not effective. I have argued elsewhere that the war that got rid of Amin in 1979 displaced almost the entire population in Wes Nile into Sudan and Congo. It so happened that Ugandan refugees in Sudan returning in the mid 1980s did so at the same time the Sudanese refugees were fleeing to Uganda due to SPLA/M rebel activities against the government in Khartoum. And yet, apart from the limited international humanitarian aid to the Ugandan returnees, the refugee population in West Nile was kept on constant humanitarian assistance, which made their standard of living better compared to that of their hosts. The difference in the standard of living for the refugees was enhanced due to the fact that they could sell their farm produce as they relied on food rations by WFP.

What follows next is a table, which indicates a summary of wars, crises and events implementing upon refugee and displacement in and from Uganda.

Table 4.1 A summary of wars, crises and events impinging upon refuge and displacement in and from Uganda

Period and event	Description	Outcome
The Army mutiny in southern Sudan (1955)	- Mass influx into Moyo of thousands of Sudanese refugees	- Self -settled - Majority repatriated after the 1972 Addis Ababa Peace Accord
The ethnic conflicts in Rwanda (1959 - 1960)	- More than 80,000 Tutsi refugees flee into Uganda'	- The settlements Nakivale and Oruchinga are established for them and their cattle - Many get out of the settlements and acquire land outside. - They are evicted and ousted back to Rwanda and or the settlements - After talks (Rwanda/Uganda/ UNHCR) they are resettled in Kyaka II - Majority repatriate in 1994
The secessionist wars in Congo 1960 **Escalation of war in Congo in 1964**	- About 30,000 refugees flee into western Uganda. - Unspecified number seek refuge in Uganda	- They self settle amongst kin along the Uganda/Congo border - They are resettled in Kazinga refugee settlement in Kyaka I - Many repatriate in 1998/1999
The Buganda crisis (1964-1966) - Conflict over the 'lost counties' of the Bunyoro Kingdom - The social unrest in Nakulabye, Kampala suburb - Lorry accident –St Mary's, Kisubi	- Armed confrontation between Buganda Kingdom and the Uganda Army. - The Kabaka is deposed - Several people are shot at Nakulabye	- A few Baganda fled with their Kabaka - Death of a few people at the palace of the Kabaka - Death of 12 school boys - Death of people at Nakulabye

Period and event	Description	Outcome
The military rule of Idi Amin (1971-1979) - Obote ousted - Suspension of the Constitution - Capital as well as human resource flight - Total collapse of the economy - Amin attacks Tanzania to annex Kagera	- Dictatorship - Expulsion of the Ugandan Asians. - Total destruction of infrastructure. - Recruitment into the army and intelligence of Sudanese and Banyarwanda refugees.	- Over 500,000 deaths - Thousands fled to exile including academicians and professionals. - Over 70,000 Asians expelled from Uganda. - Total anarchy
Short-lived governments (1979-1980) - President Yusuf Lule - President Godfrey Binaisa - Chairman Paulo Muwanga	- Increased insecurity in Kampala. - Refugees in exile are returning. - General elections are held.	- Idi Amin flees. - Thousands of people in West Nile flee to Sudan and North Zaire.
Obote II Government and National Resistance Movement (NRM) (1981-1985) - The UPC wins election and Obote installed as president for second time. - The viability of election results is questioned. - The guerrilla war dismissed as banditry. - Baganda are victimized by the army accused of hiding the bandits.	- The UPC government is suspected to have rigged the elections. - Museveni with 27 others start guerrilla war in the heart of Uganda. - Recruitment of the Banyarwanda refugees into the NRM. - Rebel pressure mounted. - The UPC government is overthrown by Uganda Army under Tito Okello	- Government counter-offensives displace people internally especially in the central region. - Government evicts the Banyarwanda. - UNHCR resettles evicted Banyarwanda. - Several Ugandans are killed and many flee into exile.
Tito Okello Lutwa (June 1985-January 1986) - Efforts to have Museveni join the government are futile. - The government and NRM agrees to Peace Talks under chairmanship of President Moi of Kenya.	- NRM rebels refuse offer to join government - NRM joins peace talks in Nairobi, does not lay down arms. - NRM intensifies recruitment and activity. - Lutwa's government toppled in January 1986.	- Total mayhem in country - Ugandans continue to die at the hands of the army - Total collapse of the social as well as the economic infrastructure. - Most of the war effects in the central region

Period and event	Description	Outcome
Breakdown of Addis Ababa Peace Pact in the Sudan in the early 1980s	- Sudan Peoples Liberation Movement/ Army (SPLM/A) launches armed conflict against the Sudan Government. - The southern Sudan also suffers famine and drought.	Sudanese refugees moving into Uganda gradually and they increase in 1986 and after. They are resettled in Achol Pii in Pader district, Kiryandongo and in several refugee settlements in the districts of Adjumani, Arua, Nebbi, Moyo
Persecution of Kenyan Somali in Kenya end of 1989/1990)	- Kenyan Somalis are displaced. Many flee to Uganda.	- They are not given status by Uganda. - UNHCR gives them mandate and they are maintained as urban refugees in Kampala.
Opposition to the Government of Kenya by some groups resisted (1980s – 1990s)	A few Kenyans (about 20) mainly young and single men seek refuge in Uganda. Their leader is resettled in Ghana.	- Accommodated in Nakivale refugee settlement. They repatriated in August 2003
The political turbulence in Somalia since the early 1990s	Somali refugees are displaced and many seek asylum in Uganda.	UNHCR extends mandate status and they are kept in urban areas until 1995 when they are asked to go to Nakivale refugee settlement. Many opt for self-settlement.

Period and event	Description	Outcome
The NRM takes over government in Uganda (1986 to date) 1. Uganda People's Democratic Army (UPDA) a rebel group by the remnants of the former soldiers in Uganda army and disgruntled former ministers in 1986 start rebel activity in eastern and northern Uganda 2. The Holy Spirit Mobile Force by Alice Lakwena launches attacks from the north in August 1986. She is defeated in 1987. 3. Government appoints a minister for pacification of the north. 4. The Lords Resistance Army (LRA) by John Kony takes over from Alice Lakwena. Has waged armed conflict in northern Uganda since 1987. Government initiates peace talks. 5. Allied Democratic Forces (ADF) (1996- 2001) with bases in eastern DRC strike in Bundibugyo.	- Pursues Acholi soldiers responsible for mass murders in Uganda many of who flee to Sudan, but some remain in the north - The soldiers regroup in Acholi - Those in Sudan make frequent invasion into Uganda. - Peace talks with LRA and UPDA by Minister of Pacification of the north - Attacks target civilians, church missions and refugees in camps. - A few rebels heed the amnesty offer. - LRA continues and extends activities to Lira, Apach and Teso. - Peace talks halt allegedly caused by non interested LRA. - Government establishes protection camps. - The government of Uganda offers amnesty (Amnesty Act 2000). - Pursued vigorously by the Uganda Army. - For the time being they have been wiped out.	- Internal displacement escalates. - Kidnapping of civilians including children continues. - Aboke girls are kidnapped - Over 100 Sudanese refugees killed. - Refugees are relocated to Kiryandongo. - Displacement of the Acholi continues. - 800,000 internally displaced persons in northern Uganda. - Loss of life and property - Many people killed and others injured. - Burning to death over 100 students at Kichwamba Technical School cause displacement into Congo and internal displacement in the surrounding areas.
The Genocide in Rwanda (1994)	- Only a few Hutu refugees sought refuge from Uganda mainly from Tanzania	About 5,000 Banyarwanda of Hutu ethnicity are accommodated at Nakivale

Source: compiled by author from research information and records

4.3 Armed conflict and Internal displacement in Uganda

In the next section we present a historical perspective of the nature and magnitude of civil and political strife in Uganda and the impact it has had on forced internal displacement of populations.

Uganda has experienced a series of episodes of civil strife since independence, which have culminated into armed conflicts specifically with each change of political leadership. Civil strife has affected practically all parts of the country in different ways during the various political regimes. The actors in these conflicts, the level of destruction, both in terms of casualties and infrastructure, the impact on the economy, the international and national responses have all been different. The discussion that follows aims at approaching the civil strife thus: The Buganda crisis (1964-1966); the military regime of Idi Amin (1971-1979); the Luwero Triangle armed conflict (1980-1985); the war in northern Uganda (1986 – to date); the war in Kumi District by the UPDA (1986-1991), and the war in western Uganda by the Allied Democratic Forces (1996 to date).

By April 2003 Uganda had 800,000 internally displaced people[17] and 200,000 of these were in Gulu and Kitgum (BBC report 13 April 2003; HRW 1997). The exact number of the internally displaced in the west as a result of rebel activities by the ADF is not known. At the same time, Uganda was hosting some 199,607 refugees, 87 percent of whom came from Sudan (OPM, 2003). These figures do not take into account those women, girls and children who have been abducted by the Lords Resistance Army rebels over the years in the ongoing civil war in northern Uganda.

The Buganda Crisis (1964-1966)

The colonial government had annexed several counties that were part of Bunyoro Kingdom to Buganda Kingdom. Soon after independence, there was use of arms to quell what was seen as an impending rebellion regarding the 'lost counties' of Bunyoro in 1964 (Kasozi, 1999). During this period, many people were shot dead at Nakulabye, a northern Kampala suburb. At almost the same time, the death, in a lorry accident, of some 12 students of St. Mary's College, Kisubi, raised a lot of questions and concern among politicians of the day. These three incidents were the forerunner to what has been a long and painful political process in Uganda riddled with gruesome spells of armed conflict and forced migration.

The disagreement that developed in 1966 between the executive Prime Minister of Uganda (Dr. Obote) and the ceremonial President (Mutesa II, the Kabaka[18] of Buganda) led to a bitter war and resulted in the Kabaka's flight to England where he ultimately died in 1969. The effects of this war were fairly localized and did not affect wide areas of Uganda, yet it is believed that the incidents were kept alive in the minds of the Baganda and have been used at opportune moments to fuel hatred against Obote and what he stood for and in the process contributing to conflict. It is widely believed that the resultant resentment of Obote by the Baganda, because of the destruction of the Buganda Kingdom[19], facilitated later the rebel activities in Luwero in the early 1980s.

The Military Regime of Idi Amin (1971 – 1979)

Idi Amin toppled the government of Dr. Milton Obote in January 1971 in a bloody coup. Amin was later to administer the country with extreme brutality and violence resulting in the death of hundreds of thousands (Kasozi, 1999; Hansen and Twaddle, 1991). The misrule and near anarchy led to total destruction of the infrastructure and to gross violation of human rights such as imprisonment without trial, murder, abductions and state sponsored violence. Many people lost their lives. To give but one example, in 1976 a female (pregnant at the time) university warden was killed and her body dumped in a forest. Many laws pertaining to dress and appearance codes for women were passed subjugating women further; they were required to wear long skirts and the use of cosmetics was banned. This time was also characterized by massive recruitment of women in special intelligence services while curtailing the activities of the women's organizations (Kwesiga, 1995).

The dictatorship of the Amin era forced many people to leave Uganda including the business people and the intelligentsia. Moreover in 1972 Amin expelled over 70,000 Ugandans of Asian origin. People lived in constant fear. Majority of those murdered were men; this had gender implications in that it created many women-headed households. Furthermore in cases in which men fled the country, the women who remained behind also assumed the role of *de facto* heads of households.

The National Resistance Movement (1981-1985)

The overthrow of Idi Amin in 1979 was subsequently followed by a series of brief and short-lived governments before general elections were held in December 1980. The elections were apparently won by the Uganda Peoples Congress (UPC) and Obote was sworn in as president for a second time. But there were claims the elections had been rigged by the UPC. This prompted Yoweri Museveni and twenty-six others to initiate the National Resistance Movement and Army (NRM/NRA) and wage a guerrilla war against the UPC government led by Obote until it was defeated in 1985 (Museveni, 1997). The rebel activities lasted five years (1981-1985) during which period the Banyarwanda joined Museveni's rebel movement in big numbers.

In those years, there had been a deliberate effort by the UPC government to evict the Banyarwanda from their homes in western Uganda. Despite denial by Obote that the government was not party to the evictions, the UPC involvement in the evictions was quite clear. The active involvement of ministers, Rwakasisi (in charge of national security) and Rubayihayo and the inflammatory and anti-Banyarwanda speeches and the eventual expulsion of Tom Unwin, the UNHCR representative in Uganda, goes further to testify that the UPC was involved. Due to international pressure and the unseemly fluid nature of the situation, Obote appointed Mbarara district official, Makaru, who had been one of the anti-Banyarwanda campaigners, to a committee set up to identify who was a refugee and who was not. The committee evicted more than eight thousand people between December 1982 and January 1983.[20]

Finally, several tripartite meetings involving the governments of Rwanda, Uganda and UNHCR were conducted in Gabiro, Rwanda. It was agreed that Ugandan nationals would be repatriated to Uganda. At the same time, UNHCR implemented a local integration project in southwest Uganda to offer assistance to those previously evicted and to strengthen the infrastructure in refugee settlements (Project records at UNHCR Kampala).

Banyarwanda involvement in rebel movement

In the meantime, rebel activities were conducted clandestinely in the infamous Luwero Triangle in the central region of Uganda. Infamous in a sense that many killings took place in this central area of Uganda in the guise of the Army looking for Museveni. The rebel war attracted Rwandese refugees to join and train in guerilla warfare and to fight alongside Ugandan rebels. These were mostly young men who were despondent with life at this stage, particularly after the injustice meted onto them in western Uganda in the early 1980s. It is actually claimed that at the NRM (National Resistance Movement) take over of Kampala in January 1986, the total number of Rwandese rebels was approximately three thousand. Their presence in the Ugandan Army was an embarrassment to president Museveni who tried to keep them in far away detaches. But their presence could not fail to be noticed as a few of them including the present president of Rwanda held such big positions in the army. On 1 October 1990, the majority of Rwandese soldiers in the Ugandan army left under the RPF (Rwandese Patriotic Front) and started rebel activities in Rwanda as a step to return to their country of origin. The take over of government in Rwanda by RPF is a long story and has been documented elsewhere (Prunier, 1995). The takeover of Rwanda government in 1994 by the RPF ignited the simmering genocide preparations and forced millions of Banyarwanda into exile for fear of being victimized; only a few Rwandese sought asylum in Uganda. Official statistics show that there are 27,890 Rwandese refugees registered in Uganda; however, unpublished research reports indicate that there are thousands of self-settled refugees in several parts of Uganda (Mulumba, 2002). The majority of Rwandese refugees are accommodated in Nakivale, Oruchinga with a few in Kyaka II and Kyangwali.

Armed conflict in Northern Uganda (1986 to date)

The origin of the current conflict is not new. It is a complex of religious, political and economic factors and cultural traditions. It lies in the deeply rooted ethnic mistrust of the Acholi, that is, inhabitants of Uganda's northernmost districts with ethnic affiliation with Acholi of southern Sudan. During the colonial administration by the British, the Southerners were employed mostly in the Civil Service while the Northerners, particularly Acholi, were recruited into the armed forces. This created a division between northern and southern Uganda; the south becoming more developed while the north, including the districts of Gulu and Kitgum the homeland of the Acholi, was much poorer with the people relying on cattle and the military for subsistence.

Other causes of the conflict base themselves on the role the Acholi played particularly in Uganda's successive governments since independence in 1962. According to most historians of post independence Uganda (Karugire, 1980; Kasozi, 1999), Acholi soldiers have been both victims and perpetrators of the violence. For instance, under Milton Obote's first presidency, they were implicated in many of the government's questionable activities. In the 1970's during Idi Amin's reign of terror, many Acholi soldiers were murdered. With the resumption of Obote (1981-85) Acholi soldiers were implicated in the deaths of thousands of civilians during the civil war against Yoweri Museveni's guerrilla National Resistance Army, which drew support mainly from people of the southern and western parts of Uganda.

The brief period (June 1985-Jan 1986) of Acholi control of government when Acholi army officer Tito Okello ousted Milton Obote could also be viewed as a cause for fighting. It should be noted that the retreating Acholi soldiers fleeing Museveni's pursuit did not all cross to Sudan. Many retreated only as far as Gulu and Kitgum, where they could rely on the support of the civilian population (HRO, 1999: 10). Many of these soldiers never relinquished their weapons; instead, they in 1987, joined other opponents of the Museveni administration to form a rebel alliance. The rebels with a base in southern Sudan made frequent invasions into Uganda to fight the National Resistance Army.

For a country based and dependent on a subsistence economy such as Uganda, the frequent rebel attacks have destabilized the countryside. For northern Uganda the region's agricultural base, education and healthcare systems have been wrecked. Hundreds of village schools have been burned and rebels desperate to get their hands on medicines have raided scores of health clinics. In a bid to contain the insurgency and to offer maximum protection, the government has placed close to a million people in camps. But at the same time it is fair to mention that a sizeable amount of donor funding is targeting the North (see, Donor News, Vol. 3 No. 2 July September 2003) for development projects.

Perhaps the only benefit of the 'protected' camps was their proximity to the Uganda army installations; otherwise camping people in a restricted area restricts their freedom of movement and has negative effects on their livelihoods. Crowded conditions and lack of food and sanitation facilities have rendered the population vulnerable to death from malnutrition and disease. According to Human Rights Watch (1997) thousands die every month, and despite the nearby military pressure, the camps remain targets for rebel attacks.

Women leadership in rebel alliances

The Holy Spirit Mobile Force, one of the rebel units, was led by self-styled Acholi prophetess Alice Lakwena. Through her claims to special encounters with the Holy Spirit, Alice garnered enormous Acholi support including the highly educated. By late 1987, with immense support, she had led thousands of Acholi soldiers against government troops; getting close to sixty miles of Kampala where they were quelled by a well-armed government force.

The war that ensued led to many deaths. Lakwena fled to Kenya. In the wake of her defeat, while many Acholi surrendered, her own relative Joseph Kony assumed leadership. Kony and his army, the Lords Resistance Army (LRA) has waged war against the southern dominated government since 1987 to date.

The Lords Resistance Army (LRA)

Although not strong enough to overthrow the government of Uganda, their atrocious activities coupled with UPDF's military pursuit have caused unspeakable damage to the Acholi and Acholiland in general and recently the districts of Apac, Lira, Katakwi and Soroti[44] . Children as young as ten have been conscripted into the rebel army. Girls, including schoolgirls[45] have been abducted and taken for wives and sex slaves. In total, the whole area of the Acholi has been turned into a permanent battle zone. According to BBC (12 April 2003), there are now 800,000 internally displaced persons in northern Uganda in several camps. Lira district alone has up to 10 camps. By 2003 the LRA had extended the battle zone to eastern Uganda. For girls in a culture, which regards non-marital sex as 'defilement', the difficulties are even greater. Reviled for being 'rebels' the girls may also find themselves ostracized for having been 'wives'. They fear shame, humiliation and rejection by their relatives and possible future husbands. They may suffer continual taunts from boys and men (who say they are) used products that have lost their taste (Panos, 1995: 12-13).

Conflict and peace making process

It is obviously the role of the government of Uganda to offer maximum protection to all residents in Uganda. By guaranteeing peace to all Ugandans it would enable them to participate in development so as to improve their welfare and that of the nation. In this context, numerous initiatives have been undertaken towards ending armed conflict and attaining peace in the North and other parts equally affected. Following persistent calls by the most affected communities including the clergy, for a peaceful approach to the resolution of armed conflict in the country, the Government in 2000 declared amnesty in respect of all persons who had been engaged in acts of rebellion. This was through the enactment of the Amnesty Act 2000. The Amnesty provides assurances and incentives to those who wish to abandon rebellion to do so without fear of retribution or revenge.

Through peace and diplomacy, Uganda has continued to restore good relations with the countries that have been harboring, abetting or assisting rebels. These include the Governments of Sudan and the Democratic Republic of Congo where diplomatic missions have reopened. The Amnesty Commission, Government, Non-Governmental Organizations (NGOs), religious leaders and community members have promoted reconciliation and dialogue with various rebel groups. Where peaceful resolution to end conflict has failed, the Government has engaged in military campaigns and operations to deter and subdue the rebel forces in the North and the Western part of the country. The Uganda People's Defense Forces (UPDF), were able to rescue 6,000 people who were reportedly being held in LRA camps (Donor News, 2003:8).

The Teso Insurgency (1986-1991)

The immediate years following the takeover by the National Resistance Movement/Army (NRM/NRA) in 1986, witnessed considerable resistance to the new government particularly in the parts with strong support for Obote. Teso in Eastern Uganda was such a stronghold area in which Peter Otai (ex-minister in the toppled second Obote government) and the Uganda Peoples Democratic Army (UPDA) in southern Sudan spearheaded the rebel activities. The war, though short-lived, resulted in aimless and unwarranted loss of lives and caused suffering to many. To try and curb the insecurity in the area, the government instituted 'protected camps' for civilians. Army barracks were strategically situated near the camps, but unfortunately for the women this turned out to be a nightmare as many women and girls were raped and infected with STDs and HIV/AIDS. Stories are told of forced marriages, physical and sexual assault, food shortages, increased levels of poverty, poor sanitation and a lack of health services leading to high mortality rates particularly of mothers and infants (Women's World no 35, 2000; The Monitor 20 August 1988). Luckily for the government and the communities, the insurgency was short-lived and people were able to return to their villages. Nevertheless, the impact the war had on the social and livelihood aspects of the people particularly the loss of cows was still being felt long after the war. (Mulumba, 1996). Situations of armed conflict and forced displacement usher in perpetual poverty as it curtails people's livelihood mechanisms. Increase in HIV/AIDS infection rates has been attributed to sexual assaults and rape incidents during the insurgency. Unfortunately there has not been much documentation on the experiences of communities during and after the insurgency in Teso.

Allied Democratic Forces – Rebel Activity

This area, formerly known as Semliki and curved out of Toro district in 1974, was renamed Bundibugyo in 1980. With a population of 120,000 people, mainly rural dwellers, the district has two counties and borders the districts of Kabarole in the east, Kasese in the south, Lake Albert in the north and the Democratic Republic of Congo in the west. It is the extreme western part of the former district of Toro. Its close proximity with DRC is seen as a potential cause of insecurity for Uganda as it provides ground for undetected rebel organization and activity.

In August 1996 the Allied Democratic Forces (ADF)[21] rebels invaded Bundibugyo district from the DRC. This attack was followed by several rebel attacks on institutions and individual homes, not only in Bundibugyo, but it spread to the districts of Kasese and Kabarole. Some of the military tactics employed in this war appeared to be similar to those used by the *Interahamwe* during the genocide in Rwanda in 1994. For instance, the attack on Kichwamba Technical School in 1997 (which involved locking up of dormitories and lighting with petrol) burnt hundreds of students to death; the very few who survived are heavily disfigured and need plastic surgery for normal functioning.

For Bundibugyo, life came to a standstill. There was failure in communication as the only road leading to the district was heavily guarded.

Electricity, solar energy, health services, schools etc., were disrupted. This increased the suffering of the residents of the district. This being a fairly new district, many problems were encountered; for even the few development projects had to stop. The area was put under emergency, the residents of the district were put in camps, and international organizations in Uganda were mobilized. Some of these were UNICEF, Red Cross, OCHA, WFP and UNHCR. However, provision of assistance proved difficult due to the insecurity in the area. One needed an escorted convoy to travel to Bundibugyo. With the fear of abrupt ambushes by the ADF, the district became more marginalized. At the time as well, the international community did not seem to be too happy with Uganda for having gone into the DRC and allegedly was continuing providing aid for Bundibugyo. The quality of life for these people had indeed declined as they continued to have a breakdown in their usual lifestyle. Their livelihoods, incomes, sanitation facilities, food availability, the upholding of basic human rights were all at stake. Violence particularly against women continued unabated in the face of uncertainties and frustrations. Some of the results have been: Overcrowding leading to high mortality and morbidity rates, increased gender-based violence, forced marriages, poor sanitation, increased sexually transmitted diseases, and overall violation of human rights. At the writing of this report peace seems to be returning to Bundibugyo even though the effects of the conflict such as HIV/AIDS and STDs linger on (The New Vision, September 5, 2003:9).

Uganda – producer of refugees

As a producer of refugees, Uganda in 1972 expelled its own citizens of Asian origin followed by political and academic intelligentsia. In 1980, almost the entire population of West Nile and Madi region were forced into exile while that of the 'Luwero Triangle' and North and North-Eastern Uganda who could not cross international borders were internally displaced. Due to the civil war in the north since 1986, Uganda has displaced many internally and internationally, as can be witnessed by the number of Ugandans in the Diaspora. The rebel activities of the Allied Democratic Forces (ADF) in Bundibugyo, western Uganda since 1996 has been the main cause of internal displacement as well as external displacement.

4.4 Concluding remarks

The foregoing chapter has analyzed the several waves of refugees into Uganda and the Internal armed conflict and insurgency in Uganda has created large numbers of IDPs with severe consequences for their livelihoods and development as well as for the development of the nation at large. The present government is trying to come to a peaceful conclusion and has recorded some recent success with the surrender of some highly positioned LRA commanders in the names of Banya and Kolo . However, peace still eludes northern Uganda and the situation continues to be particularly precarious for women and children in IDP camps. Recent news reports indicate that children escaping from the LRA were being absorbed into the Uganda Army[22] , although this had been denied by the government. Women are in a worse condition as noted by UNICEF[23]

"As few as one person in 10 has access to clean water in northern Uganda, where 18 years of war have forced hundreds of thousands of villagers into more than 200 refugee camps. An estimated 1.6 million people have been forced into squalid, makeshift settlements by the conflict, more than 80 percent of them women and children".

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[1] Banyarwanda means many individuals of Rwandan descent. One such individual is Munyarwanda.
[2] Barundi are inhabitants of Burundi
[3] Personal interview with Mr Bugingo, Refugee Studies Programme, University of Oxford, December 1997.
[4] Documents were retrieved from the Uganda Archives at Entebbe, Uganda 2001- 2002. They comprise numerous sources including copies of letters to the colonial office in London.
[5] Information in this part was obtained from the Uganda Archives at Entebbe.
[6] Umwami refers to 'King' in Rwanda.
[7] Interview with Professor Sabrino of Juba University, Refugee Studies Programme, University of Oxford December 1997
[8] During the writing of this thesis in January 2004, the Sudan government and the SPLA have concluded part of the peace pact that spells out the distribution of the oil resources. The BBC 5 January 2004
[9] *Donor News* 'Focus on Development' Vol. 3 No 2 July –September 2003 pp 7-13
[10] *The New Vision* and the *Daily Monitor*, 20 August 2002. According to the *The New Vision*, Saturday, April 12,2003, Mr. Ruud Lubbers, the United Nations High Commissioner for Refugees visited Kiryandongo refugee settlement where some 7000 refugees from Achol Pii were temporarily relocated. It had been proposed by the Uganda government to transfer this group to Nebbi for permanent settlement. This was done in September and October 2003.
[11] The OPM, UPDF and the Police relocated the refugees amidst protest and resistance. BBC 2/9/03 reported that three refugees had been shot dead and seven injured. It was reported that the land they were occupying at Kiryandongo was slated for the White Zimbabweans (see The Monitor 10/9/03)
[12] The author witnessed this in the mid 1980s during UNHCR field missions to West Nile.
[13] Many Kenyans fled to Uganda during Mau Mau days in the 1940s and 1950s but not as recognized refugees.
[14] The Kenyan refugees at Nakivale returned to Kenya in August 2003. The Monitor, 23 August 2003.
[15] The second International Conference on Assistance to Refugees in Africa (ICARA II) 1984 asserted that refugee assistance should be development-oriented and should take into account host population needs (Gorman, 1985).
[16] Personal Interview with Dr Sam Okuonzi, Ministry of Health, Entebbe, December 2001
[17] Internal displacement refers to forced migration from one's habitual residence limiting the migration within the borders of one's country of origin.
[18] Kabaka refers to the king of the Baganda
[19] The Buganda Kingdom was restored with the enthronement of the Kabaka Ronald Mutebi in 1994.
[20] The author of this report read a letter by Obote to Mbarara district officials to this effect in December 1997 at the Refugee Studies Centre. University of Oxford.
[21] It has been widely acknowledged that the ADF has been backed and funded by Tourabi of Sudan and other Muslim fundamentalists.
[22] The abduction of the 'Aboke girls' at St Catherine girls Secondary School, Aboke in which Sr. Rachel tried to get their release has been documented (see De Temmerman, Els 2001)
[23] "UNICEF decries northern conditions" In The New Vision 25 February 2005 page 4

5

The International and National Health policies

5.0 Introduction

The aim of this chapter is to present the international and national health policies and approaches which have guided the health care provision in Uganda for the last forty years. It is worth noting that reproductive health did not attract special attention until 1994 when the concept 'reproductive health' assumed centre stage after the 1994 conference in Cairo on population and development. I therefore first discuss the broad-based nature of the health policies and address reproductive health policies in the last two sections of the chapter. The chapter proceeds as follows. The first part (5.1) provides a brief overview of the health care policies of the 1950s, 1960s until towards the end of the 1970s. In the second part (5.2), I discuss the 1978 Alma Ata Declaration of the Primary Health Care (PHC) strategy, which for the last twenty-five years has been the guiding philosophy behind the provision of health care in most Third World countries including Uganda (WHO 1978). In addition, I present the Bamako Initiative as a further strategy consolidating PHC. The structural adjustment programmes (SAPs) and their influence on health care provision and the condition of women are discussed in part three (5.3). I then proceed in part four (5.4) to introduce the reproductive health policies of the International Conference of Population and Development (ICPD) and Fourth World Conference on Women (FWCW) (UN, 1994; UN, 1995). This is followed by a discussion, in (5.5), of the Health Policy and the Reproductive Health Policy of Uganda in (5.6). The chapter ends in (5.7), with concluding remarks.

5.1 An overview of the health policies before the Alma Ata Declaration

The post-War period witnessed a number of paradigms in the health and development debate. Policies and approaches to health shared the assumptions of the development ideologies of the 1950s and 1960s, which believed that Third World countries would follow the experience of the industrialized countries. Similarly for Uganda, the health policies followed the Western health care model (MacDonald, 1995) that focused on curative, urban-based and highly technological medical services, which only professional medical doctors could dispense. In addition, as discussed in chapter two, during the 1950s and 1960s development organizations perceived the economic role of

women in reproduction only as homemakers, bearers and rearers of children, and housewives. This was reflected in the 'welfare' approach to women's development programmes in family planning and population control, mother and child health care, nutrition, home economics, etc. (Moser, 1993). However, during the 1960s and 1970s it became clear that the effects of modernization were not 'trickling down'.

The 1960s were years of independence for many African countries, for instance Uganda in 1962 and Kenya in 1964. Internationally, however, for the United Nations, the growing concern was over the high mortality and morbidity rates and the likely effect this would have on the development process. It was noted that the inequalities in access to conditions that improve people's health in the Third World, particularly Sub Sahara Africa, had to be addressed (Webster, 1993). Similarly, in Maurice King's *Medical Care in Developing Countries* (1966) (the book was the result of a symposium held in East Africa), a number of doctors argued that health services were not reaching those in need for several reasons. Another concern was that health services were attempting to treat preventable illnesses such as malnutrition for which poverty and ignorance were the key likely causes. King's book emphasized the need for more preventive health measures such as immunization and antenatal care and to move services nearer to the population by building health centres and clinics in rural areas. In order to increase access to health services, the use of medical auxiliaries was strongly advocated, a leaf borrowed from the proponents of the dependencia approach (Asthana 1994: 50) and the Chinese strategy of the 'barefoot doctors'. It is said that the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) openly expressed enthusiasm for many elements in the Chinese model (Asthana, 1994: 51). Emphasis therefore focused on bringing health care closer to the people. As result for a country like Uganda, the 1960s signify the establishment of rural-based health centres and district hospitals. In addition training focused on paramedical staff.[1] This laid the first step towards accepting lay care by acknowledging that biomedical training for doctors was not necessarily 'the only, or even the best' way to provide health services. In addition, it dispelled the held assumption that disease could only be fully accounted for by a model based on biology as its basic scientific discipline. Social Scientists interested in medical care showed the importance of socio-economic, cultural and life–history factors in explaining ill-health (King, 1966: 152).

5.2 The 1978 Alma Ata Declaration: Primary Health Care (PHC)

Primary Health Care has been the leading policy in national and international health care planning for the last twenty-five years. In 1978 at the joint WHO and UNICEF conference in Alma Ata, the principles of primary health care (PHC) were formally defined. PHC was prioritized amidst high maternal and infant mortality rates, high morbidity and prohibitive costs for maintaining hospital–based and curative approaches to health. It was envisaged that properly managed and dispensed primary health care would target the people from the grassroots. Thus, among other things, the approach placed emphasis on participation of the communities. Unfortunately, however, no sooner had PHC been launched than the economic recession of the 1980s plunged the Third World countries, particularly the sub- Saharan countries, into an economic

crisis that they are yet to recover from as the discussion on structural adjustment programmes below shows.

The PHC approach was endorsed as the strategy to achieve "Health for All by the Year 2000". The Declaration of Alma Ata states that "Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (Health for All by the Year 2000, WHO 1978, Alma Ata).

5.3 Principles of Primary Health Care

Primary health care is based on five main principles (Green, 1999; 2003)

1. Equity

According to PHC, services should be physically, socially, and financially accessible to everyone. People with similar needs should have equal access to similar health services. To ensure equal access, the distribution of resources and coverage of primary health care should be greatest in those areas with the greatest need.

2. Community Participation

In addition to the health sector, families and communities need to get actively involved in taking care of their own health. Communities should participate in the following: Creating and preserving a healthy environment; maintaining preventive and promotive health activities; sharing information about their needs and wants with higher authorities; and implementing health care priorities and managing clinics and hospitals.

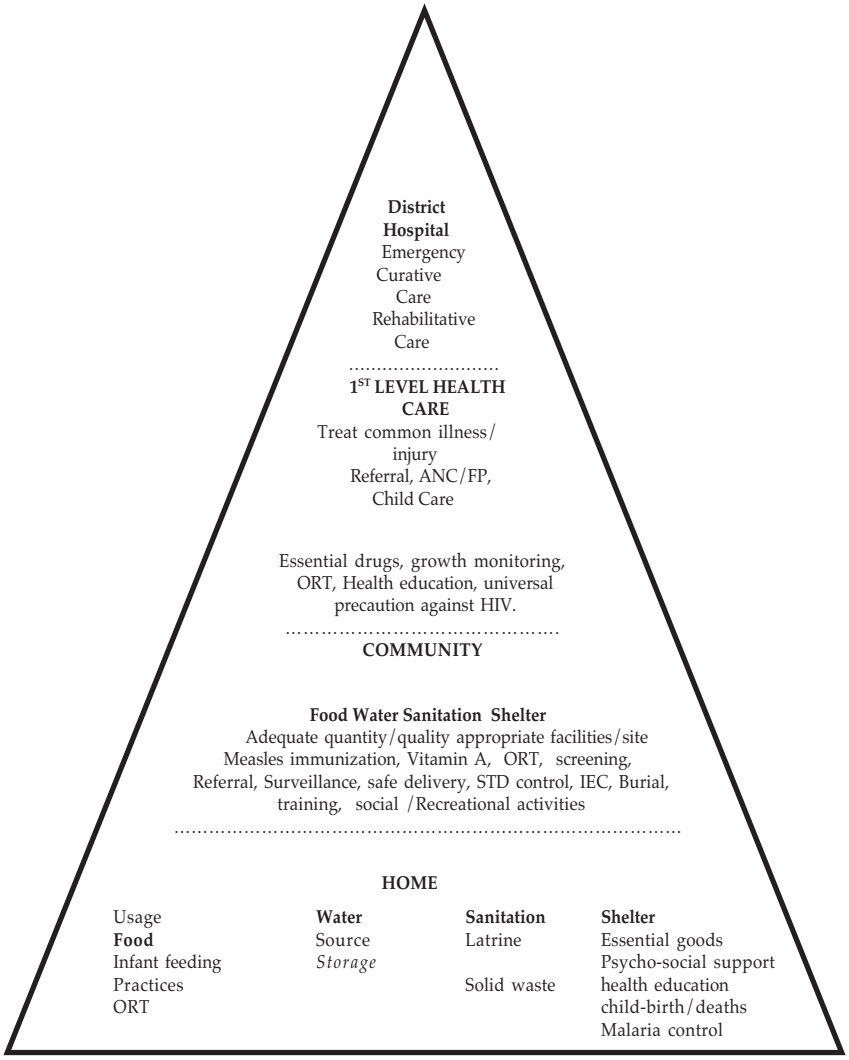
3. Inter-Sectoral Approach

PHC requires a co-ordinated effort with other health-related sectors whose activities impact on health e.g., agriculture, water and sanitation, transportation, education, etc. This is necessary to achieve social and economic development of a population. The health sector should lead this effort. The commitment of all sectors may increase if the purpose for a joint action and the role of each sector is made clear to all concerned.

4. Appropriate Methods

An increasing complexity in healthcare methods should be observed upward in the PHC pyramid (see figure 5.1). Caregivers should be trained to deliver services using the most appropriate and cost effective methods and equipment for their level of care.

Figure 5.1 Pyramid of PHC



Source: The John Hopkins and IFRC Public Health Guide for Emergencies 8-4

5. Health Promotion and Prevention

Primary health care requires a comprehensive approach that is based on the following interventions: Promotive – addresses basic causes of ill health at the level of society; preventive-reduces the incidence of disease by addressing the immediate and underlying causes at the individual level; curative – reduces the prevalence of disease by stopping the progression of disease among the sick; and rehabilitative – reduces the long-term effects or complications of a health problem.

The recommendations of the Alma Ata conference were seen as a breakthrough in official policy formulation not least for their recognition of the multi-pluralistic nature of factors behind ill health. PHC ideals were widely accepted, bringing about another paradigm shift in the health debate. Today, it is common for observers to acknowledge that the health problems of the Third World poor stem from both the 'absolute' lack of resources and the massive disparities that exist between the rich and the poor (Asthana 1994:51). By highlighting the environmental, social and economic determinants of health status, the Alma Ata Declaration recognizes that the attainment of health depends on several sectors.

The proponents of PHC drew most of their inspiration from the examples of improved health and development in China and Kerala State in India, which demonstrated that high levels of health and development could be achieved by political commitment. The Chinese health system attracted attention for its apparent focus on equitable socio-economic development, health services decentralization, preventive measures and mass participation. Particular attention was paid to the 'bare foot doctors' who not only extended basic health care to rural communities but were also accountable to the communities they served (Webster, 1993).

Implementing PHC has not been without problems. The success (or failure) of PHC should be judged within the context of the international economic climate of the time. The PHC approach was launched at a time of deepening recession and growing Third World debt. The 1980s saw the widespread implementation of structural adjustment policies aimed at transforming the poorer countries into more market-oriented economies. Forced to make cuts in their public expenditure, many Third World governments could only allocate a little of the scarce resources to the health sector and were unable to raise the budgets in view of the evident health needs of the population. Even though the Uganda government has maintained the health sector budget allocation between 4 and 5 per cent for the last ten years this has been too little to all accounts. More so, for Uganda, the problem was multi-pronged. The 1980s witnessed several armed conflicts, which compelled the diversion of money from the treasury into the resolution of the conflict. The little money, which was allocated to the health sector, remained in the urban-based hospitals, while the health of the people deteriorated further due to constant eviction and failure to access health care. But even now, several years after the 1980s, the government has to grapple with the protracted armed conflict in the north where the well-intentioned peace negotiation process with the LRA seems to bare no fruits as yet and for this, the government has to keep spending to quell the insurgency. As I indicate below, the PHC approach was a good strategy, which came at the wrong time; thus, adjustments in the form of 'target strategies' had to be made.

5.4 The maternal and child health (MCH) strategies

It was only in the 1970s that maternal and child health (MCH) started to draw the attention of the development planners (Wilkin *et al*, 1994). According to the PHC approach, maternal and child health was to be one of the essential components. It would be the key to achieving "Health for All by the Year 2000". The subsequent trend

has been to incorporate the development of MCH care in the expansion of PHC at local levels with adequate provision for referral to the tertiary level thereby providing both generalized and specialist care. Viewed critically, this approach can be said to target childbearing women and their children. There is little in these programmes to show that MCH programmes have wide coverage other than mothers and their children. This then leaves the health needs of the men, the non-child bearing women such as the pre-adolescents, the menopausing and postmenopausal women unattended.

Following the 1978 Alma Ata Declaration of PHC and given the economic and political climate of the 1980s, UNICEF with its mandate to reduce infant and child mortality, encouraged the uptake of a "target PHC strategy" using specific measures to tackle special issues within PHC. They emphasized the promotion and use of low cost measures to benefit those most disadvantaged, mothers and children, and subsequently launched a 'child survival and development revolution' (CSDR). It was hoped that considerable improvement in the well-being of the world's children could be achieved within a relatively short time through the use of simple and inexpensive techniques, particularly pertinent at the time of economic recession. However, this approach has received criticism to the effect that it ignores deadly adult conditions, which hinder their (adults') ability to support their children (Asthana, 1994: 184 citing Unger and Killingsworth, 1986).

These 'cutting-edge' techniques are widely known under the acronym of GOBI-FFF (Price 1994:140). Initially, these were just four simple measures concentrating on child health, namely; Growth monitoring, Oral rehydration therapy, Breastfeeding and Immunization. However, with the increased recognition of the role of mothers in promoting their own and their children's health, GOBI was subsequently broadened in scope to include the equally vital but more difficult and costly elements of Food supplements, Family spacing and Female education. The four GOBI strategies are distinguished in principle by being affordable, available almost universally, relevant and able to achieve rapid results. This strategy has been difficult to implement in Uganda because of some of the hindering factors already mentioned. In addition, I feel that the successful implementation of such a program highly depends on the position of women in the household, and their communities and their involvement in decision-making, which is heavily influenced by gender; their incomes and the ability to read and write which parameters elude most women in Uganda. For instance the global literacy rate for women is 45%, while that of Arua district is 28% and Masindi is (UDHS, 2000/1; Arua District Plan 2001; Masindi District Plan 1999).

The Safe Motherhood Initiative

Only until recently, has the significance of maternal health began to draw international attention. Traditionally, the improvement of women's health has been viewed largely as a vehicle to improve child health rather than as an important objective in its own right, for its own intrinsic value (Price, 1994). It can be said that the United Nations Decade for Women (1976-1985) helped to highlight the dimension of the problems associated with maternity. The several but preventable pregnancy-related causes of

death of services at the district level to cope with minor maternal surgical procedures and blood transfusions (Murray,1999).

In Uganda, an NGO - Safe Motherhood Initiative in Uganda (SMIU)[2] was established in 1988 to handle safe motherhood, family planning, and women's reproductive rights/ health community mobilization for reproductive health, advocacy and information provision. Due to the NGO's heavy reliance on external funding, at the time of this research, the Initiative was crippled by shortage of funds. There was not much on the ground to show what SMIU had achieved. The health indicators (MoH, 2003) with infant mortality rates at 88 per 1000 live births, life expectancy at 43 years and maternal mortality rates (MMR) at 504 per 100,000 live births are some of the poorest in the world (UNDP, 2003).

The Ministry of Health (MoH) has initiated several partnerships with the UN, international inter-agency organizations and NGOs, such as USAID, AIM, CARE, UNFPA to contribute to health in general and reproductive health in particular, including sexually transmitted diseases and HIV/AIDS. I discuss more about the partnerships in Chapter 6. The above trials of the several strategies and initiatives indicate one thing; that the prevailing health strategies, thus far, are not yielding the expected results and that the health status of most Ugandans is poor.

The Bamako Initiative[3]

The Bamako Initiative was launched by the World Health Organisation (WHO) and the United Nations Children's Fund (UNICEF) in Bamako, Mali in September 1987. The Initiative was meant to provide the needed assistance to the PHC sector as well as serving as a catalyst to mobilize the community and domestic resources to sustain and expand the efforts. The objective of the Bamako Initiative was to ensure that high quality primary health care was available to the entire population at an affordable price. The Initiative introduced a clear target of the district and community management and a commitment to a local financial contribution approach as a means to make PHC/MCH systems operational and sustainable on a wider scale.

The Bamako Initiative focused on a few strategies to improve the quality of health services while improving the effective use of resources. To this effect, communities were to contribute financially to their own health services, primarily through user fees, on the premise that even the poor will pay for high–quality services. It was also envisaged that community funding would be sufficient to cover all non-salary recurrent costs and that communities would participate in decision-making related to their health services through locally elected committees. The Bamako Initiative also made the assumption that village health workers would be trained to conduct outreach activities. Emphasis was placed on provision of an essential services package, which includes cost-effective interventions and generic, essential drugs and that the health services are delivered through a decentralized, district-based health system.

By the end of 1994, 33 countries, primarily in Africa, had adopted the Bamako Initiative along with countries in Asia and Latin America. The implementation of the user fee[4]

did not start in Uganda until the early 1990s within the context of the then yet-to-be achieved mentioned strategies, which have yet to be realized. For instance, in the case of Uganda, the issue of user fee was implemented on a temporary and *ad hoc* basis and was easily scrapped by the President during the 2001 presidential election campaigns when he promised to ban user fees in case he was voted back, which indeed happened and the user fee policy was abandoned. But the user fee has been indirectly charged as I point out in chapter 8 and 9 that due to the shortage of drugs at the health centres, patients have to purchase them from pharmacies, clinics and drugstores at such exorbitant prices.

The decentralization process, which started in the mid 1990s with 13 pilot districts, including Arua and Masindi, was not achieved for the whole country until towards the end of the 1990s. The essential drugs scheme covers the basic generic drugs. Unfortunately, the main common disease, malaria, is resistant to the traditional forms of treatment and requires a combination regimen of antimalarial drugs for effective treatment (Kamya, *et al*, 2002). Chloroquin as a drug of choice for treating malaria was affordable, however, after its poor performance due to malaria resistance, the recommended regimen of Amodiaquine and others is beyond the reach of most Ugandans whose GNP is US $330 (UDHS, 2001/2). In a household survey in the districts of Kabarole and Bundibugyo, it was found that the direct cost for an episode of unsuspected malaria averages Ug Shs. 4,500 (4.10 US$) in urban settings and UG Shs. 2000 (1.80 US$) in rural populations.

Arising out of the interviews I conducted in refugee and non-refugee health centres in Masindi district[5], malaria was on top of the list of the illnesses presented at the health centres. Another related issue was affordability, since there was constant lack of medicines at the government health centres, despite the fact that health centres receive the drug kits from the District Health Office. Moreover, patients seeking treatment had to travel for long distances. However, user fees are still paid by patients who attend private clinics and wards in government hospitals as well as maternity patients. As I mention in chapter 7, many of the individuals operating rural health centres are untrained nurse aides. Despite this shortcoming, it was learnt that the Ministry of Health is looking into how best the Bamako Initiative can be implemented.[6]

5.4 Structural Adjustment Programmes (SAPs)

While the 1950s and 1960s were a period of steady economic growth in most Third World countries, the modernization strategies adopted by newly independent governments locked their economies into unequal trading relationships that lie at the root of the current economic crisis. Despite the efforts to industrialize and diversify, many countries in Sub Saharan Africa remain dependent on the export of primary commodities to developed countries for foreign exchange earnings. Because of adverse terms of trade, primary exports generated insufficient wealth to import manufactured goods, industrial supplies and agricultural technology. These countries were therefore forced to rely on foreign loans to finance economic development. It became a vicious cycle. Such borrowing increased the need to earn foreign exchange to repay loans and

hence the need for primary produce. As if that was not bad enough, the situation was compounded by an increase in prices of manufactured goods as well as oil bills as a result of the increase in oil prices by the Organization of Petroleum Exporting Countries (OPEC) in the 1970s. Moreover, the economic recession of the late 1970s and 1980s reduced the demand for primary products. This led to a dramatic fall in commodity prices. As a result, the 1980s became a development disaster particularly for the primary–commodity dependent nations such as Uganda in which the situation is even more bleak because of the country's reliance on only two agricultural commodities- tea and coffee - for the bulk of her export earnings (even though, presently, there has been a deliberate effort to diversify into the non-traditional cash products such as horticulture and fish). As the real prices for these commodities dropped by more than 40 per cent through the 1980s, the Sub Saharan terms of trade declined significantly (Hewitt, 1992). In addition, most of the countries in Sub Saharan Africa have either just got over war, or engaged in fighting or are in easy proximity to areas with armed conflict. Thus, even for those countries, which are not engaged in armed conflict, closeness to war zones is likely to increase their military spending.

How did SAPs affect health? I can better argue this point with an illustration. Take, for example, the retrenchment of civil servants in Uganda as part of the cost recovery programme. It can be argued that the exercise plunged the retrenchees into vulnerability where they were left with no fall back position. In actual sense, despite their having been given send-off monetary packages, their real incomes and wages were reduced. In the past, where such a woman (and man) would claim health benefits for her/his children, (s)he now has to pay with cash from her/his pocket. With the depreciation of the Uganda Shilling and the high unemployment, it would therefore be incorrect to assume that the retrenchees got a better deal outside of the civil service. Many individuals[7] I talked to stated how their money perished in trading businesses because they had no practical and hands-on experience in business. In addition, small capital businesses were out done by the bigger entrepreneurs. The suggestion that the rural poor have positively benefited from SAPs has been challenged with evidence that urban migration increased during the 1980s. In Sub Saharan Africa, this has resulted in growing numbers of female migrants who, in the absence of other employment opportunities, turn to prostitution. This is because the greatest burden falls on to women. Their contribution to the household economy has become critical under economic crisis and increasingly many of them are seeking paid employment. At the same time, because of cuts in state service expenditure and the rise in food prices, women are having to spend more time in their role as household managers (Asthana, 1994). Health care expenditure by national governments has sharply declined for several countries. According to Stewart (1992), in Zambia, the real expenditure fell by 22 per cent from 1982 to 1985 and the real value of the drugs budget in 1986 was only a quarter of the 1983 level.

Contrasting the high levels of chronic and degenerative conditions in the West, Third World countries display high infant and child mortality from preventable infectious diseases such as measles, diarrhoea and respiratory infections. Infectious diseases can best be understood within the context of the role of nutrition. A malnourished individual,

whether a child or an adult, is more prone to infection than a well-fed individual because they lack the immunity to fight infection. People become malnourished because they lack the means to nutritious food. There is therefore a synergistic relationship between food insecurity, malnutrition and SAPs. The need to create income forces households to sell their food crops. Alternatively, households may do away altogether with growing food crops and concentrate on cash crops. For those without land, the situation is even grimmer when they neither have the cash nor the land on which to grow food. Cuts in subsidies and the removal of price controls on consumer commodities, such as food, have caused particular hardships for urban dwellers who have no land on which to grow their food. This has led to riots in several countries as was the case in Zambia over hiked maize prices by 50 per cent in 1985 (Stewart, 1992).

The decline in household incomes has placed an extra burden of work on women within smallholder households through pressure to produce more crops for sale on the open market. Heavy workloads undermine the nutritional status of women and their children. Hard physical work combined with repeated pregnancies increases the demand for nutrition and where the household income is low to meet such demands, it is likely that women will end up eating even less according to the cultural feeding practices which dictate that women eat last. The low food intake then predisposes pregnant women to easy contracting of infections and food related complications such as anaemia and small babies at birth. Maternal malnutrition affects the baby's weight, the quality and quantity of breast milk; both key determinants to its survival.

In the foregoing discussion, we have noted that during the period before 1978, health care provision was more therapeutic, urban based and required the expertise of professional doctors. The reproductive health policies during this period focused on women as child bearers and nurturers within households. Treatment targeted preventable conditions such as malnutrition and anaemia without looking at the root causes such as poverty. Healthcare provision was not getting to the people in the rural areas. However, the Alma Ata Declaration in 1978 set the stage for extensive coverage of health care and increased popular participation. I have noted the various initiatives, including the Safe Motherhood and Bamako Initiatives established to further enhance PHC, making note of the fact that despite the recommended strategies, the health of Ugandans was negatively impacted by malaria. Besides, I have also noted the constraints, which have hindered the proper implementation of PHC. Finally, I have explained how SAPs have affected the health of women and children. By way of example, I have argued that the civil servants who lost their jobs in the cost recovery programmes were worse off and lacked the incomes to pay for their health. Reduced incomes forced people to attend more to cash crops and less on food crops, thereby suffering food insecurity. As a result, pregnant women suffer anaemia and chances of having small babies become higher, hence increased neonate deaths and maternal mortality. Below, I shall focus especially on reproductive health policies in general and with specific regard to Uganda.

5.5 Reproductive Health Policies

The International Conference on Population and Development (ICPD)

In the 1960s, the 'Pill' came to the market for the first time and was embraced mostly by women in the West. In the Third World countries issues of family planning and child-spacing did not feature prominently in policies or health interventions in the 1960s, family planning in Uganda being provided on a very small scale by hospitals or an NGO - the Uganda Family Planning Association. The population policy of 1993 was the first attempt at integrating population issues into development at national level. However, the rapid population growth and the declining gross domestic product (GDP) compounded by high maternal and infant mortality as well as food insecurity and increasing poverty have been of concern to the international community policy makers and planners. As part of a development strategy, there was a need to broaden the scope from Family Planning to Reproductive Health thus moving away from demographic targets to people-oriented improvement and development strategies.

In a bid to widen the scope for population and family planning issues, the International Conference on Population and Development (ICPD) in Cairo in September 1994 adopted the concept 'reproductive health'. This concept was broad based as it took several aspects of the reproductive health process into consideration. Whereas in the past women were targeted for their reproductive function, the ICPD focused on the entire life cycle of women and men's involvement in reproductive health and the need for participation was stressed. Furthermore, the concept of reproductive health featured prominently a year later during the FWCW agenda in Beijing in 1995. While the ICPD was concerned with overall population issues, the FWCW focused on these issues as they affected women. Both conferences played advocacy roles with regard to the position and situation of women and decried the violence and denial of access to resources that befall a majority of women in Third World countries.

Paragraph 7.2 of the final document of the ICPD defines reproductive health as:

> "the state of complete physical, mental and social well-being and not merely the absence of disease as infirmity in all matters related to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant" (International Conference on Population and Development – Cairo 1994; *Plan of Action*, para 7.2).

The ICPD Programme of Action centres on a commitment to bringing about the equality of women and men and equity between them through changes in legal, political, social, economic, education, and health systems. It was also agreed in Cairo that women's lack of equal status is clearly linked to denial of their reproductive rights, their poor sexual and reproductive health, gender-based violence, harmful traditional practices and unwanted pregnancies and STDs including HIV / AIDS infection. Changing these realities requires use of a gender perspective to guide reproductive health policy-making and service delivery. This approach examines the effect of power imbalances between men and women and then develops policies and programmes that promote sensitivity and equity. Women's leadership in these efforts at the community and national levels is essential along with the full participation of men – as policy makers, partners, husbands and fathers (Family Care International – Five years after Cairo)[8] . The practical side of these recommended policies shows that within the health sector, a gender perspective is lacking to guide reproductive health policymaking and service delivery. For instance, the 59-page 'Sexual and Reproductive Health Minimum Package for Uganda (MoH,) contains, on page 33, only one section (3.3.1 – Gender Issues and STDs) with three bullets. That is all about gender. Moreover the MoH Draft Health Policy (1999-2004) is totally silent about gender in health delivery system. In reality and in practice, which was evident during the field trips, the overarching issues of power in gender relations remain unchecked. The majority of health programmes were essentially maternal and child health (MCH), the exception being Naguru Teenage Centre in Kampala, which addressed the adolescent reproductive health needs. With a population in which 60% constitute children under 18 (UBOS, 2002), it is imperative that policies sensitive to the reproductive health needs of the age category be designed and implemented in a gender-sensitive environment.

While the entire ICPD Plan of Action explicitly or implicitly concerns the well being of the quality of reproductive health of individuals, for the sake of time and space I shall only deal with those specific areas of reproductive health that are relevant to the present study.

In Chapter IV, *Gender Equality, Equity and Empowerment of Women*, the Plan of Action draws the attention of governments and NGOs to promote the empowerment and status of women, the girl child and male responsibilities and participation. The Uganda government is pursuing policies aimed at improving the status of women and girls. For instance, affirmative action policies requiring women inclusion in the Local Councils and Parliament, the extra 1.5 marks for every female entering national universities to ensure an increase in the number if girls accessing university education have been pursued. At the international front, there are several things taking place. Forum For Advancement of Women (FAWE) is implementing programmes, which encourage girls to pursue science subjects. In addition the Carnegie Corporation has a programme to offer educational scholarships targeting needy and vulnerable girls.

The Uganda government is currently running the Universal Primary Education (UPE) programme launched in 1997, in which government waived school fees for four children per family and provided textbooks for free. During the 2001 presidential election

campaign, President Museveni promised to let all children attend for free. As a result primary school enrollment increased from 2.3 million pupils in 1996 to 6.59 in 1999 (U.S. Department of Labour)[9] , and to 7.6 million in 2004 (The New Vision, September 13, 2004). It is noteworthy that the UPE Initiative encourages households to send their girl children, orphans and the disabled to school. While UPE encourages an equal boy-girl ratio of enrollment, school enrolment of girls still lags behind, but the gap is getting narrower. According to the Ministry of Education (2004) the ratio of boys to girls in primary schools has improved from 55:45 in 1996 to 52:48 in 2000 to 51:49 in 2003.[10] One disturbing issue is the fact that a significant number of school children drop by the way side and do not complete their primary education. For instance, of the 2,159,850 pupils who enrolled for P1 in 1997, only 482,021 pupils completed P7 in 2003 (ibid). Although gender disaggregated data is hard to come by, it is highly probable that majority of those who dropped out of school are girls.

Chapter VI, *Population, Growth and Structure*, draws the attention of governments to place emphasis on the importance of population trends for development with the aim of reducing the mortality levels. In this regard the governments are called upon to consider the challenges created by the large proportions of children and young people in the populations in most developing countries. In addition, attention is called to the special needs of the elderly, the indigenous peoples and persons with disabilities.

The Progress Report for Uganda on the Millennium Development Goals (MDGs) indicates that between 1989 and 2001 Uganda's maternal mortality slightly fell from 523 to 505 deaths per 100,000 live births (PRN, 2004). Government missed its target of 354 per 100,000 live births by 200 and postponed it to 2005. In order to meet the MDG target, Uganda would have to reduce its mortality rate from 505 to 131 per 100,000 live births by 2015 (ibid). It is difficult to imagine how this will be effected unless the delivery of primary health care is greatly improved from its present condition, which I describe in chapter 6.

Chapter VII, *Reproductive Rights and Reproductive Health* calls upon all countries to strive to make reproductive health accessible through the primary health care system to all individuals of appropriate age. Such care includes inter alia: family planning, counselling and education and communication services, education and services for prenatal care, delivery and post natal care, especially breastfeeding and infants' health including immunization and women's mental health and treatment of infertility. Others are proper management of abortion, reproductive tract infections and sexually transmitted diseases (STDs) and other health condition's information, education and counselling on human sexuality and reproductive health and responsible parenthood. Specifically, governments are called upon to address issues of family planning, STDs and HIV prevention, human sexuality and gender relations and adolescents.

According to the Uganda Demographic Health Survey (UDHS) (2001/2), family planning prevalence rate is 22%, including the use of traditional birth control methods. This rate is low for a population growth of 3.4% and where total fertility rate (TFR) is 6.9. Committing or inducing an abortion remains a crime under the Laws of Uganda.

The almost 20-year-old armed conflict in northern Uganda has inflicted sexual and gender-based violence to both men and women including girls who have been raped and have sustained unwanted pregnancies (De Temmerman, 2002). And yet, according to the law of the land, carrying out an abortion is criminal. It therefore becomes difficult to see how reproductive health rights can be upheld in such an environment.

The Uganda Government has been acclaimed for its role in reducing HIV / AIDS infection rate. The main approach was multi-pronged and consisted, among others, intensive communication campaigns, creation of awareness, the use of condoms, abstinence and the recently introduced ARVs (UNAIDS, 2003)[11] . However, in 2005, the approach has changed to ABC (Abstinence, Be faithful and Condom use). It is believed that the change of approach is donor driven. Nevertheless the onus remains on Uganda government to ensure a regular supply of condoms. These programmes cannot be easily accessed by the rural folk due to the fact that not everybody has a radio and the distances to the health centres in the villages are long. In addition, newspapers, which carry detailed information on HIV / AIDS, are read mostly by urban dwellers. I did not observe newspaper reading in the refugee settlements for example. Moreover, for the women, permission by husbands is necessary before they can use ARVs (Kiapi, 2005). Lastly, given the gender inequality it is difficult for women to negotiate sex (Kabonesa, 1998).

Governments are called upon in Chapter VIII, *Health, Morbidity and Mortality* to address issues of child survival, maternal mortality, women's health and safe motherhood and HIV / AIDS. I have elaborated on these issues in the preceding sections. Chapter X *International Migration* draws the attention of governments to the specific rights of the displaced people but the chapter does not address the health concerns of refugees and undocumented migrants. Nevertheless, the fertility rate in the conflict-affected areas of northern Uganda at 7.4 (Donor News, 2003) is one of the highest in Uganda. It is quite possible that the disruption in lifestyles, the high infant mortality rates and the inaccessibility to family planning could be influencing the high fertility rate.

Chapter XI *Population, Development and Education* – argues for an individual's access to knowledge which helps to reduce fertility, morbidity and mortality rates of women, and improve the quality of the working population. Although the issue of birth control is handled by the Uganda Family Planning Association and a few other NGOs, Uganda's Population Policy is quiet about regulation of fertility. Meanwhile the fertility rate of women in Uganda is 6.9 with wide variations across the country. For instance, the fertility rate in the districts of Yumbe and Kotido is 8, while that of the central region of Uganda is under 5. The maternal mortality rate (MMR) for Uganda remains at 505 per 100,000 live births. Several obstetricians and gynaecologists, particularly those who work in rural hospitals, contest this figure[12] . Chapter XIII *National Action* advises the governments on salient issues to incorporate in their policies and also advises on the average costs of implementing reproductive health and population programmes. Uganda has put in place institutional and policy frameworks and whose successful implementation and impact depend mainly on donor funding; for instance, the HIV / AIDS policy and the Poverty Eradication Action Programme (PEAP).

Chapter XV, *Partnership with the Non-Governmental Sector* promotes an effective partnership between governments, non-governmental organizations, and the local community groups to ensure the effective implementation of the Programme of Action. To this effect partnerships have been established between the Ministry of Health and the UNFPA, the United States Agency for International Development (USAID), Delivery of improved Health Services for Health (DISH), (see chapter 7 for further discussion), African Medical Research Foundation (AMREF), AIDS Information Centre and several others.

Fourth World Conference of Women (FWCW)

As mentioned above, there are only minor differences in emphasis between the resolutions of the FWCW and the ICPD with regard to the experiences of men and women and the vulnerability of women in a variety of situations. Therefore I shall not dwell much on FWCW Plan of Action except for Section E. *Women and Armed Conflict* in which the Plan of Action discusses the problems and special needs of women in armed conflict and calls upon the parties concerned to pay particular attention to sexual violence against uprooted women and girls employed as a method of persecution in systematic campaigns of terror and intimidation and forcing members of a particular ethnic cultural or religious group to flee their homes. Furthermore, the Plan of Action calls for the integration of a gender perspective in the resolution of armed or other conflicts and foreign occupation and aim for gender balance when nominating or promoting candidates for judicial and other positions in all relevant international bodies. In strategic objective E.5, Governments, intergovernmental and non-governmental organisations and other institutions involved in providing protection, assistance and training to refugee women, other displaced women in need of international protection and internally displaced women, including the Office of the United Nations High Commissioner for Refugees (UNHCR) and the World Food Programme (WFP) are called upon to take steps to ensure that women are fully involved in the planning, design, implementation, monitoring and evaluation of all short-term and long-term projects and programmes providing assistance to women refugees, and other displaced women in need of protection.

Part of the findings of this study show that far from being involved in planning, designing, implementation, monitoring and evaluation, women refugees have to negotiate their way for survival in the otherwise highly male dominated refugee bureaucracy of the refugee settlements.

Beyond ICPD and FWCW

Special review sessions called the 'ICPD +5' and 'Beijing +5, Process and Beyond' were convened in 1999 and 2000 respectively. ICPD+5 agreed on a new set of benchmarks: Education and Literacy. Governments, in particular of developing countries, with the assistance of the international community were called upon to reduce the rate of illiteracy and to improve reproductive health. Governments were urged to make sure that by 2015 all primary health care centres are able to provide directly, or through referral, the

widest achievable range of family planning and contraceptive methods; essential obstetric care, proper management of reproductive tract infections, including sexually transmitted diseases and HIV / AIDS. Others were maternal mortality reduction; this aspect , which stresses the importance of reducing maternal mortality by ensuring that majority of births are assisted by skilled birth attendants. It was preferred that governments, with assistance from UNAIDS and donors should by 2005 ensure that at least 90 per cent and by 2010 at least 95 per cent of young men and women aged 15 to 24 have access to the information, education and services necessary to reduce their vulnerability to HIV infection (UNFPA: ICPD+5).[13] It is now 2005. Although there has not been any evaluation thus far on the access to information, education and services, all indication in Uganda show that the wish is still far from being realized.

The special session "Women 2000: gender equality, development and peace for the twenty-first century" took place at the United Nations headquarters in New York from 5 June to 9 June 2000 and adopted a political Declaration and outcome document entitled "Further Actions and Initiatives to Implement the Beijing Declaration and Platform for Action". At the opening session, the Secretary General emphasized the progress made since the Fourth World Conference in Beijing. Human rights of women had gained recognition, violence against women was now an illegal act in almost every country and there had been worldwide mobilization against harmful traditional practices. But the Secretary General noted that much still remained to be done, including addressing new challenges such as HIV / AIDS and increased armed conflict. While women entered the labour market in unprecedented numbers, the gender divide still persisted; women earned less and were involved in informal and unpaid work. There has been a breakthrough in women's participation in decision-making processes, but little progress in the legislation in favour of women's rights to own land and other property. In his statement, the Secretary General focused on the importance of education stressing that it is the entry point into the global economy and the best defense against its pitfalls. Once they were educated and integrated into the workforce, women would have more choices and be able to provide better nutrition, health care and education for their children.

The special session reaffirmed the importance of gender mainstreaming in all areas and at all levels and the complementarity between mainstreaming and special activities targeting women. Certain areas were identified as requiring focused attention. These included: education, social services and health – sexual and reproductive health, the HIV / AIDS pandemic, violence against women and girls, the persistent and increasing burden of poverty on women, vulnerability of migrant women including exploitation and trafficking, natural disasters and environmental management, the development of strong effective and accessible national machinery for the advancement of women, and the formulation of strategies to enable women and men to reconcile and share equally work and family responsibilities. A number of these actions set new targets and confirmed existing ones: closure of the gender gap in primary and secondary education by 2005, and free and compulsory and universal primary education for both girls and boys by 2015; the achievements of a 50 per cent improvement in levels of adult literacy by 2015 especially for women; the creation and maintenance of a non-discriminatory,

as well as gender sensitive legal environment through reviewing legislation with a view to striving to remove discriminatory provisions as soon as possible, preferably by 2005; and universal access to high quality primary health care, throughout the life cycle, including sexual and reproductive health care, not later than 2015 (Beijing + 5 Process and Beyond)[14] .

The discussion in 5.4 above has been long, but important. Member countries of the United Nations (UN) formulate most of their policies and programmes in accordance with resolutions that are passed by the UN. It has therefore been fitting to explain the resolutions, which concern reproductive health, gender and women including women refugees and to briefly explain (where possible) how these resolutions have turned into policies and how they are being implemented in Uganda. I now look at the national policies.

5.6 The National Policies

National Health Policy (1999-2004)

The National Health Policy and Strategic Plan Frame have been formulated within the context of the provisions of the Constitutions of the Republic of Uganda 1995 and the Local Governments Act, 1997 which concerns decentralized governance and service delivery. The Mission Statement of the Health Policy (MoH, 1999) states that the overall goal of the health sector is the attainment of a good standard of health by all people of Uganda, in order to promote a healthy and productive life. Be that as it may, I have already shown the obstacles, which the health care delivery system is facing including under capitalization, poor and inadequate funding, and affordability among others. I have emphasized the ill effects of malaria, and how it impacts not on the health of individuals alone but also on their development and that of their communities. I have also alluded to the difficulties in achieving the targeted MMR of 131 by 2015.

Furthermore the Health Policy mentions Primary Health Care as the basic philosophy and strategy for national health development. Other principles are: equitable distribution of health services, good quality health care, efficiency and accountability, health promotion, disease prevention, and empowerment of individuals, care of the elderly, partnership with NGOs and private as well as traditional practitioners, co-ordination and co-operation with other health-related ministries and a gender sensitive and responsive health system. (MoH, 1999:6). The overall objective of the health sector is to reduce mortality, morbidity and fertility, and the disparities therein.

The Health Policy priorities focus on health services that are demonstrably cost-effective and have the largest impact on reducing mortality and morbidity. The major contributors to the burden of disease at all levels will be given the highest priority. These include malaria, STI/HIV/AIDS, tuberculosis, diarrhoeal diseases, acute lower respiratory tract infections, perinatal and maternal conditions attributable to high fertility and poorly spaced births, vaccine-preventable childhood illnesses, malnutrition, injuries, and physical and mental disability. The cost-effective interventions which will be *STI/HIV/*

implemented in an integrated manner to address these health problems will together constitute the Uganda National Minimum Health Care Package. This package will be reviewed regularly.

Components of the minimum health care package

The minimum package will comprise of interventions that address the major causes of the burden of disease and shall be the cardinal reference in determining the allocation of public funds and other essential inputs.

Control of Communicable Disease

Malaria

Prevention and control measures through improved case management, vector control and personal protection from insect bites at the community and household levels, selective chemoprophlaxis, intensified surveillance to help prevent and better manage epidemics, and monitoring the efficacy of existing anti-malaria drugs.

It is estimated (MoH, 2003) that 50% of the 4,200,000 children under 5 years of age currently in Uganda suffer an average of 6 episodes annually and are treated in health facilities at 2,000/= per episode meaning that Ugandans are spending (50/100 x 4,200,000 x 6 x 2,000 = 25,200,000,000/= annually for treatment of the under fives only. Of course this does not include other expenses incurred such as transport expenses while seeking treatment, treatment of adults and children over 5 years old, treatment of adults and children admitted in health facilities, chloroquine failures which require more expensive drugs, funeral expenses for children and adults who die and other expenses in form of aerosol sprays, mosquito coils and mosquito nets. During pregnancy malaria may cause maternal anaemia, intrauterine growth retardation, premature births, low birth weight which is the greatest contributor to infant mortality, still births, miscarriages and susceptibility to malaria attacks by pregnant women (MoH, 2003). Malaria does not only cause ill health and death, but also has a great impact on the economic development of the individual, the family, the community and the nation as a whole in several ways. By affecting families during the rainy season, it contributes to food insecurity and drops in incomes, as the household members cannot undertake the farm activities. In addition, there is loss of household incomes through absenteeism (as well, it affects school attendance) because of constant malaria attacks and having to attend to the sick. It is estimated that workers suffering from malaria bouts can be incapacitated for 5-20 days (Kamya *et al,* 2002). Perhaps what the above does not mention are the gendered impacts of malaria on women. Apart from suffering the bereavement of their children and relatives due to malaria, they also have to make repeated visits to health centres seeking health care as well as improvising in situations where affordability is a problem. In the health centres in Arua and Masindi women described how they treated their children with traditional medicine, because traveling to health centres meant 'losing the day' and many of them could not afford the charges.

AIDS

Prevention and control of STI/HIV through a program of intensive Information, Education and Communication (IEC) aimed at promoting responsible sexual and reproductive behaviour. Sexual and reproductive counselling, HIV counselling and testing, wide use of condoms, prompt treatment of STIs, universal blood safety, reduction of mother to child transmission, palliative care, promotion of community involvement in the care of patients with AIDS, and mitigation of the socio-economic impact of the epidemic will constitute the core elements of this component.

In Uganda, the Government, the UN and NGOs (local and international) working individually and/ or in partnerships have worked to reduce the incidence of STI/ HIV/AIDS (Kazibwe, 2002). Several programmes and interventions have been initiated to combat HIV/AIDS. Some of these include condom use, avoiding the shared use of sharp instruments (such as needles, razor blades, etc,) discouraging breastfeeding, Nevirapine and Antiretroviral therapy (ARVs). Still HIV/AIDS is the leading cause of death among individuals aged 15-49 and the immediate impact of the pandemic has been the increasing number of orphans already estimated at 2 million (UNAIDS, 2002).

According to Kiapi (2004), health workers say that many pregnant women are reluctant to enroll in HIV prevention programmes because they fear their spouses. Furthermore, even when HIV positive women are aware of the likelihood of passing HIV to their babies through breast-feeding, because of poverty, which in Uganda is 38% (PMA, 2005), they find they cannot afford to purchase the baby milk. Moreover, many HIV positive women would rather not be seen bottle-feeding their babies fearing that they will be suspected of being HIV positive. Therefore, even though there are policies in place to combat HIV/AIDS, the implementation of such programmes becomes difficult due to problems such as the ones just mentioned.

Tuberculosis

Strengthening and expanding countrywide, the provision of early diagnosis, prompt and cost effective treatment.

The problem of tuberculosis (TB) remains a silent Global killer, which has not yet received the attention it deserves (Adatu[15], 2005). It is estimated that one third of the world's population is infected with TB (WHO, 2005). Although not everybody who is infected develops the disease, over 8 million people develop active tuberculosis each year and many of them die. The most affected are the poor populations of Africa and Asia. There are 22 countries, including Uganda, which bear 80% of the world burden of TB.

HIV has fuelled the TB epidemic. A person infected with HIV has an increased risk of getting the TB infection progressing into disease and death. Women bear the brunt of the TB problem. Besides being infected themselves, they also have the social role of being the care givers. Thy nurse the sick and bear the effects of inability of family

members' illnesses and of bereavement in case of death. Women also constitute the biggest part of the force that cares for TB patients, thus putting their own lives at risk.

Lack of access to health services also impacts negatively on the well being of women. In Uganda, 40.2% of the TB cases reported in 2004 were women (Adatu, 2004). Trends of the cases reported in health facilities suggest that mortality is higher among women.

The strategy against TB adopted in the world is DOTS (Directly Observed Treatment Short course) (WHO, 2005). In Uganda, the Community –Based model of DOTS (CB-DOTS) has been tested in selected districts and proved effective. The strategy has now spread to the whole country. The five elements of DOTS are: political commitment to the programme by the stake holders, examination of sputum using a microscope, a reliable supply of anti TB drugs, non defaulting in taking the drugs, and proper recording and reporting (Adatu, 2005) As a result of implementing DOTS, Uganda has managed to increase the Case Detection Rate to 52% and Treatment success rate to 67.5% (Adatu, 2005)..

Sexual and Reproductive Health and Rights

Essential Antenatal and Obstetric Care

To ensure safe pregnancy and delivery of improved management of complications of pregnancy and childbirth including spontaneous or induced abortion and, to reduce the unacceptably high rates of maternal and perinatal deaths through timely and effective emergency obstetric care provided at strategic and accessible locations.

According to the progress report for Uganda, in the Policy Review Newsletter (PRN, 2004), the direct causes of maternal mortality include bleeding, infection, obstructed labour, hypertension and abortion. Other related causes include poor maternal nutrition, short birth intervals and early age at first birth. The lack of trained assistance at birth and inaccessibility of health care facilities, the poor attitude of health workers, to patients such as bribe soliciting by health workers limits the utilization of health facilities by women (*ibid*).

Figures show that the proportion of undernourished women has remained constant at 10%; Uganda's median interval remains the lowest in Sub-Saharan Africa. Although the number of teenage pregnancies has fallen from 43% in 1995 to 31% in 2000 (UDHS, 2001/2), the number of attended births at 38% has remained constant over the same period.

Family Planning

To provide information and services for appropriate modern family planning methods and reduce the wide gap between desired and actual use of family planning services.

Okofua and Snow (1999) assert that family planning use in Sub Saharan Africa is as

divergent as the continent's landscape. Contraceptive use throughout the region remains low although two thirds of Sub Saharan countries have family planning programmes. According to the UDHS (2001/2), the family planning prevalent rate is 22% including the use of traditional methods. Clearly, this is a low rate for a fast growing population 3.4% (UBOS, 2002). Studies in the refugee settlements just studies, men refugees were vehemently against the use of any family planning. The few women who attempted to use family planning did so clandestinely. Male refugees used condoms during sexual relations with women other than their wives and primarily to prevent STIs and HIV/AIDS.

Adolescent reproductive health

To promote sexual and reproductive health and rights of adolescent boys and girls, including sex education in and out of school, life skills against sexually transmitted infections, unwanted pregnancies and unhealthy lifestyles.

In August 2000, Uganda came up with a draft of a National Adolescent Health Policy. The component of adolescent health comprises: adolescent sexuality; fertility concerns including contraception, unwanted pregnancy, unsafe abortion, care for the pregnant adolescent, care for the infant; STI and HIV/AIDS; harmful traditional practices; substance abuse; mental health; accidents; adolescents with disabilities; occupational health; nutrition; oral health, and socio-economic consequences (MoH, 2000).

The reproductive health delivery system has continued to focus on women in the childbearing ages together with their children. There is no emphasis on the reproductive health needs of the people outside of this category including adolescents. Even if there were such programmes, they would tend to address issues of parenthood. Having said that however, it should be noted that Naguru Teenage Centre in Kampala could be about the only one organization in Kampala, which handles the adolescent –specific reproductive health needs of adolescents.

In addition, UNICEF funds the weekly *The Straight Talk,* which appears in The New Vision, a local daily newspaper. Lastly, the UNFPA has funded reproductive health projects for adolescents in selected districts including Arua. During my fieldwork, I established that attitudes of health providers played a big role towards who would/would not be supplied with condoms in the refugee settlements. Nurse providers decided who should get condoms accusing the youth of illicit sexual activities.

Violence against women

Promote and support agencies and organizations that work to reduce domestic violence, female genital mutilation and other forms of violence against women.

The Women Movement in Uganda has spearheaded several measures over violence against women. Many of these, spearheaded by individual women, have included advocacy, bringing culprits to book, interceding on behalf of vulnerable groups, research

and offering physical assistance, such as the home for battered women. Actionaid, a local NGO, has funded media (radio and newspaper) programmes in which issues of violence, HIV/AIDS are discussed.

5.7 National Policy Guidelines for Reproductive Health

In 1992, the Maternal and Child Health/Family Planning (MCH/FP) Department designed the first policy document for maternal health and family planning, which was widely disseminated to key players. Since 1999, the Uganda government has put in place a distinct reproductive health policy, the *Sexual and Reproductive Health Minimum Package for Uganda.* Since then, there have been structural and policy changes brought about by:

- The 1994 ICPD conference which emphasized the relationship between population and development and defined reproductive health;
- The 1995 Constitution which includes various aspects of women and children's rights and policies;
- The Beijing conference;
- The Decentralization policy;
- The Formulation of a new 1999 National Health Policy, and
- The development of National Population Policy in 1995.

The above-mentioned institutional framework aims at improving the quality of life of Ugandans and increased participation of the communities served in the running of sexual and reproductive health (SRH) programmes. The main components of reproductive health are: Safe motherhood, Family Planning, Infertility, Adolescent health, Integration of STD/HIV into Reproductive Health, Post-abortion care, Violence against women, Reproductive health cancers, Menopause and andropause. I have extensively dwelt on these parameters in the preceding discussion and there is no need to repeat the discussion here. Suffice it to say that there were no programmes dealing with menopause and andropause issues.

5.8 Concluding remarks

Reviewing the major findings of this chapter, it can be stated that during the period between 1950 and mid 1970s, the provision of health care was designed along the British health care model which emphasized curative approaches than preventive measures. Despite the efforts to bring health care closer to the people, the health care system was more urban-based and was not tapping the health needs of the rural population who constitute the majority of the people in Uganda.

A change in the above approach to health care management occurred in the 1970s by embracing the implementation of the Primary Health Care (PHC) strategy that resulted from the Alma Ata conference (WHO, 1978), which was later consolidated by the Bamako Initiative. We have noted that the implementation has faced many constraints including the SAPs and protracted armed conflict, thus, diverting funds towards other sectors

including defense. The SAPs have reduced real incomes of the people, hence making them poorer and unable to pay for their health needs.

There has been international concern over population and reproductive health issues in general and in the Third World in particular. These issues have been deliberated upon by the ICPD, FWCW and goals have been set. Subsequent monitoring sessions have been undertaken through specific UN sessions (for instance, ICPD+5; Beijing +5). In addition, the Millennium Development Goals (MDGs) are in line with the above goals. The discussion on the Health Policy of Uganda describes its main focal priorities. In addition the discussion also presents the components of the Minimum Health Care Package. This package, among others things, addresses the control of STI/HIV/AIDS, Tuberculosis sexual and reproductive health rights, family planning, adolescent health reproductive health, and violence against women. I have made note of gender specific hindrances in the care of communicable diseases such as malaria and tuberculosis. In addition I observe that even though several specific health policies may be in place, the implementation of the reproductive health programmes is still within maternal and child health/ family planning framework. This makes the access of reproductive health care for non-mothers and particularly adolescents problematic. Considering the high youth population in Uganda and the almost non-existence of adolescent reproductive health NGOs, renders the effective management of STIs and HIV/AIDs is rendered difficult. There was only one NGO in Kampala addressing the reproductive health needs of adolescents.

Last, but not least, the chapter discusses the National Policy Guidelines for Reproductive Health, a distinct reproductive health policy put in place by the Uganda government since November 1999. However, the components are almost a repeat of the ones in the Health Policy. This emphasizes and points to the need for integration of all these policies.

As I will argue in the next chapter, in spite of all these policies, health care still eludes the majority of people due to several factors such as long distances to health centres, scarcity of the health providers, especially in the rural areas and the factual truth that drugs are always missing.

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[1] See chapter six for a detailed discussion of health providers.
[2] Safe Motherhood Initiative in Uganda (SMIU), Plot 196 Upper Mawanda Road, Kamwokya.
[3] Most information under this section was downloaded – www.un.org/partners/civil_society/docs/bamako.htm
[4] The concept of user fee applies only to government health institutions, which had been free in the past.
[5] Interviews conducted at Kimengo Health Centre Gr.3 and Kigumba
Catholic Health Centre Gr. 3.
[6] Personal communication with Commissioner, Health Planning, MoH, October 2003.
[7] Interviews with retrenched women (4) and men (2) at Bugolobi Trading Centre, July 2003
[8] www.familycareintl.org/icpd/icpd_sr_gender.htm downloaded on 24 January 2004
[9] U.S. Department of Labour, Bureau of International Labor Affairs (www.dol.gov/ilab)

downloaded May 9, 2005.
[10] See, 'Seven Years of UPE' Ministry of Education In: The New Vision
Monday September 13, 2004.
[11] (www.unaids.org/wad/2003/Epiupdate2003_en/Epi03_00_en.htm AIDS Epidemic update
[12] Personal communications with doctors at Adjumani, Arua, Moyo Hospitals during fieldwork.
[13] www.unfpa.org/icpd5/icpd5.htm downloaded on 2 January 2004.
[14] www.un.org/womenwatch/daw/followup/bfbeyond.htm downloaded on 2 January 2004
[15] Dr. F. Adatu, Programme Manager National TB and Leprosy, Ministry of Health

6

Ministries, organizations and programmes dealing with reproductive health issues

6.0 Introduction

In the previous chapter, I examined the international and national health policies with a view to indicating the basis on which health care is provided. The present chapter discusses the national health care delivery system including the stakeholders and focus is mainly on the reproductive health care programmes. The aim is to explain how the policies are operationalized. It is divided into four main parts. In part one (6.1) an overview of health care in Uganda is presented. This is followed by a discussion of the health context in which health care is provided in (6.2). I then proceed in the third part (6.3) to discuss the training of the human resource for the health sector. In part four (6.4) I discuss the current reproductive health problems and the programs that came about after the International Conference on Population and Development (ICDP), which are the main focus for this study. I also discuss some of the factors that influence maternal mortality and morbidity. In the fifth part (6.5), I discuss the type of available organizations and how they implement the reproductive health programmes. The last part (6.6) presents the concluding remarks.

6.1 An overview of health care in Uganda

Historical background

Before the advent of church missionaries and British colonialists, individuals depended mostly on indigenous knowledge to treat their ailments. However, the failure on the part of the missionaries and the colonial administrators to understand fully how traditional medicine worked made them dismiss it as being primitive and unscientific (Iyun, 1994). Whereas its development was suppressed, it can be argued that it was not exterminated. As indicated in chapters 8 and 9, there is a general belief among refugees that some illnesses can only be cured by traditional medicine.

With respect to 'modern' health care in Uganda, the literature reviewed[1] indicates that the main reason for introducing health care in Uganda was to meet the health needs of the staff of the British Empire officials and their families. This was facilitated by the alienation of health services into the 'European only' and Asian hospitals; health care

being designed and distributed along racial lines. In the case of Uganda it was much later when at the height of venereal diseases among Africans, a hospital was constructed by the government for their treatment. On the other hand, however, the missionary health centres addressed the health care needs of Africans.

The first European medical person to arrive in Uganda was Emin Pasha (baptized name Edward Carl Oscar Schnitzer) in 1876, sent by Gordon Pasha to forge relations between Kabaka Mutesa and the Egyptian authorities (Peter Cowley, 1997:3). It is said Emin did some medical work in Uganda before leaving. Dr. Felkin sent by the Christian Missionary Society (CMS) upon invitation by Gordon then Governor General in Khartoum arrived in Uganda in 1879, but left a few months later when he escorted three envoys from the Buganda Kingdom to Queen Victoria (Neema, 1994). Thereafter, a succession of British doctors underwent service in Uganda mainly to look after the British staff and the troops at the government stations and only secondarily to treat native Ugandans. According to available records, a hospital for Europeans was in place by 1933 and next to it a newly constructed 'Asiatic hospital adjoining that for Europeans'. At this time also, according to the records '…. and the quarters (native) with their inevitable noise, and the chatter, are inconveniently near the hospital. It is therefore proposed that the compound should be enlarged, as shown edged in green on the block plan, and the new quarters sited as shown in red, where they are more or less isolated, and their inhabitants are not likely to be a nuisance to patients in either of the hospitals'.[2] This statement clearly shows that 'natives'' health was a secondary issue.

The increasingly effective health care services rendered to the Ugandan population was by the Church Missionary Society's (CMS) Mengo Medical Mission founded in 1897. This was to be the first hospital in Uganda started by Dr. Albert Cook. The starting of this hospital was an invitation to the government, which was then facing a substantial annual deficit, to leave work among native Ugandans to these organizations (Cowley, 1997). But as Mengo Hospital was beginning to take root, the sleeping sickness and venereal diseases proved to be a serious threat to the population. It was at this time that government realized that the care of the native population was an obligation, which the state could not disclaim. As syphilis took its toll on the population, Col. Lambkin of the Royal Army Medical Corps recommended the establishment of treatment rooms under medical subordinates in localities, which would be within easy reach of all patients. The first government treatment centre was set up in Old Kampala with two other centres in Masaka and Mityana by the end of 1909. Soon Mulago hospital in Kampala became the centre of operation in 1918 against venereal diseases. It is interesting to note that before 1923, Mulago Hospital focused only on venereal disease (Cowley, 1997:4), and it was called Mulago Venereal Disease Hospital. Nonetheless it was soon realized that "to treat a *man* for syphilis and then send him to another hospital three miles away for the alleviation of constipation, malaria, or leprosy, was ineffective, since patients refused to subscribe to the suggestions that they should go. In 1923, Mulago then became a hospital to treat all diseases" (Uganda Handbook, 1936). Subsequently, a medical school was established in Mulago in 1928. In addition, '*native*' hospitals were constructed at the administrative headquarters of every district and in other townships. Further, the policy of establishing sub-dispensaries in rural areas

was pursued. By 1934, there were some 88 dispensaries. The system of District Medical Officer (DMO) blossomed during this time. At this time also vital statistics reached a competent level, as in 1930 a vital statistics form was introduced in which births, deaths, deaths of infants, stillbirths and deaths of mothers as a result of childbirth are recorded (*ibid.*). The policy of paying for medical fees applied even at this time but only for Europeans and Asians. As for the natives, those in a position to do so were encouraged to feed themselves; otherwise the destitute were treated free of all charges (Handbook on Uganda, 1913). Catholic missionary hospitals, namely, Nsambya and Rubaga were established in the early 1900s. Over the years, more faith-based hospitals have been established by the Anglican as well as Catholic churches, the Orthodox and Seventh Day Adventist churches. For these hospitals, it would appear that the concern to provide health care and particularly maternal care to Africans stemmed from moral and Christian principles and had little to do with the colonialists.

Despite efforts to reach the population in the rural areas, by and large it can be argued that the mode of health care is still modeled along the western model and emphasizes more the curative aspect of disease than the preventive. The reproductive health issues that have preoccupied the health sector since the colonial times have been maternal care, child health, as evidenced by the special wards in hospitals and health centres; the sexually transmitted diseases (STDs) as can be witnessed by the special STD Clinic and a special ward at Mulago Hospital commonly referred to as *Wooda Yabazira* (ward for the brave[3]), because it is where men go when they have complications with the urinary system and catheters are inserted in their bladders. And during the last two decades the reproductive health care has been increasingly preoccupied with HIV / AIDS, as will be elaborated in the next sections.

The illusion of health care service expansion

For two decades the health infrastructure in Uganda was exposed to the political and insecurity atmosphere that reigned in Uganda from 1966 to 1986, in which it was rendered almost non-functional. The health institutions, which functioned, did so under very strenuous conditions. Having said that it can be noted that efforts have been made by the government and the civil society to improve the health sector; most of the health units with the exception of some parts in the north are now functional.

A few years into Amin's rule (1970 – 1979) the economy collapsed. The external economic climate was harsh. The brutality of Amin's regime, its incompetence, the expulsion of a majority of the business community and the flight of the qualified human resources from the reign of terror all contributed to the economic collapse. At this time also the scope of operation by the NGOs, particularly the church-based hospitals such as Nsambya, Mengo, Rubaga located in Kampala, expanded. Other church-based hospitals and health centres also expanded. But the problem this created was congestion. There were far too many patients seeking health care in these private hospitals. This obviously affected the services as they had a maximum number of patients beyond which the services deteriorated unavoidably. According to interviews held, it was common to deliver babies on floors for lack of beds due to high demand.

Yet, they were in a position to offer better care than the government hospitals, as they would receive external funding, drugs and equipment. Furthermore the staff in these hospitals were committed to their work. The reputation for high quality health care has lingered on such that even today patients flock to these hospitals daily in their hundreds[4].

Despite this, a look at the records indicates that there was actually physical expansion of service facilities between 1975-1986. However, in terms of operation, the government was unable to run these services. From the users' point of view, the expansion was illusory. In other words the dramatic increase in the number of government-owned health facilities, especially in the first half of the 1980s was real enough, although the security situation must have prevented expansion in many areas and thereby left many communities not served. But the expansion was not accompanied by a similar growth of operating and maintenance resources. This was exacerbated by the disruption of commercial networks that destroyed the link between the pharmaceutical industry and the distribution of medical supplies resulting in the lack of medical equipment and drugs and a dramatic drop in health personnel. Highly qualified staff particularly doctors fled the country. This brain drain started in the early 1970s and continues up to today. At the time there were 9,200 individuals per doctor compared with 27,600 five years later (UDHS, 2000). What is of concern is that even though the Medical Schools at Makerere and Mbarara universities are producing medical doctors every year, the distribution of these doctors in the various hospitals is not proportional to their numbers. There is a tendency for doctors to prefer working in urban areas than in the rural-based hospitals. Even when they are employed in Government or NGO hospitals, it is common practice that the doctors operate a private medical clinic on the side for survival purposes. Moreover, many doctors leave the country for 'greener pastures' abroad. A look at many hospitals in South Africa will attest to this.

The period from 1986 to date

The post-conflict and rehabilitation programs received considerable donor funding (Kayizzi-Mugerwa, 1996). This resulted in the rehabilitation of the health infrastructure in most parts of Uganda except in some conflict-ridden areas in the north. The MoH acquired a new home from the old colonial and dilapidated structure at Entebbe to a magnificent modern building in Kampala. However, it has not all been smooth sailing. Uganda was part of the World Bank Structural Adjustment Programs (SAPs) in which there were deliberate cuts in national health budgets. This meant that health care consumers had to contribute towards their health. (Before and after independence government had always provided health care free. It was the NGO sector, which charged minimally for health care services). Cost-sharing as a policy[5] was introduced in the late 1980s, but was interestingly scrapped[6] after the 2001 presidential election; however patients that attend private wards in Government hospitals are obliged to pay[7]. But even those who are not in private wards end up paying indirectly when they spend large sums of money on purchasing drugs. Despite the fact that the provision of health care is a joint effort by the public as well as private sectors, the role of women as providers of health and the price they pay in terms of saving government expenditure

is quite enormous. The health care situation in the country has been compounded by the high morbidity levels brought about by HIV / AIDS. According to a senior consultant at Nsambya Hospital " almost all beds are now occupied by AIDS patients; all one sees every day is nothing but opportunistic ailments brought on by AIDS".

6.2 The Current health care delivery system

Context

Although health is both a basic right and a pre-requisite for socio-economic development, health care eludes many Ugandans for several reasons. These include Uganda's dependency on low priced cash crops for foreign exchange, the Structural Adjustment Programmes and the armed conflict, which I discussed in chapter 5. To add to this, the HIV / AIDS pandemic has reduced the life expectancy of Ugandans to 43 years (MoH, 2003) With respect to HIV / AIDS, women, due to their lowered position in the Ugandan society, are unable to negotiate sex and are therefore more susceptible to its infection (Kabonesa, 1999). Furthermore, by nature of their reproductive role and the heavy financial drawbacks HIV / AIDS places on families, women end up with the burden of nursing the AIDS patients in addition to their other roles. Another example is drug-resistant malaria which now requires a combination of antimalaria drugs, which are expensive and are beyond the affordability of most Ugandans whose GDP is US$ 330 per capita (MoF, 2005). Moreover, the cost of living for most professionals in Uganda has meant taking on more than one job at a time, a condition easier to fulfill in urban areas than in the villages. This therefore dictates urban or semi-urban living for most health providers, thus, making rural employment non-feasible. What this means is that nursing aides and untrained personnel are the main operators of health units in rural areas[8].

Table 6.1 Selected Indicators of Uganda's population

Indicator	1991	1995	2000
Total population (millions)	16.7	19.3	24[9]
Female (millions)	8.5	9.8	12.2
Males (millions)	8.2	9.5	11.8
Population growth rate	2.5		3.4
Total fertility rate per woman	7.1	6.9	6.9
Maternal mortality rate (per 100,000 live births)	700	506	504
Births attended to by trained personnel (%)	38	38	38
Infant mortality rate (per 1000 live births)	122	81	88
Under 5 mortality rate (per 1000 live births)	180	147	152
Life expectancy at birth	48		47[10]
Average age at first marriage	17.5	17.5	17.8
Average at first birth	18.5	18.6	18.7
Contraceptive Prevalence Rate (%)	5	15	24[11]
Unmet need for F/P (%)	52	29	35
Full Immunisation coverage (%)	31	47	38
HIV Prevalence rate (%)	30	14	6.1
Population without access to safe drinking water (%)	74	58	40
Stunted children under 5 (%)	45	38	39
Poverty level (%)	56	44	35
Literacy Rate (%)	54	62	68
Primary school enrolment (millions)	2.3	2.6	6.8
GDP per Capita (US$)	251	330	350

Source: complied from Census 1991; Uganda Demographic Health Surveys for 1995, 2000-2001; Uganda Human Development Report 2000

Worth noting is the fact that the above are only averages and that there are wide variations in the different regions; the worst hit being the northern region. Although there have been great achievements in reducing the incidence of HIV/AIDS, recent evidence shows that the prevalence rate has increased from 6.1% in 2000 to 6.5% in 2001 (Policy Review Newsletter, 2004). Even though the official government view has been that of reduction in infection rates, disturbing information in the media seems to suggest that far from a reduction, the HIV infection rates are increasing in the rural

areas. As an example, The Monitor of Wednesday 9 February 2005 (page 6) had it in bold that 'Bundibugyo has 20% HIV / AIDS prevalence rate', which was attributed to ADF war. In the same article Kabarole district was said to have HIV / AIDS prevalence rate of 12%. The figures for the north where war has loomed for almost 2 decades are most likely to be higher. These variations in the prevalence rates seem to suggest that the rates could actually be higher, particularly in the rural areas than is imagined. I hold this view because the people in urban areas are more enlightened about HIV / AIDS and are aware of how they can prevent it. They are also in better economic positions to afford better nutrition and to make informed choices. Even amidst the subordinated status of women, urban women may be in a slightly better position with regards to negotiating sex than their rural counterpart.

Overall, 39% of the Ugandan's children under the age of 5 are stunted (UDHS, 2001), while 5% are wasted and more than 25% are underweight for their age (UDHS, 1995). Total fertility rates at 6.9 (UDHS, 2001) for Uganda are quite high compared to neighbouring Kenya's 4.7 (DHS, 1998) and Tanzania's 5.6 (DHS, 1999). Besides, the fertility rate in the conflict-ridden areas of the north is well above 8 (Donor News, 2003). The sanitation situation is very poor, with an average coverage of 47.6%. Regional differences indicate variations in coverage from as low as 4% in the northeast to as high as 88.5% in the south west (UDHS, 1995). 11 % of the households are within 15 minutes walk from safe water sources (UDHS, 1995). Meanwhile the adolescence pregnancy is 43% (third highest in Africa) and life expectancy at birth is 47 years (UDHS, 2001) Only 27% of the population live within 5 Km of any health facility (UDHS, 2000-2001). The overall average number of persons per health facility in Uganda is 12,000, but ranges from 4,000 persons per health facility in Kalangala District to 31,000 in Kisoro (UDHS, 1995). Such is the situation complicated not only by disease but also by poverty, war, ignorance and poor or lack of resources. In addition to the above social and reproductive health indicators, it is estimated that about 12% of Ugandan pregnant mothers carry the HIV of which 26.5% transmit it to their babies (MoH, 1999 citing Miiro F. A., 1999).

Traveling in the different districts, one cannot help but recognize the uneven distribution of services such as pharmaceutical supplies, drug stores, health centres, private clinics and qualified staff. There was a tendency even in the rural parts of Uganda for these few facilities, where they existed, to be urban-based, thereby within easy reach for the urban populations. Thus, even when it is the aim of the government to integrate maternal and child health and family planning in the overall health system, it is far from being realized. Kirumira et al., (1993), for instance, established that of the 63 health facilities in Mbarara district only 21 offered maternal health services. Similarly only 21 of the 73 health facilities in Mbale district offered maternal health services. Given that the bulk of the health units offering maternal health services are at the HC III level (see below), it is indicative of the inadequacy of the services that can be offered for women reproductive health needs in the country.

The Providers of health care

Health care can be grouped into the formal care (government and NGOs hospitals and

health centres and private hospitals and clinics); the intermediate sector (markets, pharmacies, drug shops, community health workers, and trained birth attendants), and the informal sector (traditional healers, herbalists, spiritual healers, family and neighbours). I shall now look at the government health services.

Government Health services

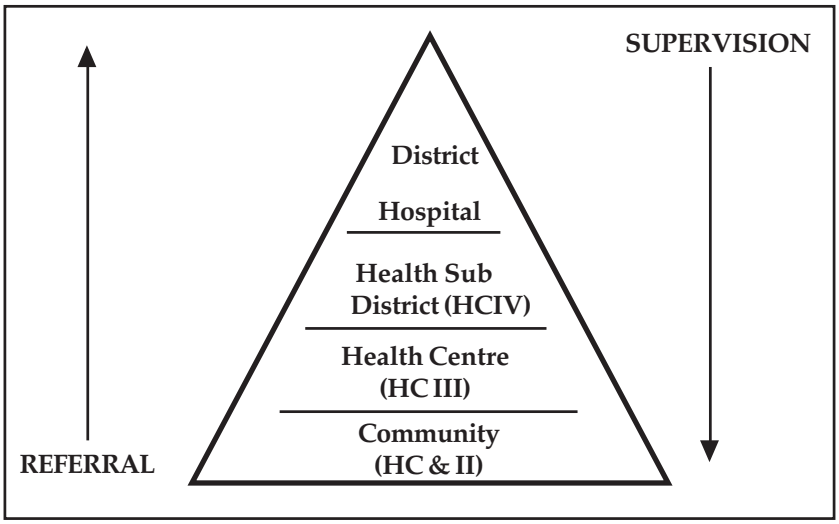
Health care is provided by the following ministries: Ministry of Health, Ministry of Defense, and Ministry of Education. The Ministry of Defense provides health care services to the staff of the ministry including the army. The Ministry of Education in collaboration with the Ministry of Health provides medical teaching and health care through the medical schools, and often participates in health conditions related to public health issues, health education and HIV / AIDS. The overall ministry charged with the health of the Ugandan population is the Ministry of Health (MoH). It offers the following services: Public Health, Clinical Services, Special Clinical Services and Research and Assessment Programmes.

Public health programmes include disease prevention and control; the promotion and control of the environment for health; the protection and promotion of the health of specific population groups, and the general health protection and program support services.

Clinical services programmes include out-patient service programmes, in-patient care and delivery of pregnant women and community–based care (TBAs and outreach). Special Clinical Services include psychiatric services and blood transfusion services.

The government health care system is a pyramidal, four-tier health system in which services are provided by the government at the apex and by the local governments at the district hospitals and health centres[12] . Government hospitals are in three categories; the national, regional and district rural hospitals. National hospitals are Mulago and Butabika, which are also teaching hospitals. Regional referral hospitals are: Arua, Gulu, Hoima, Jinja, Kabale, Kabarole, Masaka, Mbale, Mbarara and Soroti. They are also teaching hospitals.

Figure 6.1 Levels of Health Care



Health Centres are graded as HC II, HC III, and HC IV. The grading depends on the administrative zone served by the facility; parish, sub-county and health sub-district. They provide different types of services, however, a unit can work as HCII and III or IV. HC II serves a parish. It provides out-patient care, antenatal care, immunization and outreach services. In the ideal situation the staff comprises of 1 Enrolled Nurse, 1 Enrolled Midwife and Nursing Assistants.

HC III serves a sub-county. It provides all the services of HC II plus in- patient and environment health. It works as HC II for the parish where it is situated and the staff should comprise 1 Clinical Officer, 1 Enrolled Nurse, 2 Enrolled Midwives, and one Health Assistant, one Laboratory Assistant and a Records Officer. HC IV serves a Health Sub-District (HSD). It is the headquarters of the HSD. It provides all the services of Health Centre III plus surgery, supervises the lower level units, collects and analyses data on health and plans for the sub-district. It should have at least 1 Medical Officer,[13] 2 Clinical Officers, 1 Registered Midwife, 1 Enrolled Nurse, 2 Nursing Assistants, 1 Laboratory Technician, 1 Laboratory Assistant, 1 Heath Inspector, 1 Dispenser, 1 Public Dental Assistant, 1 Anaethetic Officer, 1 Assistant health educator, 1 Records assistant, 1 Accounts clerk and 2 support staff.

Table 6.2 Number of hospitals and health centres by ownership The government bed capacity is 17, 898 and that of NGOs is 7,420 (MoH, 2003) broken down as follows:

Table 6.2 Total bed capacity 2002

Hospitals beds by ownership	Government	NGO	Total
Referral (Mulago and Butabika)	2,050	500	2,550
Regional referral	2,500		2,500
District hospitals	4,500	4,600	9,100
Health Centre IV	2,832	384	3,216
Health Centre III	6,016	1,936	7,952
Total	17,898	7,420	25,318

Source: MoH September 2003

6.3 The training of health providers

The foundation of a school for training of midwives in obstetrics and the care of infants started in 1918 by Cook[14] 's wife, former Miss Thompson. Training of enrolled midwives had started at Mulago by 1900, and twenty-eight years later training for nurses began at Namulonge by the Cooks with Sister Annie Walker. Some of the trained midwives were sent to various areas in the country and ran antenatal and child welfare clinics by themselves with excellent results (Neema, 1994). In 1954 the Uganda Midwife and Nursing Assistants Council was established and was responsible for the curriculum of the nurses and midwives' training. To date the ministry if health and the missionary hospitals undertake the training of nurses and midwives at the registration and enrolled levels.

Missionary hospitals concentrate on nurse and midwife training. In addition, they offer paramedical training such as radiographers and laboratory assistants. The training of Medical Assistants[15] is the prerogative of the MoH. The MoH also trains midwives and nurses at the registration and enrolled grades. For the last ten years the Medical School at Makerere University has been conducting a Bachelor of Science in Nursing course. There are also many new universities, which offer training opportunities in nursing. The teaching of comprehensive nursing has become popular; however, it is also believed that the training may not be targeting the local market but Western Europe, where there is a shortage of nurses. Nevertheless, it should be noted that the training of nurses and midwives was supplemented by the introduction of Home Economics into the education system. Home Economics as a profession, has been criticized for contributing to the invisibility of women in society and for perpetuating female stereotypes that are linked to women's reproductive roles such as cooking, child care, nutrition, and healthcare, housewifery, laundering and other domestic work (Mtshali, 2002 citing Meintjes, 1987; Tamale, 1999). Women in Uganda have always acted as providers of health care. However, most women who have offered biomedical care services have mostly been at the lower echelons, such as nurses, midwives, nursing

aides, and dressers.

The Medical School was established over 50 years ago at Makerere University with the main goal of producing medical doctors to run the local government hospitals. For a long time only males were trained as doctors. It was not until the mid 1960s that a female by the name of Nambooze demystified the gendered medical profession. Since then, the medical school has continued to produce male and female doctors. Besides medicine, the medical school also trains paramedical students in various fields such as radiography, anaesthesia and orthopaedic assistantship and laboratory assistantship. In 1989 another medical teaching hospital was started at the Mbarara University for Science and Technology (MUST). Furthermore, the Ministry of Health trains health visitors as well as Clinical Officers purposely to operate Grade III health centres. In addition, since 2000 Uganda is witnessing the springing up of several universities both government and private, some of which offer courses in medicine and nursing. For instance, Gulu University in northern Uganda a government institution, Kampala International University and Aga Khan University private institutions offer professional medicine and nursing courses. The Table below shows the health care personnel status.

Table 6.3 Health care personnel

Cadre/1993[16]	Total
Physicians	671
Registered Nurse and Midwives	1,854
Enrolled nurses and Midwives	3,806
Medical Assistants	810
Health Inspectors	286

Source: Uganda social sector strategy report (1993).

The national ratios of health care workers to population are as follows

Table 6.4 health providers to population ratio

Doctors	1: 18,700
Reg. Nurse/Midwife	1: 8,900
Enrolled nurse/midwife	1: 3,065
Medical Assistants	1: 20,500
Health Inspector	1: 58,000

Source: Ministry of Health, 2003

The above statistics reflect the actual picture on the ground. This is because not all trained health providers serve in the country as many opt to seek employment opportunities in better paying countries such as South Africa. In addition, because of the poor service conditions, many nurses and midwives give up their profession for something better. Thus, the health sector remains perpetually understaffed and under-resourced

The establishment of NGOs mainly as church entities is still ongoing in the country today and they have been the main pillars behind the management and provision of health care even after the colonial period and specifically during the turbulent political years (1971-1986). During the colonial period, the local administration had played a significant role in service provision. Local authorities and religious missions controlled primary schools and dispensaries, while secondary schools and hospitals were under the central government. However, after independence, the centralization of planning and provision was seen as crucial for efficient service supply. When the government extended its role in the provision of services, the role of NGOs was circumscribed and was now confined to traditional fields of welfare, charitable work and provision of health facilities. The centralized form of governance was revisited by government such that by 2000 a decentralized form of government was implemented in all the districts of Uganda (Local Governments Act, 1997). This gave more power to local governments. However they still depend on central government for salaries and supplies. While the local government health management committees may make priorities, they still depend on the central government for funding. This makes them weak because the funding source is free to exercise its authority to deny or defer funding. However a few sectors and programs remain centralized, for instance the vertical programs like malaria eradication, essential drug supply and immunizations. Let us now turn to the reproductive health programs.

6.4 Reproductive Health programs

The implementation of reproductive health care is done under the following framework: Primary Health Care Strategy, Decentralization, the ICPD Plan of Action, the Fourth World Conference of Women Plan of Action and Cost Recovery Programme. This section discusses the reproductive health programmes taking care not to spend too much time on HIV/AIDS since the present study is about reproductive health in general. The MoH widened the scope of reproductive health after the ICPD Plan of Action (UN, 1994) to include Safe motherhood, family planning, STDs including HIV/AIDS, Adolescence sexuality, reproductive cancers and gender issues (MoH, 1999).

Sexual and Reproductive Health Minimum Package

The 1995 Burden of Disease study indicated that sexual and reproductive health and its complications contribute tremendously to the disease burden of Uganda. Subsequently, a technical committee was appointed to formulate the Sexual and Reproductive Health (SRH) Minimum Package to be disseminated in all districts for guidance (MoH). The package provides a national guide for operationalisation of

Reproductive Health policy with an overall output of increased accessibility and utilization of services. The package is a useful document to policy makers, donors, implementers and especially the District Directors of Health Services (DDHS) as well as operational level workers. The components of the package are: Safe Motherhood (preconception, antenatal, intranatal, postnatal care and breast feeding); Family Planning; Adolescent Sexual and Reproductive Health, and Sexually Transmitted Infections and HIV / AIDS. Others are reproductive health cancers (cervical, breast and prostate) and gender issues in reproductive health including domestic violence, rape and male involvement in reproductive health.

These components form the programs generally implemented, albeit with some variation, in Uganda for the MoH and the NGO sector. One of the greatest contrasts between developing and developed countries is the extent of risk to death women face due to pregnancy and childbirth. A risk of death which pregnancy and childbirth in Sub-Saharan Africa may be up to 1 in 16 while in developed countries it is approximately 1 in 1800 (MoH, 1999: 1). Every year more than 150 million women become pregnant in developing countries with almost 580,000 of them dying of pregnancy–related causes and 50 million suffer significant complications of pregnancy. There are 7 million perinatal deaths, 4 million stillbirths and 3 million early neonatal deaths. Maternal mortality ratio in most districts in Uganda ranges between 500-650 per 100,000 live births. The prevalence of unsafe abortions and HIV / AIDS / STDs is increasingly becoming a public health issue especially among adolescents. Cancer of the cervix is the commonest cancer among women in Uganda followed by breast cancer. The 1998 Mulago Hospital report indicated that at least 3 women were admitted every week with advanced stages of cancer of the cervix and more men were being diagnosed with prostate cancer (MoH, 1999). And yet while acknowledging such high numbers of women who die of cancer, rural health facilities with the exception of very few urban-based hospitals cannot adequately deal with the diagnosis and treatment of cancer. More to that the health education given to women in the health centres does not teach women how they can detect abnormalities. Having said this, I should recognize the once a week "*woman's page'* in The Daily New Vision and The Daily Monitor which carry a special supplement, that specifically targets women and the youth. Although pre-occupied with HIV prevention and management, they occasionally carry a section on breast and cervical cancer. But the majority of women in the rural areas do not read newspapers. It is therefore difficult to imagine how they can access such information. A visit to a few rural primary and secondary schools indicated how schools were not able to access newspapers.

Maternal and Child Health (MCH)

Good maternal health depends upon the care a woman receives during the course of her pregnancy and at the time of delivery. It also improves the chances for good health and the survival of the baby. The MCH division in the MoH is responsible for the programmes aimed at promoting maternal and child health and also reducing morbidity and mortality among these groups to acceptable levels. The high infant mortality reflects poor socio-economic conditions and inadequate preventive health

services. The mortality rate for the under 5s between 1996-2000 was estimated at 152 deaths per 1000 live births while infant mortality rate was 88 deaths per 1,000 live births (UDHS, 2000-2001). MCH includes the following:

Antenatal care and Delivery

This targets women who are pregnant with a goal of encouraging them to go to health facilities during the first trimester of pregnancy and regularly thereafter and to recognize signs of pregnancy complications. Most women receive care from a medical professional, 83% from a nurse or midwife and 9% from a doctor. The coverage of antenatal care (ANC) from a trained provider (91%) has hardly changed since 1995 (UDHS, 2000/2001). The 1995 Demographic and Health Survey showed a continuing high level of utilization of prenatal care services. The median time for mothers to start ANC visits is 5.9 months. Median number of ANC visits was 4.1 according to UDHS (1995). Therefore, pregnancy monitoring and detection of implications is late and limited. To add to this, supervised delivery by trained personnel remained low with only 38% of all deliveries being conducted by trained staff in 2001. Women in Uganda continue to be assisted at delivery in their homes by relatives or traditional midwives with no formal training. In the refugee settlements antenatal coverage was 99%, but the deliveries took place with the TBA or were unassisted. Several reasons have been advanced and include the attitudes of the health providers, distance to the health centres and mothers own attitude and gender. Sargent (1977) mentions the enabling factors (cited in Neema, 1994) as being instrumental in affecting actions. Enabling factors include the economic situation of the household, the level of education, number of live children and so on. I established that refugees were quite enthusiastic about antenatal care programmes where they were given iron tablets and vitamin A to improve their hemoglobin and immunity. This, together with guaranteed food, resulted in very few maternal mortality cases.

A safe motherhood needs assessment undertaken in 2000 (SMUI, 2000) observed that while the national policy on maternal and newborn health had been comprehensively renewed and updated, it was still not widely known to the majority of stakeholders. The assessment pointed at the lack of transport and communication in the districts surveyed. In addition, the maternal and child health services including family planning were found to be sketchy and restricted; only 24% of the health centres offered antenatal care while only 67% offered normal delivery services. Furthermore only a third of the health centres provided any form of care from complications of abortion and a third could not manage sexually transmitted diseases (STDs). During the fieldwork in Masindi and Arua, many health centres were found to be lacking properly trained health providers as well as medicines.

The majority of births (62%) in Uganda were delivered at home (UDHS, 2001/2). Births to younger women and low order births were likely to be delivered in a health facility than births to older women and high order births. Delivery in a health facility is more common in urban than rural areas (79% compared to 32%) (UDHS, 2001/2). The fact that there is no mechanism in place yet in Uganda to register all births and deaths makes it difficult to give accurate figures. Postnatally women visited health centres

primarily for immunization of their babies and not so much for postnatal examinations and family planning.

Sexually Transmitted Infections (STIs) and HIV/AIDS

Another component of the Minimum package of reproductive health policy for Uganda includes the STIs and HIV / AIDS. Sexually transmitted diseases and HIV / AIDS are known to be serious health and social problems in Uganda. HIV / AIDS leads to chronic ill health and death. The traditional STIs have various short and long term ill effects on individual, couples as well as new-borns and future fertility. It is estimated that 800,000 million Ugandans are infected with HIV while 350,000 have already developed AIDS (UNAIDS, 2004). Nearly half of the total numbers of the infected are youths, the female to male ratio being 4:1 of teenagers compared to 1:1 for adults. Adolescents find themselves particularly vulnerable because of the socio-economic condition that has given rise to the *"sugar daddy"* phenomenon[17] . This partly explains the very high incidence of STDs and HIV / AIDS amongst girls. Diagnosis and treatment services for both STDs and HIV / AIDS are still limited in Uganda, and where available, often inaccessible to adolescents. Mortality from the disease leaves behind unsupported orphans estimated at 2 million (GoU and AIC, 2004) who pose a very serious health and social problem.

Socio-cultural and economic factors play a key role in the spread of sexually transmitted infections, more so, among women. According to Bantebya (1997), some of these put women at a disadvantage as they are expected to be submissive to sex, faithful to men and must tolerate polygamous marriages. These cultural factors have enormous impact on health seeking behaviour (ibid). Women's inferior socio-economic position and inability to earn or control income is also likely to increase the possibility of commercial sex work as a survival strategy. Moreover, lower literacy levels of many Ugandan women restrict their access to relevant information. This, together with social and economic dependency on men often limits their ability to refuse sex or to negotiate safer sex. Interventions should therefore take into account these and other factors.

Adolescent Sexual and Reproductive Health

Adolescents belong to the age group 10-19 years (WHO, 1991) and constitute 33% of the Ugandan population (UDHS, 2001). According to the UDHS (2000/1), the key problem areas regarding sexual and adolescent health are associated with early unwanted pregnancy and mistimed pregnancies with 43% of the 15-19 years age group having began child bearing; sexually transmitted infections (STIs) and HIV / AIDS; and unmet reproductive health needs of adolescents e.g. low family planning usage at 7-8%.

Adolescence is a period of experimentation and high risk taking which impacts negatively on adolescent reproductive health. One of the factors likely to be influencing this is the secrecy with which sexual matters have been handled by parents. There exists a communication gap between adults and adolescents at all levels. There is a

breakdown in traditional institutions, which used to prepare adolescents for responsible adulthood. Adolescents end up depending on experimentation, peers and the media for information. Sometimes the information obtained this way may not be adequate and or irrelevant. Furthermore, poverty, illiteracy, unemployment and cultural values and norms are some of the factors that impinge on adolescent's health and development. This, coupled with a big portion of adolescent dropouts in rural areas not targeted by the limited health services, force adolescents into premature sexual relations and marriage by the adolescent girls to the equally young illiterate and unemployed boys, thus starting a vicious cycle of poor and unhealthy families.

Reproductive Health Cancers

Data available indicates that cervical cancer is the commonest malignancy of females accounting for 40% of those listed in the cancer registry. It has overtaken breast cancer that stands at about 20%. It constitutes 80% of malignancies of the female genital tract. About 90% of those affected report with advanced inoperable disease. Of greater concern is the increasing incidence among young women below 35 years. It is not known whether this could be related to the ongoing HIV / AIDS epidemic.

In the developed countries, screening for cervical cancer has increased the detection of pre-malignant lesions, namely; those that can be treated conservatively, thus reducing the need for radical surgery and radiotherapy. It has also reduced the incidence of advanced disease and increased survival rates. Screening takes the form of Pap Smear and colposcopy. It is estimated that the cost of Pap Smear is nearly US$ 5, which is not widely affordable in Uganda. However, there are many other reasons for the low response to cervical cancer screening in Uganda and they are linked to pervasive patterns of scarcity and institutional weakness as shown in Box 6.1:

Box 6.1 Institutional impediments to cervical cancer screening

- Lack of awareness of those at risk about the disease and the need for periodic screening;
- Lack of skills among health workers in handling those with cervical cancer;
- Poor referral mechanisms for patients;
- Scarcity of gynaecologists who are based in referral hospitals;
- Inadequate cytopathologists, scarcity of histopathologists and delays in processing results;
- Limited laboratory screening services;
- Lack of integration of cervical cancer screening services in Family Planning, antenatal, STD and post natal clinic;
- Lack of national guidelines on management of cervical cancer;
- Lack of a training curriculum for empowering service providers with the required skills;
- Limited radiotherapy facilities and absence of database or follow up systems.

Breast cancer constitutes 23% of female malignancies. Patients report with advanced disease as a result of several reasons, which include inadequate knowledge, cultural practices and attitudes, inadequate screening examination by health workers and people themselves, and lack of sensitization about these common malignancies. Prostate cancer affects men above 50 years and like the other two cancers, patients suffering from it present it late for basically same reasons. During the fieldwork for this report, there were no programmes for cancer treatment and diagnosis in the health units in the refugee settlements.

Gender- based violence

Rape and many other forms of sexual exploitation and abuse are a common occurrence especially among adolescent girls.

This is one of the causes of unwanted pregnancies and induced abortion and high HIV prevalence among young girls. Domestic violence is reported almost daily in newspapers yet health workers are ill trained and ill equipped to effectively handle the victims and perpetrators of domestic and sexual violence. Female genital mutilation (FGM) is practiced in one district (Kapchorwa) in Uganda but may be present in some minority groups in the rest of the country. A few NGOs in Uganda are fighting this violence as will be indicated below. Among other gender related health concerns are poor eating habits and poor nutrition among the females. Culturally, women are supposed to eat last and eat less nutritious food and there are certain foods, which women must not eat, such as chicken and eggs. There are obvious preferences for heads of families and male members of the family to eat first. Women often overwork and have hardly any resting time. This has serious health implications especially for pregnant women and it predisposes them to side effects of trauma such as *abruptio placentae*, stillbirths, abortions, and diseases related to stress e.g. hypertension.

Communities ought to know the serious implications of gender issues on health including psychological and physical effects, including suicide and murder, and they should be able to change them as part of the promotion of reproductive health. As we discuss in chapters 8 and 9, many young refugee women showed signs of psychological trauma, which could have arisen out of several incidents of rape, violence, loss and displacement. Both the World Conference on Human Rights and the Fourth World Conference on Women gave priority attention to violence against women. Although men have an important role to play in eliminating discrimination and violence against women, the policies do not indicate how this has been pursued. In fact, the policies show that men have been left out of the participation in reproductive health care. The current reproductive health services do not adequately address the special needs of men. For instance family planning, sexuality education for young men, diseases peculiar to men within the reproductive health area are some of the issues that need attention. There is a need to orient health service providers to the special needs of men and organize service delivery to address this. Health professionals should also be able to participate in efforts to change the deeply rooted socio-cultural causes of the problem.

The MoH in its five-year investment plan 1999-2004 addresses gender issues with special emphasis on domestic violence. However, the plan fails to indicate the strategies it will pursue to correct this anomaly. As already noted, men are hardly involved in the programmes and yet they constitute part of the problem of gender-based violence. Take the example of induced (criminal) abortions in which men are implicated. It is from the relationships with men, in the first place, that women and girls are impregnated.

6.5 How the above reproductive health programmes are implemented

The Ministry of Health and the district health network

The institutional framework for reproductive health in the health sector is as follows; services are offered at two levels, the central and the district levels. At the central level, the Reproductive Health division performs the following tasks: 1) policy formulation, setting standards and quality assurance; 2) resource mobilization for Reproductive Health programmes; 3) capacity development and technical support; 4) coordination of Reproductive Health services and stakeholders, and 5) Monitoring and evaluation of overall sector performance. The District level comprise the Office of the District Director of Health Services (DDHS), the District and Referral Hospitals, the Health Sub-District (HSD) or Health Centre IV, Health Centre II-III, the community level, the NGOs, and the private sector.

It is the duty of the hospitals and health centres in the district to offer reproductive health services. Maternal services, including child immunization, have the widest coverage followed by treatment of STIs. Family Planning receives the least. Patients and clients whose cases are beyond the management of the health structure in the district are referred to the nearest referral hospital. Health Centres (Grade III and below) cannot perform caeserean sections.

Such cases are therefore handled by the nearest NGO hospital or sent to the district hospital. However, on many occasions, women do not make it due to their socio-economic status and the time factor. By the time they come to the health centre, it is because they have failed to deliver at home and in most cases both the mother and the foetus are fatigued. This therefore may not give them time to make it to the hospital. However, as a part of decentralization and bringing services closer to the people, the MoH has introduced the Health Sub District zones (HSD). Health centres have been upgraded or constructed in the areas where hospitals are too far. These health centres (Grade IV) in addition to maintaining the staff as per Grade III, they should have medical doctor, assistant anaesthetist and, they should have a surgical theatre as well as blood transfusion equipment. There has been no study to appraise this new practice. However, as noted already, the doctors are few and many of the health centres are remotely located, not to speak of the meagre government salaries. During a recent visit to the HSD at Rhino Camp, I observed that it lacked a doctor and an anaesthetist and blood transfusion equipment.

NGO Hospitals

These can be divided into two categories: the non-profit making and the profit making. I shall limit the present discussion to the non-profit making sector because these organizations have treaded where none wished to venture and they have targeted the poor and the marginalized. As already mentioned, this sector is based on religious affiliation. Therefore hospitals are attached to the churches they represent, such as Anglican, Catholic, Seventh-day Adventist, Orthodox and Islam. The services they render also do not compromise the teachings of their churches. These organisations operate hospitals with bed capacity that range from 100 to 300 beds and health centres. They are located in Kampala as well in the rural areas, but the majority is located in rural areas, examples being Lacor, Kagando, Kinkizi, Kamuli, Mutorele, Maracha, Ishaka, etc. Overall, the services offered are not unduly different from those offered by the government. But one hospital deserves special mention here, Lacor Hospital. Lacor Hospital is catholic-based institution in Pader district in northern Uganda. Northern Uganda has seen no peace for the last 17 years due to civil conflict waged by the Lords Resistance Army (LRA) against the Uganda Government. The conflict has affected the provision of health care as much as it has contributed to an increase in STIs/HIV/AIDs and maternal mortality rates. The capacity of the district to provide health care was eroded by the conflict and the population had only one option- Lacor. In addition to providing health care to the general public, Lacor Hospital has had to care for the warring casualties. Besides, the hospital has provided sanctuary to civilians fleeing the war. As a result, the hospital has been stretched beyond capacity[18] . This hospital is the only one in northern Uganda with cancer treatment facilities.

Family Planning Association of Uganda (FPAU)

The beginning of Family Planning activities in Uganda and the funding of FPAU were marked by the incidental visit of Miss Edith Gates, the executive of Pathfinder Fund of the USA to Uganda in 1957. She sold the idea of family planning (FP) to a group of African and Asian women of the Mother's Union and a miniature of FPAU was formed in Kampala. At this time, most of the activities spun around creation of awareness on the effects of poverty on large families. This was done through media coverage and writing. Partly as a result of this, research on family planning started at the Medical School at Makerere University and medical students were encouraged to do studies on family planning. The government approved the activities of the FPAU and formally registered it in 1963 as an NGO under the National Council of Voluntary Social Services. The second breakthrough was the registration and membership of FPAU to the International Planned Parenthood Federation (IPPF) in 1964. This gave a sense of belonging to other advocates of FP world wide and guaranteed financial support to the movement. Provision of contraceptives, services, IEC activities and opening up of branches followed thereafter.

The Current FPAU Programme

Following government integration of FP into MCH services and provision of services in

health units in 1983, the results of the UDHS 1988/1989, the coming of the UNFPA and other donors to support population programmes, the FPAU had to review its strategies and focus of FP service provision. It left the provision of FP services in hospitals to the government and took up the role of devising innovative approaches for monitoring potential acceptors of FP methods in order to bridge the gap between awareness and acceptance. The FPAU also complimented government efforts by expanding FP especially to under-served groups, such as the youth and the rural populations and increased efforts towards the improvement of quality care.

Intervention models that would shift programmes and services to rural communities, under- served groups e.g. slum dwellers, youths and, to a limited extent, to refugees were identified and started. They included the introduction of community based distribution services, outreaches and satisfied users programme, integrated IEC marketing that aimed at promoting service sites and IEC approaches that linked agricultural analogies to RH. This initiative attracted support from the International Institute of Rural Reconstruction (IIRR). Sexual and Reproductive Health strategies have been integrated.

Mode of Service delivery

The FPAU delivers its services through a variety of mechanisms. In the first place, it has 23 *clinics* and 47 *outreaches* run by staff from the clinics. Each clinic is operated by two service providers who must be registered midwives. The services include syndromic STI diagnosis and management, HIV/AIDS prevention education and child immunization (on scheduled days). Others are antenatal, post delivery care, treatment of minor elements, information on health risks and contraceptive services.

The quality of care is guaranteed through training of service providers at clinics in reproductive health updates, backing services with appropriate methods and specific IEC messages, providing informed choices from a wider range of methods, setting days for youths and a consistent supply of commodities.

Secondly, the association has the largest *Community-based Distribution Agent* (CBDA) *network* in Uganda with 13 sites and 260 CBDAs. The agents are trained for 3 weeks using MoH curriculum to render service to continuing clients and new acceptors and to recruit new ones on contraception and to mobilise/sensitize and refer potential clients for reproductive health services. In addition they are trained to educate communities on the spread and control of HIV/AIDS and sexually transmitted infections (STIs, refer pregnant mothers for antenatal and safe delivery and spot any other health emergencies and refer them to health units).

A third component of service delivery is through *Information, Education and Communication* (IEC) activities aligned to service delivery with a view to enhancing an integrated working of service delivery outlets and the continued use of contraception and reduction of dropout. In this regard, method specific leaflets and posters have been developed and distributed at clinics through CBDAs.

Fourthly, FPAU operates *Adolescence Sexual and Reproductive Health Services* (ASRHS) with a view to increasing youth's knowledge of the reproductive system and promoting responsible behaviour. This function is part and parcel of institutions of higher learning, namely; the universities of Makerere and Kyambogo and Makerere University Business School.

Finally, there are activities in the field of *advocacy and capacity building.* Under the women empowerment strategy and FPAU project initiative in particular, FPAU has made efforts to advocate for eradication of female genital cutting in the district of Kapchorwa in addition to the community mobilisation and sensitization activities done by CBDAs. With financial support by IPPF, FPAU conducted a series of seminars on the roles and responsibilities of the CBDAs. Furthermore management tools and procedures have been put in place.

Naguru Teenage Information and Health Centre

Naguru Teenage Information and Health Centre was established in 1994 as a service drop-in centre to address the problems of youths, particularly regarding their reproductive life. It is located at Naguru clinic, a Kampala City Council health unit in the eastern part of Kampala district. The idea of the centre was partly initiated by Dr. Kerstin Sylvan a gynaecologist and a member of the Women's International Maternity Aid Organisation (WIMA). While working at the clinic, she was fascinated by the big number of girls who came to the clinic with STDs and in school uniforms. With experience from her home country, she went to seek assistance from donor agencies to provide similar services for teenagers at the clinic. This centre is the first of its kind in the country but the need for the range of services provided at the centre is nation-wide. A participatory approach is used in delivering services.

Activities carried out by the centre include; counselling on social and health problems, outreach talks in surrounding schools and NGOs, treatment of STDs and minor complaints, availing a limited range of contraceptives to teenagers, providing information, education and communication material in form of films, pamphlets, posters and books. They also organize social functions as well facilitate and direct discussions on topics selected by the teenagers. Through an examination of the counselling notes, the problems have been categorised into eight broad groups; the first six are related to reproductive health while the last two are related to social economic and health problems.

Table 6.5 Number of youths treated by type of ailment

Month 1995	Pregnancy	Vaginal Discharge	Urethral Discharge	Genital Ulcer	Other	other complaints
June	1	21	7	3	2	8
July	1	8	18	2	3	15
August	0	16	8	0	1	8
September	0	3	5	5	0	24
October	2	10	51		0	21
	4	58	89	10	6	74

Source: Naguru Teenage Centre Medical records 1995[19]

Marie Stopes[20] *(Uganda) (MSU)*
Marie Stopes Uganda was established in 1990 as a limited company by guarantee and without share capital. It was duly registered with the NGO Registration Board as an NGO in 1992. The NGO is affiliated to Marie Stopes International of UK, a British Charity whose aim is to enable people exercise fundamental human rights to determine the size and spacing of their families to improve on their health condition.

MSU's chief mission is to ensure the individual's fundamental human rights to have children by choice and not by chance. Their main goal is the prevention of unwanted pregnancy through the provision of contraceptives. MSU business ethos is that people wishing to space and limit their families are not sick nor do they have symptoms.
They are not patients but clients who have overall priority over all MSU employees regardless of position, status and qualifications.

Box 6.2 MSU's mission

- Respond to unmet FP / RH needs;
- Reduction of maternal and infant deaths;
- Reduction of unwanted pregnancies;
- Enable couples attain sustainable family size;
- Contribute to increase in CPR;
- Contribute to gender equity and empowerment of women and men;
- Build sustainable MSU centres nation wide.

Implementation of the programmes is through a network of integrated static centres with satellite clinics, while mobile outreach clinics and community-based programs serve the countryside. Tubal ligation, vasectomy and the provision of *injectables*, pills, IUD, foam tablets and condoms are among the methods offered. Clients also come in for STDs treatment, Pap Smear, Immunisation, Infertility, Antenatal and non Reproductive Health services. It was observed that most women do not know about the services offered by MSU.

The United Nations Population Fund (UNFPA)

The health sector has received considerable funding from different sources (see table 6.8). It should be noted that the discussion in this section is limited only to the programmes where UNFPA has had a direct involvement. UNFPA extends assistance to developing countries with economies in transition and other countries at their request to help them address reproductive health and population issues and raises awareness of these issues in all countries. UNFPA has been supporting the efforts of the government of Uganda since 1987 to raise the quality of life and improving the standards of living for the people. The programme started by putting in place an institutional framework, both at national and district levels, followed by drafting an explicit population policy. A population secretariat within the Ministry of Planning and Economic Development has been put in place to coordinate the implementation of the policy and programmes. Development partners of UNFPA include UNICEF, WHO, USAID, UNDP, World Bank, and others. UNFPA carries out in the first place programmes related to *MCH and FP*. These programmes aim at increasing contraceptive prevalence; strengthening the training capacity of the national logistics, strengthening the training capacity of the national Institute of Public Health; strengthening the IEC component and the integration of HIV/AIDS control activities within MCH/FP and strengthening institutional and manpower capacity to implement comprehensive MCH/FP. They also aim at developing and producing training curricula on family and life saving skills and increasing monitoring and supervision. In this context extension of UNFPA support increased from 13 to 26 districts. Instead of 156 service points, the programme exceeded its target by integrating RH/FP services into 783 of the total 1044 health centres in 26 districts. A total of 78 health units were also renovated and furnished and 704 MCH/FP kits were provided. In addition, training was also offered as indicated in the table below.

Table 6.7 UNFPA-funded training activities

Category trained	Number
Training of Nurse Aides in RH/FP	435
Training of midwives life saving skills	110
Professional trained in health information systems and logistics	74
Clinical instructors trained	14
TBA trainers trained	30
TBAs trained	3195
Doctors trained at Master of Public Health (MPH)	7
Doctors trained in RH and sensitization of community leaders	22
District health trainers in programme planning and financial management	39

Source: UNFPA/GoU: Fourth Country Programme (1997-2000)

A community-based distribution network was developed on a pilot basis in one sub-county in each of the 26 programme districts to complement the health facility service.

In the second place attention was paid to *Information, Education and Communication (IEC)*. The third GoU/UNFPA Country Programme witnessed a significant move from a project approach to a programme approach in the area of IEC. Achievements in this area include the development of a National IEC strategy for both formal and non-formal sectors and the institutionalization of Family Life Education units in a number of line ministries. Other achievements have been the strengthening of individual technical and management capacity to develop, produce and evaluate IEC materials and sensitization of a range of conservative groups about RH/FP issues.

In 1995, UNFPA also initiated a pilot activity in one Sudanese *refugee settlement* in Uganda. Support focussed on reproductive health and family planning activities and consisted of training midwives and TBAs, a small-scale CBD programme in the camp and the provision of contraceptives and condoms. An evaluation in 1996 showed that assisted deliveries rose from 30% to nearly 80%, a significant increase in condom use and a slight increase in use of contraceptive pills by nearly 2%. Financial resources for this activity were provided from the Division of Arab States and Europe.

Fourthly there were UNFPA supported activities in the field of *Gender, Population and Development*. UNFPA continued to support a WID/Income-generating project within small farming communities to promote women's socio-economic and self-reliance and thereby influence their own health and fertility behaviour. UNFPA supported a post-

Beijing workshop, which discussed a range of intervention programmes to implement recommendations of the International Conference on Population and Development (ICPD) Platform of Action. UNFPA funded gender sensitization seminars to senior cadres and officials in different line ministries with a view to promoting gender awareness and influencing public service decisions and processes. The fund also initiated a pre-project activity to document the issue of bridewealth, which has been a key factor in maintaining the submissive status of women.

Delivery of Improved Services for Health (DISH)

The United States Agency for International Development (USAID), through a bilateral agreement with the Uganda government's Ministry of Health, funds the DISH project, one of the largest reproductive health programs in Uganda. Focusing on about 30% of the population, the project operates in 12 of the country's 45 districts, namely Jinja, Kampala, Kamuli, Kasese, Luwero, Masaka, Masindi, Mbarara, Nakasongola, Ntungamo, Rakai and Sembabule. The DISH project aims to increase service utilization and change behaviour related to reproductive maternal, and child health through increasing the availability of integrated reproductive maternal and child health services and improving the quality of these services. In addition, DISH aims at enhancing the sustainability of reproductive maternal and child health services and increasing knowledge and perceptions related to maternal and child health.

The first phase of the DISH project ran from June 1994 to September 1999. Pathfinder International was contracted to oversee the implementation of DISH I. The DISH project was in its second phase, when I conducted this study and was running from October 1999 to September 2002. The Johns Hopkins University (JHU) was contracted to oversee the implementation of DISH II. The DISH project carried out the following specific activities in order to achieve its objectives:

- *Ongoing training of nurses and midwives to equip them with skills needed for providing integrated reproductive and child health services*. Integrated services refer to a scenario where one health care provider can offer a client in need the whole range of reproductive and child health services, preferably during a single visit to a health facility.
- *Continued support of Community Reproductive Health Workers (CRHWs)*. Under contractual arrangements between Pathfinder International and selected community-based NGOs, DISH trained and supervised 539 NGO Community Reproductive Health Workers in selected areas. These workers, through family visits, provide integrated reproductive services at the community level.
- *Continued building capacity in Health Management Information System (HMIS) and Logistical Management Information System (LMIS)* for the Ministry of Health and support to the 12 project districts to computerise, manage, and monitor these systems. The DISH project compiles data for project monitoring and evaluation purposes from these systems.
- *Continued building capacity in financial management:* focused training on fee-for-service (FFS) schemes. Four hospitals in Jinja, Masindi, Nakaseke, and Luwero benefited from this training.

- *Ongoing Information, Education and Communication (IEC) activities.* The DISH projects conducted IEC activities through the JHU to increase reproductive and child health knowledge and to encourage positive reproductive and child health attitudes and behaviours.
- *Continued project management, monitoring, and evaluation.* Pathfinder International conducted the monitoring and evaluation component of DISH , based on the periodic measurement of selected key indicators in the project districts. The first assessment of the DISH project impact using data from the 1997 survey showed remarkable increase in the use of modern family planning methods, increased use of STD / HIV services, better knowledge about child nutrition and moderate improvement in use of antenatal care and delivery services.
- *Activities through other collaborating agencies through grants or work contracts.* Under arrangements initiated in the DISH project's first phase, the AIDS Information Centre (AIC) carried out HIV testing and counselling; The AIDS Support Organization (TASO) conducted care and support services for people with AIDS; the African Medical Research Foundation (AMREF) trained doctors and medical assistants in STD syndromic management; and the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) provided pre-service training for health service providers. In addition, the Social Marketing for Change (SOMARC) project carried out social marketing of family planning methods including condoms, oral contraceptives and injectables.

The discussion in the above section clearly shows that there are continuing efforts to diversify the mode and nature of implementation of reproductive health care. Where in the past the role of reproductive health was the responsibility of hospitals and the FPAU, it can now be seen that partnerships have emerged including the UNFPA and NGOs to spearhead reproductive health care implementation. Granted, the majority of the programmes are dependent on donor funding, but the efforts of the government and the NGOs ought to be acknowledged as well.

Table 6.7 Donor-funded reproductive health projects (1991- 2001).

Project title	Funding Agency	Location / Project description	Amount	Time frame
Sexually Transmitted Infections Project	WB, Germany (KFW), Sweden (SIDA) GoU	Prevention of sexually transmitted diseases, care for the people with AIDS and the other related diseases country wide	US$73.4m	1994 - 2000
Delivery of Improved Services for Health (DISH)	USAID	Reproductive health in the districts of Kamuli, Luwero, Masindi, Jinja, Kampala, Maska, Rakai, Mbarara, Ntungamo, Kasese, Sembabule.	US4. 40m	1995-2000
Reproductive Health Project UGA/93/PO3	UNFPA	Reproductive health in the districts of Kampala, Iganga,,, Mpigi, Arua, Hoima, Tororo, Mubende, Bushenyi, Mukonom Pallisa, Kibaale, Kiboga, Moyo, Soroti, Ntungamo, Gulu, Kalangala, Moroto, Kotido, Kumi, Nebbi, Kitgum, Lira, Maasindi, Rukungiri, Kamuli, Katakwi, Adjumani, Busia	US$ 4.7	1991-1996
Community Reproductive Health Project (Phase II)	USAID and CARE- USA	Reproductive health and prevention of STIs in the districts of Kabale, Kisoro and Rukungiri	US$ 6.6m	July 1996- June 2001
Contraceptive Supplies	USAID, ODA, UNFPA, GTZ	Supply of contraceptives	US $ 1 m	1996
WHO Programmes	WHO	PHC Women and children's health (WCH)	US $ 0.2352m US $ 0. 193 m	1996 - 1997
Uganda Family Health Project	ODA through CARE	Reproductive health, rehabilitation of facilitates and strengthening district health services management in the districts of Mbale Kapchorwa, Palisa.	US $ 14.9m (U K £ 9.9)	April 1994 – Sept 1999

Source: Various Documents i.e. UNICEF Plan of Action, MoH Health Inventory, Sexual and Minimum Package for Uganda 2000

6.6 Concluding Remarks

By way of summary, let me now recapitulate the salient issues in the chapter. The overview of the health sector shows that provision of health care to the Ugandan population was not a priority for the colonial government, hence the encouragement of the missionaries to spearhead the health care provision and training of health human resource. However, the government was involved at the pandemic of venereal diseases. Mulago hospital was initially established to handle the venereal diseases and was called 'Mulago Hospital for Venereal Diseases' (Cowley, 1997). Subsequently, approximately 48% of the health care provision is by the NGO sector, which indicates the crucial role played by the faith-based sector. Apart from the teaching of medical doctors, which appear to be the realm of the state universities and government hospitals, and recently Kampala International University (a privately owned and operated university), the teaching of nurses, midwives and paramedics is a joint effort of the government and the NGOs.

We have noted further that bad politics in Uganda negatively affected the provision and utilization of health care. The constant wars caused destruction to the infrastructure (this is now being rehabilitated through donor funding) and the government infrastructure suffered most. The resulting overwhelming numbers filled NGO hospitals to a point where they could hardly manage.

Reproductive health care has been managed under the conventional maternal and child health and family planning (MCH/FP) for several decades until the post-ICPD when efforts are being made to address the recommended aspects of reproductive health. This can be seen through the new programmes introduced and the number of projects implemented by non-governmental (non church based) organisations. In addition, we see that there are clear policy guidelines for the adolescents.

Be that as it may, the implementation of reproductive health programmes in rural hospitals and health centres appears to be done within the traditional maternal and child health and family planning (MCH/FP). My own impression is that there has been a hurry in implementing international policies without necessarily preparing the ground as it were. The mode of the health delivery system is still predominantly therapeutic and is still urban based. Lack of transport is common at the district level. It is therefore difficult to see how outreach health programmes could be undertaken with such poor logistics. The decentralisation process, in particular the health sub districts (HSD) has yet to deliver any concrete and tangible results due to financial and human resource constraints. The health sector depends entirely on the central government for drugs, human resource, salaries and allowances. The highly professional cadre are located in urban centres particularly in Kampala. The low morale of the rural health staff, due to poor pay, most likely influences the negative attitudes they have towards patients.

[1] Health-related records at the Uganda Archives, Entebbe and the Colonial Office, Kew Gardens, Kensington reviewed by the author in 1997.
[2]Memo written and signed on 31 March 1933 by the Acting Director of Public Works. Records at the Uganda Archives, Entebbe, retrieved in July, 2002.
[3] Urology Ward
[4] Out patient Records at Kuluva Hospital in Arua in October 2003, Nsambya and Mengo Hospitals in Kampala in June 2003.
[5] There were no standard guidelines for efficient implementation of this policy. Hospitals and health centres charged what they liked and accordingly used the proceedings as they saw fit.
[6] A senior health official was conducting research in October 2003 in those hospitals, which maintain private wards with a view to making recommendations for the re – introduction of co-sharing. (Anonymity was requested).
[7] The public outcry against the co-sharing policy was justified by the then Permanent Secretary Tumusiime Mutebile (now Governor, Bank of Uganda) when he referred to the SAPs as a bitter pill, which had to be swallowed to get better.
[8] I noticed this in some of the health centres in the districts of Arua (Rhino Camp health sub district), Moyo (Ofua HC) and Adjumani Ciforo HC).
[9] Census 2001
[10] UDHS 2000/2001
[11] UDHS 2000/2001 this percentage includes post partum abstinence
[12] Since decentralization is still in its infancy stage, the district hospitals still rely heavily on the central government for financing.
[13] When I mention the number of staff, I mean to refer to the ideal staffing levels. However, not all units are staffed as required.
[14] Albert Cook was a British missionary doctor. He started Mengo Hospital, one of the biggest Anglican Hospitals in Uganda.
[15] Currently known as Clinical Officers
[16] Although my efforts to obtain more recent figures failed, it is unlikely that the situation has greatly improved because of a trend for medical doctors to seek employment elsewhere particularly in South Africa and the UK.
[17] The phenomenon '*sugar daddy*'/'*sugar mummy*' refers to a situation where poor girls and boys are exploited sexually by adult men and women because of money
[18] It is believed that as result of the high numbers of the casualties seeking medical care that one of the founding doctors contracted HIV/AIDS and died.
[19] It should be noted that these clients were seen at the very beginning of the clinic before its existence was widely known.
[20] Interview with the Programme Director at Kireka July 2002

7

The study area and 'host environment'

7.0 Introduction

In this chapter, I focus on the study area and the host environment. The main purpose of the chapter is to show the socio-economic and political situation of the host environment, including its vulnerability with a view to assessing its capacity to host large numbers of refugees. The study area comprises Uganda, the districts of Arua and Masindi, and the refugee settlements, which together constitute the 'host environment'. With the exception of a few areas in West Nile, in which the people, who, themselves were just returning from refuge in the Sudan in the mid 1980s, willingly accepted the Sudanese refugees by offering them land, refugee settlements in Uganda were established in rural areas without necessarily seeking the opinions and attitudes of the hosts regarding their own attitudes towards and perceptions of hosting refugees in their area. The arbitrary location of refugee settlements and the subsequent refugee-specific development of the settlements appear to be polarising the hosts and refugees, as the recent land skirmishes[1] in Nakivale refugee settlement show.

The chapter contains four sections. Section one (7.1), is a summary about Uganda. In section two (7.2), I discuss the refugee-hosting districts of Arua and Masindi including the refugee settlements of Rhino Camp and Kiryandongo. Section three (7.3) discusses some of the perceived problems inherent in the provision of humanitarian assistance, which target refugees in communities where the differences in need between refugees and their hosts are negligible. The chapter ends in 7.4 with concluding remarks.

7.1 Uganda

Geography

A former protectorate of Great Britain, Uganda gained independence in 1962. Geographically, Uganda with a total area of 241,038 sq. kms of which area under land is 197,097 sq. kms and 43,941 sq. kms under water and swamps is situated astride the equator within eastern Africa at Latitude 4 12'N &1 29'S; Longitude 29 34'E & 35 0'E. It is a land locked country and borders with Sudan to the north, Congo to the west, Kenya to the east, Tanzania and Rwanda to the south. For its exports and imports, Uganda depends a great deal on the ports of Mombasa and Dar es Salaam and air

transport to and from Entebbe airport. This dependency has often landed Uganda into problems. For instance, during the previous KANU government in Kenya of President Moi, the Kenya/Uganda border would get closed any time there were differences in opinion between the two governments. Similarly the fact that Uganda shares borders with several countries in the Great Lakes Region (GLR) makes quite prone to receiving and hosting refugees from Eastern Africa.

The country's rural and urban populations are concentrated in the Lake Victoria crescent in which much of the country's coffee is produced, as well as some tea and livestock products, fish and staple food crops. As in most African countries south of Sahara with the exception of South Africa, Uganda depends on traditional cash crops, such as coffee and tea for its foreign exchange. Therefore, a drop in the international price of coffee and tea greatly affects the earnings of the country and increases its dependency on donor funding. Having said this, it should be noted that during the last ten years or so there has been a deliberate effort, spearheaded by Mr. Yoweri Museveni, the President of Uganda, to consolidate the investment sector through the diversification of the cash crops. Responding to the investment call, there is now sizeable investment in horticulture, aquaculture, the growing of vanilla and livestock, which increased the export of cut roses and chrysanthemums, vanilla and goats to Dubai[2].

The good soils and biannual rains that Uganda enjoys enhance its agricultural potential. While majority of Ugandans depend on agriculture for their livelihoods, there are also some pastoralists, such as the Hima and the Karamojong with heavy concentrations of livestock from which they derive their livelihood in the less densely populated districts, such as Nakasongola, Kotido and Moroto. Most of the country's minerals, such as copper, cobalt, iron ore, gold, tin, and salt are located in western and southern highlands.

Demographic Characteristics

The population of Uganda has witnessed substantial increase since 1948 (UBOS, 2002). For instance, the population has continued to grow as follows: 1949 – 5 million, 1959 – 6.5 million, 1969- 9.5 million, 1980 – 12.6 million, 1991 – 16.7 million and 2002 – 24.6 million. However, like many other countries in Sub Saharan Africa, Uganda suffers from grim social and health indicators. For instance, fertility rates at 6.9 (UDHS, 2000) are among the highest in the region, when compared to Kenya's 4.7 (1998) and Tanzania's 5.6 (1999)[3]. Moreover, Uganda's maternal mortality rate (MMR) at 506 per 100,000 live births is one of the highest in Sub Saharan Africa (UDHS, 2001).

There are variations in fertility rates in the several districts of Uganda. For example, the fertility rates range from 9.7[4] in Kotido district to 4.7 in Kampala district. Others are Yumbe with 8, Moyo 8, Gulu 7.4, Kalangala 6.4 and Moroto at 6.0 (Population Census 2002). In addition, the average growth rate for Uganda is 3.4%, a very high percentage that cannot contribute favorably, considering that at least 50% of the population is under 18, towards the national poverty eradication programme. Furthermore the districts with very high fertility rates are also the most 'marginalized' in terms of resources and access to social services when compared to the rest of the districts. Take Yumbe district, for example, with a population of 253,325 has 14 health units (12 Governments and 2

NGOs) (compare with Kiboga with a population of 231,718 with 34 health units, of which 28 are government) (UBOS, 2002). It is also possible that the high fertility rates could be a result of socio-cultural influences (Akosua, 2004), such as the culturally-prescribed women subordinate position in the household (Omari and Creighton, 1995), and low levels of education, which are directly related to family planning use.

Table 7.1 Demographic characteristics (2002)

Indicator	**Year 2002**
Total Population	24.6 million
Population growth (Average)	3.4 %
Northern	4.6 %
Eastern	3.5 %
Western	2.9 %
Central	2.7 %
Sex Ratio	96.0
Males	12.1 million
Females	12.5 million
Women of reproductive age group (15-49)	5.7 million
Children < 1 year	1.2 million
Population aged 0-4 years	4.9 million
Population density	126 person/km2

Source: Population Census (UBOS, 2002)

Rebel Activity in Northern Uganda

Another factor, which has contributed to the population dynamics, is the protracted war in northern Uganda, where also the growth rate is 4.6% (UBOS, 2002). The almost twenty-year old armed conflict in northern Uganda has constrained the capacity of the local and central government to deliver efficiently social services including family planning services and the ability for the people caught up in war to utilize whatever little services are available. According to Donor News (2003), fertility rates for northern Uganda have increased as a result of war.

The almost twenty-year old protracted war in northern Uganda has left thousands dead and forcedly displaced tens of thousands from their homes to seek refuge in other areas of Uganda, such as Arua and Masindi. In a bid to contain the insurgency, many civilians caught up in war have been relocated to camps for the internally displaced in their own areas of origin. Those who have been forced to migrate to other districts have had to adapt to new and strange environments. Our research in Masindi showed that the social services, such as, schools and health care services were particularly

overstretched, as they had to deal with the extra unplanned for caseload of internally displaced persons in the nearby Ranch 36 whose proximity to the refugee settlement proved beneficial as they were able to access (although 'unofficially' in many cases) social services like health care and education in the settlements.

The Economy

Uganda is a low-income landlocked East African country with a per capita income of about US$ 330 and a population of 24.6 million. The economy is largely dependent on agriculture, which accounts for 43% of GDP and 90% of total exports (Statistical Abstract, 2004). In terms of human development, Uganda is ranked 158th out of 174 countries world wide (Human Development Index, 2004). Currently 38% of Uganda's population live on less than 1 dollar per day and are unable to meet their basic requirements[5] .

The economy of Uganda has always been tied to the stability of the country (Kayizzi-Mugerwa, 1997). When the National Resistance Movement (NRM) Government assumed power in 1986, it inherited a nation torn by conflict, and an economy shattered by years of war and political instability. Inflation was about 200% per annum, fuelled by severe macroeconomic imbalances and acute foreign exchange scarcity. Industrial production was negligible and agricultural production was disrupted with most produce being smuggled out of the country. Kayizzi-Mugerwa (*ibid*) observes that the return of peace, at least in the southern parts of the country, and a more effective government have enhanced policy credibility and have boosted investment. Most of the expansion has been in the modern sector of the economy, where capacities had slackened over the years.

In a bid to heal the economy, the NRM government, as a condition for the World Bank/IMF financing, has had to implement economic reforms through structural adjustment policies (SAPs). Several studies have showed how these reforms have had negative impacts on the populations, with women being particularly hit hard (Adedeji, 1999).

Uganda has registered a reduction in poverty. According to the Uganda Government (MOFPED, 2005), 56% of the population was living in poverty a decade ago as compared to 38% now. But even 38% is not good enough. In addition, government's heavy investment in universal primary education has more then tripled the number of children enrolled in primary school from 3 million in 1997 to over 7.6 million currently. The gender gap in most levels of primary education has also been narrowed (*ibid*). Despite this, recent revelations indicate that there is a disparity between the children who start school and those who complete.

Furthermore, it has been recorded (MoF, 2005) that there is evidence that Government's universal primary health care policy and the recent reforms within the health sector have brought about a significant expansion in the usage of the health system. Out Patient Department (OPD) attendance has increased dramatically in most health facilities across the country, from 9.3 million new cases in 1999/2000 to 17.7 million in 2002/03. The proportion of people in the poorest 20% of the population who seek care

when ill also rose from 46% to 73% between 1999 and 2003. The Government has also built 400 new Health Centres (HC II) and upgraded 180 HC2 to HC III status (including maternity services). In addition, the prevalence of HIV has fallen from 30% in 1993/04 to 6% in 2003/03 (ibid). However as I have indicated above and in chapters 8 and 9, problems still persist with acquisition of drugs in the health centres, the rude attitude of the health providers especially nurses and the low figures of professionally trained health providers for rural health centres.

Politics in Uganda

The internal system of Uganda has been factional since independence in 1962 and has overshadowed all efforts at sustained development. A decade of difficulties led to the 1971 military coup by Idi Amin, which shattered a growing economy and involved the country in chaos where lawlessness brutally became accepted civil behavior. Under Amin, moves to centralize economic power were continued. An economic war against the powerful Asian community was declared in 1972 and 50,000 Indians and Pakistanis were expelled. Their expulsion contributed significantly to a worsening of economic mismanagement and the shrinkage of the official economy. A few years into Amin's rule the economy collapsed. The coffee boom from 1975 to 1977 (when world prices increased by 35% because of frost in Brazil) gave only temporary respite to the downward spiral. Amin's own over throw in 1979 left the country in a power vacuum. Three governments came and went in quick succession before a semblance of national consolidation returned under the second presidency of Milton Obote. The 1980 elections that returned Obote to power were widely recognized to be unfair and manipulated. Opposition to the Obote election was widespread, both in parliament and *in the bush*[6] while the Uganda People's Congress (UPC) reaction to this opposition was harsh and strong. Killings and disappearances were commonplace in and around Kampala as well as other towns and villages. The ensuing insecurity destabilized the service delivery system in two major ways: many health and other professionals left the country and the near total anarchy in the country made work difficult.

By 1985, divisions had developed within the government itself along ethnic lines between the ruling northern tribes. These divisions led to the July 1985 coup when Okello overthrew Obote. But the new leadership continued with wanton killings and atrocities directed at the civilian population especially in and around Kampala. Eventually, the January 1986 victory by the NRM led by Yoweri Museveni overcame a much divided and weakened military government. The NRM has tried to promote discipline and has been perceived to be committed to management of public affairs and improvement of national security.

Decentralisation and the Local Councils

The period before the National Resistance Movement (NRM) government, political, economic and administrative powers were centralized. When the National Resistance Army captured power in Uganda in 1986, they consolidated a new form of popular governance. The popular governance was based on a hierarchy of resistance councils

(RCs), which were later renamed local councils (LCs). At the lowest level, the basic LC cell is composed of at least ten households in a locality. These cells then expand into wider patterns (village, sub-county, county, district) with a local council at each level, to form a pyramid like hierarchy whose summit is the national parliament. According to Langseth and Mugaju (1996), it marked the most far-reaching measures to decentralise administration that has ever been attempted in Uganda. The decentralisation and local government reforms started with the enactment of the 1987 Resistance Council / Committees (RCs) Statute No 9, which legalised the resistance councils and gave them powers of jurisdiction at the local level.

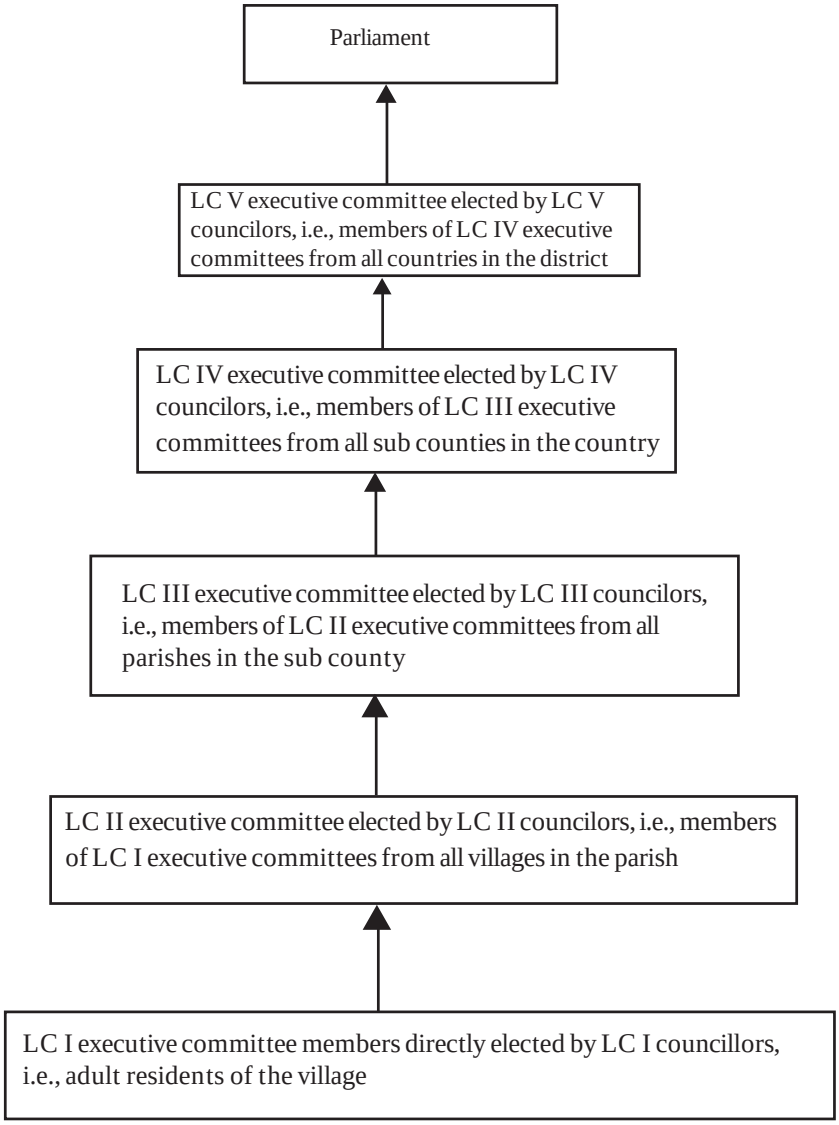
At LC 1 level, all village residents are de facto members of village resistance council and these elect members who constitute the village local council (LC1). At LC 2, members of LC 1 from each village in that parish become members of the parish local council. These members elect 9 of their peers to constitute the parish local council (LC 2). This same process is repeated to form LC 3, LC 4, and LC 5 (see figure 7.1). Each LC is under the organizational leadership of a chairperson. At each LC level, there are posts for a secretary for Mass Mobilization and a secretary for Women Affairs. The government uses extensively the LC system as a two- way channel for communication. These political structures were legalised by the 1993 Resistance Council Statute, which was in turn enshrined in the Uganda Constitution of 1995 with amendments made in the Local Government Act, 1997. The main objectives of decentralization were as follows:

Box 7.1 Objectives of decentralization

- To transfer real power to the districts and thereby reduce the workload on remote and under-resourced government officials at the centre.
- To bring political and administrative control over services to the point where they are actually delivered.
- To improve financial accountability and responsibility by establishing a clear link between payment of taxes and provision of services
- To improve the capacity of local councils to plan, finance and manage the delivery of services to their constituencies.

However, the implementation of decentralization has not been without hitches. The constraints and challenges have been presented in three broad categories (Golola, 2001:9). First, are the difficulties associated with a general lack of financial and human resources, which have hindered policy innovation and limited the independence of local governments. Second, are the complex centre-local relations, whereby political confrontations at the centre, at least their results, have tended to flow over to the districts and further below, thereby altering policy parameters at the local level. The third aspect relates to the political and economic dynamics at the local level itself.

Figure 7.1 The hierarchical structure of the Local Councils and Committees



Source: Tamale, 1999: 70

7.2 Arua District

Arua district borders with Sudan in the north; Yumbe and Adjumani districts in the East; Nebbi district in the south; and Democratic Republic of Congo (DRC) in the west. With respect to hosting refugees, Arua district by virtue of its proximity to Sudan and East Congo, has continued to receive and host refugees from both these countries.

Arua district with a total area of 7,879.2 sq. kms is about 520 kms away from Kampala City. Although the original inhabitants are the Lugbara (Middleton 1966), by virtue of its location, Arua district represents many ethnic groupings including Alur, Kakwa, Madi, Nubian, Arabs and Somalis. The district is divided into seven counties and twenty-six. sub- counties. The main languages are Alur, Lugbara. Kakwa and Madi. The tribes share ethnicity with neighboring border tribes of the surrounding districts and countries. It is believed that the sharing of ethnicity in the area has influenced the good reception, which refugees have received in the district. It was also observed that ethnicity was instrumental in the high numbers of self-settled refugees in West Nile.

Administratively and politically, Arua district is divided into a hierarchical layer of administrative and political units (this has been discussed in detail in the previous section), except for the fact that the district has, in addition, a Resident District Commissioner (RDC), and District Security Officer (DSO) appointed by the Office of the President. The war that ousted President Amin in 1979, did havoc to the infrastructural set up of Arua district in general and the social services in particular. Almost the entire population was involuntarily displaced beyond borders and fled into exile in the Sudan and Democratic Republic of Congo (DRC) and beyond. Upon return from 1986 onwards, it can be said that a lot in way of rehabilitation has been done. Although the district has registered marked improvement in the infrastructure including schools, health services, roads and communication, it could still improve further.

Demographic Characteristics

Table 7.2 gives a comparative overview of key demographic indicators for Arua District and the national indicators.

Table 7.2 Key demographic indicators

Indicator	Arua	National
Population	855,055	24.6 million
Annual growth rate (%)	2.7	3.4
Life expectancy	44.1	49
Infant mortality rates per 1,000 live births	100	88.3
Crude mortality rate per 1,000 live births	240	203
Maternal mortality rate per 100,000 live births	373	506
Wasting (%)	5	5
Total fertility rate	6.7	6.9
ANC attendance (%)	90	90
Assisted deliveries (%)	23	38
Fully immunised infants (%)	28	36.7
Safe water coverage (%)	54	25.5
Latrine coverage (%)	52	41
Male literacy rate	77	65
Female literacy rate	46	45.7

Source: Uganda Bureau of Statistics, 2002

From the above table, it can be noted that, in some few cases, Arua has slightly better indicators than the national ones. For instance, safe water coverage is 54% compared to the national of 25.5%; latrine coverage at 52% is better than the national at 41%. But then, there are fewer women (23 %) delivering in hospital and health centers than the national deliveries at 38%. On the whole, the indicators for both Arua and Uganda paint a grim picture.

The health provider/population ratio for Arua district indicates that, for every 44,000 people, there is 1 doctor while 1 midwife serves 7,600 women. The ratio for a clinical officer is 1 to 21,000 people and that of nurse is 1 to 3000 (UDHS, 2000/1).

Economy

Like it is with the national economy, the economy of Arua is dependent on agriculture for food and income. Agriculture is mainly subsistence and occurs on smallholdings of approximately two acres using mainly simple farming implements such as hoes, pangas and harrowing sticks. Subsistence farming has poor potential reliable income, as it is dependent on weather conditions, which are not easy to guarantee. In addition the people practice mixed farming keeping cattle, sheep, goats and pigs and growing food crops like cassava, beans, maize, sorghum, millet, simsim and groundnuts. Only 0.5%

of the population is engaged in commercial agriculture. Cotton is produced on a small scale. The single main cash crop that is grown is tobacco. However, it is not quite clear what dividends the people of Arua get from the tobacco. With such a rudiment economic survival, it is not hard to imagine that the district is not in a position to host big numbers of refugees, which at present are over 200,000 (UNHCR, 2004) for the registered and an unknown number of the self-settled.

Moreover, it has been argued that the tobacco curing process places heavy work demands on the women who must collect firewood for the curing in addition to their own gender roles. Furthermore, there has been degradation of the environment due to cutting of trees for firewood.

Health Services

The health services of the district can be divided into formal and informal. The formal health sector refers to the government health units, the NGO (not for profit) health units, including faith-based health centers and NGO (profit making) health centers; while the informal refers to drugstores, local herbalists, divine healers and the traditional birth attendants (TBAs). There are three hospitals in Arua district including one government, a referral hospital and two mission hospitals (one Catholic and one Anglican) with a total bed capacity of 400. In addition to being a centre for internship for medical doctors, Arua hospital undertakes training of enrolled nurses and midwives. The government effort is augmented by NGOs, bilateral and multinational organizations that support the health system including Save the Children (SCF), the German Development Service (DED), World Vision (WV), UNHCR and UNICEF.

In addition, the district has a total of 62 health units[7] including five health units in the refugee settlement (see chapter 8), but these are unevenly distributed with the areas of Madi Okollo, Koboko, and Terego largely underserved.

Both the government and the NGO sector including faith-based organizations operate the health centres. There are also 'private for profit' nursing homes, clinics and drug stores. The private for profit organizations seem to fill a lacunae of missing drugs at the hospitals and the health centres. The discussions held with non-refugee and refugees decried the exorbitant cost of drugs at the pharmacies, clinics and drugstores (please see chapters 8 and 9 for a detailed discussion). Arua hospital with a 280-bed capacity is the referral hospital for West Nile region. It offers outpatient, x-ray, AIDS testing and dental facilities. It is also a regional blood bank for the West Nile region.

The role of traditional healers in the delivery of health care is very crucial. Recent studies give a different significance to traditional medicine (OXFAM 1995). The fact that there are 168 registered traditional healers (of whom 18% are 'organized' into 3 societies) reveals that traditional healers represent a significant source of treatment for both nationals and refugees. It is believed that about one third of patients in formal health services had first visited traditional healers. (OXFAM, 1995). Only 23% of the district deliveries are attended to by trained health providers (UDHS, 2001).

Other basic services – water, power and communication

Other basic services in Arua town include; water and power supply. Power supply is generator dependent and is rationed for only about four hours in the evening (6-10 pm). Most organisations such as the UNHCR sub-office, CARE, SNV depend on own generators for power supply. Outside town, water supply is by wells and rivers and there is a lack of power supply. The population depends entirely on traditionally generated fires for cooking and lighting. At night, most people use specifically made small tin lamps that use paraffin and cotton wicks. Those who can afford use paraffin-operated lanterns/lamps.

The transport sector has very few observable vehicles, with majority belonging to the UN and international NGOs. There are very few privately owned vehicles offering public transport. The fuel supply is erratic and makes vehicle transport quite expensive. This situation made the fieldwork of my study extremely difficult as will be discussed below. The most common form of transport facility is footing and the use of a bicycle. But the sandy nature of the roads makes even the use of bicycles difficult. The district as a whole has an inadequate road network. The existing roads are murram and in a poor state which has hampered transportation in the district. The district has an airstrip, which facilitates air transport. It is the only convenient means of transport out of the district, but it is out of reach for most people.

7.3 Rhino Camp refugee settlement

Geographical and Physical Features

The 225-hectare-refugee settlement was established in 1993, following an influx of Sudanese refugees escaping armed conflict in south Sudan. Thousands of them camped at a transit camp at the border town of Koboko where they received emergency assistance while plans were made to have them removed to a safer place for security purposes. Rhino Camp refugee settlement is a conglomeration of 42 sub-settlements commonly referred to as clusters. The current registered refugee population is 25,439 (female population 12,245; male population 13,194). This figure does not include the self-settled refugees elsewhere in the district. The refugee settlement fence is only bureaucratic in that the clusters are interspersed within local hosts' land. Refugees and their hosts benefit from the same resources, such as water, schools and health care facilities.

The Rhino camp refugee settlement is government-gazetted land located in River Nile (Albert) basin. It borders Rigbo sub-county in northeast, Gulu district in the east, Madi Okollo and Ajai in the south and Terego in north. It is a continuation of the Ajai Game reserve formerly the home of the now believed –to –be extinct white Rhino. The refugee settlement is approximately 60 kms from Arua town. The Yoro Base (headquarters) of the settlement is 11.5 kms from the main road. This road was constructed by UNHCR to be able to access the settlement and it stops at the base camp. The settlement is located in a remote area that has a population density of between 50-149 persons per sq. km. At an altitude of between 500-1000 meters , it is a relatively flat region with an average

annual rainfall of about 1000 mm. The climate is humid tropical with high annual rainfall but with two short dry seasons and constant high temperatures. The vegetation is a mixture of tropical dry savanna and tropical savanna woodland. There are no major forests. The soil is largely sandy and suitable for cultivation of only a few types of crops like simsim, sorghum, groundnuts cassava and finger millet. Refugees engage in the cultivation of these crops for food as well as cash crops. The economic activities comprise mainly subsistence farming, such as agriculture and animal husbandry. The cultivation of tobacco and cotton is restricted to the nationals as refugees are not allowed to engage in perennial crops; despite this, a few of refugees engaged in tobacco and cotton growing. Animal husbandry such the herding of cattle, goats, sheep among nationals and goats, chicken, ducks, among refugees is undertaken on a small scale. Before the establishment of the refugee settlements, the area was sparsely populated. This was most likely due to the hostile nature of the environment in this area (tsetse fly-ridden, poor soils, mosquitoes); the natives of the area only come in periodically during the planting and harvesting seasons. However, the population has tended to settle permanently in areas surrounding the settlements due to the availability of social services and for fear of losing their land to refugees.

Refugee Administration

Uganda's refugee policy maintains that refugees are a ' temporary' phenomenon and that they would soon return to their country. It is within this framework that refugees are accommodated in established refugee settlements across the country until they are able to return to their countries of origin. Refugee administration is made in accordance with the existing refugee act, the Control of Alien Refugees Act (1960) (Chapter 64 of the Laws of Uganda, 1964 edition). It is according to this Act that directives and orders have been put in place for regulating refugee return to their country of origin and for making provision for their residence while in Uganda. Some parts of the Refugee Act (para 8:1-5) are as follows:

Box 7.2 Parts of the Refugee Act

1. It shall be lawful for the minister or any person appointed by the minister for that purpose, by order in writing to direct any refugee or any class of refugees to reside in a refugee settlement or in such other place in Uganda as may be specified in the order.

2. Any order made under the provision of this section may contain such supplementary or incidental provisions for the purpose of controlling the movements of any refugee or class of refugees to whom or to which the order applied as the person making the order may deem necessary or expedient.

3. Any refugee to whom an order made under this section applies may by a subsequent order be directed to move from a refugee settlement or other place in which he has been required to reside to any other refugee settlement or place.

4. Every refugee to who an order made under this section applies shall be informed of the nature and contents of such order and shall forthwith take steps to comply therewith.

5. Any refugee who fails to comply with the terms of any order made under this section shall be guilty of an offence.

Consequently, refugees like in so many other countries in the world have no choice of where to go, where to live, irrespective of their status and duration. In most instances (with a few exceptions, when land is given by the communities such as in Adjumani and Moyo), refugees are settled on land gazetted by government. It was against this backdrop that Rhino Camp refugee settlement was established. Nabuguzi (1998: 60-61) has observed that these settlements are physically isolated and bureaucratically fenced. He argues that refugee settlements are institutions that control and marginalize refugees, since their establishment appears to have no economic motive.

Despite the decentralization policy, refugee matters in Uganda are centralized and fall under the Office of the Prime Minister (OPM), and are handled by the Refugee Secretariat under the headship of the Director for Refugees. The settlement commandants, answerable to the Office of the Prime Minister, are recruited centrally and are in charge of the refugee settlements. The Director for Refugees has the power to transfer the commandants to any refugee settlement in Uganda and to recall them to the headquarters. The government maintains a refugee desk office, heavily facilitated by UNHCR, in the district head quarters of each refugee-affected region in Uganda. For instance, there is a refugee desk officer in Arua, Adjumani, Mbarara and Fort Portal.

A Narration of How Refugees Moved to Rhino Camp

The process started in mid 1995. The move itself was a trying experience for all, the organizers as well as the refugees. For the women in particular, the period is an experience they would wish to forget. Talking to them, some narrated how they delivered

babies in the open at the Landing Bay, with no assistance. A couple of women informed me of how they bled profusely into coma; others speak of how they lost their newly-born babies. Refugees talk of how they were heaped onto trucks and driven to the river where they would then cross on a ferry to the western side of the river Nile. According to the medical assistant on duty then (he has since retired), there were not sufficient facilities to cater for the sick and the vulnerable. Upon landing, refugees were registered and food ration cards and plastic sheeting were issued in many of the cases. "The plastic sheeting in useful only after you have put it up to roof your hut, not when you still have it in your hands' many refugees told me. It actually took days for the refugees to move from the Landing Bay to their allocated plots of land. The reception camp at the Landing Bay lacked proper sanitary facilities. This coupled with the malaria mosquitoes led to many deaths particularly of young children. The Medical Assistant still remembers how he spent sleepless nights 'putting up drips'. The process of movement ended with the allocation of land. On arrival, each refugee was allocated 0.3 hectares, but this was distributed to only a few of the refugees. Still, there were problems. The bushes had to be cleared and a house to be built. Many refugees had to borrow *pangas (*machete-like knife*)* from fellow refugees (as UNHCR had not given every head of household one) to cut and clear the bushes and to cut trees for building. There were many days of waiting to be done, sleeping in the cold with mosquitoes biting. Women not accompanied by men found it extremely hard at this time. However, they claim that due to the experience, all were going through at this time, men were very cooperative and helped build huts for them. The first shelters built by refugees were temporary. They made sure that, at least with the plastic sheeting, one had a roof over one's head. The sides to the shelters were protected by grass and leaves from trees. With time they were able to construct proper houses. The children suffered most. Interviews indicated that many children died at this stage. Documented evidence indicates there were many cases of malaria treated at the health unit. The relocation process was interrupted by the insecurity in Arua district in 1997, which particularly affected refugees in Ikafe settlement where Sudanese refugees spontaneously repatriated (Payne, 1998). During the year 1998, a total of 10,214 agricultural plots of 0.2 hectares per person were allocated to all active settlers (98/UGA/LS/403 report) for cultivation purposes. Currently, there is a total of 9,282 heads of households (including single individuals) making a total of 25,439 refugees (UNHCR, 2003) in Rhino Camp. Farm implements including seeds and hoes were distributed in addition to food rations. Refugees cleared their plots of land and started planting. Meanwhile the construction of health units, primary schools, and the sinking of boreholes went on. The pattern of dwelling units is organized in clusters. Each cluster accommodates an average of 15 households. The average household membership was found to be six[8]. The land for residential purposes is 20m by 30m while the land allocated for agricultural purposes was increased to 0.3 ha per member of household. Plots in each cluster are marked and given a number. In chapter 8, I make note of how the land allocation per head was a motivating factor for producing more children.

Implementation of refugee programmes

The UNHCR does not normally implement its own programmes, however, it may do so

while it scouts for implementing partners. In the Rhino case, tripartite agreements were concluded with the UNHCR, the Uganda government and the implementing partners: CARE, CARA and DED with CARE drilling the boreholes (later the drilling was done by OXFAM), DED the health sector and sanitation and CARA food distribution, road construction and forestry. It should be noted that all implementing partners were international. Local input including the government was minimal. Only local labour was solicited. This therefore gave advantage to the international NGOs and did not contribute to capacity building of the locals and sustainability of the projects. CARA was purposely created in the early 1990s with the purpose implementing the refugee programme at Rhino Camp, but in 1995, CARA's services were terminated and DED took over the implementation of the whole refugee programme. DED is a developmental NGO, but currently relief work in refugee settlements in Arua and Nebbi districts. As long as local capacity is not helped to grow and consolidate itself, Ugandans will continue to depend on external expertise even in matters that appear manageable.

The World Food Program delivered the food while MSF, in the initial period, undertook immunizations. It is said that the local district officials worked very well with the agencies to ensure that refugee lives were protected. This resulted in the seconding of some health personnel, including a medical doctor, to the refugee health centres.

Refugee matters are centralized. A settlement commandant recruited by the Office of the Prime Minister (OPM) is in charge of all refugee affairs in the settlements. Although, he (all settlement commandants were men) is supposed to report directly to headquarters in Kampala, there are good public relations between him, the agencies and the district. In addition, refugee leaders and Ugandan liaison officers work hand in hand to facilitate matters related to refugee issues. Refugee settlements are bureaucratically fenced and refugees are supposed to be cleared by the commandant before they can move out.

Health Services

Despite its remoteness in location, the Rhino Camp refugee settlement has a well-organised health delivery system. There are four health units (2 HC III and 2 HC II) and they serve an estimated refugee and host population of 25,000 and 17,000 respectively. Despite the ongoing Self-Reliance Strategy (SRS), the district has not yet absorbed the health units. They are in a peculiar position where they are neither registered NGOs nor government health centres. In a way, this was due to the nature of the emergency and the hospitable attitude of the District Medical Officer at the time. I view this complacency to registration as depicting power relations in which case the government 'fears' to insist on UNHCR's registration of the health centres. However there is need for all concerned to ensure the legalisation of these four health units.

As part of decentralisation, the government established a Health Sub District (HSD) at Rhino Camp and the government-owned Rhino Camp Health Centre was transformed into a Health Centre (HC IV). This status makes it the nearest referral point for emergency obstetric and gynaecological cases from the refugee settlement. Although the government in conjunction with UNHCR has equipped it, it still has problems with

staffing. In 2000 a German medical doctor (female) was recruited to serve in the nearby government Health Sub District (Rhino Camp HC IV), but was relocated to Mbarara Hospital soon thereafter after failing to adopt to the local conditions[9] . At the time of our fieldwork, the HSD did possess neither the personnel nor the emergency equipment to perform caesarean sections and blood transfusions. Most obstetric referrals are still made to the bigger hospitals in Arua which is very far away.

7.4 Masindi District

Geography and history

Masindi District with a population of 369,600 people is located in the mid-west part of Uganda, 130 miles from Kampala and borders the districts of Gulu in the north, Apac in the east, Nakasongola in the south east, Kiboga in the South, Hoima in the southwest and the Democratic Republic of Congo (DRC) in the west. The district comprises a total area of 9,326 sq. kms of which 8,087 sq. kms is land area, 2,843 sq. kms is wildlife-protected area, 1031 sq. kms under forest reserve and 814.4 under water. The arable land covers a total area of 7,332 sq. kms. The rainfall pattern is generally bimodal and rains fall during the months of March to May and August to November with an average of about 1200 mm per year. On the whole, the district enjoys adequate surface water and subsurface water with the exception of Kimengo and Kibanda sub counties where the sources of water are salty. This fact contributed to the undesirability of the borehole water (which had cost huge amounts of money to construct) in Kiryandongo refugee settlements where refugees preferred pond water to borehole water claiming the later smelt and tested bad.

Historically, Masindi district in northwestern Uganda belongs to the Bunyoro-Kitara Kingdom. Its original inhabitants are the Banyoro and their language Runyoro. However, the district is now home to some 56 tribes. It is also home to many Kenyan nationals who sought sanctuary in Masindi in the early 1940s since the Mau Mau days in Kenya (Lwanga Lunyigo, 1998). The early 1990s saw approximately 10,000 Sudanese refugees relocated to Kiryandongo refugee settlement from Achol Pii in Kitgum district following incidents of insecurity. The refugee numbers changed overnight in August 2002 when following several LRA attacks (in which hundreds of refugees were killed) close to 25,000 Sudanese refugees were transferred to Kiryandongo.[10] Masindi district has experienced a rise in population through the self-settlement by the internally displaced persons (IDPs) from the war-affected areas of northern Uganda. The consequences of high mobility of individuals, particularly from a war zone to a relatively peaceful zone are many; some of these are health related. It is quite likely that HIV / AIDS rates and STIs could have risen as people moved from northern Uganda to settle in Masindi. This has implications on the health of the communities, food security and development.

Economic activities

Agriculture is the mainstay for the population in the district. Maize growing is a popular agricultural activity. It has been said that maize was first introduced into the district by

the Kenyans seeking sanctuary during Mau Mau era settled there (Lwanga Lunyiigo, 1998). Refugees in Kiryandongo participate in maize cultivation with vigour, which they have sold to World Food Program (WFP) on several occasions. Unfortunately, the maize prices are not always good. In 2002, refugees failed to sell their maize profitably when the maize price plummeted from Sh. 250 to Sh. 40 per kilo. Other food crops and vegetables include: millet, beans, cassava, groundnuts, sorghum, field peas, Irish potatoes, sweet potatoes and bananas, tomatoes and cabbages. Cash crops include tobacco, coffee and cotton. In addition, there is also ranching. Animals include sheep, cattle, and goats. Small–scale activities included pit sawing; saw milling, cotton ginning and manufacture of jaggery, furniture and processing of hides and skins, oil and grain milling. In addition, Budongo Saw Mills and Kinyara Sugar Works have offered employment opportunities to many people in Masindi.

Health Care Provision in Masindi

The health care infrastructure suffered a lot of neglect and destruction during the period preceding the 1986 NRM government. Due to almost thirty years of poor governance, insecurity and near total anarchy that befell Uganda since independence, Uganda suffered brain drain loss in all sectors. The sector hit most was the health sector (Nabuguzi, 1998). Despite the long history of medical training in this country, the doctor/population ratio at 1: 18,700 (MoH, 2003) leaves a lot to be desired. Upon completion of their medical degrees, coupled with the poor pay and conditions of service in Uganda and high remuneration and good conditions of service abroad, many doctors leave the country for the so called greener pastures. The structural adjustment programs imposed by the World Bank have further hindered improvements to the health care system. They have also diminished people's ability to utilize health care, which in most cases has to be paid for now. The health care rendered in the households falls on the shoulders of women. The HIV/AIDS epidemic in Uganda has not helped the health situation, its toll being quite heavy on the most productive age bracket.

Like Arua district, Masindi was one of the pilot districts under the District Health Service Pilot & Demonstration Project (DHSP). The main providers of health care are the government, church-based NGOs, private practitioners and traditional healers. There are 39 health facilities, which include two hospitals (Masindi hospital with 78 and Kiryandongo hospital with 104 beds). Furthermore, the district has 18 health centres (HC III) and 19 (HC II). The total district bed capacity is 391 beds (MoH 1998).

During fieldwork, I managed to travel and conduct some interviews in health centres outside of the refugee settlement. The discussions I held with the Clinical Officer at Kimengo Health Centre III revealed the long distances walked to the health centres to be hindering access. For many patients, the long distances (more than 20 kms) were deterrence to seeking treatment. Even though only 27% of the population (nationally) are within five kms of a health center (MoH), long distances to healthcare units were a constraining factor to accessing health care not only in Masindi but also for the rest of rural Uganda where 80% of the population lives. It is therefore little wonder that many

women do not attend hospitalized deliveries. According to women FGD in both refugee settlements, the onset of labour occurs usually at night. In a socio-economic set up like the one in Masindi and Arua, it is difficult for the pregnant women to access health providers except when 'everything else has failed'.

Another problem observed and which the health providers pointed out was the paucity of qualified nurses to work in the rural health centres. Many health centres in Masindi did not have professionally trained health providers. Nurse aides in the districts operated almost 50% of the health units. For instance the staff at Busa Health Centre III included 1 clinical officer and 5 nurse aides. Similarly, Mutunda Health Centre had 1 midwife and 4 nurse aides. Private services constitute of small clinics, nursing homes and drug shops of which nurse aides ran the majority. Very few clinics are operated by doctors and these are located in the trading centres in the district and along the main highways. The remaining clinics and health units are taken care of by clinical officers, nurses and midwives.

7.5 Kiryandongo Refugee Settlement

Background

Kiryandongo refugee settlement, situated in Masindi district between Kigumba and Bweyale, measures 3,725 hectares and is part of an old ranching scheme of the Uganda government. It is 143 km from Kampala on Kampala-Gulu road and 7 km from the main road. Although located near the main road, it is not readily accessible. This is in agreement with what Nabuguzi (1998: 61) calls 'bureaucratic fencing'. To get to it, one needs permission from the OPM and from the settlement commandant as well as from the UNHCR.

Before being allocated to refugees, the area used to be a cattle ranching scheme of the government in the 1970s. Presently, the refugee settlement occupies some three ranches 1, 37 and 18, hence the names. The aim of the settlement programme is to provide security and to facilitate local integration to the refugees. On the Kampala-Gulu road, the settlement is about seven kilometers off the road on the eastern side towards the Panyadoli hills. With a history of good rains, it is located in one of the most fertile districts renown for maize and tobacco growing. The terrain is hilly covered by thick bushes and forests with most parts of ranch 18 being rocky and not productive. In addition, there are hardly any rivers in the settlement. This makes water a scarce commodity.

With the land issue partly resolved in May 1992, the government made available 2500 hectares for the settlement and 599 households out of 1563 residing at the transit camp were allocated plots of land. By the end of May 1995, the Government had allocated 3,725 hectares of land for the integration of the whole refugee population. This resulted into the allocation of land plots to another 964 households. By 1999 all refugees had been removed from the transit camp and had been allocated settlement plots. The size

of plots ranged from 3 acres to 10 acres depending on the size of the family. Ranch 18 is the most recent and undeveloped of the three ranches and the farthest away from the social services units. Land in Ranch 18 is infertile and not easily cultivatable and yet it accommodates the majority (60%) of refugees. Ranches 37 and I have been weaned off World Food Program (WFP) food rations except for 165 and 312 individuals respectively who are either students or extremely vulnerable refugees. Only very few refugees in Ranch 18 are still receiving food rations despite the quality of soils in the ranch

Organizations in the settlement and refugee integration

The protection of refugees in the settlements is a prerequisite of the Office of the Prime Minister (OPM), which is represented by the Settlement Commandant in whose charge this function of protection rests. The Equatoria Civic Fund (ECF), a locally based Sudanese NGO is implementing vocational training as well as secondary education. The Comboni Sisters operate a nursery school. The Catholic Church accords spiritual as well as tangible assistance to refugees in matters related to education, health and livelihoods. The Catholic mission situated in the middle of the settlement moved with the refugees from Sudan and is a source of inspiration for many Catholics. In addition, *Saving Grace* an NGO affiliated to the Protestant Inland African Church and located behind Palorinya Hills donated a 30-bedded children's ward onto the existing health centre. In addition the NGO also continues to offer assistance to primary school-going children and conducts literacy classes for adults.

Refugee Integration and self-sufficiency in Kiryandongo

While UNHCR and OPM are responsible for determining the numbers to be fed, the responsibility for providing food rations to refugees is done by World Food Programme (WFP). This process goes on until refugees are perceived to be self-sufficient. It is the present policy of the UNHCR to withdraw funding from settlements where the population is deemed to be self sufficient in food production. The food aid policy is that after two successful farming seasons, rations are decreased to 50%. After one more successful season to 25%, and if a fourth consecutive successful harvest has been achieved, rations are stopped entirely (UNHCR/PTSS Mission Report 95/20). It is at this point that responsibility for maintaining and administering the services for the settlement population is expected to be assumed by the district authorities. Such was the case in Kiryandongo in 1996, when the UNHCR started to phase out its assistance. Funding was withdrawn. The implementing partner, Inter Aid ceased operating in the settlement in January 1997 and withdrew its capital equipment and handed over the administrative responsibility to the Refugee Directorate staff in the settlement. The government at the OPM level and the district opposed this move; feeling they were not quite ready to take over 'UNHCR" responsibility without facilitation. It was expressed by the district officials that during the handing over of the refugee programme to the district, not even a typewriter was handed to the district. As the Medical Officer later exclaimed *"there was nothing to hand over but refugees"*. It was therefore not surprising that the district authorities resisted the assuming of the refugee responsibility. Years later during the fieldwork for this report, the primary schools in the settlement had not been absorbed under the Universal Primary Education scheme. Health wise, although

Panyadole receives the quarterly Drug Kits from the district health services and occasional supervision, it nevertheless, does not have the staff salaries paid; these are paid for by the UNHCR. Generally, however, this refugee settlement is somewhat self reliant in food.

Land Allocation

The size of land allocated to refugees varies and depends on several factors such as the time of relocation and size of household. The first refugees to be settled in Kiryandongo in 1990 received 1.2 to 4 hectares (3 to 10 acres) depending on size of family per household in relatively fertile areas of ranch 1 and 37 from where they continue to get good yields from their labour. Refugees who came in the mid 1990s were resettled in Ranch 18 where 45 per cent of the land is either rocky or swampy and prone to water logging. This was partly acknowledged during a UNHCR mission in 2000 when an official noted that although land is available and accessible in Kiryandongo, "the one in Ranch 18 is scarce, infertile and unarable", proposing that the percentage of refugees in Ranch 18 occupying this portion of infertile land need to be shifted to land suitable for agriculture if they are expected to be self-reliant in future. Land fertility therefore is crucial to food security and integration. Despite that proposal, approximately 60 per cent of the refugee population in Kiryandongo reside in Ranch 18.

Panyadole Health Facility

Health-care provision in the settlement is the responsibility of Local Government. As already discussed, apart from the protection function, UNHCR has withdrawn[11] its services on the premise that Kiryandongo has attained self-reliance in food production. This has also resulted in the handing over to the local government of the health care unit. Panyadole health centre is a special Grade III health centre established in the early 1990s. It has more in-patient beds that other HC III centres in the district and until recently it was for the exclusive use of refugees in the settlement. This was the case despite the fact that the services in government hospitals and health centres were poor at the time (they were only starting to recuperate from the 30-year turmoil in the country). During the initial years of its establishment, the UNHCR-funded health centre with three outreach health posts was the envy of the surrounding communities. It had well-trained, well-equipped and well-remunerated staff that included a medical doctor, a registered nurse, a clinical officer, several enrolled nurses and midwives and auxiliaries. In addition to a fully operational ambulance and three monthly drug kits by MoH, the health unit enjoyed an abundant supply of drugs by UNHCR. The continuous inflow of the IDPs from northern Uganda to areas surrounding the settlement has escalated the demand for health care.

Since the handing –over of the health unit to the district authority in 1997, the reports are that the standards have changed for the worse. The medical doctor and nursing sister have since left. Not only has the number of patients gone up but also the demand for drugs. UNHCR can only supplement the drugs not available in the health kit supplied by the Ministry of Health and even then only for refugees. It appears there are

many more people being attended to at the health centre than were planned for. There is still confusion about cost sharing. A year ago, we were told, refugees and nationals were expected to pay something towards their treatment, but this is not the case any longer. During the 2001 presidential election campaign 2001, President Museveni promised to do away with cost sharing if he were returned to power. Thus, upon his return as President, the cost sharing stopped. But the midwifery section has maintained the cost sharing and insists that mothers-to-be provide basic items needed to conduct a delivery such as gloves, razor blade, and cotton wool and baby wrapping clothes. In practice the cost sharing is indirect, due to fact that patients are forced to purchase missing drugs from pharmacies, clinics and drugstores. However, UNHCR makes special provisions for the refugees for the purchase of the medicines for the refugees.

The scene at Panyadoli Health Centre is hectic. First of all, it seems the caseload is too big to be handled by one Clinical Assistant. Secondly, in almost all cases the drugs are not available. Refugees are advised to get them from pharmacies and / or drug stores. The drug stores in the small trading centre in the settlement do not stock all necessary drugs, as by law it is limited to stocking Class C medicines only. Surprisingly, some of the drugstores sold prohibited drugs such as antibiotics, sulfonamides and steroids; this was in the face of unqualified and incompetent staff. This posed a problem of affordability; many refugee families and individuals were too poor to afford the prohibitive medicine prices. In spite of the fact that UNHCR has put in place an allowance for extra drugs for refugee patients, drug shortage remained a problem in Kiryandongo.

The location of the health unit close to the entrance of the settlement posed some logistical problems to refugees situated in far off settlements. Refugees in Ranch 18 who comprise 60 per cent of the settlement residents and those at the far end of ranch 37 have to walk long distances to access health services. Time spent walking and the waiting that has to be done at the health centre was a hindrance to health seeking. In the period of Inter Aid health care implementation, which ended in January 1997, about 3 outreach posts were maintained to administer First Aid to those living far away from the health centre and who might be in urgent need of health care. However, since OPM took over the implementation, these outreach posts have been done away with due to lack of resources and the failure to "facilitate" the community health workers. As I shall indicate in Chapter 9, the ambulance in the settlement did much more than carry patients to referral hospitals; it also transports refugee offenders to the Police.

7.6 Concluding Remarks

The foregoing chapter has discussed the study area. Uganda has been discussed in terms of its own disadvantaged position having suffered from bad politics and governance, total insecurity and near total anarchy for several decades and the ongoing armed conflict in northern Uganda that usurped government energy and funds to counter attack it. Even when the government has focused its attention to the rehabilitation of the health sector, the social and health indicators show a poor health situation of the population in particular the children and women. The health care delivery system is compounded by the fact that professional health providers prefer

working in urban areas of Uganda; in addition, many have left the country for greener pastures in other countries, especially the West.

The West Nile region, a refugee hosting area, having suffered destruction to the infrastructure during the war, which toppled Amin, is only beginning to find its level after substantial rehabilitation. The implementation of the health care still depends greatly on the NGO sector and on the central government despite the decentralization process. And like other districts in Uganda, Arua suffers from a lack of professionals to operate the health centres. Thus, it is the nursing aides who do the bigger share of health care provision in the rural health centres. This has severe health implications.

The refugee health unit facility in Rhino camp appears to very ambitious most likely because it was established by UNHCR. Currently four health units serving an average of about 45,000 individuals (refugees and nationals) are not cost effective and cannot be sustained should UNHCR eventually phase out. The health units need to be evenly spread out from the current concentration. On the other hand the health facility in Kiryandongo is stretched out even though it is still within the catchment area of the general hospital. Despite this, the health unit is neither fully owned by the government nor by UNHCR. This ambiguity in ownership makes the operations difficult. We have seen that long distances to the health centres and non-availability of drugs pose problems to health care seeking. Refugees in Rhino camp share ethnicity with the local people, while the ones in Kiryandongo are dissimilar.

The discussions have noted that the settlements are not particularly endowed with facilities to ensure food security. This contributes to malnutrition and high mortality especially of the under 5s and morbidity particularly of pregnant women, the aged and the disabled. This was much more so in Kiryandongo. Some parts of Rhino Camp and Kiryandongo are not productive and in the case of Rhino Camp refugees are kept on 100 per cent food rations, which encouraged dependency and depressed the work ethic.

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[1] On several occasions, the nationals along the margins of Nakivale settlement and the refugees in the settlement have regularly conflicted over resources particularly land, which they feel belongs to them and not to the refugees.
[2] Ministry of Finance Planning and economic Development – Poverty and Analysis Unit (The New Vision 26 January 2005
[3] Source: www.measuredhs.com/countries/country .cfm downloaded 12 January 2004
[4] There are 56 districts in Uganda and they keep on increasing. The fertility rates are higher in the northern districts including the conflict-affected districts of the north.
[5] Ministry of Finance Planning and economic Development – Poverty and Analysis Unit (The New Vision 26 January 2005).
[6] This period (1981-85) characterized the time Yoweri Museveni and the NRA fought the incumbent Obote's government for suspected rigging the geneeral election results in 1980.
[7] The number might be slightly lower with the creation of Yumbe district.
[8] There was a tendency to register single men as heads of household thus reducing the total number of heads with dependants smaller, thereby increasing the number of dependants.
[9] Personal communication with Rhino Camp refugee settlement officials.
[10] During September 2003, the Achol Pii caseload has been relocated to Yumbe District in West Nile amidst protests that the district was insecure.

[11] UNHCR made a short term withdraw from Kiryandongo. Due to the insecurity in northern Uganda in 2002, which forced the refugees at Achol Pii refugee settlement in Pader district to be relocated, UNHCR had no option but to resume its services to the refugees in Kiryandongo.

8

Gender relations, livelihood security and reproductive health: Discussion of findings and experiences from Rhino Camp refugee settlement.

8.0 Introduction

This chapter is the result of an actor-oriented[1] and gender analysis of the lifeworlds of actors in planned humanitarian activities in Rhino Camp refugee settlement and the interfaces they are engaged in. The analysis takes place at two fronts. First it recognizes the patterns of power and gender relations within the social organization of refugees. It further acknowledges the changes taking place during refuge and how as a result livelihoods are affected and the strategies refugees devise in response. Secondly it undertakes an actor-oriented analysis of the different lifeworlds of actors in humanitarian activities. As it was practically impossible to study in detail all sectors of the refugee assistance programme, I decided to focus the analysis on reproductive health care for reasons already explained in chapter 1. The data presented in this chapter attempts to answer the main research question which concerns how gender and power relations affect the livelihood security and reproductive health of refugees and how women refugees respond to these processes. I however also include some data on primary education as a way of showing the constraints that hinder refugee girls from attending school. Taking the Madi as a representative ethnic group of the tribes in Rhino Camp, I discuss in the sections 8.1 the social organization of the Madi including gender arrangement patterns and the changes that have taken place as a result of displacement and in section 8.2 the nature of livelihood strategies devised as responses to the processes. The discussion in section 8.3 concerns the gender-specific problems with the present primary education in Rhino Camp. In section 8.4, the analysis extends to the reproductive health programmes, the implementers and beneficiaries, in other words the social actors involved in the reproductive health project. The aim is to explain the linkages and networks that develop between the social actors. Section 8.5 discusses sexual and gender based violence. The conclusion in section 8.6 sums up the main issues which arise in the chapter.

8.1 Gender relations among the Madi

The main aim of this section is to describe the social organisation including the gender relations of the Madi tribe in somewhat larger detail. I consider this information to be

largely illustrative of the gender relations of the Southern Sudanese refugees in general. This is because the Madi have quite a number of similar characteristics as the other Sudanese including the Kuku, Kakwa and Bari. Moreover they comprise (35%) (out of the 8 ethnic groupings) of the total refugee population in Rhino Camp. A practical consideration was that several Madi women spoke English and Swahili. In the remaining sections of the chapter, I have, however, combined in-depth information collected on the Madi with observations elsewhere and data from the survey, which also covered the other tribes.

Rules, norms and practices

According to Kabeer et al., (1999:12), gender relations are an aspect of broader social relations and, like all social relations, are constituted through the rules, norms and practices by which resources are allocated, tasks and responsibilities are assigned, value is given and power mobilized.

Gender relations among the Madi do not operate in a social vacuum, but are shaped by the ways in which their institutions are organized and reconstituted over time. The fact that they are organized on a patrilineal clan structure and practice patrilocal marriage means that the children belong to the husband's clan and family. A clan is the major sub-division and comprises all people who trace their origin from the same descent. Men and women are members of patrilineal descent groups; however, only men transmit this membership to their offspring. There is no intermarriage permitted within the clan as clan members are regarded as brothers and sisters. Sexual relations between relatives are condemned. Women retain membership of their patrilineage. As such, reproduction takes place within the context of the Madi patrilineal descent category. Should a woman die before payment of dowry, the husband will not be permitted to bury her (for more details, see below a case in point collected by the author in previous fieldwork in 1999). Failure to settle bride wealth spells bad omen. In addition, in the case of a man dying before fathering any children, his younger brother (or relative on his father's side for that matter) marries the wife and the children born out of the union belong to the dead man. Children born to the wife belong to the husband even when he is dead. However, should a couple fail to produce children, the woman is blamed for infertility. We can therefore appreciate the importance accorded to the continuity of a man and of a clan. Through the father, the sons have a claim over the productive resources of the lineage, whether these consist of land for cultivation or cattle and fishing equipment. Among the Madi, a lineage usually incorporates people from two to three generations living together in huts, either in a compound, or spread out within a clan area. Family clusters form the basic household. Men are figures of authority and all junior members, regardless of gender, are expected to respect their elders. Male children are accorded special value because they are responsible for continuing the family and the clan. The social relations of human reproduction and production among the Madi clan organization gives advantage to men as it enforces patriarchal control of women by men. Land ownership is in the hands of men. Inheritance is patrilineal. A married woman, however, has access to land in her marital home but not in her natal home.

Case 8.1: Defying local custom

Limo, a fifty-five year old man working in Kampala formed an intimate relationship with Susan, a Sudanese refugee working as a sales girl in one of the Arab stores in Kampala. Her parents were refugees but did not stay in the settlement even though they had many relatives there. They resided in Lama near Moyo town. Limo was Madi and hailed from West Nile, even though it was speculated that he was a Sudanese Madi who had earlier on worked under the Amin regime in the Intelligence and in the process became a Ugandan. Susan moved in to stay with Limo whom she referred to as her husband. And whenever Limo introduced Susan to his friends, he would refer to her as his wife. The couple lived together for about seven years. Their inability to have a baby was always brushed off. Unfortunately a few years later Susan contracted HIV / AIDS and died. Limo's friends mobilized funds and logistics to take Susan's body for burial. Limo decided to take the body to her parents' place for burial. Susan's relatives were up in arms for his failure to pay dowry before living with her and stopped the burial from taking place until a fine was paid. He was asked to pay an enormous amount of money, the equivalent of five cows, ten sheep and five goats plus several litres of beer. It took friends to fundraise to pay the fine and pleas by the elders from Limo's side to bury Susan (personal communication with Limo 1999).

Marriage, bride wealth, parenthood and division of labour

Marriage among the Madi is marked by the transfer of bride wealth from the minimal lineage of the bridegroom to that of the bride. By the rules of exogamy that regulate the choice of a wife, a man may not marry a girl of his own clan. Madi daughters are considered to be a source of wealth within families; parents are responsible for identifying suitable partners although the more educated and urbanized youth find their own partners. Marriage is embedded in patriarchal lineage and is considered both necessary and inevitable. The society expects a successful marriage to be blessed with children. More so, a marriage is fulfilled when a woman gets a son. This cultural expectation motivates women to have as many children, until a son is born. Transfer of bride wealth from the boy's family to the girl's family endorses settlement of marriage. Bride wealth settlements are reached through negotiations and if prohibitive, payments may be made in instalments. Should the marriage fail, the bride wealth is returned to the husband's family. The average bride wealth among the Madi is 100 spears, 100 arrows, 15 hoes, 7 cows, 20 sheep, 7 goats, *gomesi*[2] and beer for the mother, a k*anzu*[3] and a special kind of spear for the father. It is said that the arrows and spears are distributed among the bride's paternal and maternal kin. The transfer of arrows marks the establishment of the ties of affinity between the two lineages. The beer for the mother is a consolation for the loss of her daughter. The size of bride wealth is likely to triple if the girl is educated. We established that the refugee situation reduced incomes and made payment of bride wealth difficult. This encouraged elopement and sexual activity outside of marriage. It also reduced the value and prestige of women.

Due to the 'modernisation' and the influence of christianity, the Madi maintain two main forms of marriage, the 'Traditional' and the 'Christian' form (although the camp

has some few Muslims, I shall confine this discussion to non-Muslim practices). Christian marriage entails a civil contract between a man and a woman and is registered by the State and the Church and is dissolvable through divorce or death. The traditional marriage is governed by customary procedures, which involve the payment of bride-wealth and can be dissolved under laid down rules governing customary marriage, such as barrenness and adultery by the wife, although adultery is first punished by beating. It is common to find the two types of marriages in a household with a man having married one wife in Church and the other wives customarily. Moreover, a Christian marriage does not exempt a man from paying bride wealth. Essentially marriage signifies a process of household formation. Marriage was the main channel by which men and women gained access to individual land for farming and residence. Access was differentiated by gender; men were allocated land by their fathers and, women gained access to use rights to her husband's family land upon marriage and upon the number of her offspring. Based on the refugees' narratives, women with children got more land and had more power.

Barren women hardly had any land. Each wife and her children were assigned distinct land and were not expected and permitted to encroach on each other's land. In case of land disputes, these were solved by clan elders. Women did not inherit land outright. They depended on the discretion of their fathers-in-law, and, in old age, their sons. In the event that a daughter failed in marriage and returned to her natal home, the clan gave her a small piece of land for subsistence. Remarriage after widowhood occurred frequently within the lineage. Widows are 'inherited' by the brothers-in-law (and occasionally fathers in law). This practice, though initially intended to offer protection to the widow and her children, is now viewed as a negative custom and is being discouraged due to the prevalence of HIV / AIDS. Deaths, just like in any other setting, occur in refugee settlements; however, the reporting of these deaths is not straightforward. Wife inheritance takes place discreetly for fear of losing a ration card. Another common custom among the Madi is polygamy, which allows a man to marry many wives. Field discussions indicated that traditionally, women must be under the protection of men.

Social relations and interactions within the household are determined by age and the gender of the individual and they extend to the kin and neighbours. Social relations are particularly important in the time of famine when households depend on transfer of resources such as food, labour and money. The Madi women depend very often on their mothers, sisters in law and neighbours in times of crisis that are frequently related to diminished food reserves. I was also made aware of the role of the Verona Fathers who 'can help to give one food' in the Sudan. It was therefore crucial to be affiliated with the Church. Food exchange was done during the harvest seasons and during food shortages when the practice constituted a coping strategy. There was a tendency to give plenty during the harvest with a view to receiving during the period of food scarcity. How was it in Rhino Camp? I witnessed that women belonged to church groups, business groups, digging groups and self-help groups. One characteristic strand running through these groups is teamwork and reciprocity of the kind of "You scratch my back and I scratch yours". Thus, women depended on each other within their

groups for assistance, however not without bottlenecks as I show below.

Madi men are the head of households and make most important non-routine decisions. The behaviour of men is sanctioned by the clan elders to whom women and younger men may resort in case of family conflicts, though occasionally among the Madi it was common for the woman to turn to her brothers during such conflicts. The men's role of protecting their wives and children ensured they have access to land. And when sick, he is supposed to make sure they receive the required treatment. Once in a while also a man may buy his wife/wives dresses, especially around Christmas. The women are expected to be submissive to their husbands and their in-laws irrespective of gender. They are expected to cultivate and provide food to their households and to help the husband with cash crops. In addition women are expected to undertake all the duties in the home that concern the wellbeing of the households. Thus, it is with the foregoing gender expectations that the socialization of girls and boys is undertaken. The socialization process is enforced further by participation in rituals such as child naming, marriage, death, burials and last funeral rites. Women's position in subordination changes with time. The elder wife assumes authority over her co-wives. It also changes when she acquires a daughter-in-law, whom she has power over.

The refugee situation appeared to have changed the above scenario. Women did not need men to have access to land, therefore their dependency on men for survival decreased. As UNHCR recognises household headship irrespective of gender, it was easy for women to acquire land in their own right. In addition, they also acquired food without much ado. Nevertheless the conflicts increased between and among genders. People accused each other of witchcraft and poisoning. Because of the disintegration of communities, itself an effect of forced migration, the social support and conflict resolution mechanisms to a great extent also disintegrated. This created a vacuum and gave men leeway to resort to violent means while trying to solve family conflicts. The women on the other hand felt empowered when they did not have to depend on men to provide health care as the health facilities were free. But as Hilhorst (2000: 105) asserts: "It is not enough to evaluate development interventions for their allocation of material benefits. In addition, we should question how discursive notions that are introduced with development interventions may alter local social realities". The social reality in as far as gender relations were concerned in this particular case was the increased frustration among men who felt cheated of their authority. This observation is in agreement with Turner's observation (2000) that Barundi refugees in Tanzania accused UNHCR of making better husbands to their wives. Subsequently as well, because of a lapse in the socialization process, the children are "difficult to control". As we shall see in later sections the youth appear to have lost direction. With very few models to emulate, they resort to casual sex, loitering and vagrancy in the settlement. Girls in their teens were particularly vulnerable to sexual abuse in these circumstances.

Kinship, Descent and Family

Kinship determines a person's place in society, as rights and duties and claims to property largely depend on the genealogical relationships to other members (Mair,

1972: 69). Kinship links the primary social groups- the ones that are found in all societies whatever other principles of organization there may be. It is the most basic principle of organizing individuals into social groups, roles and categories. It is the socially recognized relationship between people in a culture who are, or held to be biologically related. People are kin if they have an ancestor in common. In most southern Sudan ethnic groupings with the exception of the Azande who are matrilineal, descent is traced through the male in a patrilineal kinship system. All Madi descent lines go back to a common set of brother ancestors and they think of their tribal unity as being due to the ties of common blood.

Kinship gives people claims to land for cultivation and to other kinds of property, to mutual assistance in the pursuit of common interest, to authority over others, and obligations which completed these claims. Kinship ties are connections between individuals, established either through marriage or through the lines of descent that connect blood relatives (Giddens, 1996: 294). Because most definitions of the family tend to view it as nuclear or extended, I have decided to use the concept of household, despite its definitional problems (the concept of household is discussed in detail in Chapter 2).

The refugee experience appears to have transformed the nature of households. The research findings show that refugee households split due to a number of reasons. First, forced displacement sent household members fleeing in disarray. Second, the settlement pattern followed by the settlement officials was insensitive to the people's way of residence. The settlement authorities allocated plots to refugees on first come first served basis. This resulted in different ethnic groupings finding themselves with 'strangers' for neighbours and this reduced the network system. Third, households split strategically as a survival mechanism. Men had several wives in the various settlements, but the women presented themselves as single heads of households with claims that their husbands had disappeared or died. This was advantageous to the women and their families because they got land, food and non-food requirements under their control. But the men lost out as a result; their authority was compromised, as they did not want the settlement officials to know they were the husbands to such women. The land allocation policy exacerbated the situation as it gave additional land to each additional child. For the settlement officials, there may seem to be an apparent bigger number of female-headed households when in fact these women have husbands who keep moving from cluster to cluster. It was established that almost two thirds of women respondents were in a polygamous union, even when officially they were heads of their households.

The triple role of women

The concept of the *triple role* of women has been extensively used by Moser (1993) in her book *Gender planning and development: theory, practice and training*. According to her, in most low-income Third World households, women have a triple role. 'Women's work' includes *reproductive* work, childbearing and rearing responsibilities, required to guarantee the maintenance and reproduction of the labour force. It also includes *productive* work, often as secondary income earners. In rural areas this usually takes

the form of agricultural work. Women also undertake *community managing* work around the provisions of items of collective consumption, undertaken in the local community. Needless to say, it has been difficult in my study to demarcate clear cuts of the above-stated roles. What I intend to do in this section is to show the degree to which the roles change with the new refugee experience and how refugees as social actors reproduce and manipulate power relations to create room for manouvre for themselves. Perhaps I should point out from the outset that we are dealing with refugees (peasants) in a rural setting where the livelihood is based on agricultural subsistence.

The multiple activities of women associated with reproduction

The discussions held with Madi women and men gave the general view that the main role of women is to bear and rear children. As such, all tasks associated with childcare are the responsibility of women. These tasks include household responsibilities such as cooking, cleaning, food growing and processing, and child minding, collecting water, fetching firewood and washing. In addition it was the woman's duty to care for the sick, the old and the disabled. Customarily it is also the responsibility of women to brew. In the settlement, the brew is made from maize and is said to be more lethal than the brew from sorghum or cassava.

Despite the very rigid dichotomy, I noted some changes in gender roles. Take land preparation and digging, culturally a male activity, as an example. The women are doing that now and view the land preparation process as a form of liberation, since according to them, they have "gone beyond culture". By doing men's work, which the society has valued in comparison with women's work, women feel they are closer in status to men; never mind that it was energy and time consuming. This change was caused principally by the absence of men in the refugee settlements and their (men's) failure even when present to live up to the expected behaviour. The duty of the Madi men to build houses and for the wattling to be done by the women did not change. In addition women are supposed to cut grass for thatching; that did not change either. What proved cumbersome in Rhino Camp was the grass searching trips; women spent days away from the home looking for thatching grass. Women's other roles in as far as building a house is concerned were comprised of smearing the floors with cow dung and termite mound. A well-made floor gave prestige to the men but put extra labour on women who were indeed over loaded with household chores.

Another time-consuming activity for the women was brewing. Brewing was not only an income generating activity but also a social activity. Alcohol crowned all important events, happy and sad, in the communities. Therefore for many women refugees, maize rations went into brewing of alcohol. They instead cultivated sorghum, cassava, groundnuts, millet and peas and vegetables, which formed the main part of their diet and part of what they sold for income. Some of the food such as millet and sorghum was kept for rituals. Cultural tastes and preferences, though putting pressure on women's work, dictated the extra activities. Food processing such as harvesting, sorting, winnowing and grinding of simsim, millet and sorghum was time consuming, quite repetitive and required extra labour. Most women abandoned their grinding stones

when they fled, so they had to borrow grinding stones or to take grain to the mill at a cost. Grinding stones have particular value for women, they symbolise the special role of the women. Middleton (1965) when writing about the Lugbara (ethnically-related to the Madi) notes that upon death, women used to be buried with their grinding stones and fire stones. Moreover, it was mentioned that some husbands were fussy and insisted on stone-ground sorghum. Even when women in the settlement could not provide such labour, but because it is a woman's activity, men in the settlement could not help. In the words of one man: *"How can I, a man, be seen fetching water? It is for the women and children. In fact if you see me with water, I am going to sell it. My woman has to fetch water for me to bathe"*. We can appreciate that the refugee experience increases the tasks and activities for the women and lessens men's.

The multiple roles of men and women

These include the production of goods and services for income and/or subsistence. Although performed by both men and women, for the women they were additional to the reproductive roles. The women helped their men with cash crops willingly, helping with picking and drying and even carrying on their heads to the market place. To an ardent observer, these acts might be attributed to submission and gentility. However, these actions of men and women refugees '(re)construct gendered systems of dominance and power by acting out gender norms and expectations in the *settlement*' (Tamale, 1999:121). By maintaining the status quo in the gender relations in the daily social interactions, refugees were reproducing and perpetuating gender inequalities. Nevertheless, the women created themselves room for manoeuvre when they cultivated for themselves extra plots to ensure food supply and some for sale. The men had special granaries in which they stored their grain so did the women. But the women's were depleted sooner as they stored food for household consumption and some for sale. The men sold their grain, although in times of scarcity they consumed part of it. In addition, cash crops such as cotton, tobacco and coffee, are men's crops; we saw plenty of these around Katiku Cluster even though refugees are not permitted to grow perennial crops such as coffee. Women helped in the curing of tobbaco by fetching firewood. As most of men's crops are seasonal, they were left redundant most of the time, which gave a general impression that "*men just sit*". In contrast back home in the Sudan men usually got up very early in the morning to dig, go hunting and or/fish. Men *disciplined* their wives and children through beating and denial of certain privileges. While the Dinka and the Nuer are renowned for cattle keeping in Sudan, the refugee experience has changed their outlook; there was a group of Dinka and Nuer refugees in Katiku B engaged in making and selling of furniture. Nevertheless, it should not be taken for granted that men are idle just for the sake of it; their wives provided sufficient labour. In polygynous marriages in the settlement, women look after their children including feeding and educating them. According to the women, men are just onlookers who complain they have no resources to help their families. But as we shall see in the section on livelihoods, men are quite active in retail trade and bicycle repair, and as casual labourers.

From the foregoing discussion, it can be argued that two things have happened to

women's roles. First, women's roles have become more complex and time consuming in a particularly vulnerable situation. Food processing and grass searching and cutting take time. Secondly, women have also taken on new roles; land preparation and digging, and as heads of household. According to Chant (1997) female household headship is constrained at every stage of the life cycle because of society's value to uphold male household headship. I should not be seen to paint only a rosy picture of the refugee households. It became apparent that when the expectations overrode the reality, conflicts arose in the households. During the discussions women were all the time '*cursing*' their *good for nothing* husbands. *Kazi yawo nikuomba chakula* (their duty is to ask for food), plus the husbands were always physically fighting with other men at drinking joints and with their wives. The intra-household relations were further made worse when men could neither go fishing nor hunt when they could not provide for their households. Their power over land is diminished, as has the authority over wives, since each head of household irrespective of gender is allocated land in their own right by the refugee authorities. Thus, women and men and the refugee organizations (the UNHCR and Government of Uganda) by allocating land directly to refugee women reproduce, bend and transform the different rules, values and norms of the refugees. The Dinka have lost their preoccupation with cattle and have diverted to other trades such as carpentry. The situation is therefore not totally hopeless for the men who switch to new projects.

The activity profile in Rhino Camp

The purpose of the profile is to show the time budget of women and men refugees. The activity profile of women refugees in Rhino Camp indicated that activities increased leaving women with few hours to sleep. Such a profile should guide the policy making of rural refugee schemes.

Kiden is Kuku by tribe and is about thirty five years, married with six children (Siripi Cluster)

05.30– 06.00:	Gets up and wakes up the children. While children are getting ready for school by 07.30 she sweeps the compound, the kitchen and the main house and lights the kitchen fire on which she may put beans or maize seeds or water. Breastfeeds the baby, puts the baby on the back and proceeds to the farm plot to weed and bring home food.
10.00-12.00:	Kiden returns to prepare breakfast for husband and children. (This is a Sudanese custom for breakfast to be eaten that late). Children come back for breakfast. With her baby on the back, she carries firewood on her head and vegetables from the garden on top of the firewood as well as her hoe. After preparing porridge she rushes to the bore hole to get water. She feeds the baby and puts the baby on her back. Washes cups and saucepans. Splits firewood.
12.00- 14.00:	Prepares and serves lunch to children who come back at 13.00 hours. Washes dishes and splits firewood. Feeds the baby and puts her to bed.
14.00- 17.00:	Leaves the baby with younger daughter who does not return to school in the afternoons.

Returns to the farm for more weeding. Brings cassava and vegetables.

17.00-21.00: Goes to borehole for water. Washes the younger children, while the older ones wash themselves. Goes to the borehole for water for next day. Delays because of the long queue for water for the next morning. Peels cassava and splits it ready for drying. Takes simsim (sesame seeds) for grinding at neighbours stone. Prepares simsim sauce with vegetables.
Prepares *Ugali (*mingled cassava flour*)* serves dinner at about 21.00

21.00- 23.00: Heats up water for bathing for self and husband. Serves husband dinner. Washes dishes.
Washes baby clothes and her own for next day use. Puts property in compound inside the house and kitchen. Feeds baby. Goes to bed.

After compiling this activity profile, I decided to share its contents with the women discussion groups. Their response was that it did not represent a typical woman's day as it skipped several activities such as group digging, going to the market, attending to the old, taking children for immunisation or for treatment and church activities. It ignored the long queuing hours at the health centres and the boreholes. It also did not take into account the social visits, or calamities that befall refugees such as deaths and burials. They also mentioned that some afternoons are reserved for income generating activities. For instance, on a market day she may go to sell her produce and buy paraffin, sugar and soap. She may also join other women to make mats, pots and crafts. It was interesting to note how women combined the different tasks to save on time. As an example, a pregnant woman would leave home for the market carrying on her head grain for sale and milling. In one of her hands she would carry an empty jerrican, which she would leave with her friends near the water borehole. On her way to the market she would stop over at the health centre for check-up after which she would proceed to the market. After selling her grain or having it milled, whichever the case, she would return and on her way home pass by the borehole for water. Women always planned their days with precision: knowlegeable and capable as a proverbial 'actor'. One needed to take account of their work by observing the activities and the time they spent on them during the different calendar seasons, i.e, land-clearing, bush burning, digging and planting, weeding, harvesting. Each season assumed different activities. The most demanding season was the harvesting season, because it was also a season for feasting and this put a lot of pressure on women who had to cook and brew. With limited outside help women get quite tired. It also contributed to the reasons why women preferred to have large families.

I asked the school-attending adolescents to write down the activities they engaged in over the weekend. The boys helped with farm work, played football and visited friends. Some indicated they 'relaxed' and read novels on Sunday afternoons. Surprisingly, many of them collected water, which I later learnt was for washing their uniforms. The girls helped with housework chores and in the plot.

Through participant observation, I was able to trace the following activities for men; men went out of the settlement for piecework (*leja leja*), for own income. This activity was not performed on a daily basis, but on an *ad hoc* basis as the need arose. Piecework was undertaken during morning hours. Men also cultivated their gardens. A few men had curing houses for tobacco. Most afternoons were spent drinking in the settlements. A majority of the men, though not participating actively in productive roles for sustaining the household, worked in the markets and outside of the settlements for wage labour. Within the settlement men with businesses went daily to the markets to transact business after which they were engaged in drinking until they came home at night. I must say something about drinking. In most African communities (with the exception of fundamentalists), it is customary for men to drink 'with friends' after a hard day's work, but it should not absolve one from their responsibilities. As such, it should not be construed to mean that drinking is a new culture. What is new in the settlement is the over drinking against all odds and the irresponsibility and the violence that it breeds. Other activities included selling of second-hand clothes, charcoal burning and selling, and bicycle repairing. Many also left the settlement for employment outside of the settlement for long periods. Many of the men go to southern Uganda where some have relatives and or to work as casual labourers. In addition men also made several trips to southern Sudan. This was evident from the SPLA clearing letters that I saw. Although the discussions did not make it explicitly clear, it was rumoured that some of the refugees belonged to the SPLA. In addition quite many men left the settlement in search of education opportunities, always returning to claim their rations. Male refugee leaders were also members of the refugee welfare committees (local administrative councils) that helped with refugee administration.

8.2 Livelihood Security

The aim of the discussion in this section is to show changes in livelihood strategies and the adaptations refugees make to face the new challenges. In this section, I describe the livelihood strategies, food security and access to land and the significance of these processes to reproductive health. Refugee livelihoods and the conditions that sustain them are diverse, but first of all we must get to understand the different meanings of the concept 'livelihood'.

The Longman Dictionary of Contemporary English defines livelihood as the way one earns money to live on. De Haan (2000:343) explains that 'livelihood is not necessarily the same thing as having a job and does not necessarily even have anything to do with working. Moreover, although obtaining a monetary income is an important part of livelihood, it is not the only aspect that matters'. For Ellis (1998), livelihood encompasses not only income in cash and in kind, but also the social institutions, the gender relations and property rights required to support and sustain a given standard of living. Long (2001) emphasizes material and labour resources as well as the adaptive and coping strategies that individuals employ to sustain livelihoods. Anderson et al., describe the concept in terms of strategy; as the overall way in which individuals and collectivities try to structure coherently activities and actions within a relatively long-term perspective. Therefore, livelihood strategies are long term plans for success and are higher order

constructs which form general prescriptions for action' (Anderson et al, 1994:20). Engberg (1996:151) defines a livelihood as 'the mix of individual and household survival strategies developed over a given period of time that seeks to mobilize available resources and opportunities. Furthermore, the World Commission on Environment and Development (WCED, 1987) defines livelihood security as "adequate stocks and flow of food or cash to meet the basic needs". Livelihood strategies include paid and unpaid work, accumulation and investments, borrowing, food production, income enterprise, social networking, community managing and cooperation and changes in consumption patterns and sharing (Engberg 1996; Francis, 2000). I therefore situate the present discussion within the above broad definitional framework.

Livelihood Strategies

Access to income proved to be one of the biggest challenges of refugee life in Rhino Camp; this was partly averted by the food distributed by the World Food Programme (WFP) and by food grown in the plots. As I mention in chapter 7, the assumption behind the settlement scheme was that refugees would produce food for consumption and have a surplus for sale. However, this was based on false premises, because even after almost nine years in the camp, there are hardly any refugees with sufficient incomes. The refugee population was still on food rations (though gradually being phased out) during my fieldwork in 2002 and 2003. It is certain that farming alone cannot provide refugees with adequate living. About a quarter of refugees have sufficient food stocks but no cash for other necessities; the tendency is to sell a little of the food for money for other necessities which again exposes them to food insecurity and thus the cycle re-starts. Even if refugees produced surplus, they would be producing the same cash crops like any one in the camp and in the surrounding areas; this then would reduce the demand of the cash crops and reduce the selling price. Moreover, during harvest season, businessmen from Arua buy the refugee grain at give away prices. I noticed the same thing with the charcoal-making group; the price at which they sold a bag of charcoal was a fifth of what I paid in Kampala. Given this reality, what do refugees do?

Interviews and observations indicated that refugees diversified their activities to make a livelihood. Because the demand for cash was so high, the refugees undertook several income-generating activities (partly to spread out the risks) and in the process paying less attention to the growing of food crops. But even in situations where they had sufficient food crops, some of them sold them for cash. That the markets were vibrant may not be the same as traders making money. Some refugees went to the markets for social interaction and newsgathering. The propensity to buy was low in refugee settlements; however, the markets attracted the nationals as well who had more money. There is a daily market at Yoro, and four other markets that operate once a week in Olujobo, Ocea, Mairaba and Matangacia. Furthermore, there were others in Ngurua and Eden operating on a daily basis. Among the commodities sold in these markets were utensils, basins, cloth, bicycles, radio and bicycle spare parts. Men owned the shops while women operated restaurants and tearooms. The youth (boys) played cards, chewed *mairungi* and smoked *njaga*. At Ngurua A market place, for example, there were well stocked shops. One particular shop had a stock worth about Ug Shs 300,000

(about US$150). These were retail shops that sold sugar, salt, cooking oil, coffee and tea. Refugees cannot afford to buy items in kilos or litres. There are special measurements that start from Ug. Shs. 100 to allow even the poorest to buy. These items such as sugar, salt, and oil measured in small amounts are commonly bought by women. The bigger and more expensive items such as bicycles and radios can only be bought once and by only a few people. This was the case even in the comparatively richer southern parts of Uganda. Economic activity was low. What made the market vibrant were social activities – playing of cards, drinking and sharing of news about Sudan.

Apart from shops and restaurants, we observed several *Jua Kali*[4] income generating activities. There was a carpentry project by Dinka refugees in Katiku, some were making sculptures, while others were builders and bicycle repairers. In addition men sold pork, mutton and goat meat, cigarettes and tobacco. Among business people, there were some with shops in the towns of Arua and Koboko. There was a male refugee who owns a four million shilling boat (about US$ 2,000). A group of men burns trees and makes charcoal for sale to individuals from Arua Town who transport and sell it in Kampala. And when the charcoal burners complain about the low selling price, they are soon reminded they did not come with trees from Sudan. I should point out here the relative short-term nature that refugees attached to their projects. Taking the Dinka for instance, they informed me how they made the chairs just for short-term survival as they were waiting for something better. They all aspired for further education and I was given letters of application to post in Kampala on their behalf. Others were anxious about resettlement and wondered when the interviews would be due in Kampala. On the whole however, it can be argued that many women and men refugees were engaged in selling and / or buying something. This view endorses Francis' (2000:56) suggestion that diversified livelihoods may involve combining farming with wage labour, trading, selling services, or producing commodities for sale. This is precisely what is happening in Rhino Camp. "The challenge then becomes to understand how people construct livelihoods, what factors shape the strategies they follow' (Francis, 2000:57).

Business enterprises were gendered; women and men conducted their businesses separately because that is how it has always been done. This also points to the gender boundaries and norms that men and women work out during the gender negotiations (Mohammed 1995:28). Tea rooms aside, the women also made and sold crafts, mats, baskets, brooms, table clothes, chair backs and crotchet pieces. They also sold edibles, such as pre-packed roasted ground nuts, maize, pancakes, cooked cassava and or fried cassava chips. Besides selling locally made alcohol in the markets, women refugees sold simsim and groundnut paste as well as live goats, chicken and ducks. In addition women owned gardens, bicycles and domestic animals. It was observed that although women and men participated in income-generating activities, women participated in the not so-well paying ones and in edibles like cooked food and *kabalagala (*pancakes*)* which took time to process, but could not be easily stored. Men with businesses maintained some form of bookkeeping, but women did not know how to do this. It was therefore difficult to know if their businesses were viable. The women seemed more at ease and happy if they could buy some sugar and soap for the children.

The poor knowledge of business planning made women businesses non-profitable in my view. For instance Poni of Siripi said she brew alcohol for sale. Apart from the maize, firewood, water and labour, which she did not have to buy, she had to hire a distilling tube and the aluminium containers. I concluded that had she to pay for the labour, water, maize and firewood, the business would not be viable. That is why I feel some of the women businesses are more social than economic in nature.

Food Security

Davies (1993) asserts that when resources from which households draw their food and livelihood are in a critical condition, food security is usually the first to be affected. FAO submits that food security entails food availability, that is sufficient in quantity and quality, safe and nutritious food, supplied through domestic production, net imports and available net stocks (FAO, 1997). Food security also refers to stability of supplies meaning a reliable supply of food products at all times and for all people (space and time). Furthermore, food security concerns access to supplies, namely, sufficient resources, social and demographic factors and physical access affecting the ability to acquire food, and food utilization which refers to adequate diet, care and hygiene practices, water and sanitation (Mtshali 2002:40). For the refugees, food security meant having granaries full of food grain and not having to beg for food. But they decried the situation in Rhino Camp where they could not cultivate enough to store. The use of indigenous knowledge and harnessing the environment for a livelihood was important to the women, but this resource is often not been mobilised in camp settings as also Chambers correctly observes (Chambers, 1983:5).

Women refugees were able to recognise several different types of ground: uncultivated land; ground left to fallow for a few years, new fallow after cropping which has not yet regained its fertility; later fallow which shows by the presence of certain plants that its fertility has been restored and it is again ready for hoeing; newly cleared and hoed land which is left for a few months before second hoeing and planting. All these have specific terms and the Madi know that different crops need different soils and rotations.

Women reminisced over how in their countries they were able to 'rest' land to enhance productivity referring to what Boserup calls shifting cultivation (Bozerup, 1970). They also decried their inability to detect the fertility of their present soils. "*We knew where to plant which crops, but here we do not have that choice and we end up with poor yields'*. To these women also, food security referred to the indigenous knowledge they possessed to identify forest food reserves in times of famine. The present forests were not only alien but also inaccessible due to the movement policy barring unauthorised movement outside the settlement. The allocated plots of land could not be left to rest because there was demand for growing food crops and surplus for sale. There were three major ways refugees could access food, namely, through cultivation, buying and UNHCR food rations.

For sustainable household food security in a refugee situation, women need access to critical resources, such as land, credit, agricultural inputs, education and extension

services, exposure to indigenous knowledge, appropriate technology and decision making processes. With the exception of land, women could not access those resources. Moreover, the land given was constant except by an additional child and some of the plots were in the rain shadow, which made them unproductive. Agriculture depended mainly on rain; there were no fertilizers distributed, accessing them meant having to buy them.

There were no credit facilities and the extensionists focused more on men than women, thereby shaping women's cultivation practices. How did women overcome this? One of the coping strategies employed to overcome the land infertility issue was sharecropping with the nationals (even though this was not without mishaps, such as the landowners wanting to take over the crops).

How does the discussion thus far link with reproductive health? It is my contention that there are synergystic relationships and linkages among the processes under study, disturbance of any one inevitably disturbs the rest. The quality of reproductive health therefore affects and is affected by gender and livelihood security and refugee situations and the reverse can also be argued. Thus, the lack of or poor access by women to information in their role of food provider, processing, storage and assuring the proper balanced diet for herself and members of the household can affect the nutrition of the children as well as the adults in the household. Difficulties in securing a properly balanced diet in refugee situations have led to high mortality and morbidity rates. It was established that many infants die although these deaths are not reported. These have repercussions on the reproductive health of women refugees. There are several quite educative reproductive health programs aired on radio stations and in the newspapers in Uganda. Unfortunately very few were in a position to own radios. Of particular significance is '*Straight Talk*' a weekly publication in *The New Vision*, a daily newspaper which discusses issues relating to reproductive health, STDs and HIV/AIDS, pregnancies, diet in pregnancy and so on. There were no newspapers sold in the settlement most probably due to lack of readership. Women refugees' source of information was their social networks - the market, the self-help groups, the health centres and the church. This meant one having to leave the home amidst such heavy workload to look for news. Nevertheless, as practically everybody goes to the market at least once a week, it was a nice source for socializing. Radios could easily be bought but their operation was difficult for women who could not afford to buy batteries and also had no time to listen to important news.

Food Distribution System

Food for refugees is distributed along two approaches. The cluster system, where refugees line up for their food rations in clusters and upon being called, they receive their entitlements. The scooping of food rations was done mainly by the women and the refugee leaders manage the food log. This system applies to Rhino Camp. In my view this is a better way as it ensures food is given to the rightful owner. Another system is the semi-Malawian[5] system. Refugees are organized in groups determined by family size within the respective clusters. The food for each family size group is handed over

to the chairperson of the food committee, who signs the waybill for the food on behalf of the group.

This system obtains in Nakivale settlement in western Uganda. Each refugee is supposed to get 1900 Kcal per person per day distributed on monthly basis as follows: 13.5 Kg of cereals, 4.0 kg of pulses and 1.5 Kg of fat. This is per recommendation of the WFP and UNHCR in collaboration with the WHO (UNHCR/WFP: Guidelines for calculating food rations for refugees, 1991). The group then distributes the food amongst themselves. Meanwhile in Rhino Camp men formed the majority of the chairpersons of the food committees.

Getting the food in appropriate amounts to those who need it is a process, which faces many barriers. Even in refugee situations where there is supposed to be accurate registration and efficient assessment and monitoring of the situation, there is much manipulation, abuse and inefficiency in food distribution system[6] . This discriminated against women. The rations an individual refugee eventually consumes may be inadequate due to bribery, nepotism, political motives, or because they have been sold to diversify income in the anticipation that future rations would be inadequate. It may also be inadequate because the agency distributing the food is inexperienced in food distribution and/or lacks control. The scooping method where many women were involved is getting phased out. This implies that food distribution is in the hands of men once again. Another constraint crucial to food security concerns poor food management by the implementing partners. For instance, poor food storage in Parolinya, Moyo district disorganized the food distribution system and led to the abandonment of 'first come first served' approach to food distribution. In a similar vein, rats and weevils destroyed food which refugees received as part of their rations.[7] It is obvious that the nutritional levels of children and women, particularly pregnant and lactating women were affected. Eating from the same plate is an old age African custom, but it can be disadvantageous to young children with small palms. I noted that the palm helpings of children and the speed at which the adults and children ate disadvantaged them and made communal eating unsuitable for refugee situations.

Gender is an important variable in refugee household food security. It influences the intra-household dynamics and shapes the direction of most decisions in the home. As already noted men and women refugees, with the exception of a few cases, tended to do what is expected of them. It is therefore crucial in the planning of refugee food supplies to take gender into consideration. Taking the case of the unaccompanied Sudanese (boys) in Kakuma as an example, they almost died of protein malnutrition not because they did not have proteins (plenty of beans were supplied constantly) but because of a conflict in gender roles as they were not accustomed to cooking (Kathina-Juma, 1998).

The food distributed in Rhino Camp was referred to as *"monotonous"* and at times *"unpalatable"*. WFP food rations consisted mainly of maize seeds or flour, sorghum or Bluras and beans. Occasionally cooking oil and salt was distributed, but this was not a matter of course. There were many complaints about the inadequacy and insuffuciency of food rations. Food deliveries were also not constant. This posed a problem to women

whose crops had not matured. The way out was to reduce the number of meals eaten. Many refugee households ate one full meal a day. Another quite significant problem was the taste of the food supplied by WFP. On many occasions maize was bitter. *"That is why we use it for brewing "* a woman refugee in Ocea said. This recalls an incident in neighbouring Adjumani when thousands of metric tons of maize meant for refugees went sour and had to be dumped (The New Vision, 6 December, 1994). Although opposed by the UNHCR and implementing partners, the practice of selling food and non-food rations was inevitable; refugees had several unmet needs. Refugees sold food rations to buy non-food items not supplied such as soap and paraffin, sugar and salt.

During my fieldwork, food rations were being phased out in Rhino Camp. However, despite the agricultural extension work, the prevailing agricultural practices were based on traditional systems, which assumed the availability of vast areas of land. Land, however, was getting scarce by virtue of overuse and due to natural population increase. Given the present donor fatigue, it is important that attention to food rations be refocused onto intensive agricultural production technology in refugee settlements.

Land and food production

The following discussion took place in the canteen of the guesthouse where I stayed in Rhino Camp refugee settlement.

NGOs and gender planning

Project Co-ordinator (PC): Welcome back Simon. Where did you go today?
Simon, the extension officer: Oh, we went everywhere. We went to Ocea, Yelulu, Kaligo, Eden, Tika and Olujobo. Several refugees won prizes for good farming practices
Researcher: That sounds splendid. Of the winners, how many were women?
Simon: There were no women. You see although each woman is given land, they do not own it. And this creates problems for us. So we treat them as wives of farmers and the men the farmers.
PC: We should consider recruiting a gender person next year (2003). (January 2002, Rhino Camp Settlement Guesthouse.)

The above discussion bears critical implications with respect to gender planning. It shows that there is still a big gap between gender rhetoric and practice. It also shows how social actors shape practice in their attempts to explain phenomena. It is true that women did not get the attention they deserved even in the activity they perform most. Men had their part of the allocated land and the crops they cultivated were for sale. The women's part of the land had subsistence crops for consumption at home as well as for sale for women's income. Rarely did women sell all their produce.

Other challenges faced in land management include poor soil fertility of some areas in Rhino Camp, which led to poor yields, hence the continuation of food rations for some groups in the settlement. The late distribution of seeds for planting and failure of some of them to germinate led to food insecurity. Food insecurity is likely to lead to poor

nutrition and to infant deaths, which is likely to influence childbearing. Discussions indicated infant deaths occurring although they were hardly reported. Moreover, one of the reasons for high birth rates was due to the apprehension refugees have about their children dying. There were reports of land disputes between nationals and refugees.

> "The natives have left their cows loose from their ropes moving in the agricultural fields without control during the day, but mostly at night. They roam all night grazing in the residential plots and also destroying latrines and bathing shelters. With this destruction of crops, if we tell the natives to have control over their animals, they deliver threatening words against refugees due to land ownership and so on" (Men group at Ariwa III).

This statement endorses what the settlement commandant said that nothing refugees can own anything apart from land which is held in their trust by the Uganda government. Conflicts of this nature have happened in other refugee settlements elsewhere (Nabuguzi, 1998). From what could be observed the nationals were sceptical about the introduction of the self reliance strategy (SRS) in 1999, already discussed in chapter 4, erroneously equating it to land ownership by refugees.

Hindrances to livelihood security

Restricted mobility of refugees

Section 21 (3) of the Control of Alien Refuge Act (Uganda Laws, 1964) states that "Any refugee who –

Box 8.1 Restricting refugee movement

(a) Without the permission of the settlement commandant leaves or attempts to leave a refugee settlement in which he has been ordered to reside; or

(b) Disobeys any order or direction of the director or of a settlement commandant; or

(c) Conducts himself in a manner prejudicial to good order and discipline, shall be deemed to have committed a disciplinary offence".

The Law of the State of Uganda governs the mobility of refugees and is quite constraining. The government, through the settlement policy, allocates land to refugees and expects them to reside there and to seek clearance should they wish to move out of the settlement. Refugees have no say in this policy, although many try to resist it. A recent example of minimal choice concerns the relocation by force by the Uganda government (OPM, the Police and UPDF) to Nebbi district of some 20,000 Sudanese refugees who had been previously settled in Achol Pii in Pader district, but were displaced by LRA rebel attacks in July/August 2002 and had been temporarily relocated to Kiryandongo.[8] These incidents must have gender implications. There were sections of refugees who agreed to relocate as per government directive and those who rejected the offer. The women refugees were caught up in this scuffle and most likely bore the brunt of losing their relatives and having to look after the injured. One could also see the implications of the displacement on their livelihood strategies.

While normally the government does not always enforce the travel permit policy, failure to adhere to it by refugees could be used to deny them their entitlements. For instance, it is policy that refugees from rural settlements seeking any form of assistance have to be cleared by the settlement commandant. This means that they should carry along the travel permits and other accompanying documents. Failure to produce these has rendered many refugees destitute in Kampala. It was observed in Rhino Camp that the biggest part of the duties of the commandant was to issue travel permits. Resulting from the minimal home responsibilities, men refugees benefited most from travel permits. The ability to leave the camp as and when necessary was a forefront issue among the wishes of men refugees, some of who wished to seek employment outside of the settlements. Others expressed a need to visit their relatives outside of the settlements for financial assistance.

The ability to move outside of the settlement was quite significant to the well being of women refugees. Among factors that contributed towards women's immobility was the physical and bureaucratic enclosure in which women were kept (by husbands and the system) barring them from the freedom to move as they wished. One such process was the long queues of refugees seeking travel permits. On the several days I spent at this office, only a small number of applicants were women. There were several explanations for this. Women were lumbered with home chores; as such, they could not easily travel. They also lacked the money to travel exemplified by the meagre financial resources at their disposal. Another important reason they did not seek travel permits was the likelihood that they would miss the food distribution. One of the women respondents said in Swahili:

> "Mama, ata wewe unajuwa maneno ya chakula ni maneneo ya bibi. Sasa uki safiri kama mwanaume, na UN inafika hapa na chakula na wewe apana yiko, nani anapatia mtototo yako chakula? Tena bwana akirudi akiwomba wewe chakula utasema nini. Si yeye anatwanga wewe kwa bure?", Meaning 'Madam you should understand that food matters are women matters. If I should leave the settlement and miss the UN food rations, what shall I feed the children ? And supposing the husband comes back and asks me for food, what shall I say, won't he beat me for nothing? (Ngurua A).

For the above woman, food security meant the ability to provide not only for the children, but also the husband (and relatives) and to avoid violence. There were several views regarding livelihood and food security, but a common strand running through all of them was the women's ability to feed their children. Even when the settlement policy required that refugees seek travel permits, we noted that men's attitudes were also quite instrumental in the mobility of women. Some of the men's views concerning women leaving the camp were embedded within stereotypical socio-cultural gender ideology over women's place and roles to the extent that the men refugees felt that if women left the home, it would be empty. Women had to stay home and look after children. Other remarks concerned the health of children and the nursing and nurturing roles of women in the home. Most remarks by men surrounded the societal expectations of women's role and place in the home. The settlement commandant's own views and attitudes contributed to the low mobility of women refugees. During a discussion with him[9] it became apparent that he also held the view that women should stay at home as he related the situation to his own:

> "Imagine this son of mine (his wife had just delivered a baby boy). Supposing the 'madam' leaves him and goes to Kampala and I am also recalled to headquarters, what is likely to happen to him? It is better we get a small girl to look after him, then she can go".

With such an attitude, the settlement commandant is likely to pose an obstacle to the mobility of refugee women. This is in agreement with Forbes Martin's (1995) argument that for many women refugees, the camp could be the first and last place in exile. Women expressed a wish to travel outside of the settlement for medical treatment and to solicit funds from their relatives, which was an impossible task. Despite this, women's own perceptions of themselves and the expected social behaviour determined what they did. According to Obbo (1990:222) 'women's consciousness is structured partly by the socialization process which enculturates the gender ideals of the dominant ideology, and partly by women's pragmatic negotiations of gender roles'. Thus, we observed women scoffing their fellow women who 'failed to look after their homes, but instead went gallivanting all over the place'. Livelihood was also attached to the ability to "give the man children".

The longevity of men and women depended a great deal on the future care given by the children. Thus, bearing children was likened to banks where one saves for the future. As mentioned above, women are not only under the control of men and the settlement establishment, they are also under the control of fellow women. Apart from scorning, the mothers in law regulate women's behaviour in accordance to the norms and customs of the ethnic group. A woman may be given a derogatory name depending on a sad or bad occurrence that befalls a family when she has either just married or is in charge of the home. For example a woman with infertility problems was called "Ingumba" meaning " the infertile one" in Nakivale refugee settlement. These things do not stop in the countries of origin; they follow the women wherever they go. In

Matangacia, I witnessed a mother in law exchanging words with a daughter in law for leaving the baby to cry. She wondered why the baby was not put on the back.

Table: 8.1: Summary of livelihood strategies in Rhino Camp

Country of origin: Sudan	**Remarks on Livelihoods**
Men	Women
• Cultivate own plots for cash crops (maize, sorghum, cassava, tobacco, cotton and coffee) • Leja leja (piece work) • Rear and sell goats, sell birds • Sell tobacco and simsim • Operate retail shops • Sell bicycle spare parts and repair bicycles • Carpentry, sculptures, builders • Barter food rations for nonfood essentials • Migrate to southern Uganda to work in sugar plantations • Migrate to work as wage labourers on land and forests • One operates a boat • Sell second hand clothes • Work with Implementing Partner • Operate shops at border area of Koboko • Make and sell charcoal	• Cultivate own plots for subsistence and some cash crops (cassava, beans, sorghum, ground nuts, greens, maize, potatoes and peas) • Piece work (leja leja) for the nearby Lugbara and Madi tribes • Brewing and selling alcohol • Make and sell pancakes, roasted groundnuts, simsim cakes • Sell agricultural produce, such as cassava, simsim, sorghum, beans, maize and green vegetables. They also sell cooked edibles • Make crafts such as mats, baskets, brooms, tablecloths, chair backs and crotches • Own bicycles and use them to transport items to the market • WFP rations of 8 Kg of maize flour; Part of the rations sold to buy other basic needs –soap, salt, medicines other foods • Rear and sell sheep/goats • Rear and sell chickens, ducks, and turkeys • Remittances from relatives abroad • Petty trading on market days. • Making clay pots • Traditional Birth Attendants • Nurses and midwives, un licensed teachers • Work for food in the surrounding areas and sell their own food. • Women operate restaurants and tearooms in markets • Sharecopping

Source: Compiled during fieldwork.

8.3 Education

The specific aim of this section is to show how the education facility in the settlement does not take into account the gender specific needs of refugee girls and how girls are taken advantage of by those in 'superior' positions.

Gender-specific characteristics of refugee primary education in Rhino Camp

A total of thirteen (13) primary schools are operational in Rhino Camp refugee settlement. In the year 2001 there were 3549 refugee boys and 2529 refugee girls enrolled at the primary schools. The number of non-refugee children enrolled at the same schools was 1683 for boys and 1246 for girls (DED Education Dept. 2002). We noticed some striking dissimilarity with the education behaviour between refugee and non-refugee children. There was age difference at which the children started school. Refugee pupils tended to start first year of primary school at age 9 or 10. Normally in Uganda the recommended age to start primary school is six. For several reasons as will be discussed below, the rate of absenteeism was quite high. School starting age and level of absenteeism had gender connotations and were skewed against refugee girl pupils.

Table 8.2 below indicates that the enrolment figures for boys are higher than those for girls. Boys and girls dropped out of school. In a project evaluation report, Kyaddondo (2000) states that only 50 per cent of the school-going children are attending primary school. Surprisingly however, boys and girls missed schools in almost equal numbers. But girls missed for slightly more days and for longer periods. Most girls in their puberty missed school up to three days each month during menstruation for lack of sanitary towels. They also missed school to help their mothers with babies particularly on market days. The girl child was also not spared on funeral days and feast days as she was called upon to help with home chores. But I was also struck by the number of young teenage girls selling alcohol in markets. This can only be explained in terms of high levels of poverty among women; hence, this was a coping strategy, but in the process keeping refugee girls out of school. Boys spent many days away from school doing *leja leja (digging piecework)* to generate income. Discussions indicated that parents expected contributions from children.

Table 8.2: selected schools – enrolment and attendance by gender in 2001

School/gender	M	F	M	F	M	F
ARIWA	353	228	327	211	10	8
EDEN	292	191	254	158	15	13
OLUJOBU	349	246	317	231	13	13
TINKA	537	382	472	287	63	85
TOTALS	1,531	1,047	1,370	887	101	119

Source: DED office, Rhino Camp January 2002

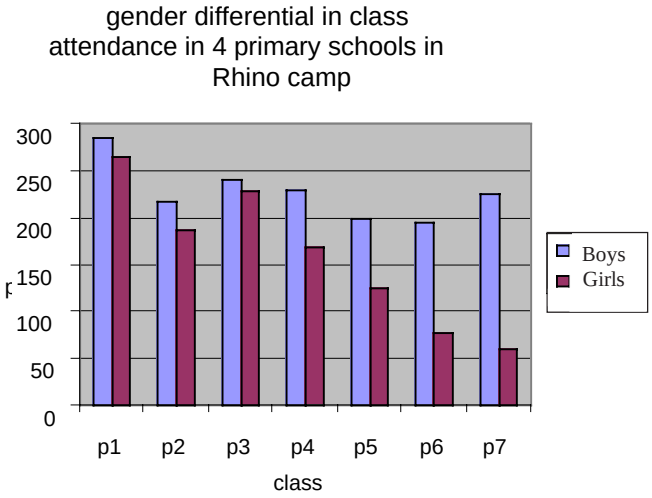
From the above one can see that there are gender disparities in the enrolment of refugee children in the sub settlements. However, the rate of absenteeism is almost the same for girls and boys with one exception in Tinka. Boys absented themselves due to engagement in casual work and travel. Others were reported to be indulging in drugs and card playing. The girls' absenteeism was attributed to staying at home to help with domestic chores.

The fact that refugee children start school late places a particular strain on their ability to continue with school and to sustain their livelihood because as adolescent adults, their needs increase. Refugee children start school late due to several reasons such as time lost during the armed conflict and during the asylum seeking process during which they mature physically and their attitudes towards education may change or remain ambivalent. Therefore, even though UNHCR offered free schooling, there were subtle reasons, which made the little contribution of Ug Shs 900 (about 50 US cents) for the parent and teacher's association (PTA) a repelling factor.

After getting to school and realizing they are quite big for primary school, most girls said they preferred to leave and get married. This attitude was compounded by the parents who insisted on marriage for their daughters "before they get pregnant". Pregnancy was another significant factor why girls dropped out of school. Figure 8.1 shows the classes at which girls start dropping out. This stage also coincides with the setting in of puberty, which for refugee girls is in Primary 4 onwards (compare this with Ugandan girls in conflict free zones whose puberty sets in between 11 to 13 when they should be in Primary 7 or Senior One). A number of refugee schoolgirls indicated that they experienced their first menstruation in primary 4 and 5. It is not surprising then that parents married them off before they could become pregnant. Girls and boys in primary school engaged in premarital sex quite often and discussed this without inhibition during the focus group discussions. Moreover, the insecurity that obtained in the area some few years back scared parents. In 1998, rebels attacked parts of Arua

and Yumbe districts and abducted eight girls from neighbouring Imvepi refugee settlement in which one girl died[10] (Payne, 1998).

Chart 8.1 Gender differentials in class attendance in Rhino Camp.



The drop out from school by girls could also be linked to the socialization process of these girls (Obbo, 1990) when marriage is stressed as the benchmark. A teacher at Wanyange Primary School revealed that many girls dropped out due to pregnancies. Moreover, schoolgirls at Eden and Tika primary schools confirmed their sexual activity engagement. "I was given condoms by the nurse. When they run out I asked for the pill but I feared it might be seen so I asked for the injection but the nurse refused". (17-year old pupil in P5, Tika II). Pregnancies were a major cause of girls' dropping out school. Another cause could be the staff in the settlement (most likely the drivers and staff co-opted to do construction work in the camp) who entice the young refugee girls into sex as the following case study seems to suggest.

Case Study 8.2: *Construction company driver makes 12 year old pregnant*

A contract was awarded to one firm to construct a primary school in the settlement. During the construction of the school, one of the drivers employed by the Construction Company started a casual discussion with a 12-year old refugee girl who was 15 years his junior. The driver lived with his wife at the Base Camp. The driver enticed the girl with sweets and had sex with her. When the parents found out, they were furious with the driver and urged their friends to chase him out of the village. Armed with sticks, hoes and any other implements they could lay their hands on, the refugees stormed the construction site baying for the driver's blood. However someone had tipped the driver off before and he was able to get into his truck and drove to the base camp. He reported to the Police at the Base Camp who instructed him to park the truck at the police post. He then boarded another truck, which took him back

to the nearest major town before moving to Kampala by bus. The settlement authorities got to know about this and asked the police to investigate the matter fully. The witnesses and the parents of the girl were interviewed. However the girl denied any wrong doing and said she was not forced into sex. The driver had by now contacted the parents through a third party and had paid the traditional fine. The details of this were not clear and the case hit a snag (Interview February 2003).

Parents' behaviour and attitudes have been associated with the school drop out of refugee girls. Statements such as "*wasichana ni masumbuko tu*" – girls are nothing but problems or "*mwisho yao ni kuolewa*" – their end is marriage - could be heard in relation to why parents do not encourage their daughters to complete their primary education. Poverty and the demands of survival have also been responsible for the girls' inability to complete school and to engage in sexual activity with a view to making money as the following case study shows.

Case study 8.3: Urban woman refugee seeking urban life as children miss out on education

Nuella Kiden (not real name) is a 40-year old woman refugee, Kuku by tribe and hails from southern Sudan. Her childhood was non-eventful. She says she married at an early age because she did not go to school. Her parents were peasants and it was said that her father had been a refugee in Uganda during the 1960s. He returned to Sudan in the 1970s and died a few years later. He left four wives (her mother has since died) and many children. Nuella was born at Kajo Keji and grew up in town. She married a Muslim with whom she had three children (2 girls and 1 boy). Her husband was unfortunately killed in 1995 in the Sudan for unknown reasons. That same year she was forced to flee to Uganda when the conditions became unbearable due to the civil war. Initially she was accommodated at Rhino camp from where she manouvred to go with her children to Kyangwali[11] . Because of her urban upbringing she found rural life in Kyangwali unbearable. She then decided to leave and settle in Kampala where she rented a room in Kivulu (slum area) at 20,000 shillings per month (US$ 10). Her children are all in their teens. The first girl is in Senior Three (2002), but the other two were temporarily out of school due to lack of school fees. Several methods have been employed to cope with survival. Nuella sells fried pancakes and cassava chips. She also sells brooms; carpets made out of papyrus reeds, and ripe bananas. But because there was heavy pressure on her to pay the school dues of her children (as UNHCR could not pay for her as long as she remained in Kampala) she was forced to devise other means. She encouraged the elder daughter to engage in prostitution at night while she attends school during the day. With serious caution against unprotected sex; the girl accepted. According to the mother, the condom backfired and she became pregnant. Nuella said she had to lie to a friend to borrow money, which she paid the doctor to terminate her daughter's pregnancy. Meanwhile the younger daughter turned down her mother's proposal to engage in

> prostitution. She instead does menial jobs such as fetching water for money, selling vegetables and hair plaiting. The relations between the younger daughter and her mother are strained; she wishes she had another place to go to. Nuella informed me that she does all this because she wants to make sure that her children have a good future by going to school. She says she works so hard to look for school fees. Moreover she says she had to change her children's names to Ugandan names to avoid being suspected that they were not Ugandans. In case they returned to the refugee settlement, they would use the names on the ration card. She also had just leant that UNHCR was assessing people for resettlement to Australia, so she sent her 14- year old son to Kyangwali to obtain a resettlement application form (Kivulu Kampala July 2003).

The above case is complicated and multifaceted in nature. It is a coping strategy in as much as it is riddled with health implications. It depicts a desperate mother who, while wishing the best for her children, chooses the wrong methods of doing it. Children in their teens do not appear to have much say concerning their mother's decisions, which if challenged are likely to end up in conflict and rejection. The engagement in prostitution by the first daughter, at the face of it, could appear to bring in money, hence her attending school. Viewed critically however, the activity exposes this girl not only to STD/HIV and to imminent death, but also to criminality as induced abortion tantamounts to a crime punishable by the Courts of Law in Uganda. The policy that all refugees must reside in the settlement regardless of their backgrounds forces refugees into unscrupulous activities. This can be seen clearly in the above case when the mother changes her children's names for survival and to reduce the likely ostracism. However, when opportunities appear to be opening on the other side then she sends her son to apply for resettlement.

8.4 Social Actors and UN-funded Programmes

In the previous section, I based most of my discussion on refugees as social actors. In this section I aim to analyze, from a social interface and gender perspective, the lifeworlds of actors in a reproductive health project funded by UNFPA. The intervention is best analyzed in terms of ongoing processes of interaction and negotiations between representatives of different social orders and it is these interactional processes, which shape the actual place, meaning and function of such organizations. The discussion will be as follows. First, I will identify the social actors involved in the project**.** The second part describes how the reproductive health services (i.e., safe motherhood, contraception and family planning, the management of sexually transmitted diseases including HIV/AIDS and adolescent sexuality) are rendered and the interactional processes occurring between the 'technocrats' (the health providers) and the 'beneficiaries' (refugee patients). Three case studies are presented to further elaborate the discussion in this section. The third section discusses the vulnerability of girl refugees and defines the issue of what I consider to be dominating and repressive power relations between the project staff and contracted staff versus the refugee girls. I indicate how due to the deeply embedded gender ideology, the girls fail to secure

redress and instead are encouraged by their parents to marry the very perpetrators of violence against them. As a way of concluding the chapter I discuss salient issues that arise from a social interface and gender perspective.

Non Governmental Organizations - German Development Service (DED)

The German Development Service (DED) is the overall UNHCR implementing partner in Rhino Camp Refugee Settlement. DED is a Germany-based Northern Non-Governmental organization (NNGO) and does development work in Africa. However the role of this NGO in Rhino Camp is skeletal in that it operates only as a conduit for UNHCR project finances. DED does not sponsor any development project of its own right in the district, but it does development work with the Uganda government and has a main office in Kampala. In 1994 DED implemented only the health sector of the multisectoral refugee assistance programme in Rhino Camp, the other sectors such as construction, agriculture and forestry, water and sanitation, food distribution being implemented by other Northern-based NGOs, such as CARE and CARA. In January 1996 DED assumed total responsibility for implementing all UNHCR programmes in the settlement and maintained most of the staff from the other NGOs. A German national was appointed programme coordinator (PC) in charge of the refugee programme. The German nurse previously in charge of health left. The establishment of a health programme depended a lot on local human resources; this led to the recruitment of a substantial number of health providers from the district health system. At this time, the construction of three health centres had been completed and the fourth was near completion. At the writing of this report (February 2004) DED was implementing, on behalf of UNHCR, other refugee assistance programmes at the neighbouring Imvepi camp in Arua district and in the district of Nebbi for the recently transferred 20,000 refugees from Kiryandongo (formerly of Achol Pii).

The District Health Authority and the appointment of a medical coordinator

The appointment of a medical co-ordinator in a post emergency phase was a new innovation as previously the health sector has been managed by clinical officers, nurses and midwives. With the support of the District Medical Officer, Arua, a medical doctor (male) from Arua District Health Services was seconded to the refugee health project as medical coordinator. He assumed a supervisory role and had his offices at the Base Camp, together with a medical assistant, a nutritionist and community worker. With the exception of cases of an emergency nature, he had set days when he would visit the rural health centres and checked on in-patients and other matters. Related to health is the community services sector responsible for community development, social welfare, vulnerable groups, income generating and skills training. This sector maintains a social worker, community worker and a nutritionist. The community development worker visits and makes recommendations on the management of the vulnerable cases, while the nutritionist is responsible for the supplementary feeding. The health project maintained a communication radio system and a 24-hour stand-by ambulance. In addition the section has easy access to project vehicles for transportation.

The number of Health Providers and beneficiaries

Recruitment of health providers has been a continuous process and it coincided with an increase in the number of health centres. In 1994, due to the emergency nature of the refugee influx and the health overtones, the health personnel were recruited on demand. The emergency nature of the refugees attracted many health providers to what was once a remote and isolated *tse tse* fly ridden area. Goyen *et al* (1996) comment of the attractive remunerations and allowances offered by humanitarian aid projects and how this robbed the Goma (DRC) health structure of human resource. During the first six months of 1998 in Rhino Camp there was a total of 52 medical staff, including 1 medical doctor/coordinator and 26 support staff employed in the four health units to cater for a refugee population of 28,000 and a host population of 17,000.

Weary of the protracted nature of armed conflicts in Africa and its own funding position, UNHCR raised concern over the staffing position. This led to a reduction of staff and by 2000 the staffing situation had reduced although it was still higher than the recommended and affordable staffing levels of government (for comparison, see table 8.3 and 8.4).

Table 8.3 Refugee Health Units Staffing in 2000

Staff category	Siripi H/C III	Olujobo H/C III	Oduobo H/C II	Ocea H/C II
Clinical Officer	1	1		
Reg. Nurse/midwife	1	1	1	1
Enrolled nurse	1	1		
Enrolled midwife	1	1	2	1
Nurse aide	4	4	4	5
Laboratory assistant	1	1		
Health assistant	1	1		
Guards/compound cleaners	2	2	2	2
Total	12	12	9	9

Source: Rhino Camp refugee settlement.

Table 8.4 below is a government guideline for the acceptable and affordable staffing pattern of rural Primary Health Care Units

Table 8.4 *affordable* government staffing patterns for PHC units

Type	H/C Gr III	H/C GR II	H/C Gr 1
Clinical officers	1	1	1
Enrolled nurse	1	1	1
Enrolled midwives	2	1	1
Nursing aide	2	2	1
Lab. Assistant	1		
Clerical officer	1		
Other support staff	3	2	1
Total	11	7	5

Source: Health Planning Unit Ministry of Health

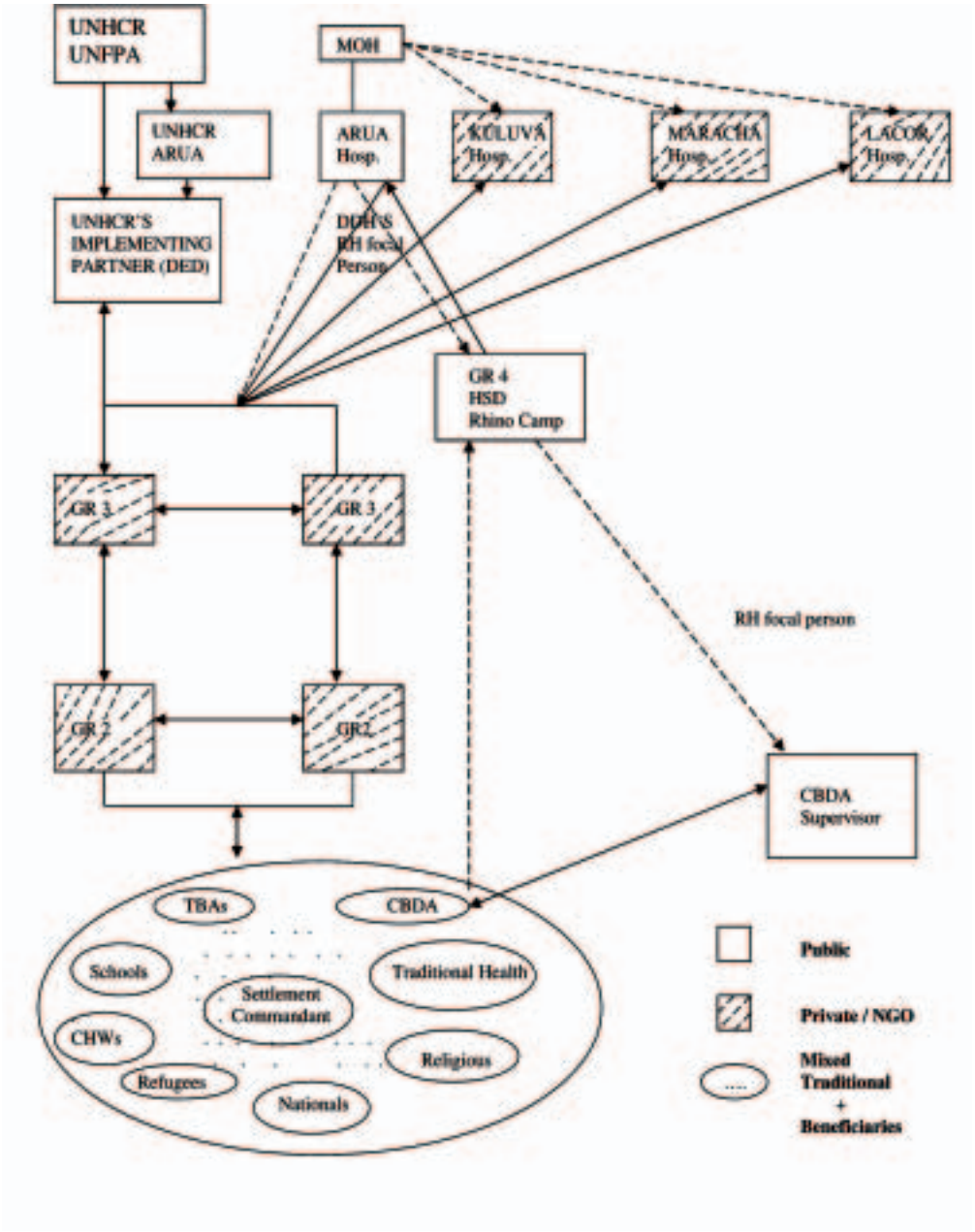
United Nations High Commissioner (UNHCR) and United Nations Population Fund (UNFPA)

Although not so visible in the settlement, the UNHCR wields much power and is influential in what takes place there. It is the duty of the UNHCR sub-office in Arua town to keep track of the sectoral programmes in the settlement. UNFPA has its main office in Kampala and was the sole funder of the project. It employs its own reproductive health focal person dealing with refugee reproductive health issues.

Uganda Government (OPM)

In addition to its permanent presence through the recruitment of a settlement commandant, the Office of the Prime Minister (OPM) maintains a refugee desk in Arua Town. The aim is to monitor early warning for refugee movements in the region.

Diagram 8:1 Showing the Provision of Reproductive Health Care at Rhino Camp Refugee Settlement



Explaining the details of the above diagram

Diagram 8.1 is an illustration of the Rhino Camp refugee settlement health structure and also indicates some of the social actors. Arrows point to the direction of referral of patients. The NGO[11] sector in the diagram refers to the religious based hospitals such as Kuluva, Maracha and Lacor, which are funded through other sources and also to the refugee health centres. The private hospitals receive limited funding from the government (indicated by interrupted lines in the diagram). In principle they (exception being Lacor located in Gulu district) fall under the District Director of Health Services (DDHS) who is the overall officer in charge of the health services for the district. However these private hospitals and centres act fairly independently and are registered with the NGO Board. They also complement the work of government since in most cases they are better staffed and better equipped. The refugee health centres are neither registered with the NGO Board, a prerequisite for operation, nor with local authorities or with the MoH. But because the DDHS (formerly DMO) had been involved right from their inception, some how they kept a blind eye and treated them as if they were registered. Subsequently, they receive the drug kits just like any other district health unit. It is not quite clear what sort of problems this is likely to cause in the future especially at this stage when the UNHCR and government have introduced the self-reliance strategy (SRS) in which UN funding has been remarkably reduced.

Essentially, patient referrals from the settlement should be received and attended to by the Health Sub District Health Centre (Grade IV) of the district at Rhino Camp Bay, but because it is not sufficiently staffed or properly equipped, it is bypassed and refugees with complications sent to Arua. This is long distance referral and is affordable for now as UNHCR pays. However, in the case where free ambulance facility stops as a result of the self-reliance strategy (SRS) the district might find it more practical and life saving to equip and staff the HSD. Currently, there is no rigid policy that insists on patient referral being done progressively most likely because patients pay for the services in NGO hospitals to which they are transferred.

The traditional sector refers to the application of traditional practices and beliefs during the provision of health care. Although placed at the bottom of the diagram, the traditional sector permeates through the healing process of whatever orientation. Pregnant women refugees attended antenatal clinics but also contnued to have TBA services. "It is quite common to find a patient in hospital applying "traditional" medicine to complement western medicine". The sector consists of traditional medicine and its application differs from western medicine. There are about 168 registered traditional healers in Arua District, 18% of whom are 'organized' into three societies. The fact that many ethnic groups in Arua cut across borders should guide our realization that the same tribes in Sudan also regard traditional medicine with high esteem. It is generally taken for granted that traditional healers represent a significant source of treatment. About one third of patients who eventually came to formal health services had first visited traditional healers. Traditional Birth Attendants (TBAs) who also fall within this sector were accorded higher status by local people than were other village health workers (first aid workers). Illnesses that could not be handled by the 'western' medicine

of the village health workers, were always referred to the traditional sector for specialized treatment. Within reproductive health, cases such as obstructed labour, puerperal psychosis, impotence, failure to sustain a penile erection, infertility, incompetent cervix that leads to frequent abortions, and painful periods were treated by the traditional sector. Traditional healers were particularly popular with puerperal psychosis. Accordingly, this condition should never be taken to *Mzungu* hospital (European medicine). Postnatal depression was attributed to evil spirits, witchcraft and infidelity of both man and woman. It necessitated the services of a divine healer to cleanse the parents and chase away the evil spirits. It became evident during the research that one person could profess to expel spirits, deliver babies (and even cows) and deal with all other reproductive health conditions just mentioned. Matters to do with witchcraft may also be handled by the same person, although there was some sort of specialization. Mediums and witchcraft had specialists. Let us now look at the provision of reproductive health care.

Daily Practices in Reproductive Health Programmes

Safe Motherhood Programmes

Uganda's Health Policy refers to safe motherhood as constituting four pillars, namely; antenatal care, safe delivery, essential obstetric care and family planning (MoH, 1999). However, the policy does not say much about refugee health. I have therefore resorted to the *Inter-agency Field Manual on Reproductive Health in Refugee Situations* (UNHCR 2001:20) for parameters. Safe Motherhood includes antenatal care, delivery care (including skilled assistance for delivery with appropriate referral for women with obstetric complications) and postnatal care including care of the baby and breast-feeding support. The Manual further recommends that sexually transmitted diseases, STDs/HIV/AIDS prevention and management, family planning services, and other reproductive health concerns are integrated within Safe Motherhood activities (ibid). The following section discusses the extent to which the above-recommended services are accessed and utilized. It also discusses what happens in practice at the settlement health centre.

Antenatal Care

According to the *Inter-agency Field Manual on Reproductive health in refugee situations* (UNHCR, 2001) the main objective of antenatal care is to:

- Perform risk screening: Identifying at risk pregnancies that require close monitoring, age less than 17, or greater than 40, grand-multipara, short stature, obstetric history of any previous complication are the best predictors of risk. Even with good screening, however, it is not possible to identify all the women who subsequently require assistance. Female genital mutilation (FGM) is a particular risk in some countries. Women, who have been subjected to this especially to infibulation, should be identified during the antenatal period.
- Detection and management of complications: Acute complications like

abortions or ante-partum hemorrhages are rather easy to recognize; others are less obvious such as hypertensive diseases, anaemia or an associated STD.

- Observation and recording of the following clinical signs:Height, blood pressure, search for oedemas, proteinuria, (if indicated by clinical signs), uterine growth, foetal heart rate and presentation. A syphilis test is recommended on all pregnant women during pregnancy. A home-based maternal record card may be used.
- Maintenance of maternal nutrition: The recommended minimum nutritional requirements of a pregnant woman have been set at 2200 kcal of an appropriate and balanced and culturally acceptable diet. This may require supplementary food if the basic food ration available or distributed to refugees is inadequate. Two particular nutritional deficiencies may require attention i.e. iron deficiency anaemia and iron deficiency disorder (IDD).
- Health Education: The following topics should be part of the education activity related to antenatal care provision, the choice of the safest place for delivery, the concept of clean delivery, the major symptoms of complications (bleeding, abdominal pain and headache). The appropriate response to them by the woman herself or the community, the promotion of exclusive breastfeeding, immunization and family planning.
- Preventive Medication – Antenatal clinics should be able to deliver the following medications: Iron folate prophylaxis (anaemia occurs in about 60% of pregnant women in developing countries), Tetanus Toxoid immunization (TT) (at least 2 dozes per woman), anti malarial (according to country policies) and antihelminthics (hookworms) in endemic areas. Iodized oil may be given in areas of moderate or severe IDD and following national protocol.

The Practice

The following explains what happens in practice at the antenatal care (ANC) clinics. Antenatal care is part of the reproductive health care programme where pregnant women seek care for their pregnancies to ensure a safe delivery and a live baby. Such care is normally the prerogative of trained enrolled midwives. Of the four health centres in the settlement, three employed enrolled midwives and one had a registered midwife. Women refugees valued this service. The study found that 97% of pregnant refugee women attend ANC at least once. All health centres were within fairly easy access (between 5-15 Km). Antenatal care attendance offered opportunities, in addition to iron and vitamins, all consulting women refugees were given supplementary feeding rations in the last trimester. This could explain why there were more antenatal visits during this period. But there was another explanation. Women explained that should things go wrong and one goes to a health centre without a card, '*it will be war with the midwives*'. The card was insurance for emergency care.

By attending ANC, women believed they would get information concerning their health

and that of the pregnancy. Examinations such as the checking of blood pressure, swelling of legs, weight, and urine testing and the position of the baby were very important. Women also knew that syphilis kills and is likely to kill the baby before delivery. Hence the blood specimen taken from each woman to detect syphilis (VDRL)[12] is quite welcome. Despite their being semi-illiterate women refugees knew exactly what to expect at ANC. An interview with a midwife at Siripi stressed the fact for effective treatment of syphilis, they insisted on treating the sex partner as well, however this approach had many problems. Women refugees feared telling their husbands and even when they did, men refugees resisted, became violent and accused women of infidelity.

It is desirable for a pregnant woman to get two doses of Tetanus Toxoid (MoH, 1993), but this was not properly communicated to the women. Majority of women got TT only once. Besides, hygiene and nutrition lessons are also conducted during the ANC sessions; the content of the lessons was found to be quite elementary and did not go beyond hygiene and baby care. I also felt that issues to do with HIV/AIDS were not addressed. Midwife Zerupa indicated that once women received the vitamin A tablets and after ascertaining that the position of the baby is "straight", they usually did not return to ANC. She stated further that women would continue to visit the ANC if they know there is something wrong with themselves or with the baby. She gave an example of an elderly woman whose baby "lay across the uterus". This woman kept up with the visits and constantly requested the midwives to change the position of the baby so that she can deliver normally, which was not possible and she was referred to hospital for further management. "But there are those who would rather consult the TBA even in such conditions" she said.

The very high maternal and infant mortality rates in Sudan were the result of poor and at times non-existent health care in southern Sudan. The new refugee situation was seen as providing an opportunity for availability and affordability of health care services. In my view, the new situation was a catalyst to propagation. Reasons given for this included self-replenishment for those who had died in the war. Women refugees were not totally ignorant; they had some knowledge of danger signs during pregnancy. Many indicated the signs to be vaginal bleeding, swelling of legs, loosing weight and appetite and "little blood" (low hemoglobin) citing sources of this knowledge base to be grandmother, mother, TBA and friends. This shows the significance of social networks. Dependency on social networks was not without problems. A breakdown in social networks in refugee situations disrupted the transfer of local knowledge. Local or indigenous knowledge refers to the 'systematic body of knowledge acquired by local people through the accumulation of experiences and understanding of the environment in a given culture (Mtshali, 2002 citing Warren and Rajasekaran, 1993; Chambers, 1983). A traditional birth attendant (TBA) played a significant role in the pregnancy process. She constantly applied her ideas, experiences and information in the reproductive health process through the pregnancy examinations and prescriptions. In addition to supplements and medicines supplied at the ANC, she gave herbal and clay medicines to expectant mothers.

At the health centres, in cases where risk is detected, such as anaemia, previous ceasarean section, mal-presentations, obstruction, ante partum hemorrhage, high blood pressure, fits, and stillbirths, the pregnant women were referred to the bigger hospitals of Kuluva, where DED had a standing agreement with the hospital. The transfer process was complicated by many factors like domestic chores, care of children and lack of patient attendant. I follow up this discussion with an illustration of 'an encounter at the interface'.

Case study 8.4: *Health/Hygiene lessons*[13]

> The midwife did not mind me sitting in during the lessons. The health lessons are part of the antenatal care and are conducted by midwives at the outpatient wing of the health centres once a week on Thursday afternoons. Though not mandatory it is desirable that women seeking ANC attend. Visual aids are used to explain the lessons. The main purpose of the lessons is to teach women about their anatomy and physiology, the food requirements during pregnancy, diseases of the reproductive health system and basic hygiene. They are also geared at enabling the women to get the skills of detecting dangerous signs in pregnancy so that they can be addressed early enough. The women are about 20 and they sit in class fashion with the midwife facing them. On the midwife's left is the flip stand with the visual aids. She then begins the lesson in Juba Arabic, which they all understand. The midwife also knows Juba Arabic because she was a refugee in the Sudan not so long ago. The lesson is about anatomy and physiology. The midwife uses pictures as visual aids at which there is no reaction, but every time she mentions male and female genitalia, the women hide their faces out of embarrassment. Apparently such words must never be mentioned anyhow, in any case, not in public. All the same the midwife goes on teaching. More pregnant women come, some at the very end and by the time we are through, there are about 35 women (though not all are for check-ups). No questions are asked during or after the lesson. Though late, in a way I am impressed by the attendance. The ANC checkups begin, vitamins are supplied and cards are endorsed for supplementary feeding. I later learnt at Kuluva that attending ANC was one way of getting a maternity dress from the husband. Husbands valued ANC and to be able to do so one has to be wearing a maternity dress.

Regarding the above, my view is that the midwife as the technical expert, and the refugee as the beneficiaries had their own 'projects' they wanted satisfied. The women perceived the midwife as the other and this created a boundary where on one side were the women refugees who acted as if they did not know anything and on the other the midwife who taught 'for the sake of it' whether they understood or not. By showing a certain degree of submission they were reliving what West and Zimmerman call 'doing gender' (West and Zimmerman, 1994). The encounter was embedded in a domain of unequal power relation, which they shaped and mediated. This can be seen from the standing position of the midwife and the use of the visual aids which the women had no interest in or which they did not understand. The women also do not ask any questions. The logic behind the lessons is based on an assumption that the women

need to learn the hygiene lessons and that possibly they have no other choices. We are forgetting that in most of the African set up the passing on of knowledge and therefore power is acquired through several sources. The other fundamental issue is that women know that to get 'proper' treatment one has to tread the correct line. They have also heard from their social networks how women who disobey the midwife's orders are treated. So, as a response, they must sow the seeds of trust in case they need her care now and in the future. They are therefore constructing and reconstructing their own identities as well as those of the midwife and shaping the outcomes of the encounters. So, the midwife is retained in the position of power and they in their so-called powerless position. In other words, they do not converge. The failure by the midwife to enrol the women in her project can be visualised when she mentions 'vulgar' words not to be mentioned in public. She forgets that the women she is dealing with have a set of values and norms they treasure. She also does not give them a chance to ask questions and does not ask them what is wrong when they look embarrassed when she mentions in vernacular the 'genitalia'. But management and the medical coordinator, who with their different projects in their arenas do not get to know about this. For them, at the end of the day, it will be a question of accountability; how many clinics operated, how many pregnant women were examined, how many TTs were given, how many delivered and so on. It will be a question of numbers, submissions and asking for more funds. The midwife therefore, bottom as she may be among the health providers on the organisational chart, directs the path the project goes. As Long (2001:70) correctly observes 'interface interactions presuppose some degree of common interest, they also have a propensity to generate conflict due to contradictory interests and objectives or to unequal power'. This could be seen clearly. Each of the actors (refugee and midwife) had their own projects, they were therefore pursuing different goals even as they sat and listened and even as the midwife taught. It was clear what they wanted was ANC checkups and vitamins but they knew they would not be able to get them unless they sat into the classes.

Management of STIs including HIV/AIDS during pregnancy

A perusal through the treatment records at Siripi health centre in the first six months of 2000 indicated that STIs were rampant in the settlement. It should be pointed out that the treatment of STIs was integrated with other treatments and did not constitute a special day for STIs. Hence, at the end of the discussion I present a case of a patient seeking treatment for malaria.

Table 8.5: STIs (men and women)

Month 2000	Total number of patients	Total number infected	Per cent (%)
Jan	302	37	12
Feb	298	54	18
March	493	91	18
April	305	52	17
May	335	56	17
June	307	86	26

Compiled from OPD records at Siripi Health Centre, January 2002

Records and interviews indicated gender differences in seeking STI treatment. More men than women sought treatment for STIs. Moreover, the recommended form of treatment by WHO based on clinically presented signs and symptoms was gender discriminative in a sense that it was easier for men than women to detect the signs and symptoms. This was problematic in a sense that women could be infected without showing any signs and symptoms. A big percentage of domestic violence in refugee homes resulted from STIs and yet the treatment approach requires the patient to bring the partner for treatment. Women expressed anxiety over the health providers' insistence on treating the sex partners claiming that, at times, out of embarrassment the men resorted to violence, accusing their wives of having other men. The mobility of men was another problem that raised concern; men were quite mobile and stayed away for long periods. The clinical officer in one of the health centres indicated that the health providers may have wished to treat the couple but cannot insist due to circumstances. By and large, health care providers held the view that management of STIs is quite difficult. Majority of the men tended to have loose sex in the settlements and outside as they exonerated culture to have given them the liberty to have sex when and where they want. These practices have had hazardous effects on reproductive health. "Women get treated successfully only to come back a few months later with the same disease". However, the fact that syphillis diagnosis is done only during ANC visits excludes non-pregnant women (or pregnant ones who do not consult), the adolescents and men. Whera women refugees knew about syphilis, they were totally ignorant about gonorrhea, genital herpes, chlymadia, trichomanas vaginalis and candidiasis and related sexually transmitted infections. This poses problems for the health providers as the treatment for STIs is based on the syndromic approach–a regime recommended by WHO which bases treatment on signs presented. The records indicated that of the patients seeking treatment for STI infection, close to 50% were women. I will now present a normal case of a refugee seeking treatment and the degree of interaction between her and the health provider.

Case study 8.5: *Health Provider/Patient Encounter*

Health centres are divided into three or four sections, namely; the out-patient department divided into general medicine and antenatal sections and the in-patient also divided into maternity and general wards. The general section and general wards attend to the non-maternity cases. The senior health provider is either a clinical officer or as I have already explained an enrolled nurse. The health facility also caters for the national population from the surrounding villages. When patients come, there are fixed cemented benches on which they sit under a shade. There is also a wooden bench near the consulting room such that the movement of patients is from the block benches to wooden bench to the consulting room in that order. The consulting room has three people; the enrolled nurse, the drug dispenser and the records clerk. The door to the consulting room is open so that patients can get in and out easily. It also lets in fresh air. After patients have consulted, this normally means after they state their complaints, then the 'diagnosis' is made and treatment is prescribed on patient's card. The patient then gives the card to the records clerk who enters the details in the Register and the dispenser gives out the prescribed medicines in small envelopes. Should there be need for an injection it is given behind the curtain. A quick example of the many I witnessed is as follows:
Name: Kennedy Avutia Age: Adult
Refugee / National: Refugee
Settlement: Simbili 1 Block A Plot 11
Impression: Malaria
Treatment: Chloroquine tabs: 4 stat, 2 six hours later and 1x1.
Paracetamol 2 prn.

The two treatments are put in small envelopes with the directions for use as I have shown them. The patient is supposed to exit as soon as possible for there are many others waiting in the queue. The six exit interviews I did showed that the patients did not ask what was wrong with them, nor did they understand how to take the medicine. They depended on someone at home to explain what was written on the envelopes. However, in the event that the directions are explained, it is done with such speed that the patients will still not understand. And then the use of the medical jargon is another hazard. The patient will be told in literal terms in English (that is if he understands English to take 4 tabs stat). What is the meaning of 'stat', does everybody understand that language? At this juncture the project is in the hands of the health providers and very little to do with UNHCR or DED or MoH. Very few people would understand the above directions. This is not limited to refugee health centres but it is a chronic problem everywhere in Uganda. The lack of confidentiality was another issue I noted. Three people in one room left no room for confidentiality. All sexually transmitted infections carry a degree of stigma and very few people would want others to know they are suffering from STI. This aspect needs to be addressed.

Furthermore, the fact that patients do not ask what they are being treated for is in a way a response to the way they explain the signs and symptoms of their illness. All patients whether refugees or nationals, 'feared' to ask their ailments and the health providers

did not volunteer to inform them what their impressions were of the ailments. As I have already mentioned the consulting room is left open for easy entrance and exit. However when a patient is consulting most of the time the patients at the wooden bench can hear what is being said. A woman patient had a problem related to sexually transmitted infection. As she was getting out after treatment, she was reminded loudly not to forget to ask her husband to come for treatment. I found this terribly embarrassing, but as I have already mentioned, the social interface encounters can be arenas of power struggle and conflict.

Delivery Care (Intrapartum period)

The intrapartum period refers to the delivery process of a foetus (baby). It starts with the onset of labour pains and ends with the successful expulsion of the pregnancy products. The person attending to the woman in labour has to deal with the woman and the coming baby. Therefore, skilled assistance is essential to delivery care. The ensuing discussions highlight the programmes offered and how they are utilized as well as the reasons for women's preference to deliver in their homes or with TBAs. There are maternity wards attached to all the health centres in the settlement. A woman approaches the ward when she starts getting labour pains, where she is monitored and assisted to deliver. Labour is a critical stage for anything can go wrong with the mother or the baby. Therefore constant check of the woman's blood pressure, the protein in the urine and the feotal heart are monitored periodically. Should any of them go wrong, then the woman is transferred to a hospital. Kyadondo (2000) established that only 10 per cent of the deliveries take place at health centres, 80 per cent are assisted by TBAs and the remaining 10 per cent deliver by themselves or are assisted by their relatives and friends. The national figure of assisted births is 38 per cent (UDHS, 2001). The following case study indicates what is likely to go wrong.

Case study 8.6 *Mariam (15) maternal and fetal distress: referral case to Kuluva.*

I was sitting in the shade of a mango tree in front of the health centre conducting some interviews when Mariam 15 was brought in a wooden box on a bicycle career pushed by one man as another guided the direction of the bicycle. I learnt later that the men were brothers. To take a photograph would have shown lack of empathy on my part, so, I restrained my self. I approached the three as they arrived at the maternity ward. The health providers knew that I was there to conduct research and treated me as one of them. So I actually participated in the admission formalities such as filling in forms.

Mariam was born in Adjumani district in Ogujebe Transit Camp of Sudanese refugee parents, who, at the closure of Ogujebe were relocated to Rhino Camp. Her father has since gone to Sudan. Before getting pregnant Mariam lived with her mother and four other children younger than she is. Her uncle (brother to her mother) living nearby and his wife are is the one who sometimes used to look after them. Mariam's mother has a bad leg, which she sustained during child delivery (foot drop). She does not walk properly and needs help with lifting heavy objects. Mariam was a primary four pupil at Siripi when she got

pregnant. Her husband, a young man of about 18 (who was pushing the bicycle), had not paid dowry but his parents have agreed that they will pay in Sudan as they have nothing here. For now the two are living with the parents of the boy but have applied for their own plot of land. Mariam works in the mother in law's *shamba (*garden*)* and when she has time she helps her mother in her *shamba*. She also fries pancakes for sale at the market.

Mariam has been attending ANC and has a card to show for it. Two days ago, she started getting pains. She was asked why she did not come to the health centre. She said they (mother in law and TBA) told her she would come when she is ready because first babies take long to be born. The midwife asked her if she has taken any medicine at home and she said no. Meanwhile she looked 'dry' and tired. An examination by the midwife indicated that not only had she ingested medicines, she had also inserted medicines in her vagina. The midwife was annoyed with her and asked why the health providers should always get the miserable cases. " It is after they fail and then come and we are expected to perform miracles. Another day a national died here after pushing at home for so long, by the time she came the baby's hand had prolapsed, she had to die". Mariam said she was not the one who put the medicine but her mother in law. And apparently she was asked to push as soon as she started getting pains, no wonder she was so tired. " And you young girls instead of going to school you go in for boys, now you see what you were looking for. Look at him there what can he do for you; when he can't even help himself, Haki ya Mungu". "You are lucky the baby is still alive, you are not like this other girl from accross the river who came when the baby was already dead". Meanwhile they put Mariam on a drip and made arrangements for the ambulace to take her to Kuluva some fifty miles away.

Arrangements had to be made to inform the parents which was done by one of the men.

Three days later - I went to Kuluva and saw Mariam and was able to talk to her. She had undergone a ceasarean section and had a baby girl. She was being nursed by her husband and was able to give more insight of her situation. She informed me that when the pains started she told the husband and her mother in law. The mother in law called a TBA, who, as soon as she came instructed her to push. Every time she stopped they would beat her. She pushed until she could not push any longer. In the meantime they kept giving her medicines meant to quicken the labour pains so that she can deliver quickly, but the medicines did not work because she kept vomiting. When they saw they could not manage they asked Marios (husband) to bring her to the health centre. He then he had to go and borrow a bicycle but by the time he got back with the bicycle she had 'lost all strength' and was unable to sit on the career. So they had to improvise. Riding the borrowed bicycle, Marios rushed to the market place 5 miles away and had an open square wooden box made and sat her in so that she could be easily transported.

The reason why I am presenting this case study is to show the power relations at work. The mother in law and the TBA wielded so much power over this girl that she really did

not have much of a choice. As social actors, they manipulated certain values and norms in order to maintain their 'domains' or 'boundaries' from which they derive authority and wield power. By giving her the traditional medicines, beliefs are reproduced which in a way provide a choice. But the question is 'Who is making the decisions? In fact, no matter how much she had wanted to deliver at the health centre, chances are that she would not have done so had things not gone wrong. The other aspect we have to consider is the issue of access to resources. I have already in section 8.3 talked about teenage pregnancies and how they narrow their self-realization opportunities. Mariam is a good case in point. If at 15 she gets pregnant and marries a man almost her age, how can they access resources? I understood the boy was a secondary one student at the Self-Help Secondary School and was working *leja leja* to pay his school fees. People's access to strategic items like bicycles and motor cycles (not to speak of cars) is so limited. By a critical look at this case, we can appreciate the problems rural refugees go through to have their patients transported. Is it a wonder then that so many die in the rural villages? The encounter at the maternity ward does not have to be repeated here, it speaks for itself. According to Long (1999:10) "..... lower level field personnel are more than simply employees or subordinates of government or other agencies. They also are implementers, consciously transforming broad guidelines into specific forms of practice". We have already seen the power midwives wield.

Post Natal Care (PNC)

Postnatal care refers to the health care given to a mother and the baby during the pueperium[110] . Newly delivered mothers are expected to return to a midwife six weeks after delivery for examination and guidance. It is at this time also when counselling regarding family planning and immunization of children is undertaken. The midwife normally examines the abdomen, the genitalia for any abnormal discharge, the breasts and lactation, the urine, blood pressure, any swelling on legs and checks for any signs of anaemia. The midwife then may attend to any abnormalities detected or refer the mother to a doctor. As the Table below indicates, attendance at PNC at Oduobo, health unit, is quite low.

Table 8.6: Postnatal care attendance

Year 2000	Refugees	Nationals	Total
September	13	0	13
October	10	4	14
November	3	1	4
December	1	2	3
January 2001	10	6	16
February	7	6	13
March	9	12	21
Total	53	31	84

Source: Compiled from PNC records book at Oduobo

Observing the many women with babies in the refugee settlement, I concluded that there were more deliveries taking place than there were postnatal check-ups. The notion of postnatal care by refugee women appeared to be alien and was appreciated only within the context of illness and child immunization. It was the policy to conduct postnatal examination before the immunization of the babies. Even then, not all refugees had their children immunized, for instance, in Achol Pii refugee settlement in Kitgum in 1995, refugees rejected immunization after suspecting that immunized children died or they got TB as a result.[14]

Stating preference for home delivery

Several reasons were given to justify home deliveries. It was a consensus that TBAs were easily accessible at any hour and do not introduce 'strange' delivery position. Furthermore women preferred home deliveries because of the cultural rituals associated with the naming of the child. These functions can only be performed by men and women in the home of the newly delivered mother and in the presence of the TBA. Going to a health centre signified illness and pregnancy was perceived as a normal process. Hence, they did not see the reason why they should deliver at the health centre. "Once the midwife examines your 'stomach' and tells you the baby is in good position, there is no need to deliver at the health unit" (Respondent – Oduobo health unit). Women are expected to be strong enough, to tolerate and to deliver with as little fuss as possible. A woman who 'fails to push a baby' is frowned at. 'Weak and lazy' women are given names by their in-laws which carry negative connotations about them showing they 'killed' a baby during birth or 'refused to push the baby'.

Other sentiments were raised with respect to home deliveries. Newly delivered mothers are massaged by mothers, mothers in law, or TBAs in order to clear the 'inside; in addition, soup made out of cow and / or goat intestines is given to clear the uterus and to increase breast milk. To add to this, a special kind of porridge is made for the new mother to stimulate lactation. Mothers at PNC said the main reason they came to the clinic was to have their babies immunized. During this period, depending on the culture of the tribe, childbirth may signify several festivities, especially if it is a boy.

The targeting of males for the training program of health workers in the Sudan compounded the situation. Female health workers are few and at long distances and yet in matters related to pregnancy and childbirth women prefer to be managed by fellow women; hence the recourse to TBAs and traditional healers. Another factor viewed with fear and apprehension by women, is the belief that when they go to health units to deliver "the birth canals are slit open" to facilitate delivery. Subsequently, they are sutured amidst a lot of pain. Women constantly echoed the extra pain inflicted on them by way of injections and use of other strange gadgets such as forceps. "The treatment accorded to women in labour by TBAs outshines the experiences at the health unit. TBAs are known to literally carry primigravidae on their laps for comfort and to reduce the labour pains, which is not done by midwives and nurses in health units" (Anisia Achieng[15] – KI, November 2002). The interview with a TBA showed that according to her there was no traditional delivery position. "The position of the baby dictates the delivery position. The position therefore

may be 'on the side', upside, or squatting" (Iyom Dinka-Bor TBA)". And yet the health centres maintain only the lithotomy (dorsal) position. TBAs are famous for not using sutures to stitch any vaginal tears sustained during deliveries. Women refugees were satisfied with the herbal douches and fomentation that are applied to any lacerations occurring during delivery. The case below illustrates how the beliefs of Dinka TBA shape her midwifery practices and how in turn this affects her clients.

Case Study 8.7 *How Iyom conducts and manages home deliveries*

Elizabeth claims she is 40 although she looks older than that. She says she left Sudan in 1996, passed through Koboko transit refugee camp and was relocated to Rhino Camp by UNHCR the same year. She is a married woman with grown up children. Two girls are married and of the three boys, two are in school in Khartoum and one is in Kenya. She says she left the husband in Sudan. She has not heard from him, but understands from other refugees that he is fine. The reason Elizabeth is located in Ariwa III was on purpose. For some reason all Dinka refugees were settled in one area. "it is very good because I can then look after my people like I used to in the Sudan, and I will go back with them". She says she has been TBA since 1977. She learnt the trade from her mother. She also assists to deliver cows, although this is something she has not done in the settlement, as "there are very few cows". She says she can also deliver breech presentations.

During her time in the settlement she has never had any maternal or neonate death. She says this is because of the good advice she gives to the women such as good feeding practices, hygiene and to take their children for immunization. She says she has not experienced female genital mutilation (FGM), although she heard that there was one girl from Nuba Mountains who had undergone FGM in the settlement. Regarding home deliveries, Elizabeth says that these are encouraged very much for various reasons. First in the Sudan there are no hospitals where women go to deliver; they deliver in their homes with the help of the TBA. The few missionary health centres available are very far and are not easily accessible. Second there are custom related practices that must be done to the pregnant woman during pregnancy and labour and to the child to make sure they do not die. The TBA takes a keen interest in the pregnancy from the beginning. For example Elizabeth gave the example of oil from the *Komo* tree, which is smeared on the abdomen of the pregnant woman to align the position of the baby in uterus. In addition the advice given regarding food intake is viewed as crucial in determining the eventual outcome of the delivery. Pregnant women are advised against eating honey, eggs, and groundnuts because if they did the baby would be too fat and difficult to deliver. Furthermore during a twin pregnancy, there is a special style of palpating the abdomen to make sure the twins (*mandiet*) are not born before full term.

In case the twins are born prematurely, there would be need to visit the witch doctors. She doubts very much that the midwives in the health centres can do such things. The delivery position is determined by the position of the baby. But most times it is the squatting position (knee position). After the delivery

she examines the woman genitalia to see if there were any tears sustained, after which she will administer the medicine. But she advises that it is not important because the woman is not supposed to sleep with her husband until the child is running by which time she would have completely healed.

After ten days of the baby's birth, a sheep is slaughtered, food cooked and beer served to welcome the new baby. Clan leaders assemble and they feast over the naming of the baby. Naming is done along the genealogy of the clan that goes back three or four generations. The baby is taken to the shrines for cleansing and purification. The traditional healers retain some of the herbs used for this purpose. Some of the Dinka names for the healing herbs are: *Achitak* (eggplant) used for constipation, *Reer* (Neem tree) used for stomach pains and malaria, *Achuathialwei* for fever and malaria and *Ruat* for skin diseases. Ruat is similar to Okrah. The seeds are dried and crushed, then roasted to a black colour, after which they are ground to produce oil, which is smeared on the skin rash. The umbilical cord is guarded jealously from the time if falls off on the third or fourth day. This is because its subsequent management is believed to bring luck or misfortune to the family. The chord stump is kept together with a hair strand up in the roof-top of the house. It is supposed to stay up there to ensure production of more children. But should it get lost deliberately then the woman becomes barren. The placenta or after birth requires special treatment as well. It is washed and then mixed with cow ghee and then covered with millet grain. A small hole in the ground is dug in which the placenta is placed. Thorns for protection are placed on top of the filled up hole. Should it be taken, the woman will be rendered infertile. They do not refer to the word burial of placenta; rather they say placing the placenta, because if one mentions the word burial, it is the same as saying you have buried the baby. This custom should be contrasted with the western biomedical behaviour of burning placentas in specially constructed incinerators. This could be one very important reason why women do not have their babies at the health centres. Elizabeth also noted that there are particular mental illnesses that are likely to affect the pregnant woman (sometimes this may occur after delivery). The woman appears to be mad and this is caused by mistreatment by the husband and in laws and / or if the bride wealth has not yet be paid.

The conditions may also occur if the pregnant woman disobeyed some cultural beliefs such as paying the gods their dues. Regarding family planning, she says she knows only child spacing of 3-4 years through sexual abstinence and breast-feeding. She recommends that the man and his wife should have separate houses. *"The Dinka are very strict with this practice,"* she says. In fact she mentioned that if a man is caught having sex with his wife before the right time the elders have a right to separate the couple, because they would be going against the norm. For a punishment, the man will be beaten so hard, he would never do it again and that is why men have many wives. The Dinka's believe that if sex is indulged in during the lactation period, breast milk will stop and the baby would die. On infertility, she said that there are special medicines

> that she gives the woman. However infertility should not make the woman leave her home, because if she goes back to her parents her sisters in law might become barren. According to the Dinka custom, a barren woman is free to stay but the man would have to marry another wife for the purpose of getting children. With respect to the barren wife, her parents are expected to return some of the bride wealth. (*Ariwa III*)

While preference for TBAs has been noted, we also established the negative consequences that crop up in the delivery process. TBAs do not appear to possess good enough skills to easily detect an abnormality in the labour process. Many a time, women in labour are referred to health units when the foetus is already dead and when there is gross maternal distress. During fieldwork, I found that many women, particularly teenage mothers, lost their babies due to failure by TBAs to make quick diagnosis and therefore timely referral. Interviews with key informants at Kuluva Mission Hospital (the main referral point for refugees from the settlement) indicated that many were referred for many reasons including chronic malaria, anaemia and obstructed labour. These complications were not easy to detect by a TBA, hence the late referral and death of women and their babies. But the Matron was quick to chip in and say "at least the prognosis for refugees is better because they have an ambulance but not so for Ugandan women who are brought in, literally at death point on stretchers and on foot'.

Another distressing complication that resulted from poor management of labour was fistula. Fistula is a condition that often develops during obstructed labour, when a woman cannot get a Caesarean section. Obstruction can occur due to malnutrition and pregnancy at a young age (both of which lead to small pelvic width, and thus pronounced cephalo-pelvic disproportion). The woman can be in labour for many days without medical help and if the obstruction is not interrupted in time, the prolonged pressure of the baby's head against the mother's pelvis cuts off the blood supply to the soft tissues surrounding her bladder, rectum and vagina, leading to tissue necrosis and fistula is the result. This results in continuous leakage of urine and she could also lose control of her bowel movement. This is a physical, psychosocial as well as medical problem for the woman and her relatives. These women are often rejected by their husbands and are shunned by the communities due to the humiliating smell of urine and/or feaces. I was made to understand that a few fistulae cases existed in Rhino Camp, but that they were due for repair at Kuluva Hospital (the repairs were done by specialists who came in especially for fistula-repair one a year). My efforts to interview the affected women were unsuccessful.

Emergency Obstetric Care

A health unit should be well equipped with both equipment and human resource to handle deliveries short of surgery. I found the health centres equipped with blood pressure machines, delivery kits, oral and injectable antibiotics and oxytoxics. Baby resuscitating equipment such as intubation equipment and oxygen were missing in all health centres. In addition, broad vaginal spectrum and plasma substitutes were not available. Two of the health providers had been taught how to perform a vacuum

extraction. None of the health centres was equipped for an emergency evacuation of uterus and/or caesarian section nor did they have blood transfusion facilities. The district-operated Grade IV health centre at Rhino Camp Bay did not have these facilities either at the time of this study, although it was in the plan to have it equipped to HSD level. A placenta incinerator has been constructed at each unit. However according to some of the refugee customs, placentas should never be incinerated. Spontaneous abortions were reported to occur in some cases. The health providers in the settlement normally treat the complete abortions (miscarriage), but the incomplete ones are referred to Arua, which is 50 miles away. There have been reports of maternal deaths arising out of incomplete abortions complicated by heavy bleeding and infection. Induced abortion as a method of getting rid of an unwanted pregnancy was mentioned by a health provider at one of the health centres as an occurance. The girls used crude methods and ended up with pelvic infections. Although practically all adolescents interviewed agreed to having heard about it occurring in the settlements, I was not able to identify any one who had undergone any induced abortion. According to the health providers, induced abortions were occurring among single adolescent girls mentioning a few deaths from peritonitis.

Contraception and Family Planning

Birth control is not a new phenomenon, a wide variety of contraceptive methods having been used for centuries the world over. The most common practice of pregnancy prevention in many African societies is post-partum sexual abstinence (Ntozi, 1995). Refugees held cultural beliefs about negative outcomes if the couple indulged in sexual relations *"before the baby left the back"*. This study established that sexual abstinence involved women and men differently. For the mothers, it was real sexual abstinence; she slept in her own house where the husband was not expected to get to her. However, for the men it was not real sexual abstinence; they continued to indulge in sexual intercourse with other wives and even girlfriends outside of marriage.

While Mushanga (1973) reiterates that the Banyankole use magical means to prevent pregnancy, Ntozi *et al.* (1993) claim that the early resumption of sexual activities was a big factor in influencing the high fertility rates among the Banyakole of Uganda. Furthermore, it has been documented that among some tribes such as the Kikuyu, Sukuma and Luo, twins used to get killed (Molnos, 1968). Among the Baganda, a child born feet first was killed to prevent it from becoming a thief or a murderer (Roscoe 1911:54). It should however be borne in mind that the methods mentioned above were not used consciously to prevent births; rather they were applied more to avert misfortunes than to limit fertility. A child with extra digits, for example, was considered as a bad omen among the Baganda.

Knowledge of birth control at Rhino Camp

During focus group discussions, questions were undertaken to establish the refugees' knowledge of birth control methods, which are used to limit childbirth. The women responses were as follows: abstinence, breast-feeding, pills, injection, condom, and

contraceptive herbs. The men mentioned, in addition to the above, withdrawal. However, in-depth discussion indicated that there was variance between knowing and actual understanding. For instance, out of the 20 women interviewed in Ariwa III 15 mentioned knowing the condom as a family planning device, but only one had seen it and none had used it. Similarly, few viewed abstinence as a form of birth control. To them abstinence was a value and cultural expectation and had nothing to do with family planning. It was therefore not a conscious family planning practice, but a subconscious one. On the other hand women regarded breast-feeding as a form of contraceptive, failure of which led to pregnancy. A woman would be asked if the child has stopped breast-feeding – in essence, this meant that if the child is not breast-feeding then why is the woman not pregnant? For the community, the women were expected either to be pregnant or to be breast-feeding at any one time. Without a doubt such perceptions influenced fertility. Men's knowledge of family planning was more than that of women. Of the 50 men interviewed 97 per cent had knowledge about family planning methods. However when it came to use, men hardly used any family planning leaving everything to women. Moreover the men were quite adamant regarding use of condoms with their wives. Most would say "Sisi natumia mpira kwa malaya" meaning 'we use condoms with prostitutes'. Interestingly, among the responses none alluded to permanent methods such as vasectomy and tubal ligation. In addition they had no knowledge of the loop and diaphragm.

Of the 130 refugee women interviewed, 91 per cent know at least one family planning method, but as mentioned above, the understanding of the methods was hazy. They understood family planning to refer to means of spacing children in order to give room for growth and to offer the mother sufficient time to breast-feed her baby. This was how it was taught during the health lessons at the health centres. When asked to mention the methods used to achieve this, the majority mentioned the services at the health centre or that given by the CBDA. None knew how, for instance, the pill or the 'safe period' worked. Women refugees were completely ignorant concerning the way the contraceptives worked. It was pure cram work and is probably a result of illiteracy on the part of the women. This shows that there is unmet need for family planning. Be this as it may, women refugees tended to be discreet regarding family planning even during face-to-face individual interviews. I later discovered that about 35 women were on Depo Provera (injectable) in one of the health centres and had hidden their cards with the midwives. As confidentiality had been assured, even after seeing the cards, I never interviewed these women.

A total of 60 adolescents (30 boys and 30 girls) were interviewed. Unlike the adults, adolescents exhibited a deeper understanding of contraceptives and discussed them without inhibition. They identified family planning methods to be: the pill, the injection, non-penetrative sex, withdrawal, the condom, safe period, and abortion. The majority of the adolescents had some knowledge of how *the pill* and *injection* worked. "The pill prevents egg production, so does the injection". Although they could not go into the nitty gritty of the contraception process they at least had some idea. Approximately 100% of the male adolescents and 92% of female adolescents knew of at least one family planning methods. The male adolescents knew many more methods than the girls.

The condom is commonly referred to as a weapon, suggesting that its use goes beyond family planning. Popularly called *mpira* a (rubber / plastic) the condom, however, is not popular among adult men and its use is associated with prevention of sexually transmitted infections, HIV / AIDS and prostitutes. However the adolescents found it quite useful in the prevention of pregnancies and STIs and HIV / AIDS. The irregular supply of condoms for the adolescents forced them to recycle condoms[115] . The withdrawal method is quite popular amongst the adolescents who refer to it as "pouring outside' or pulling out. However they also admitted that the method was not safe in today's time of HIV / AIDS. The adolescents cited the rhythm method (also called the safe period). But in essence none knew how it worked and it was unpopular because according to a group discussion at Tika 1 "the girls who relied on this method got pregnant". Non-penetrative *sex* was mentioned as referring to sex outside the vagina and included other non-coital activities such as kissing, fondling and assisted masturbation. It was interesting to note that the adolescents discussed sexual matters without inhibition.

In general, men's attitudes towards family planning were negative as it was viewed as strange and interfering with nature. The majority of the refugees was Catholic and said family planning was against their religion but they did not constitute an orthodox group. We concluded that in addition to one's religion, the negative attitude to family planning must be associated with a combination of factors, such as socio-cultural and economic ones. There was a tendency for men to tie bride wealth with human production with many saying they had to have something to show for it. To a great extent also, women's attitudes were no different as they placed very high premium on child bearing for various reasons, some of which were to consolidate their status and for old age care.

The use of Family Planning

Several authors have documented the extent to which power and gender relations influence human reproduction at the household level (Neema, 1994; Sargent, 1987). Refugee narratives indicate that women are under the control of men and senior women relatives with respect to human reproduction. Women needed permission from their husbands before using any artificial family planning and they were under constant watch of their mother in law in cases where they lived in the same compound. This was demonstrated when some women used family planning discretely as I have already mentioned. The men also were quite clear about condom use and disapproval of their wives using family planning and the exhibition of the community's expectations of themselves and their wives concerning child bearing. An earlier program report (Kyadondo, 2000) showed contraceptive prevalence rate (CPR) at 16.8% lower than the national figure of 23% (UDHS 2001). However, almost two years later the sample of 130 women (this study) in ten randomly selected clusters indicated a user rate of 13.5% including women who abstain from sexual relations (8%). Only a small percentage (5.5%) used contraceptive pills and a miniscule part used the 'injection' and / or condoms. The user rate had dropped most likely due to the phasing out of the UNFPA project in which aggressive methods of user enrolment had been used. Sexual abstinence was not only the most widely practiced form of child spacing, but also the most culturally accepted among the southern Sudanese.

Men, Polygyny and Contraception.

Male refugees abode by the cultural expectation that they should not visit the huts of their lactating wives "until the babies were running". This method in actual fact encouraged polygyn. Accordingly, a majority of men had several wives and rotated from hut to hut, cluster to cluster. The surprising phenomenon is that the man wished to assume the headship when he visited his wives. And the women knew he was the head. Men were generally against modern contraceptives including the use of condoms. Men expressed the desire to have as many children as possible so as to compensate the high bride price. " If we are to have fewer children, what was the purpose of the high bride price?" On the question concerning use of modern family planning one of the men said, "modern family planning was responsible for teenage pregnancies and school dropouts. Children practice what they do not understand". Another: "family planning is bad for our community where many people have died during war in the Sudan". Only a miniscule proportion of men appreciated the use of family planning: "it enables men to continue enjoying sex with their wives without fear of pregnancy". To a great extent it can be argued that men control the sexuality and shape the direction of the sexual relations.

The issue of *"sleeping under the same blanket"* literally meaning sharing a hut with the wife and children and other dependants was blamed for frequent pregnancies in refugee households. Because each refugee household was issued with one blanket by the UNHCR, they are forced to share the same hut and blanket thus encouraging sexual relations in 'public'. Accordingly, this encouraged children to indulge in early sexual activities. This has also been blamed for frequent pregnancies.

Condom Use

In today's era of the HIV / AIDS pandemic, the condom has been widely recommended for the prevention of STIs and HIV / AIDS. This has resulted in a fairly high percentage of condom use in Uganda. In refugee settlements condoms were supplied at the health centres and by the community based distribution agents (CBDAs); the assumption being that the refugees had been sensitized and made aware of the importance of condom use. The main finding was that there was a negative connotation to the use of condoms. Condoms were never used with wives, but during sex with 'outside' women, such as prostitutes and to guard against HIV / AIDS. In my sample of 40 men, all men said they would use (or used) condoms outside of marriage, noting strongly that using a condom with a wife would raise suspicions of infidelity.

The condom was popular among the adolescent boys, however, they feared to use it as they suspected that sometimes condoms have holes. "We have been told that condoms are not 100 per cent safe because they could have holes". This perception negated the use of condoms among some adolescents. What appears to have annoyed the adolescents further was the irregular supply of condoms. "The health providers discriminate; once they see you are not a married man, they do not give you condoms". The girls pointed out that the health providers actually discouraged them from using family planning claiming ' they will burn their eggs'. It is therefore clear that the attitudes of the health providers to

an extent influenced the use of family planning.

8.5 Sexual and Gender-Based Violence

Vulnerability of women

I reiterate in this section that the social positioning of women in socio-cultural hierarchies and other institutions denigrates and predisposes them to lack of resources thereby making them vulnerable to insecurity found as common place in refugee situations. But what is vulnerability? According to Chambers (1989), vulnerability is characterized by long-term factors that weaken people's ability to cope with the sudden onset of shocks and stresses, exposure to risks, risks and defenselessness. He further suggests that the understanding of vulnerability must take into account the context-specific nature of risks and shocks, and the capacity of households to manage such risks. In addition, Ellis (2000) describes the most vulnerable households as those that are both highly prone to adverse external events and lack of assets that could carry them through periods of adversity. He further asserts that livelihood risks and increased vulnerability are reinforced by social factors such as insecure land tenure and insecurity of wage employment. The above definitions extend beyond the meaning often used by social workers to refer to individuals in a population who need special treatment because of a particular physiological need, i.e. disability, pregnancy, age, et cetera, such as referred to by Black (1994). According to UNHCR's approach to the definition of vulnerability, there were physically disabled refugees, pregnant women, single women, elderly men and unaccompanied minors in the settlement. However, my discussion focuses on women's vulnerability that results from the gender ideology and perceptions about the female gender and gender asymmetries. Hence, within my approach I combine several definitions to explain the degree of the vulnerability of women in the settlement. Case studies in this section go to show the complex nature of vulnerability and how refugees cope and adapt to their situation to generate livelihoods.

Gender-based vulnerability

The type of vulnerability in Rhino Camp covered a wide range of women; the married, the single head of household, the unaccompanied and the deserted, and the mentally retarded and mentally deranged. There were also men who were vulnerable by virtue of age and health. The above categories presented varied needs, which at times could not be solved by the camp community services officials. Many of these needs included women with drunken and violent husbands, poverty, lack of help to put up shelter, lack of access to resources such as food and milk for the baby and lack of medicine. There is another group of young women and teenage girls who are mentally unstable, who all have been taken advantage of and made pregnant. The responsibility of looking after the girls and their babies fall back to the parents who themselves are in a desperate state. One such case is Ester, who I present as case study 8.8 below. What struck me most was the deliberate sexual exploitation of girl refugees in Rhino Camp and the lack of institutional mechanism to address this problem. The violence manifested in several forms seemed to stem from the unequal power relations between the poor women and

girls and those in 'powerful' positions. This section can best be illustrated through the presentation of case studies.

Case study 8.8: *Mentally deranged Ester*

> Ester, a twenty-year-old refugee young woman ran towards me as I approached the compound. Right behind her were two men (who I later established were father and uncle) running after her with the purpose of apprehending her before she hurt me. As a stranger, practically all refugees in the area gathered around to see who I was and what had brought me. After introducing the purpose of my visit to the refugee leader, the refugees started to leave one by one. I was then led to Chapman's (Ester's father) homestead. The main reason I went particularly to this compound was because I had been informed that there was a young woman who ran mad after confinement and had subsequently wanted to eat her baby. I was concerned because this was strange behaviour, which indicated something was wrong. The Compound had three grass-thatched huts, one for the father and his wife and the younger children. Ester the first born of nine children and her bigger siblings slept in the second hut. The third hut functioned as the kitchen and also served as a store. At times other relatives slept in it. The courtyard was not very tidy but had a good tree shade where most of the family social functions such as eating and discussions took place. We sat under this shade during the several interviews for this case. The huts were fairly new as the family had arrived only a few months before, but we also learnt that they had just been rebuilt as Ester had burnt them.
>
> Chapman's family is one of the very few monogamous families I came across in Rhino Camp. Next to the stool I was offered to sit on was Ester's mother Ana, an old and wrinkled woman. I was informed she was forty years but going by the looks she could have passed for sixty. Ana has a reproductive history of having produced 12 children at full term but one died at birth in Sudan and another child died of measles in DRC and recently she lost one child of five in her present cluster. She also had three miscarriages resulting from fever. It was suspected that some people in the village where she lived in Sudan were jealous of her and bewitched her. Meanwhile during the initial interview two baby boys I mistakenly took for twins sat on her laps. I was informed one was hers and the other Ester's. As they fought and cried for the breast one could not help but notice the flabby and flat milkless breasts so hurriedly and painfully scrambled for by the son and grandson. It was obvious the breasts were beginning to dry up. The women relatives attending this interview said Ester's mother could be pregnant since they did not see any other reason why the breasts should be dry. Taking this statement a little further I asked if *mama* was ready to take on another baby amidst all the problems. The husband affirmed children were from God saying further that in a situation like this where one was not sure what the next day would bring, it was good to see that God gave them children. Meanwhile Ester's mother looked starved and could have done with a good meal. Ester's parents are Sudanese and belong to the Azande tribe

near Central Africa. The family fled Sudan to DRC in late 1990s due to the ongoing civil war in southern Sudan. Chapman was the head of the clan as such he fled with his entire clan, which included his mother, three brothers and their wives and children. Unfortunately Chapman's mother died of malaria in DRC. I was informed the main reason they fled was because the men resisted conscription in the SPLA claiming that only the Dinka and Nuer were being promoted. In DRC, they were at a refugee camp operated by UNHCR, but there were no education facilities for the children. In addition, the education system was French-based, which they do not use in Sudan. This, coupled with the ongoing war in Ituri Province in Eastern DRC forced them to relocate to Rhino Camp in 2001.

In Rhino Camp the clan comprising three households was allocated land plots, each head of household was given plastic sheeting for a makeshift tent while they built more lasting huts for themselves (they were given *panga* and a hoe). For the huts they had to depend on the ecosystem for the trees, grass and the mud. There was also a well nearby where the women fetched water for mixing the mud for the walls. Before the Chapman family relocated to Rhino camp, Ester had been raped by a gang of men and had become pregnant. She was pregnant when the family came to Rhino Camp. It was never clear who raped this young woman because she appears to have been traumatized by the incident. Thereafter when the baby, Maliyamungu, was born Ester neither appreciated the fact that she had a baby nor did she want to have anything to do with him. At one point it was stated, because of her mental condition she wanted to eat her baby. It was clear the baby would die if left in Ester's care as she completely rejected it. Ester appeared to be suffering from puerperal psychosis, a condition a few women suffer from during and after child delivery. The clan sat and decided to withdraw the baby from Ester and hand it over to his grandmother (Ester's mother) for breast-feeding. During the interview Ester's mother never said much. When I inquired why she was not saying much, her husband and brother in law who had taken full control of answering all the questions said she was just a woman who did not know much. "Yeye bibi tu peke yake hajuyi maneno mingi". She only smiled when talked to and it was difficult to obtain a confidential interview. The clan had met to discuss the likely causes behind Ester's mental condition. Chapman informed me how he had spent '*so much money*' to send for a traditional doctor from Zaire (DRC) who was good at these conditions. This was after the traditional healers in the settlement had failed. In addition the Ugandan traditional healers asked for so many things such as white chicken, goats, sheep which the refugees cannot afford. Asked why he had not brought the case to the officials of the settlement, he said Ester had been taken to a health centre and all she was given was 'an injection and a few tablets, and yet every one who has seen her says she is suffering from an African disease (ugonjwa wa kienyeji) and needs African medicine'. At the settlement health centre they said she was suffering from malaria and that is what they treated. All people participating in the discussion agreed in unison that the condition was 'traditional' and western medicine could not manage

it. For the time being they were administering the medicine by the traditional healer from DRC. However, this was not without hitches. The cooperation of Ester was necessary. The medicine was in several preparations, namely, it came in form of dried roots, ground powder, oil and a feather. Ester had to agree to drink the boiled roots, sniff the ground powder, to cover her head over a basin of hot water for a steam inhalation and to rub the medicine all over her abdomen including the genitals (according to Chapman, this would have been best done for her by her grandmother who died in the DRC), and to tie the feather in a particular part on her chest. It was doubtful that Ester's mental condition could allow that. Should the present treatment not be effective, Chapman has been told of a good traditional healer in Kenya. He and his brothers are putting together resources for this purpose.

Meanwhile, Ester's mental condition can only be summarized by the three skirts she wore, a blouse with a breast in and the other out and the fiery look in her face. I never heard a single word spoken by her. I was informed that she had set one of the huts on fire, which caused destruction to the few possessions they had. The situation was pathetic indeed. The few belongings such as the only one mattress, a few blankets, clothes and water jerricans for water collection had been destroyed by the fire. Having lost their belongings in this manner, they had no option but to sleep on grass mats as well as cover themselves with grass mats. Those without mats slept on the bare mud floor. Meanwhile the settlement authorities had not taken any remedial intervention for this family with a psychotic and violent daughter.

As new arrivals in the settlement, the family was still on 100 per cent food rations however we noticed during the fieldwork that the food supply was irregular. For a nursing mother of two, the situation meant constant suckling at the expense of one's life. This resulted in weight loss and constant fatigue for Ester's mother, who in addition was constantly worried about Ester. In a nearby shade sat Ester's siblings in tatters with blown up tummies and brown hair quite suggestive of *Kwashiorkor* malnutrition and intestinal worms. Meanwhile the family members had not succeeded in growing sufficient vegetables and legumes to supplement the diet. For the family this meant one *posho* meal a day without sauce and or accompanying vegetables. For an already frail nursing mother of two the precarious conditions of refugee life meant more hunger and deprivation. Listening to this story and observing the apathy and poor living conditions of this family led to the assumption that the refugee situation must have a profound impact on the quality of health in general and reproductive health in particular.

The above case study does not pertain to Ester alone. It concerns the whole clan who are worried about her case and who strive to put resources together to get treatment for Ester. At the same time Ester's mother's health is jeopardized because of Ester's health. The family cannot absorb the risks because the particular location, time and poverty of the family predispose it to further vulnerability. The family members show the

importance they attach to social networks when they mention that Ester's grandmother would have managed to apply the medicine but she died in DRC. But they do not give up hope. The coping mechanisms they employ are: getting Ester's mother to suckle Ester's baby (her grandchild) and to get traditional medicine for Ester as they strongly believe the disease is 'traditional'. They also take Ester to the health centre for treatment but are disappointed with the treatment she is given.

Case study 8.9: *Violence, rape and desertion*

> Shewla is a 17-year old mother of a six-month-old baby girl. She came to Uganda in early 1990s as a young girl refugee with her mother, stepfather and two siblings. Her own father died when her mother was expecting her. Although she does not remember much about her childhood, she says that they were settled in Ogujebe Transit Camp (This camp was in Adjumani district and attracted a lot of pomp and business and jealousies. The refugees did not want to leave because of the economic gains, particularly from sale of relief items. It was forcefully evacuated in 1998). Her parents were relocated from Ogujebe Transit Camp to Siripi Cluster in Rhino Camp. Shewla attended Siripi Primary School and completed Primary Six satisfactorily. While in second term of Primary 7 in 2000, she asked for a lift from one of the DED drivers to Arua (about 60 km away) to go and pick up her clothes. The driver agreed and gave her a lift to Arua. However on arrival to Arua, she says the driver informed her that she was now his wife and that he had written a formal letter to her parents. The poor girl did not know what to do next. She refused to believe him and according to her she spent two weeks eating and sleeping with the neighbours. She did not know where she was. After two weeks she was over powered by the driver and another man (most likely a relative of the driver). At this time she was not even let out to talk to the neighbours but was continuously raped and kept inside the driver's house in Arua. She says she wanted to escape, but had no money for transport. Eventually the driver decided to bring her back to Yoro Base Camp. By this time she was already pregnant. She actually says she wished she could get rid of the pregnancy. She says she was so mistreated through abuses and neglect that she wished to end her life. During the interview she repeated her wish to abort if she had had the chance. It was not her wish to become pregnant yet nobody came to her rescue. Her mother, a mother of three was totally against the idea. If anything her parents encouraged her to stay with the driver seeing as he had made her pregnant. They saw that she was better off with him than to have a child without a father. As there were not that many choices, she had to go and stay with the driver during pregnancy and even afterwards. She eventually delivered at Siripi being assisted by her mother who is a TBA. During the interview with Shewla, she would occasionally break down. She talked of the times she ran way from the 'husband' abandoning the baby and how they searched for her for days until she was found. At one time she hid in the bush and would hear them searching. She said the driver used to starve her. At times he used to give Uganda shillings 1000 (50 US cents) for paraffin, beans, *posho*, oil, tomatoes. This money would

never be enough. He then had a habit of following her to the well to ensure she does not run away. As if that was not enough, he would use nasty words to address her. The driver caused an accident with the Agency vehicle and ran away from duty. (He also sensed he was about to be laid off). Shewla had now been deserted, but she is happy. Apart from the reduction of mental and physical torture, she hopes she can lead her life once again. She has expressed her wish to return to school and complete her primary seven after which she hopes to continue with secondary school. Her mother is willing to stay with the baby. Meanwhile she was looking for employment to save for school fees. At the time of this interview, Shewla would be given casual work at the canteen where she would peel potatoes, fry *chapatis*, and make *samosa*s for a small fee. A few months after the interview, this girl rang me in Kampala and asked me if I could sponsor her for further education.

The above case study depicts the vulnerability of refugee girls and shows how those in positions of relative power can and do take advantage of them. Shewla's plight signifies hopelessness of the refugee situation, which is disempowering. There are not many 'viable' choices. Various normative values are employed by her own parents who reason that perhaps their daughter would be better off by marrying the driver. Second, the termination of a pregnancy may appear easy on paper; however, it stands the test of time in actual refugee situations. Here is a situation where the raped and pregnant girl wanted to terminate the pregnancy and yet her mother and possibly many around her opposed it. As earlier mentioned, inducing and effecting abortion in Uganda tantamount to a crime. Thirdly the practical gender needs of this girl were only being met through short and ill paid casual work. Indeed her desire to pursue education appears to be the main strategic goal for the transformation of her present position. Meanwhile, although the implementing agency knew very well what had happened, the only step they took was not to renew the driver's contract.

8.6 Conclusion

The overall main problem is the subordination of women and gender inequalities in the Third World countries. One of the arguments I raise in chapter 2 is that gender inequalities are reproduced and perpetuated to a great extent by the failure of the prevailing policies to meet the strategic and development needs of women. This chapter examined how development is brought to the refugees of Rhino Camp. The chapter discusses the nature of social relations and the gender arrangement patterns and how these are disrupted during refuge. The changes are influenced by three main factors: 1) the disruption that breaks down the normal lifestyle; 2) the effect of the new refugee setting; and 3) the implementation of humanitarian aid. In this last section, through a set of actor-oriented and gender analytical concepts; I conclude by discussing how these processes particularly affect the existing gender relations.

Gender relations and access to resources

The government of Uganda allocated government land totalling 225 sq kms for the

purpose of settling Sudanese refugees fleeing armed conflict in southern Sudan. The land survey and plot allocation was done by UNHCR. Land was allocated to each head of a household, irrespective of gender amounting to 0.3 ha per member of a household. Women had the liberty to plant what they wanted for food crops as well as cash crops. This may appear as empowering for the women, but how sustainable is it? Although the study identified that in some cases households headed by women were deliberately created in view of the likely benefits, nonetheless this change in ownership of land created gender conflicts. Even in refugee settings, men wished to be in and to feel that they controlled resources. I could see how some women displayed a non-caring attitude towards their husbands because they did not have to depend on them any more and how this infuriated the men. As we shall see in the next chapter, the Kiryandongo women refugees have threatened the men with serious consequences when they get back to Sudan now that they (women) have become empowered. It is true in some cases that women are the heads of households, however the sex ratio as I indicate above is almost 1 to 1 and many of the households are headed by men. The problem then is not who is the head, but who owns the resources. This condition has resulted into gender struggles. Women refugees in Rhino Camp aggressively took on the opportunities as well as the challenges in the refugee space. But at the same time they manage to comply within the circumscribed gender position. They did this by helping the men to cultivate their crops and all tasks they are supposed to do (even when this is done amidst complaints). At the same time they keep up with the duty to cut grass for the thatching of the houses. "Such struggles are founded upon the extent to which specific actors perceive themselves capable of manouvering within particular situations and developing effective strategies of doing so" (Long, 1999:3). During violent conflicts involving bodily harm to the women, the women shelved their husbands, in so doing they are producing and reproducing their gender identities. One other thing we should also note is that gender relations, "especially those being negotiated at the societal level are not geared towards the abolition of one sex because both have expressed needs for each other" (Mohammed 1995:28).

Power

Another point that deserves discussion is the notion of power in gender relations. In her study in Mexico, Villarreal (1994) makes reference to the socio-political spaces opened up by the interaction between the women and different social groups within the village and among themselves. This has also been evident in Rhino Camp. She notes further that such spaces are characterized by the creation of new identities and relations in which power based on existing and newly formulated interests and values are generated. Villarreal argues that " rather than assuming the existence of relations of domination/subordination based on cultural mores and differential access to critical resources (material, social and ideological), she sets out to explore the ongoing processes by which power relations emerge out of the interplay of elements of compliance, conformity and submission as well as resistance, defiance and opposition (Long, 1999 citing Villarreal, 1994: 263). Thus subordination implies both an action imposed from 'outside' and a self-inflicted condition (Long, 1999:11). This notwithstanding, I argue that the sources of power in each sphere are differently allocated to men and women. For example within the household, women may appear to have more power than with

regards to certain external issues and negotiate with a frame of reference provided by household relations. As child bearers and child rearers, their knowledge of children may give them greater bargaining power for themselves and for benefits on behalf of their children. On matters pertaining to religion, politics, etc., men have greater influence and through such frameworks are likely to make decisions concerning the well being of women. In such cases therefore, the men should be able to appreciate the significance of rural technology for processing food, cooking, cleaning, fetching firewood, carrying water, all traditional responsibility of rural women.

Any change in gender roles? Although there was a change for women as they acquired household headship and started digging, I did not witness men doing women's work. For instance, I did not witness any man brewing. The division of labour was quite rigid. Some men, however, were seen as 'helping' their wives by taking the grain to be milled and carrying sick children on bicycles to health centres. Relations between people or groups are not only a question of tasks, responsibilities and procedures. They are given form, reproduced and reshaped in day-to-day interaction. Have the socio-cultural attitudes and perceptions of gender altered? What does this mean in terms of social conflicts in homes? I wish to quote a statement by Hilhorst: " It is not enough to evaluate development for their allocation of material benefits. In addition we should question how discursive notions that are introduced with development interventions may alter local social realities" (Hilhorst, 2000:105). As mentioned earlier many humanitarian programmes were effective in meeting some of the practical needs of refugee women, such as healthcare, food rations, etc. However, participation of refugee children in primary education was embedded with gender inequalities. It was also noted that the modalities of distribution of non-food items, such as blankets were insensitive to the refugees' cultural values and practices. Men were forced to sleep in the same huts with women and children because of the one blanket supplied to a household. Viewed within a reproductive health perspective, the one blanket given to each household, according to the refugees, encouraged sexual activity and hence high birth rates.

Refugee aid and social actors

Planned interventions are based on several assumptions; I will only mention a few here. First, is the assumption that those 'with' resources command the power and the authority over those 'without' resources who are powerless and weak. Secondly, as knowledge is power, it also follows that the powerful possess the knowledge as well. Thirdly, the development interventions are premised on the basis of "modern scientific knowledge where the centre is sophisticated, advanced and valid, and conversely, that whatever rural people may know will be unsystematic, imprecise and often plain wrong" (Chambers, 1983: 76). Fourth, most refugee projects are based on the assumption that they are short lived as refugees would soon return to their homes. Thus, on the above (not the only) assumptions the planned intervention in the form of refugee programmes is implemented in Rhino Camp.

Planned interventions of whatever nature provide space for the interaction of actors (or key players). Long refers to this point of interaction as the interface. According to Long,

interfaces typically occur at points where different, and often conflicting, lifeworlds or social fields intersect, or more concretely, in social situations or arenas in which interactions become oriented around problems of bridging, accommodating, segregating, or contesting social, evaluative and cognitive standpoints. Interface analysis aims to elucidate the types and sources of social discontinuity and linkage present in such situations and to identify the organisational and cultural means of reproducing or transforming them (Long, 1999: Introduction). This intersection point was quite crucial for recognising the strengths and weaknesses of the actors. For instance, the rural folk (read refugees) though with a lot to offer in terms of problem solving (particularly food and health related needs) through their repertoire of indigenous knowledge were never consulted because the whole development process started from the position of modern science and sophisticated knowledge versus the weak and ignorant. Moreover, refugees have been viewed as 'powerless victims' in great need of assistance. I did not, for example, notice at any one moment when refugees were asked for advise on how they would tackle any of the multitudes of problems in the settlement. Women in most Third World societies are known to possess local knowledge (Chambers, 1983), however, in refugee settlements they were never encouraged to transfer it. The question commonly being asked in the maternity ward, "how much 'dawa ya kienyeji' (local medicine) have you taken?" carried negative connotations. Those who admitted they had used 'traditional' medicine were frowned upon, which forced refugee women to resort to denying. This approach would appear to be wrong, as 'traditional' medicines preoccupies the day to day living of most Africans (during sickness) before they seek for western medicinal interventions.

According to Long (2001), each of the different social actors brings into the interface their own lifeworlds. Lifeworlds is a term used to embrace different dimensions of social life. According to Ubel "it refers to material-economic dimensions, in terms of production and reproduction; to social dimensions in terms of relations, networks, groups and organizations; as well as to the cultural and ideological dimensions of people's lives, in terms of their perceptions, values and ideas" (Ubel, 1989: 187). This would infer that it is important how we analyze the processes of the various lifeworlds, which interact in a particular social arena. But we should not hierarchize lifeworlds, because the minute we do we shall be falling in the traps of 'modernity'. Recognizing the multiple realities (the different meanings and interpretations of phenomena by different actors) of the social actors should facilitate our understanding of the diversity in the social practice of every day life. This diversity also provides an opportune moment to design appropriate technologies for the target population (refugee actors).

Refugees, just like the other actors, also bring into the arena their own values, aspirations and norms. Just like any other community, they wish to preserve their culture. We noted that the division of labour was clear and distinct, with gender roles skewed in favour of men. Yet the displacement cut men off from their 'space'. The activities, hunting, fishing and blacksmithing of Sudanese men are hampered by the quite restricting refugee policies. But refugees should not be viewed as some disembodied categories. As social actors, they are knowledgeable and capable and employ their agency to strategise their livelihoods. They get jobs as food distributors (we should not

confuse this with the female roles of food provisioning, the job has a salary and other benefits that go with it). They also manoeuvre their way into the DED compound and get salaried jobs. There are more men on DED pay roll than women except in the health sector, where the ratio is almost equal. Men create room for manoeuvre and many move out of the settlements for casual labour outside. Many of them also have gone for higher studies while maintaining their households in the settlement. Although interface interactions presuppose some degree of common interest, they also have a propensity to create conflict. Thus, because of the perceived inequalities in terms of benefits by the nationals, conflicts emerge when goats and cows are let loose to destroy the refugees' crops, hence deploying such situations to their advantage. The differences between paradigms are displayed clearly in the one example I give where men farmers receive prizes (when in actual terms it is the women who have been doing the farming). Although gender planning has taken centre stage in most of the UN, the implementation as can be seen is still lacking. This appears to be endorsing the views of Human Rights Watch: "At times policies promulgated by UNHCR and practices in the field may be at variance with each other as in several cases interpretation is solely done by the implementing NGOs" (Human Rights Watch, 1997). Nevertheless, as Long (1999:10) argues, "field personnel are more than simply employees or subordinates of government or other agencies. They are also implementers, consciously transforming broad guidelines into specific forms of practice". In this chapter, I have shown how such specific practices emerge in Rhino Camp.

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[1] The notions of actor-oriented and interface analysis are based on the work of Norman Long as explained in Chapter 2. For further details see, Long, N (2001) *Development Sociology: Actor Perspectives*. London: Routledge, part one pp 7-92.

[2] For women, this comprises a long dress of any colour tied in the waist with a sash; for men it is a long tunic, usually white or cream in color.

[3] Kanzu is a long robe worn by men, particularly Muslim men.

[4] Swahili word referring to informal, quick and short-term employment.

[5] This system was first used in Malawi on Mozambican refugees.

[6] Workshop Report of the Improvement of the Nutrition of Refugees and Displaced People in Africa, University of Nairobi December 1994.

[7] WFP/UNHCR/OPM/Partner Joint Assessment Mission for the Sudanese Refugees in Northern Uganda, September-October, 2001.

[8] These refugees had rejected a government offer of settling in the Yumbe district on the pretext that insecurity reigned in the area. Their refusal resulted in government using force to move them. In the process it is reported three refugees were shot dead and seven others sustained injuries (The New Vision, 2 September 2003; The Monitor, 2 September 2003 and BBC 7.30 1m African news 2 September 2003).

[9] All settlement commandants in Uganda are men.

[10] Personal communication with doctor at Imvepi Refugee settlement in Arua District

[11] Protection cases requiring immediate evacuation are accommodated at Kyangwali refugee settlement in Hoima district.

[12] 'NGO' refers to the implementing as well as not for profit hospitals. The refugee health centres are not registered with government neither are they with the NGO Board. However I refer to them as NGO health centres.

[13] This test is done at the HC III only.

[14] I attended three of such sessions.

[15] Pueperium period refers to the six week period after delivery.

9

Gender relations, livelihood security and reproductive health: Discussion of findings and experiences from Kiryandongo refugee settlement

9.0 Introduction

This chapter discusses gender relations, livelihood security and reproductive health of refugees in Kiryandongo refugee settlement from an actor-oriented and gender perspective. It is an attempt to contribute to the understanding of the day-to-day realities of refugee life. I have already presented a brief history of Kiryandongo in chapter 7. The selection of Kiryandongo was purposive in that it is one of the oldest settlements for Sudanese refugees established in the early 1990s. The settlement was declared self-sufficient by the UNHCR in 1997 and receives only minimal assistance from UNHCR. In addition, though there are different ethnic groups in the cap, the refugee population is more homogeneous with the Acholi forming the majority (70%) of the refugees there. It will be noteworthy that the population of Kiryandongo changed overnight in August 2002 by the relocation of some 24,000 refugees from Achol Pii refugee settlement in Pader district after an attack by the Lords Resistance Army (LRA).[1] The relocation of refugees to Kiryandongo caused setbacks to the settlement, but that is outside of the scope of this study. My research concerns the old caseload of 12,483 refugees (UNHCR 2001). The discussion proceeds as follows. The first part (9.1) discusses the social organization of the Acholi and in the process I highlight the apparent changes that have taken place due to displacement and the gender implications these have had on the refugees. The second part (9.2) discusses the livelihood security including the issues of land allocation and food security as well as the coping and livelihood strategies refugees engage in. In part three (9.3) I proceed to discuss the education of the refugees and the gender-specific constraints affecting them. Case studies are presented in the appropriate sections. I discuss health care in part four (9.4) and in part five (9.5) I discuss vulnerability and the position of unaccompanied children based on two case studies. The conclusion in part (9.6) summarizes the key issues surrounding refugee livelihood and reproductive health experiences.

9.1 Gender relations among the Acholi

Acholi refugees constituting 70 per cent of all refugees in Kiryandongo form the majority compared with all the other gropus combined. I therefore focus the discussion on the social organization especially at this group. This was also facilitated by the ability of the group members to speak English and Swahili. The remaining findings, however, also include results from the survey and case studies collected among other ethnic groups in Kiryandongo.

Rules, norms and practices

The Acholi[2] are Nilotic people whose origins are in central Sudan (Atkinson, 1999). Currently their population extends to northern Uganda and was dissected by the Scramble for Africa. It is said that the number of Acholi in the Sudan outnumbers that in Uganda. Despite the existence of distinct differences, the Acholi belong to the Nilotic tribal groups (Butt, 1952). They are Luo speakers and share their origins with the Alur, the Luo of Kenya, the Padhola and Langi of Uganda. In addition, they are a patrilineal and patrilocal group who have no particular central authority. The political organization of the Acholi is at a relatively small scale and decentralized in nature. Their order is based on lineages, which are corporate groups based on descent, with an overlay of chiefly rule, the Rwot (chief).

Kinship and descent

In the Acholi society, statuses are ascribed; meaning that rights and duties, and claims to property largely depend on genealogical relationships to other members. Kinship links primary social groups. The ties of kinship give people claims to land for cultivation and to ownership of property. It also gives them authority over others depending on the social and political arrangements. For the Acholi, material life seems dominated by kinship – based agriculture, in which iron hoes were used to cultivate grain and other crops. Politically independent single-village communities, each with a dominant core lineage are common. Common social and cultural beliefs and practices are shared over wide areas, the need to marry women from outside one's own lineage (and thus circulate special goods as a requirement for bride wealth) and the periodic exigencies of warfare, drought and famine must have promoted ties extending beyond the small political entities (Atkinson, 1999).

Marriage parenthood and entitlements

Marriage provides a child with a socially recognized father and socially recognized mother. In most patrilineal societies, a child cannot belong to its father's lineage unless its parents have married in the appropriate way. If descent is patrilineal like it is with the Acholi, the child of a marriage belongs to his father's lineage. When this is done, through his father he has a claim on the productive resources of the lineage, whether these consist in land for cultivation, cattle, a fishing boat or even possibly a trading business. He can draw on these not only for his own subsistence, but also for special

needs such as the payment to make his marriage legal, or the payment for a compensation for a wrong done by him to a member of another lineage. Like the Madi, the social relations of human reproduction and production among the Acholi clan organization gives advantage to men as it reinforces patriarchal control of women by men. Land ownership is in the hands of men. Inheritance is patrilineal. A married woman has access to land in her marital home, but not in her natal home.

Gender division of labour

The economic activities of the Acholi were mainly agricultural and pastoral to a lesser degree. The agricultural activities targeted food sufficiency. Most of the crops grown were non-perennial grain crops. They included finger millet, bulrush millet and sorghum, simsim, pigeon peas, cow peas and green vegetables. Domestic animals included goats, sheep, cattle and chickens. Although agriculture has been primary wherever rainfall permits, farmers throughout the eastern and central Sudan seem to have almost always supplemented the cultivation of crops with the keeping of domestic animals. It is documented that the Acholi suffered reduction of their cattle due to tsetse fly infestation. Yet, cattle played an important role among the Acholi and their relatives the Nuer and Dinka.

Hunting was a male activity and extremely important as a social activity and source of food (meat). It was also the source of tribute for the *Rwodi (*chiefs). The Acholi also collected many other non-domesticated food resources including many species of fish; the leaves, shoots, stems, and fruits of numerous edible plants, shea butter and honey from wild bees.

Iron working was also an important activity of the Acholi as a means of production. The most important iron implement was the hoe and the most important productive activity was agriculture. Other iron implements included types of knives, axes, spears, blades and arrow tips. Most men relied on either spears or bows and arrows as their main weapons. This means of production based on rudimentary tools and human energy, always requires much effort. Two features of agriculture made labour demands particularly intensive among the Acholi. First, both finger millet and simsim, the preferred staple crops, require extremely high labor inputs. Second, the short rainfall season means that great amounts of work must be done during restricted periods in which clearing, sowing, and harvesting can be successfully be carried out. This required men to be an integral part of the work force. Cooperative labour groups were and still are common in those regions of Africa where subsistence is based on grain. Successful food production for the Acholi required and still requires considerable effort. According to a study of similar people in Zambia (Atkinson 1999: 60 citing Stewart Marks), food production and preparation takes up to two thirds of an adult's total work time. Farming itself absorbs about a quarter of the time worked. This direct farm work is spaced unevenly throughout the year; it is also shared unequally by men and women. Men alone do the heaviest field preparation tasks. Building and repairing huts and granaries, tasks also shared by males and females, take an additional 10 per cent of annual work time.

According to Atkinson (1999) the most time-consuming work of all is food preparation and beer production. Including collection of firewood, this takes up 50 per cent of the annual hours worked. As all these last named tasks are "women's work", the labor input of men in these societies is easily over emphasized. Women put in more than half of the total hours worked in the society and this does not include women's role as primary childcare and health providers. Women also contribute most of the labor for collecting wild vegetables, another 5 per cent of total work time. Despite its high profile, the mainly male domain of hunting (including trapping and fishing) occupies less than 4 per cent of the total time spent in productive labor throughout the year. The object of all this labor was to produce normal surplus to ensure the food supply in a season of poor yields.

Let us now examine the dynamics in Kiryandongo. How has the refugee experience affected the above processes? The following section discusses the types of marriage and social relationships in households including the gender roles. The main social actors identified are the women and men refugees.

Social Relations in the settlement - of marriages and human relationships

The sample for the survey comprised 200 respondents and constituted 120 women, 50 men and 30 adolescents. Apart from the adolescents, all respondents were married. Marriage in African communities is a major status symbol for men and women. It is also viewed as the very essence of continuity because through marriage life is reproduced. Resulting from exposure to several external factors, such as the missionary and colonial factors and Islamisation, marriage has undergone transformation. Two types of marriages were identified in Kiryandongo; the monogamous and polygynous type. The bottom line for marriage sanction was the payment of a bride price (or satisfactory negotiations to settle the bride price at a future date). Proxy marriages were organized; others were conducted on promissory understanding to pay bride wealth upon returning to Sudan. Significant numbers of adolescents just eloped and lived together; main reason given for this was poverty, high bride wealth and or pregnancy. Discussions revealed "marriage now and ritual ceremonies later when one has paid the bridewealth". Majority of the marriages in Kiryandongo fell under customary or traditional norms and they were conducted among the refugees themselves without outside interference. There was tendency for monogamous marriages to be solemnized by the Church and hence the state. But as I mentioned in chapter 8, this was no guarantee for the household to remain monogamous ad infinite. Marriage unions were expected to result into begetting of children. As I elaborate later in the chapter, the number of children consolidated the position of the wife. She was regarded to be in a higher position than one without children. Overall, men in Kiryandongo headed the majority of households.

Of the women interviewed during the survey, 75 per cent were in a polygynous marriage, with a majority saying they were three wives. The adolescents were single and claimed their next of kin to be elsewhere in Uganda or Sudan. A couple of Azande (the only Bantu group in the camp) refugee adolescents said their next of kin was their elder sister, a nun serving in Egypt. Currently these children were in the care of the Comboni

Sisters at the settlement (one of them, Teresa, provides an interesting case study, 9.4). Separation was common but not evident as the separated soon formed new relationships, which led to marriage. Single women were frowned upon and women refugees abhorred being called "*Malaya*" (prostitute).

Dependants

For this discussion, the term dependant is used to refer to any individual whose livelihood is the responsibility of a head of a household. The majority of dependants consist of biological children. Other than children there are older parents, nephews and nieces and siblings. The population under 18 is approximately 60 per cent. The concept dependant is very crucial in the administration of refugees in a settlement, for it forms the basis of entitlements. Food, non-food items and land are given depending on the number of dependants one has. Many times refugees did not report deaths of their children even to this researcher for fear of losing the associated entitlements. However, during my fieldwork, I observed many graves signifying refugee deaths even when records hardly indicated any refugee deaths. Whereas refugee statistics show an almost equal number of men and women refugees, the fact is women in the 15-49 age group outnumbered men since men moved in and out of the settlement. The issue of men's movements is not new. Sudanese men were known to travel to southern Uganda for temporary employment for bride price payment and bicycles after which they would return[3]. Moreover, it was observed that men registered their presence during the last UNHCR census in July 2001, when in fact they resided elsewhere. It can be argued that men's constant absence from the home has become a social reality for the women. It is therefore quite possible that refugees have registered themselves in more than one settlement. The practice beefs up refugee numbers and confuses project programming. The size of the household was affected by the refugee experience and ranges from 1 to 14 members (two men said they had 14 and 16 dependants respectively), with an average household having 6 dependants. The unaccompanied (the young and older refugees) in Kiryandongo posed a social problem for the administrators who also lacked the resources for looking after them. Women refugees would pose as single heads of households only to find later that the husband was in a different Ranch or settlement. In one specific case where the woman refugee had sworn she was single, the burial of her dead child had to be postponed until the arrival of the husband. Well-established norms can come 'for review' when material conditions change.

Homesteads and compounds

Unlike Rhino Camp that had a cluster system of residence, refugees in Kiryandongo were allocated plots on which they constructed their houses and cultivated, thus forming a compound or homestead[119] . This reduced the distances women had to travel to access their plots. At the inception of the refugee scheme, a single refugee would be allocated one acre (0.4Ha) of land and the maximum allocation was 10 acres (4Ha) for a head of household with more than 6 dependants. They were also given hoes, sickles and seeds. Men cleared land and constructed houses while women provided grass for thatching and water for the walling earth, while they also mudded the floors. It could

be observed that care was taken to restrict oneself to the gender division of labour. In this way refugees, as social actors, actively reproduced the culturally ascribed spaces.

The compounds were quite tidy and it was the duty of the women to sweep them every morning. The nature of refugee homesteads varied from a single house to many houses. The houses were in the form of huts; that is, one roomed round structure with an entrance and grass thatched roof. Most domestic activities such as cleaning, washing (some of the washing would be done at the borehole), and bathing, cooking and eating dishes were performed outside of the houses in the compounds. A kitchen was a smaller version of the main house. The single house homestead was associated to a monogamous couple with small children. The man lived with his wife and their children in a hut. In a few cases they also built huts for their very old relatives in their compounds. The older refugees married in Sudan before fleeing to Uganda and many have acquired other wives whilst in the settlement. The war in Sudan and lack of social services were constantly blamed for the reduction of the Sudanese people and underlay refugees' dislike for family planning. In a virilocal and patrilineal society such as the one under study married women were expected to reside with their husbands; in polygamous settings each of the wives has her house.

Grown-up children slept in their own huts, such that one found many huts in a compound. There were separate huts for boys and girls. Grown up children posed a specific problem when they needed to get other land upon marriage. The children who were below ten when they fled to Uganda are now in their early twenties and are demanding land. Traditionally this would have been the responsibility of the clan in general and the father in particular, however in refugee circumstances it is the duty of the government to allocate them land. Viewed from this perspective *refugeeness* eroded male authority and responsibility.

The refugee process brought one major difference in the residential patterns – individual residences modeled along the nuclear family set up. In Sudan, the tendency was for the clan to live together (that is, grandfather, son and grandson with their wives and children) on the same communal land. The children and the young would eat in the homes of their mothers, stepmothers and or grandmothers. But the new residential pattern is individualistic and opportunistic to the refugees who established *de facto* households. For polygynous marriages, the tendency was for the couple to split up. A husband would stay with one wife in the compound and have the other two or three wives register as single heads of household and acquire their own compounds (and agricultural land) in the same settlement. From an actor's perspective, it can be argued that refugees created room for manoeuvre and the possibility of exerting some control, prerogative, authority and capacity for action (Villarreal, 1992:256). The new reform in distribution policies by UNHCR, made sure that the distribution of food and non-food items was targeted at the head of the household irrespective of gender. This led to the creation of many more households than there would actually have been. In cases where the husband acquired another wife in the settlement, she would stay on her allocated plot of land and the husband would occasionally visit her. The majority of polygynous households spread across the three ranches, such that it was easy to find a man with a

wife in all the ranches. And this did not stop here; men refugees had wives in other settlements as well. Women refugees referred to their husbands as *'mobile husbands'* meaning that they never stayed in one place. Briefly let me mention an example, a rather sad one. A pregnant refugee woman in one of the Adjumani refugee settlements came to Kiryandongo to visit her husband and to get food. He was not in Kiryandongo when she arrived and nobody new his whereabouts. Meanwhile she went into labour, which became complicated and she died and was buried in the grounds of the health centre.

The absence of men and the presence of women as heads of households did not unduly affect decision-making. This was most likely because even in the Sudan women in polygamous households were accustomed to making some decisions concerning their families. Such decisions included education of children, clothing, seeking health care, food provision and sale of surplus. This finding invalidates the general assumption of the inability by women to make decisions. This is surely not applicable to women refugees in Kiryandongo. Male headship became an issue only when there was need to negotiate more plots of land as women could not negotiate or buy land. In addition, they were not to sell their husband's livestock or fowl. On the whole, women refugees confirmed they made the day-to-day decisions regarding the managing of their homes.

From the foregoing, we note that the refugee household presents definitional problems. We can note that the refugee household is complex and dynamic with constantly altering boundaries. Therefore, in our analysis we employ a multi-definitional approach of the household. First a definition by Rudie (1995) in which a household " … is a co-residential unit, usually family-based in some way, which takes care of resource management and primary needs of its members" (Rudie, 1995:228) is employed. Rudie's definition bears three important dimensions of household livelihood, namely, residence, family and resource management. However, in view of the constantly changing nature of the household in refugee settings (such as the creation of 'women headed' households for expected benefits, reliance on decisions by the family members who may be away but who make remittances, de facto and de jure households), there is need to view a household as concerning a group of individuals related consanguinally or socially with a common interest and who may be living together or apart but who constantly meet for important structural functions. This observation is in agreement with Guyer and Peters who observe that the household far from being a discrete entity, its boundaries are often very permeable since the units are embedded within wider structures. Furthermore, the household encompasses the domestic sphere as a contributor to and product of wider cultural and social processes (Guyer and Peters, 1987).

Changes in gender roles

Gender roles refer to culturally prescribed roles for men and women in a given society. They are not static but change in different social and economic circumstances. In Kiryandongo, the performing of daily activities was confronted by struggles and contestations between the social actors (the refugees). The refugees divided the plots of land into two sections; one section for the wife for her crops and the other for the

husband. This arrangement is within the cultural norms of land arrangement in Sudan where each woman is allocated her piece of land and is not expected to encroach on others' land. The role of feeding the family was the woman's duty from her piece of land. It was therefore her job to plant the food crops that would ensure the household had food security. In Kiryandongo, women were not permitted to plant anything in their husbands' plots. In the face of double production i.e., for food consumption and for sale, it meant women had to seek other plots from elsewhere for cultivation. As a coping mechanism, many women did sharecropping. This was a typical case of 'a social situation wherein the interactions between actors become oriented around the problem of devising ways of 'bridging', accommodating to, or struggling against each other's different social and cognitive worlds' (Long and Villarreal, 1996: 147).

Like is the case in Rhino Camp, in Kiryandongo there was a change in the gender roles with respect to land preparation and digging, and with respect to '*bona fide*' heads of households. Several studies of coping strategies in crisis situations have observed such changes (Jiggins, 1986; Twigg and Bhatt, 1998). Jiggins, for example notes that there is flexibility in situations of uncertainty and gives the example of how men in Tanzania welcomed a proposed water facility because they said, 'Water is a big problem for women. We can sit here all day waiting for food because there is no women at home' (Jiggins, 1986:10). It can be seen that men supported the water project so as to have their food cooked, and not for anything else. Still it can be argued that men were not willing to carry water but to help to bring it nearer to the women. In a way, this is a positive response as the water project in addition to improving the homecare functions, the time spent at the wells would have been greatly reduced allowing women to attend to personal issues perhaps. Forbes Martin (1995) asserts that in refugee situations, women are forced to assume new roles they are not used to. This was manifested in the land preparation and to a small degree in their roles as heads of households. But what increased significantly was the intensity of the daily tasks such as the fetching of water and fuel wood. Women indicated food processing as a time-consuming yet inevitable process. The activity profiles showed that men were engaged in fewer activities such as digging, charcoal burning, cutting wood, selling at the market than women. Charcoal burning as an activity increased the incomes of men. However, not only did it cause destruction to the environment, it also extended the distances women had to traverse in search of firewood (see diagram 9.1). Trying to reverse the environmental destruction the UNHCR has planted 50 acres of trees in the surrounding areas alongside the main road to the north. On average men's working days lasted 6-7 hours. Women, on the other hand did more, such as digging, weeding, cleaning, cooking, washing up, washing, fetching water, fetching firewood, food processing, nursing the sick, etc. They also went to the market and took sick children to health centres. Women worked longer hours than men did and their tasks were repetitive. For most women, the day started at 5 a.m. and ended at midnight. This finding is in agreement with earlier studies conducted in the Kiryandongo and Ikafe refugee settlements for Sudanese refugees (Payne, 1998; Thirkell, 1995).

In any homestead, women had to socially relate with many more people than just the husband; for instance, in-laws or her own relatives staying with her. In Kiryandongo,

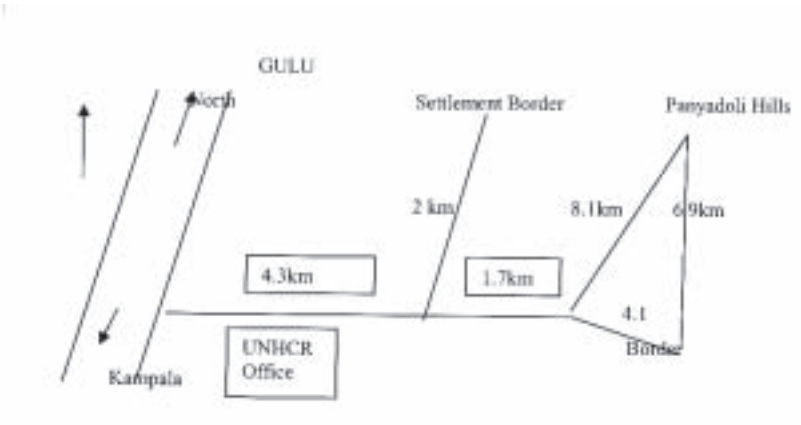
due to family disintegration resulting from forced displacement, homesteads are not the typical Acholi style where one finds many dwelling units. Many times, one finds a lonely hut without neighbours. Women complained about losing their kin networks when they were scattered by the war. The completion of household chores becomes a problem when one lacks the usual social support mechanisms. They said they missed assistance during burials, and during the planting and harvesting seasons. From discussions it appeared this forced them to produce more babies. Many of the women constantly reminded me how no African ever stays alone. "Even barren women get children of their sister or brother'. To try and address this social network issue, women actively joined women digging groups, market groups and were active in the women's association on the settlement. All these activities cannot be accomplished unless one has help. This could partly explain why many girls drop out of school. Women therefore tried to enrol others in their activities especially because those enrolled were sympathetic and had similar interests. In this way, conflict was reduced. As domestic work is strictly women's work, boys had less to do where most male activities like ironwork, fishing and hunting did not exist in the camp environment. Men would say during interviews how they missed hunting; fishing and ironwork, but agreeing also that this allowed them more leisure time than women.

The collection of firewood

Fuel-wood gathering is a female activity. The first few years at Kiryandongo witnessed a near complete destruction of trees through charcoal burning and selling. Trees in the settlement were cut, first by men engaged in charcoal burning and now also by women who have joined their men folk in the trade. Male refugees sold the charcoal to buyers from the city. They then would buy women's charcoal at a give away price because they were desperate for cash only to make profit from their labour. As I have mentioned above, this activity depleted the trees. As a result women refugees have to walk now several kilometers in search of firewood. Anastasia a mother of eight (age range 1-12), narrated how she after walking several kilometers to Kimogola in the Panyadoli hills, had to spend at least two days before returning to her home. The settlement has a total area of about 3725 ha with a road network of about 27.1 km long. Diagram 9.1 below shows the distance women travel for firewood in Panyadoli Hills. The first day was spent cultivating for the owner of the forest, the second day in collecting (only picking what has fallen down and splitting if necessary to lighter weights) and then carrying the bundle on ones head back. The women are not supposed to cut trees but *pick only*. For many women refugees, the fire wood collection process is "the most laborious and time-consuming". Interestingly, despite efforts in other refugee settlements at conserving energy, there is nothing in Kiryandongo to suggest that these women benefit from energy-saving stoves. How can one link fetching of firewood with gender based violence? Women indicated that the time they spend in the forests denies their children the necessary care. Moreover, women without proper child minding facilities end up carrying the babies on their backs and leaving the other children at home. As mentioned already, the sexual division of labour gets clearer demarcations in refugee situations. Men get jittery when they have to stay with little ones and have to meet their needs during the time the women are away. Upon return from the forests, it is not strange that

men ask them where they have been for that long. Usually such questions ended up in physical fights. How women dealt with these problems depended a lot on the resources at their disposal. Some women stored the residual maize stems and even bean and peas residuals, which they later used to cook their meals. They also resorted to the quicker cooking food such as groundnut and simsim sauce, or vegetable relish and the mingling of *Ugali* (cassava and sorghum flour). In addition, they tended to prepare the day's sauce and vegetables in one go and warm it up during serving. This was how they saved on the fuel energy.

Diagram 9.1 Road Network showing distances women travel to fetch firewood



Fetching water in Kiryandogo

The duty of fetching water is a female activity in sub Saharan Africa. I established that there is a direct relationship between gender relations and violence in Kiryandongo. Water collection is a time consuming activity. Women reported how their husbands were insensitive and continuously accused their wives of having affairs with men on the pretext of fetching water. Such arguments ended up in beatings and bodily harm. As case study 9.1 indicates, sexual violence took place and water fetching provided the opportunity for such abuse. Girls and even older women said they were raped on the way back during the dry season when the water table receded when they spent more hours at the well and returning home after dark. An older woman expressed her feelings over the reporting of rape incidents. "How can an old woman like myself report that I have been raped? It is better to keep quiet". Many said 'no matter how early one is at the well, darkness will catch them there". During the dry season women literally slept at the borehole to beat the queue. Men also queued up for water at the boreholes, but their water was for sale, or for their bathing and washing of their clothes. The Masindi district is known for its lack of fresh water rivers. In addition, the poor maintenance of the boreholes rendered them non-functional. Of the 36 initial boreholes, only 20 were operational. And yet the demand for water kept rising with an increased population. Within this context, it is little wonder that many hours are spent in queues to the detriment of girls' education.

Children especially girls help their mothers to fetch water. Could this be a justified reason for wanting and having many children? Role conflict can be a source of social conflicts as Ana's case below illustrates.

Case Study 9.1 Gender roles and violence

Ana is a married Sudanese refugee woman of about 25. She is married to the driver of the refugee settlement commandant. The two are the main characters of this case study. Every morning before my fieldwork into the settlement, I would pass by the office to say hello before going about my fieldwork. On this material morning I noticed that the driver had sustained a cut on his forehead. I was informed that he been involved in a bitter fight with the women who prevented his wife from getting water before she went to school in the morning. We were still discussing how unfair that had been when we saw an elderly woman, her son and husband approaching the office. Apparently word had gone round that they would be coming to the office to avenge the assault on them by the driver. And the Police at nearby Bweyale had been notified. So when the 'wronged' group arrived at the office, they were put into the ambulance with the driver. What amazed me was the fact that although the driver was the accused, he was the one who drove the entire group to the Police Station. A few hours later the driver and the commandant were back to the office. Upon inquiring about what could have sparked off the incident I was informed that Ana was a mother of two children whose husband had died in the Sudan. He had been a soldier in the SPLA. Meanwhile Ana had acquired a new husband, the driver of the Camp Commandant. He was also a refugee with secondary school education, which earned a good job and quite lots of respect. In most instances, the respect extended to the borehole as well. It was learnt that every time Ana and her children went to fetch water, they did not need to get into the queue; after all every body knew she was the wife of the driver and she was also in school. But there were those who did not care about it. On one morning in the usual style Ana went to fetch water before she could go to school. The queue at the borehole was long and most women had been there since the small hours of the day. Her attempts to get water before queuing were thwarted by an elderly woman. Ana resisted the opposition and was intent on getting the water. A scuffle ensued; many other women joined the old lady and they started to beat Ana. One of her children ran and informed the driver what was happening. He did not take immediate action waiting for the evening to go and attacked the old woman at her home who had also informed her people of the incident. The driver then beat the husband and the son of the old woman. The driver appears to have taken them by surprise; they had to mobilize themselves and plan a counter attack. At the Police, they were accused of causing bodily harm. As I left a few days later, rumour had it that they bribed the Police who let them go. They were back in the settlement and one wondered what they were planning next

During an interview with Ana, she expressed many problems that confronted her. With two children that did not belong to the present husband and her

inability to have a baby with her current husband made her future quite insecure.

"Which man will tolerate me if I do not produce him children. Even this fighting he is doing is not because of me, it is because he thinks people by denying me water are despising his authority".

The gender roles in Ana's case constrained her ability to attend school. She had to make sure food was cooked, water fetched, clothes washed and ironed, and completed several other chores. This left very little time for her reading. She is also worried about the cause of the death of her first husband. She is worried it could be AIDS. She has the ambition of becoming a clinical officer. She also informed us of how there are so many young women in the settlement, who wish to resume studies, but who are constrained by home problems.

Looking at this case, we note that during the gender struggles described above, social actors used their positions to transform and manipulate the rules for their own interests. The borehole was the intersection point where the struggle over resources and meanings take place. Understanding these relationships would be the key to shaping the ultimate practice that would be beneficial to all actors. I have pointed out that of the 36 boreholes only 20 were functional and yet the demand for water kept on increasing. The fact that the refugees could not repair the boreholes after UNHCR had left exposes signs of dependency where refugees were always used to having things done for them. On the other hand, it could be due to "modernization' where spare parts cannot be found. The fact that water collection is a woman's duty can be seen to shape human action with regard to the repair of the boreholes, in this case a man's job. I learnt later that the spare parts could not be easily obtained.

9.2 Livelihood security

Understanding livelihoods involves more than one view. One should view the household not only as an economic unit but also as the locus of relationships who are enmeshed in a web of relationships within it and beyond (Francis 2000:146). The concept of livelihood has been sufficiently explained in the previous chapter. My aim in this chapter is to show the changes, which have taken place in the livelihood security and how this has shaped the ensuing livelihood strategies. However before proceeding, I want to add a word about strategies. Anderson *et al.*, (1994: 20) define strategy as "a useful shorthand for the overall way in which individuals and possibly collectivities, consciously seek to structure, in a coherent way, actions within a relatively long-term perspective'. The time element therefore is significant as we examine strategies. Two types of strategies have been identified, the long term and coping strategies. Coping has been defined as short-term response to an immediate decline of food (Davies, 1993). However in a study of refugees such as this one, which involves many uncertainties and crises, I prefer to refer to coping as the way refugees respond to the daunting challenges of refugee life. This is broader and more encompassing. In the process of my discussion I shall refer to the strategies refugees devise in this broader fashion.

Bweyale Trading Centre

The trading centre is about 10 kilometers from the refugee settlement. From the turn off point to the settlement, it is about 6 kilometers on the Kampala-Gulu highway. Before the establishment of the Kiryandongo settlement, there was only a couple of shops and nothing much by way of economic activity. But the presence of refugees has changed its outlook. There is brisk business going on there, as it is a stopover for the traffic moving to the north and the south. It has not only offered economic opportunities to refugees but also to the internally displaced persons (IDPs) from the districts of Gulu, Pader and Kitgum and the nationals of the surrounding communities. There is daily heavy traffic of women refugees carrying their grain and other items for sale to the market in Bweyale. Here they sell fish, millet, sorghum, cassava, pots, mats and crafts, tobacco, green vegetables, simsim and groundnut paste. In addition they also sell cooked snacks and pancakes and alcohol. A few refugees own shops and sell groceries, maize grains and milled flour. Two refugees own and operate milling machines. Two male refugees own lodges. Other men sell clothes (new and second-hand), shoes, handbags, cloth material, and many more. There are also a couple of drugstores operated by refugee men and a health clinic by Ugandan doctors. Men sell goat meat and beef. Half the shops (the total was about 35, but they increase all the time) belong to the refugees in Kiryandongo many of who have moved to their businesses but are retaining their wives in the settlement. The analysis in this section shows that men are more active in activities that generate income and are outside of the home. Moreover, it can be seen that almost all refugees reserve time to attend the market for their respective 'projects', but each in their own domains.

Land, agricultural activity and food security

I decided to discuss the above-mentioned variables jointly, because they are strongly linked and influence each other. Land as a resource can provide food as well as income derived from the sale of food and cash crops. Therefore, the size and productivity of land and the agricultural practices including the cropping patterns are crucial for food security. Associated with this is the amount of labour and capital refugee households have at their disposal. Furthermore the food insecurity will also influence or be influenced by the consumption patterns and food intake. Food security is defined by the International Conference on Nutrition as "access by all people at all times to the food needed for an active and healthy life"(Mula, 1999:29 citing FAO). For the refugees in Kiryandongo food security always meant to have some food stored in the granary at all times.

Agriculture is the mainstay. Initially refugees with more than 5 dependants were allocated 10 acres of land, and seeds and other farm implements were distributed. This gave the refugees the opportunity to grow cash as well as food crops. In a way it can be argued that the land allocation policy was an incentive to large families even when the primary objective of allocating land to the refugees was to assist them to become self- sufficient in food. Refugees in Kiryandongo settlement were sustained on food rations until 1997 when the food rations were gradually phased out after successful bumper harvests the previous seasons.

This prolonged period of food distribution accorded the refugees room to accumulate capital (through the sale of the food they cultivated) to start other income generating activities as discussed in the previous section. Men and women formed digging groups and made good use of the land. Women were in addition assisted by other women and their children. They had bumper harvests in year 1995 and 1996 and actually sold their maize to the World Food Programme in Kampala. (it was on this that the phasing out of humanitarian assistance was based). However, thereafter, the crop has not been so successful most likely due fluctuations in rain seasons, the increase in population and the unproductive land in Ranch 18 and refugees have experienced food shortages.

The basic source of livelihood for the majority of refugees in Kiryandongo is derived from land. I observed, during fieldwork, that refugees who reside in Ranch 1 and 37 had good yields from cultivation. But as a source of income, the earnings fluctuated and were influenced by season and amount of food sold and the market prices. In 2002 the supply of maize exceeded demand. The price of maize grain dropped to Ug shs. 40 from 200 per kilo. Men and women sold their maize separately. This way, they created their own social domains from which they derived their gender identity and authority and were able to wield power. I also noted differences in what men and women planted. Women planted several crop types such as simsim, cassava, sorghum, beans, maize and green vegetables; much of this was consumed at the household level and smaller amounts sold to vary the diet and buy other necessities such as paraffin, soap, cooking oil, clothes and medicines. Women also inter-cropped not so much as a coping strategy but as a food enhancement strategy (this is done all the time, not only during famine). Men on the other hand, concentrated on maize and cassava, which they sold and used some of their money (although this essentially fell on women) to buy school items for their children.

Land is now becoming a scarce commodity in the settlement. This is most likely due to high birth rates and family reunions that increase the population and to the rocky, infertile and unproductive soil in many parts of Ranch 18. Refugees in these areas found basic survival difficult. They had to look for land for cultivation in other areas far from them. The Acholi IDPs who appear to have integrated in the settlement were blamed for the emerging land scarcity. The pressure placed on land is solved by "borrowing" land from the hosts or from refugees with bigger plots of land. It was expressed that only men negotiate matters related to land. This, therefore, gave men the advantage of growing cash crops. Other factors blamed for low productivity of land consisted of soil exhaustion due to mono-cropping, poor farming practices and post-harvest losses caused by limited marketing opportunities. However, women as knowledgeable and capable beings were not just 'disembodied' and passive categories, to use the words of Long (2001). They devised ways of getting over this problem by 'borrowing' and share-cropping. In the face of the growing demand for land, there is a need to apply better agricultural practices or adapt more intensive methods. There is not much livestock, although both men and women raise goats, chicken and keep beehives.

There have been periods of food insecurity in the camp; these have been influenced by

a number of factors. I have already mentioned the poor soil fertility in Ranch 18 and the increase in population. Another factor mentioned by the refugees was the irregular supply of food by WFP. This problem was particularly evident during the early 1990s when the refugees were totally dependent on food rations. In addition refugee households have experienced food insecurity during seasons of prolonged drought and the unreliable rain pattern during the last ten or so years. This period coincided with reports of high malnutrition levels for the age group under five.

Coping strategies

The discussions showed different experiences for men and women. Most men went away to look for casual labour for their livelihood. Many migrated to the southern part of the country in search of wage labour (women were later to complain that some of these migrations end up being permanent, as men do not come back). Others exchanged their labour with food from the nationals in the villages in Masindi. Young men deserted the settlement altogether deciding to move to Kakuma refugee camp in Kenya where they were assured of food and 'possible resettlement'. Most of the time, their movement involved going through Sudan and presenting oneself in Kakuma as new refugees from war ridden Sudan. The women on the other hand, remained with their children. They devised several coping strategies. In anticipation of food shortages women sun dried and stored green vegetables (*marakwang);* they also stored processed simsim and groundnut paste. Some sold the domestic animals and chickens to buy food. They searched for wild fruits and fed their children on unripened mangoes, thanks to the great endowed with mango trees in this part of the country. They also changed the consumption pattern to one meal a day in periods of scarcity. Food preparation practices also changed in some cases. Refugees mentioned how they poured a lot of water in the sauce and / or how they ate *ugali* with no accompanying relish or sauce, "just salt and water". They begged from neighbours who, like them, had nothing. In addition, they resorted to *leja leja* in exchange for food from the nationals. However, this was compounded by the fact that the nearby villages were soon depleted of food as well. This implied that the women had to walk even longer distances in search of food, which they did on a daily basis as they had to return home to look after their children. During such times of food shortage, women were known to go to bed on empty stomachs. "How can we eat when children are looking at us?" Breastfeeding mothers suffered doubly, first, with their own hunger and second, with the hunger of their suckling babies. Refugee women came to each other's rescue in this time of need through social networks. A group of women would decide to go to the villages in search of food and while there they would take on (*patana*) piecework jointly. They would do this in a few homes and then distribute the food among themselves. This way, it would be easier and quicker for them. But the girl children were always withdrawn from attending school to look after the young ones while their mothers went to search for food. Another strategy was to send some of the children to their relatives in other settlements or even back to Sudan. Some women mentioned they had relatives who sent them money from abroad. It was difficult to establish how much was sent but it was used to buy food. Relatives included husbands and brothers who as refugees had resettled in the USA and Canada.

The above were coping and short-term strategies, which changed as soon as the food security improved. However, presently land seems to be the only viable source of food and income. There is a need for the refugee women to cultivate for food consumption and for sale. This trend is likely to lead to food insecurity due to over-use of land and a reduction in the output and the tendency to sell all the food to obtain income for other needs.

Table 9.1 Summary of coping strategies by gender at Kiryandongo

Men	Women
• Exchange labour for food • Casual labour • Sell domesic animals • Migrate to southern area • Seek refuge status in Kakuma in Kenya	• Prepare and store *marakwang* in anticipation • Reduce on meals • Serve ugali without accompaniment • Increase volumes by adding water to sauce • Forage for wild fruits and vegetables • Feed children on mangoes • Leja leja in groups for food • Go without food • Send children away to relatives • Sell chickens

Other income-generating activities

In addition to the selling of food, other income-generating activities (which comprised the long term survival strategies) include *leja leja*, selling firewood, motor bike transportation (*boda boda*), grinding mill, ox plough hire services, traditional birth attendants, traditional doctors, carpenters, cobblers, drug store operators, health providers, teachers, video and disco owners and pottery. In particular, brewing and distilling were a major activity for many women. The profitability of this activity was difficult to estimate due to the fact that most of the inputs were not purchased. This includes cassava, maize, labour, firewood and water. There was no official and organized micro-finance activity; women operated their own lending and borrowing groups. There is a small trading centre in the settlement with shops on each side of the road. In addition, there are two restaurants, one of them operated by a woman refugee and a barber's shop. Behind the shops is the daily market where refugees buy their food stuffs such as dry fish, cassava, leafy green vegetables, sorghum, and *Ajon or Lira Lira (local brew)* The shops sell mainly groceries. I identified two women shopkeepers working jointly with their husbands. The remaining shops (about 15) belonged to men refugees. The drug store in trading centre belongs to one refugee man who employs a young woman to sell medicines. A woman shopkeeper, Angelina, a senior three leaver had five children. She is an Acholi from Uganda married to Michel, an Acholi refugee from Sudan.

Michel was pursuing degree studies in education in Kampala under UNHCR sponsorship. Angelina informed me of how she was not permitted to use any money from the shop until the husband said she could. And this had to wait until he came back for holidays. She however consoles herself that she does not have to dig as she is on food ration, because her husband being a student is still on food rations. And in any case it was his money that started the shop and as long as she is free to use the cooking oil and the sugar and soap from the shop all was fine. For Angelina accepting and rationalizing the situation was a coping strategy, which kept her in equilibrium. As a social actor, Michel is manipulating the gender ideology to his benefit. When he restrains Angelina he is manipulating certain norms and values to the domain from which he derives authority and wields power.

Women's Associations

Diicwinyi Refugee Women's Association is registered with the government as a community-based organization (CBO) run by 28 refugee women, who are all Acholi. The main aim of the CBO is to act as an umbrella for the smaller women's clubs and to train women in income generating activities. The CBO has an administrator, a treasurer and a secretary (apparently from one area in Sudan). Some 10 women's clubs are registered under the Association. The CBO received an initial grant for its activities from Equatorial Civic Fund (ECF; a local Sudan initiative). Activities of the Association include training in 'modern' farming, goat rearing (currently, they have over 50 goats), nutrition and training in small business skills. In addition, 42 widows engage in fish selling. However the CBO management was accused of using their position to keep out the non-Acholi. Some Acholi refugees also accuse the organization of being sectarian by assisting only those who belong to their clans. It was therefore observed that the CBO had experienced conflicts and contestations. Unequal power relations appeared to have shaped the direction of the CBO and the interaction between the women members. By using this power the CBO management created room for manoeuvre where they could recruit members of their choice. Discussions with the non-members seemed to suggest that the administrator was 'a cruel woman who only liked the Pajolu and the others listened to her because they are her relatives.' I later discovered that she was a relative to the owner of the organization, which funded the CBO. Besides most of the members were kin related. These women wielded power over others in a bid to secure their own livelihood and that of others, who represented their interests. Thus, they viewed others with suspicion and contempt and in so doing managed to keep them away. As the discussions progressed it was learnt that some of the goats were slaughtered and consumed during funeral rites or other important occasions. This was always decided upon by the administrator. As for the women members who sold fish, they once in a while brought some to the top management team.

Thus, it can be argued that although all refugees are exposed to the same refugee situation they respond to it differently. We can view the interactions as sites for conflict, incompatibility and negotiation. Although interface interactions presuppose some degree of common interest, they also have a propensity to generate conflict due to contradictory interests and objectives or to unequal power (Long, 2001: 69). The nature

of the livelihoods, the coping and survival strategies of refugees in Kiryandongo point to the behaviour of social actors, each with their own 'projects', which they tried to enroll others into. When an Association is formed for the common good of refugee women, it is quickly high jacked (and almost personalized) by a few people to whom allegiance must be made. We have also seen that there does not always appear to be clear-cut, mutually exclusive alternatives for women refugees. The above endorses the eclectic nature of human practice to live in and adjust to all sorts of environments and situations.

Table 9.2 livelihood strategies by men and women refugees at Kiryandongo.

Men	Women
• Charcoal selling • Selling fire wood • Shoe repairing • Teachers • Blacksmith • Carpenters • *Leja leja* (piece work – digging) • Selling cash crops (tobacco, sorghum, maize) • Wage labourers • Tailoring • Shopkeepers • Bicycle repairing • Operating video and disco • Oxen ploughing hiring services • Motor bicycle transport	• Charcoal burning and selling of charcoal • Teachers • Nurses and midwives • Traditional birth attendants • Beer brewing and distilling • *Leja leja* (piece work – digging) • Cultivating for home consumption • Selling surplus in market • Pottery • Selling in market • Selling chicken and domestic animals • Apiary

9.3 Primary education and the girl refugee

It had been hoped that the refugee pupils would be absorbed in the Universal Primary Education (UPE) programme with the handover of the refugee scheme to government, but this was not the case. As such, refugee children are not included in the district plans and do not benefit from UPE. The education of refugees is still the function of the UNHCR. During the years (1991-1996), four primary schools were built. The UNHCR pays the teachers salaries. Some of the teachers are qualified teachers while others work as licensed teachers. The only nursery school in the settlement is operated by Comboni Sisters. Apart from *Saving Grace (*an American NGO affiliated to the Episcopal Church*)* that offers literacy program for adults, there were no provisions for older women to attend school. The primary schools were enthusiastically attended, however, the table below shows girls' enrolment to be 39%.

Table 9.3 School enrolments by gender in two schools 2002

Name of school	Girls	Boys	Total
Bidong Primary School	129	242	371
Panyadoli Primary School	309	453	762
Total	438	695	1133
Per cent	39	61	100

Source: compiled from study findings

Just like in Rhino Camp, the retention of girls progressively reduced as the classes got higher. Girls dropped out due to several reasons, the main one being pregnancy. Reports kept emerging of a teacher who "is fond of making young girls pregnant" having made up to three primary school girls pregnant during the year 2000 and 2001. Due to his status and the power it yielded, matters were settled traditionally. This meant paying fines and marrying the girls. This appears to have been an unfair use of his power and position as a teacher over the powerless refugees. Would a statement such as this one by Chambers refer to this scenario, "What can and should we, as uppers, do to make our realities count less, and the realities of lowers – the poor, weak and vulnerable count more?" (Chambers 1997: 101). What was most disturbing was the powerlessness of the parents. The parents seemed not to know their rights and thus, were unable to take legal recourse. On the same note, the boys who made girls pregnant were reprimanded and some imprisoned. Making matters worse, a male teacher after knowing he was HIV-positive, lured girls through money and other gifts into sexual relations. He died in 2002. But the use of power by those in formal positions of power, such as the teacher I refer to above, does not mean others are without it. The fact that he meets very little resistance means that his subordinates adapt to the prevailing order in anticipation of possible conflict, which might work to their disadvantage. According to Schrijvers (1986: 18), "It is in such a situation that powerlessness has its most absolute form: when a category of people without questioning, and without protest, willingly serves the interests of the powerful".

Gender-specific constraints to girls' education

Several factors were identified as contributing to the gender inequalities in access to education. Many parents were quite anxious about their daughters getting pregnant. As I indicate below, girls in the settlement were quite vulnerable to incidents of gender-based violence. Parents blamed mixed schools, which "gave too much room to students to misbehave". Most mothers were willing to send the girls to school before they 'developed' breasts after which they would remove them from school fearing the teachers as much as they feared the boys. As one mother said: "[y]ou see for us we are refugees and when a teacher wants your daughter and is willing to pay even a very small amount of money, the father will just accept it and your daughter goes for nothing. Even the teacher can have many women, he doesn't mind ……".

The male/female ratio of teachers was unbalanced as can be seen in table 9.3 below. Of the total 41 teachers in the three primary schools, only 7 were women and only a few of them were trained teachers, the majority serving as unlicensed teachers.

Table 9.4 teachers by gender and school

School	Male	Female	Total
Arnold	16	4	20
Bidong	8	2	10
Panyadole	10	1	11
Total	34	7	41

Source: Compiled in July 2002

The age at which girls start school is therefore quite important in this respect. Generally in refugee settlements, girls and boys start school late. I have already discussed this issue in the previous chapter and there is not much difference in Kiryandongo either. I noted that the absenteeism rate for girls was higher than it was for boys. Causes for the absenteeism rotated round role expectations within the gender division of labour. One ten-year-old girl narrated how she had stayed home to look after the baby while her mother went to sell *'Ajon'* (local brew) in Bweyale.

The commoditization of girls was yet another significant constraint to girls' education. Bridewealth arising out of girls' betrothal was used to pay for the boy's education and the bride price for his wife. In this case the girl becomes a commodity which when sold the proceeds offset bad debts and help to transact business. This could therefore underlie the hurried nature of the way girls are married off. Poverty is another factor. Most men said that they married off their girls to prevent pregnancies. And that it was also the custom to use the money from the bride price to pay bride price for their sons. This view indicated that due to poverty and the men's wish for the sons to progress in school, there was need for bride wealth from the girls. Early marriage also allayed fears that the girls would get pregnant and start producing in "their fathers' compounds". The girls and their mothers seemed to have had little say in these marriages, which appear to be forced. Young girls are then exposed to early pregnancies. It has been noted that adolescent pregnancies contribute to the high maternal and infant mortality rates (UDHS, 2000/1).

The girl refugees themselves confirmed that the girls were more interested in getting married than attending school. What was not clear was why this was the case. Getting married and having children rather than going to school appeared highest on the ranking grids given to the girls during interviews. It was also observed that the socialization process placed undue psychological pressure to the girls. They were constantly asked to stay home and help; always reminded how they would soon be withdrawn from school before they got pregnant.

A casual walk through the settlement or even a visit to the health centre indicated high numbers of teenage mothers, many of them below 15. The girls' attitudes to education seemed negative.

The lack of a 'girls only' toilet also seemed to be crucial to girls' attendance. Girls indicated that they feared to share latrines with boys especially when menstruating. Parents echoed this problem as well. Related to this was the lack of sanitary towels for girls. Most girls did not know how to protect themselves during menstruation and lacked the provisions for doing so. Like in Rhino Camp, the majority of teenage girls in primary school said they missed school at least three days each month due to lack of sanitary towels and anticipated embarrassment. Girls and boys engaged in unprotected sex, which in many cases resulted into pregnancy. For the quite young mothers this can be dangerous as Anen's case below shows.

Case study 9.2: Violence, teenage pregnancy and death

Anen is a twelve-year old mother. She was born in Kiryandongo settlement in 1991 and is the third born of her mother. She has several other siblings by her mother and stepmothers. She started primary school at Bidong Primary School when she was eight. According to her former teachers she was one of the brightest girls they had at school. Her home was not far from school; as such she was never late for school in the mornings. But she explains that in order to achieve that she had to fulfill some of the domestic chores the evening before. She was expected to fetch water for the next day and to clean the compound. In addition she was supposed to help her mother with any work that could be done in the evenings. As such, she hardly had time for homework. She feels she did well in class because she wanted to 'beat' the smaller children. During the dry season, the boreholes experience a recession of water table. This means refugees have to pump the boreholes harder and spend longer hours at the water point. On the day under discussion, Anen had been in the queue for a long time until her turn for pumping came. This was well beyond eight o'clock at night. Those who have been at Kiryandongo will agree that it can get very dark in the settlement at this time. With a 20-litre jerrican on her head and a 5-litre jerrican in her hand, she and two older girls set off to their homes. No sooner had she walked a mile than she was ambushed and raped by two teenagers while another group of three boys 'watched the road'. The two older girls managed to escape. When she reported the matter to the parents, they used this as an opportunity to solicit money from the boys and their parents so that they 'kill the case' on the grounds that they are 'home boys'.

However, when it became apparent that Anen was pregnant it was difficult to tie the pregnancy to any one boy. Each one refused responsibility. Anen's grandfather was very upset due to fact that "they had not eaten anything" from Anen. He said they were waiting to see the baby and who it resembled then they 'might get something from them'. Meanwhile Anen's pregnancy progressed and had a very difficult labour with TBA who after failing to deliver her sent her to the Health Centre.

> At the Centre, she was referred to Kiryandongo district hospital where a caesarian section was performed and a baby girl delivered. During my subsequent visit to Kiryandongo, I was informed that she developed complications and died. The baby survived and is cared for its grandmother.

Anen's case is not in isolation; it represents many like it and poses a great challenge to the education system as well as to the humanitarian interventions devised as means to reduce workload. The main workload that befalls refugee women and their daughters and which was quite pressing in Kiryandongo were the fetching of water and firewood collection. Women expressed that it was usually during the performance of these roles that they were raped or they got into violent conflict with their husbands in the homes. The young girl, Anen, had to fetch water and sweep the compound as some of her duties the evening before. Her mother informed me that the water was fetched on a daily basis because they did not have enough water containers for storage. In addition water was used not only in domestic activities but in economic ones also; it was constantly used during brewing and serving *Ajon* (this alcoholic beverage demands that hot water is constantly poured in the pot from where it is served). The social networks available to Anen were meager themselves. Her own parents, particularly her mother insisted she helped her by fetching water and sweeping the compound; this because she herself was over-stretched with work.

That Anen underwent a ceasarian section is not surprising; her pelvis was not developed enough for a normal delivery (Harrell-Bond and van Damme, 1997). The subsequent nursing as well as medical care upon discharge from hospital appears to have been inappropriate and insufficient. In addition the subsequent handling of the boys who raped Anen left a lot to be desired. This was the same treatment accorded to most men in the settlement who raped girls. "You see these are home boys, so we have to be careful how we treat them" was constantly echoed by the refugee leaders and members of the refugee welfare committees. Yet, the fact that one was a neighbor in Sudan or even in the settlement does not give one the authority to rape unabated. The customary mechanisms employed to solve conflicts of this nature are gender blind and benefit men while they do harm to women. In the specific refugee situation where children start school late, sex education in the school syllabus starts when the girls and boys have reached puberty, by which time it could be a bit too late. They need to engage in sex education as soon as possible because loose sex appeared to be frequent. Let us now look at secondary education.

Secondary education

The current UNHCR education policy in Uganda is to offer free primary education in all the refugee settlements. Also a few UNHCR scholarships are available for education at secondary and university levels, but these are quite competitive. Sponsored students have in their package tuition, boarding, and food fees. Self-sponsored students however, have to meet all their costs. In self-help schools in the refugee settlements, parents (or students) have to pay teachers. Students in the self-help schools pay a fee of Uganda shillings 15,000 (about US$10).

Kiryandongo operated a self-help secondary school in the settlement run by the Equatorial Civil Fund (ECF) a local initiative by the Sudanese in Diaspora. The main goal is to enhance the education of the southern Sudanese. It however attracted only a few refugee students the majority opting for Ugandan schools outside. Because the few UNHCR scholarships for refugees at this level had to be stiffly competed for, many would-be eligible students found it next to impossible to attend secondary schools resulting in spontaneous self-elimination. Girl refugees were the worst hit because they have to fight extra hard to get to that level. The Catholic Diocese (maintains presence in the settlement) of Torit paid school fees for an unspecified number of girls; however, this was pegged to the availability of funds. The topping up for boys by the Diocese was in its last year in 2002. UNHCR was also paying fees for a few students in the self-help school as well as in schools outside but there were more boys than girls. I have in the preceding sections pointed to the socialization process of girls as an obstacle to their furthering education. Nevertheless, there were a few exceptions such as Margaret's case below.

Case Study 9.3: violence, displacement and sexual abuse mar educational ambitions.

Margaret Arach is Sudanese Acholi refugee woman who was born over 30 years ago in Torit District, southern Sudan. Before being trapped in the war in southern Sudan she had completed primary six. She is currently a registered refugee and resides at Kiryandongo Refugee Settlement Cluster "Q" in Ranch 37. During our interview she confided she did not know the exact date or year she was born, but according to her name, which signifies war she suspects she could have been born during the war in either Sudan or Uganda. But by her looks, she is well past her teens although one can never be exactly sure; rough living ages individuals. Four years ago she enrolled at the secondary school in the settlement and during our discussion in 2002 she was sitting for her "O" levels at Atapara Secondary School in Lira District; Atapara being the nearest examination centre to her school to the Self-Help Secondary School in Kiryandongo. Her story goes as follows:

It was during 1986 in Torit district at the height of the SPLA insurgency in southern Sudan, when rebels were abducting people and forcing them to join the rebel movement that Margaret was kidnapped with 16 others from their hide out. Based on her story, Margaret must have been about 16. She says that when the rebels shot scaring bullets in the air, the group abandoned their hide-out and fled in disarray. Margaret found herself with another girl of about the same age in the forest. They bumped into a group of SPLA rebels who did not harass them immediately but told them they would be taken care of and be taken to schools in Ethiopia where there was free education. After two months of residing in the wilderness, "the officer in charge of this group lured me into his hut and raped me by force and kept me under guard as his wife". This information apparently went around and got to some higher command. The 'in charge' was summoned to headquarters on transfer and a new commander was flown in to replace him.

The new commander ordered that the eight girls who were abducted be taken to a place called Diima from where they would be picked and taken to the Bongo Military Training Camp in Ethiopia. The eight girls (7 Acholi and 1 Lotuka) were from Eastern Equatoria Province in Sudan. "I did not even know I was pregnant, so I underwent the training for only six months. It was after I complained of being ill that the pregnancy was detected". She was then moved to another place where she under went on-the-job training in nursing the wounded. Meanwhile she was told efforts were under way to trace the officer responsible for the pregnancy, only to be told later that he deserted and his whereabouts were not known. She had a normal delivery at the health care wing of Bongo Military Training Camp, but hardly sufficient time to recuperate before she was enrolled for training. After one-year training in health care in Bonga Military Training Camp, she was asked to go and work at the hospital in Diima. After two years, Margaret and others were sent for an ambush for the National Army somewhere inside southern Sudan. She was supposed to remain in the rear command post with the medical cop to handle the victims. She is grateful that the enemies never fell prey as they changed course and they were withdrawn by order from the High Command in Boma in southern Sudan. But as they retrieved, they fell into the Lord's Resistance Army (LRA)[4] ambush and some six of them were taken as Prisoners of War (POW) within southern Sudan. Unfortunately Margaret was taken by force by the Second-in- Command, an Acholi officer with LRA. There were no negotiations and according to Margaret: "I had no choice but to continue to live like his wife without anybody's consent" referring to the consent by her relatives, father, brothers and clan and the payment of bride price. She had three children with this man.

In January 1993, the 'husband' planned that they depart for Northern Kenya (Kakuma Refugee Camp), where they would both register as refugees. As they left some time in February, they fell into an ambush in which she suffered injury to one of her eyes from sharpnels. Although the eye was operated upon at Nairobi Hospital, she still has very poor eyesight in that eye. According to her, she only sees through one eye. During her time at Kakuma Camp she learnt that her father was residing in Achol Pii refugee camp in northern Uganda. With her four children and with the help of friends she organised and escaped to Uganda in 1998 so as to reunite with her father. When she got to Acholpii she learnt that her father had relocated to Kiryandongo refugee settlement. When she eventually joined him there, she opted to return to school where she was sitting for her "O" level this year (2002). She has been assisted to pay the school fees by the Diocese of Torit. Her children are also in Primary schools in P1 to P4 under the sponsorship of UNHCR.

Literacy and refugees

The low literacy rates of Sudanese refugees have a historical background. The most significant factor is the uneven development of the South and North Sudan, which continues to affect the two regions and its people.

According to Nyaba, the colonial concentration of economic, political and administrative development in the North at the expense of the South created socio-economic and political disparities between the two parts (Nyaba, 2000). Owing to the policy of absolute exclusion, the South had no access to education facilities except from the Christian Missionaries (*ibid*). It is a long known fact that the southerners of Sudan have been marginalized in all aspects of life including those for self- advancement such as health and education (Johnson, 2003). Discussions with refugees in Kiryandongo and Rhino camp pointed to the marginalization suffered at the hands of the Khartoum government, which resulted in the illiteracy for many of the refugees. The results of the survey indicated that approximately 44 per cent of refugee women have never attended school. The few (22.5%) who have attended have not had more than 4 years of primary schooling and in a refugee setting they are not exposed to reading skills. The lack of exposure to reading materials has diminished even the little reading skills they had. Only about 1.2% of refugee women completed eight years of education in Uganda in the 1960s; for these women, this was their second time round as refugees in Uganda. The low literacy levels are bound to have implications on the survival of their children.

Table 9.5 Adult refugees attendance of school by gender

Years Attended	Men Frequency	Women Frequency	Percent (n=170)	
			m	f
0		75		44
2		25		14.6
3		11		6.5
4		2		1.2
5	8	4	4.7	2.4
6	7	1	4.1	0.6
7	10	0	5.9	0
8	20	2	11.8	1.2
9+	3	0	1.8	0
	2		1.2	
	N=50	N=120	29.5	70.5

Compiled from survey data

As indicated in the above table, men were relatively fewer, but had relatively higher educational attainment than women. The only available program for adult literacy was the one offered by *Saving Grace*, an American church-affiliated NGO at Panyadoli. Discussions with women showed that they appreciated literacy classes. But the timing of the classes hindered their participation, as did the long distances they had to walk back home at night. The very low literacy levels of refugees in general and of women in particular appears to have negative influence in several aspects of refugee life, including, for instance their own health and that of their families, nutrition for the children, the education for their children particularly daughters.

Apart from primary education, which UNHCR continues to support, secondary education and literacy education needs have relatively been ignored by the UNHCR.

In summary, we have seen that only about 39 percent of the girls are enrolled for primary education. And even for those who are enrolled, the chances to complete primary education are minimal due to various reasons, but most importantly due to sexual abuse by teachers, unwanted pregnancies and gender roles. The boys as well face hindering constraints. They absent themselves from school to work for casual labour in order to raise the necessary resources to pay for secondary school education. The literacy levels of the adult refugees in the settlement are low and yet this need is hardly receiving attention. The next part is about health care programmes.

9.4 Programs and organizations dealing with issues of reproductive health

The aim of this section is to show how health services, as a form of planned intervention, were established and implemented. It also describes the role of the various social actors and the eventual outcome. I shall not delve deeper into the reproductive health programmes as there was no specific project for reproductive health unlike in Rhino Camp. Health care provision followed the normal routine as is tenable in most health units in Uganda. I intend therefore to discuss the phases that have characterized the health delivery system in the refugee camp and to show the interactions and relationships among the social actors and how these have shaped the social practices of the actors in the real of general health. I have identified the social actors to include the UNHCR, the implementing NGOs, the district officials, refugees, nationals, health providers working with NGOS and the WFP. The first section presents an overview of the phases of health care delivery in Kiryandongo. The section that follows is an interface analysis of encounters in a nutritional programme. The analysis highlights the salient emerging issues.

An overview of provision of health care in Kiryandongo.

Due to the precarious nature of refugees at the time of their transfer from Achol Pii in 1990, the initial provision of health care was done by MSF-Holland until 1992. We can refer to this phase as the *emergency phase*. The health providers included a European doctor and nurses who worked alongside professionally qualified local health personnel the majority of who are refugees. Related to health is nutrition, which was managed by WFP and AVSI respectively. Immunizations against measles and meningitis were done and measures taken to control likely communicable diseases in overcrowding situations were undertaken. Meanwhile, the results of the mid-upper arm circumference dictated which child was to get supplementary feeding. The first two years of the project were indeed quite busy. The main goal of the project was to keep the mortality and morbidity of refugees as low as possible. The health facility was equipped with an ambulance for the referral cases. Health care was delivered in the usual way as obtained in the national programmes and could be accessed in outpatients, maternity and pediatrics sections delivered in make shift shelters until the completion of a 57-bedded health centre (HC III) and a TB ward in 1991. The out-patient section was operated by Toni, a Sudanese clinical assistant who has since received further training in Uganda.

Using the syndromic approach recommended by WHO, this department deals with the normal complaints that include malaria, intestinal worms, typhoid, chest infection, sexually transmitted diseases (STDs) and other complaints of a general nature presented by refugees. He is assisted by an assistant. The maternity wing was operated by an Acholi refugee midwife trained in Uganda assisted by TBAs. The maternity wing was also in charge of the family planning and child growth monitoring. The majority of staff are refugees; they include enrolled nurses, laboratory assistants and support staff. Refugee health services were restricted to refugees and were not available to the surrounding communities themselves distressed after several years of neglect and squander and only just beginning to recover. Other health facilities in Kiryandongo Sub County included a 100-bedded hospital about 15 km away, a missionary health centre (HC III) and some few clinics and drugstores in Kiryandongo town.

After the emergency period, MSF-Holland handed over the management of the health care to Inter Aid, an American NGO, which in addition to health, took over roads, food distribution, forestry, education and sanitation projects of the settlement. This was the *post-emergency phase*. Inter Aid recruited a full time doctor and a registered nurse- midwife. In addition it retained the local staff. The provision of health care was in line with the primary health care approach, except that refugees, by virtue of their situation were not charged user fees. The four outreach first aid posts that had been established in the settlement continued to operate. Refugees had quicker access to services. The health sector organized training courses for traditional birth attendants (TBAs) (all refugees) and about 25 were trained. The doctor and nursing sister made daily rounds; at times they would make two rounds (the in-patient capacity was only 50 beds plus 7 maternity beds, which apart from the children were never maximally occupied.).

During 1996, the project funds were drastically reduced. The assumption was that the refugees were self-sufficient because they had recorded at least 3 bumper harvests. 'Kiryandongo is a success story' could be heard everywhere in refugee circles. The doctor and nursing sister left. Salaries for the local staff were laid off. The health centre had to start charging refugees user fees (even though initially before the withdrawal, UNHCR was against this idea). It was also decided the surrounding population could benefit from the facility. Health committees were formed but they never incorporated any nationals even when it was only nationals being charged user fee.

Inter Aid quit at the end of 1996 and the refugee programme and the health sector were handed over to the Ministry of Local Government (then the ministry in charge of refugee matters) and the district health authority. We can call this the *regular and normal phase.* Discussions with the District Director of Health Services (DDHS) and the nursing officers indicated that the handover was incorrectly done. Masindi district had been one of the pilot districts for the decentralization process and yet they were not involved in the health planning of the refugees in their district. The district had not been prepared to take over the health care program for refugees and was not in a position to include the salaries of the staff in the district health plan. They questioned how Inter Aid left 'not leaving even a typewriter behind'; what were they expected to use. It was obvious there were struggles and conflicts around the departure of Inter Aid.

The DDHS took over the supervisory role and ensured that the health centre received the quarterly essential drugs supply. Since 1997, the Sudanese clinical officer and midwife under the supervision of the DDHS have operated the health centre. The staff salaries were paid by UNHCR. The DDHS in Masindi had seconded some health providers for regular training. For example, the midwife had completed a course AMREF-funded reproductive health course while the clinical officer had just completed a pediatric course.

The foregoing discussion about the implementation of this planned intervention helps to throw more light on why some humanitarian projects succeed while others fail. Drawing upon my presentation of the sequence of the programme, let us try to make sense of it by submitting it to interface analysis. The first batch of health providers was European (the doctor and nurse). It was in their interest to do a good job for their organization. After all, the MSF is reknown for timely health interventions in disaster situations. In addition, the staff that were employed were almost 100% refugees. They viewed this as their project, not only for refugee health, but also for their livelihood. However, for other actors (significant 'others', but not consulted) the bringing in of 'experts' presupposed that the people 'on the ground' were unable to manage, and that their capacity was reduced. The experts then had legitimated power and authority. MSF-Holland was legitimated as the expert and accorded with the authority to manage the health care provision in a refugee emergency. The notions of legitimation and authority also presuppose that others are marginalized and powerless. Marginalization is viewed as a process in which one category of people are pushed out of those sectors in the production process which yield power, towards the periphery. Once this process is completed, one assumes that there are inequalities created. In this case there appears to have been poor communication with the government officials as I later discerned from the interviews. "It seems we were despised. Had the local capacity been harnessed, they would have been able to provide the necessary appropriate care".[5]

Whereas MSF-Holland was in charge of the health sector, there were other social actors with conflicting vested interests in the project. An example I can give is the nearby Kiryandongo hospital (about 15kms away). The UNHCR would have thought it more prudent to strengthen its capacity to handle refugee ailments (which are not any different from the local ones) than to build a whole complex in the same catchment area, thus marginalizing refugees even further. The feelings of the medical superintendent of Kiryandongo Hospital could be detected when he pointed out that there had been a plan to donate an ambulance to the hospital, 'but all the plans were thwarted with the building of the refugee health centre'. The new health unit gave the impression that they were competing. The interests (projects) of the central government had also to be put into consideration, since they have always pursued an encampment policy. The UNHCR by putting up the construction of the refugee settlement, employment of staff and the drawing upon MSF and AVSI, etc, legitimated its further fund raising pleas. According to Long (1999) negotiations at the interface are carried out by individuals who represent particular constituencies, groups or organizations, which could be seen in this case.

During the post emergency phase, the role of the full time doctor and full time nursing sister was ambiguous and uncalled for in my view. At this time the refugee population was only 9,000 and they had gotten over the emergency phase. Moreover, this was a function, which a doctor from a nearby hospital could have fulfilled. Again it goes to show the poor co-ordination there was in the district. In any case this was a project, which could not be sustained prompting the doctor and the nursing sister to leave. Each of the above social actors had their own 'projects' and not necessarily the health of refugees at heart. The attitudes and opinions of the actors have been shaped by the intervention practices and interactions among the various participants. For a few years, there had been no contact between 'national' and 'camp' health providers and their beneficiary groups, while non-refugees would not be allowed to use the ambulance stationed in the camp. Yet, when the nationals are eventually permitted to use the facilities, the user fee is introduced and targeted at them only and not the refugees. In one of my interviews with a senior nursing sister about refugee health, she submitted that she had not seen any refugee, as she understood 'they had their hospital in the camp'. This statement showed that, because the majority of people believed that refugees essentially belong to the UN, there seemed to be a stereotyping even when it came to social services such as healthcare and education. These attitudes have been further endorsed by UNHCR, which has isolated the refugees by keeping them in the rural settlements and catering for them in their isolated environment, which further marginalizes them.

Nutritional programmes

Nutritional programmes are implemented to correct malnutrition in children under the age of five. UNHCR supports these programmes based on welfare policies. In Chapter 2, I argued that welfare policies assume that women are passive recipients of development and that motherhood is the most important role for women. I dismissed these assumptions as inward looking, since they do not address women's structural needs. They only address the practical needs of women and are therefore short term. The main assumption behind the nutrition programmes is based on food insecurity or the inability by the mother to wean successfully. Such an assumption is limited because it looks at 'here and now' processes as it were. According to Moser (1993: 59 citing Macpherson and Midgley, 1987) 'because of welfare policy's compatibility with the prevailing development paradigms of modernization, it was continued by many post-independent governments'. It was also assumed that 'social welfare institutions should come into play only when the normal structure of supply, the family and the market breakdown' *(ibid*.). Thus, the malnutrition of children in Kiryandongo is addressed by the health providers within the context of food insecurity and a lack of knowledge of weaning foods. This theory has been questioned by those who claim that even in natural disasters, the relationship between malnutrition and poverty is not straightforward. The relationship is influenced by several factors including the health environment, peoples' livelihoods, the frequency of exposure to food insecurity and the development of coping strategies. I have already pointed to the poor productivity and rocky nature of some of the plots in Ranch 18. While it had been suggested to keep some sections on food rations to improve the nutritional levels, some under-fives from other Ranches well endowed with food also suffered from malnutrition.

Thus, the argument that the causes were beyond food security was credible. This can be seen from the fact that even those refugees with fertile land and those who were kept on food rations due to poor soils suffered (their children) from malnutrition.

The feeding programme was designed to teach women the correct methods of feeding their babies. Programmes were residential at the health centre and required that the parent or guardian stayed for an average of four days at the centre. In addition, malnourished children with kwashiorkor and marasmus were admitted and fed on milk, soya flour, powdered fish and green vegetables (popularly known as *mukuza*). For the mothers, the programme was cumbersome as it uprooted them from their homes where they had several other duties to attend to. Studies undertaken on complex emergencies bear the evidence that social and political marginalization is the most important determinant of vulnerability (Jaspars and Shohan, 1999). Therefore, knowledge about the process of marginalization and dispossession as causes of vulnerability is crucial for formulating programme design, targeting and distribution mechanisms that will actually reach those most in need. Without this knowledge, food aid, like other resources, is more liable to manipulation by the most powerful. By dealing with the symptoms of poor feeding, the programme failed to tackle the root causes of malnutrition. One grandmother whose daughter had died during childbirth leaving her with 4 grandchildren was at a loss in the centre. She expressed her concern over the three grandchildren she had left at home. She asked who was more important, the three children at home or the one in the hospital and pleaded with the nurses to discharge her or else she would abandon the child at the center, which in fact she did. The nutrition programme attracted mostly first mothers and twin mothers. Mothers overburdened with workload simply did not attend and their babies died.

I also learnt that many mothers associated marasmus and kwashiorkor conditions with pregnancy. They believed that children acquired that condition because their mothers were pregnant without further explanation that it could be due to the cessation of breastfeeding and poor weaning practices. From the above, it can be argued that malnutrition was a function of several factors some of which included the complex nature of gender roles, lack of awareness, lack of household help, age, poorly conceived and designed policies which when viewed at close range have no connection with food.

9.5 Vulnerability and unaccompanied minors and gender- based violence

Although not initially in the sample, because of the major problems they presented, I decided to include unaccompanied minors in the study with a view to highlighting the nature of the needs they encountered in the settlement.

According to Chambers (1983) vulnerability refers to lack of buffers against contingencies. But in a recent publication (Bankoff, Frerks and Hilhorst, 2004:1-9), the authors highlight the embeddedness of vulnerability in complex social relations and processes. This view therefore makes the task of defining the concept vulnerability not a simple one.

The sense in which I use the concept refers to the exhausted capacities of refugees to cope and/or the position one is placed in which makes them easily attacked, what Niehoff and Price refer to as "..... which can break down in a situation of stress because of a lack of assets and inability to develop effective coping strategies" (Niehof and Price, 2001:17). Hence refugees become vulnerable *to* abuses, food shortages, to exploitations because their capacities to handle the situations they are in have failed. In other words they are vulnerable to something and not vulnerable per se. 'Unaccompanied' is a term used by the UNHCR to refer to single refugees of any age (but mostly young) and gender who have no relatives or any form of support in a refugee situation. It is this situation that renders them vulnerable to denial of resources and abuse. In my study, the term 'unaccompanied minor' refers to children below age 18 responsible for their own livelihood and that of others in the refugee settlement. It was established that there were 127 unaccompanied minors whose parents and guardians had abandoned them or had died leaving them in a precarious and vulnerable situation. As a coping strategy, special arrangements were made between the settlement and one Catholic Bishop to have the minors taken to Kyatiri orphanage in Hoima district where they were put into schools.

Discussing their plight with one of the nuns at the orphanage, it was pointed out that poor access to basic resources such as school fees, medical care, shelter, food was noted as affecting their performance at school and their general standard of living. The need to satisfy the basic needs led to unbecoming behavior. Some became street kids and girls were lured into prostitution. Their vulnerability exposed them to gender-based violence such as rape, defilement, forced marriage and early pregnancies. Further discussions showed that these children lacked care and guidance. Left on their own, they tended to indulge in activities such as drugs and loose sex. Girls in particular were found to be less serious about education and many became pregnant quite often. This forced the caretakers to encourage them to pursue vocational training in practical skills such as tailoring and craft making.[6]

Some minors have left the settlement for the urban areas. The case I present below concerns an unaccompanied minor in charge of siblings. Although not Sudanese I feel that it is representative of how forced displacement and refugee situations create vulnerability. It also shows the resilience of refugees and how they apply the meagre resources at their disposal for survival. I interviewed Khasifa in Nakivale refugee settlement in August, 2002 and then again in Kampala in June, 2003.

Case study 9.4:Unaccompanied minor with siblings

> Khasifa Ali Farah is a 23-year-old Somali refugee who fled Somalia at the age of 14. She completed Intermediate school (primary) in Somalia. She fled as a result of war in her country. Her parents are believed to be in Ethiopia. Many of her brothers were killed, while rebels abducted her only sister. She fled Somalia in 1994 and spent two years at the Kenya/Somali border as a hostage to a group of Somali rebels of the United Somali Congress who confined her during which period she says she was sexually abused by over twenty Somali rebels. In between the confinement Khasifa became a 'wife' to three rebels (these men

were not of her clan). She was all the time beaten and not allowed to talk to any body. Meanwhile another woman from her clan in similar situation hatched a plan for her to run away from the men. Khasifa managed to escape to Nairobi with her two younger brothers and tried to seek asylum in Kenya. She was rejected but heard that her case might be accepted by UNHCR Uganda. Somali truck drivers of her clan gave her and her brothers a lift to Kampala. All this time she depended on the mercy of God and the help of people for she had no money and she had no work as she was still very young.

She described her life in Kenya as the worst of all her experiences. She says she was not only raped in the 'usual way' but was sodomised on many occasions. She feels she got infected with gonorrhea and syphilis and probably that is why she did not get pregnant. She is worried that she could be infected with HIV / AIDS through violent and brutal sexual encounters.

She arrived in Uganda in 1997. At the UNHCR office in Kampala her request for asylum was accepted provided she was willing to stay in Nakivale. She proceeded to Nakivale[7] refugee settlement with her brothers in western Uganda and lived there for two years from 1997 to 1999. She however says she left the settlement on her own accord because the conditions were bad. The Somali refugees have a fairly efficient social network system. It is possible some of her clan's people could have persuaded her to leave the settlement and to return to Kampala. She claims that in Kampala she at least has friends who help her once in a while even though UNHCR has denied her any assistance as long as she is in Kampala.

Her main needs at present were related to health care and the capacity to pay medical bills and those of her siblings, high food costs, lack of employment and income. In addition, the lack of proper identification by UNHCR and Uganda government posed a problem to Khasifa and her brothers. They were constantly in problems with the Police, as they had to explain who they are and why they carried no identification papers. At one time she says her brothers were detained for lack of proper identification. Friends had to 'pay' to have them released. Lack of proper identification placed them in a vulnerable situation where in many cases the Police extorted money. The shelter they occupy leaves a lot to be desired. It is a one bed roomed house in the slums of Kisenyi in one of the filthiest areas with a lot of crime, drugs, and prostitution. On getting into Khasifa's 'house' one needs candlelight to be able to see one another.

What is her plan for the future? I asked. She says she would like to get a job and pay school fees for her brothers. She also plans to look for her younger sister who was abducted at about the same time as herself and bring her to Uganda. She then says she would like to start a cooking business "because there are many Muslims here". The main hitch is start-up capital. She says once they get to know one is not Ugandan, then they do not give a financial loan.

The above case depicts four areas of concern, namely; disruption, violence, lack of social support and poor access to resources. Khasifa lost parental and relatives' guidance as a result of disruption due to forced displacement. The disruption rendered her vulnerable to violent attacks possibly because of her gender specifically and in general due to the mayhem and anarchy that has been the order of the day in Somalia for over a decade. But at the same time, she did not just wait for a good Samaritan; she sought help from friends while at the same time keeping in close contact with her siblings. She demonstrates signs of resilience even at such a young age. Whereas she was an unaccompanied minor when she fled, by the time she got to Uganda where she was recognized as a refugee, she was of age and it is most probable that the conditions of her having been an unaccompanied minor upon flight were not taken into consideration. The conditions of her stay in Uganda were restrictive. The refugee policy in Uganda restricts refugees to stay in settlements, irrespective of one's background.

Although Khasifa accepted to reside in the rural settlement, this could have been done by way of a short-term coping mechanisms. She knew quite well that if she did not go to the settlement, she would never be registered by UNHCR and the Uganda government as a mandate refugee, and thus would have risked losing out on the benefits that accrue to mandate refugees. The current refugee policy does not disaggregate between urban and rural refugees. Refugee settlements in Uganda are agricultural and suitable to refugee populations whose subsistence depends on cultivation. Khasifa's story is full of saddening episodes. She is young, separated from her parents, sexually abused, kept as hostage, some of her brothers killed, her sister abducted and she has the moral responsibility of looking after her young brothers. This was a strong reason for her to receive therapy for sustained psychosocial trauma. Further discussions with her indicated that she was always worried and anxious about the probability of having been infected with HIV during the two-year period when she was a hostage. There are no HIV / AIDS testing and counseling facilities in refugee settlements in Uganda. It is possible she could be suffering from STDs, in which case she needs treatment. But in her situation, where she hardly can support herself, it is difficult to see how she can treat herself. This then increases her vulnerability to HIV / AIDS and morbidity. She stays in an environment, which is affordable (to get to her room we had to light a candle), but which in her condition of need is very enticing to prostitution. She is youthful, energetic and quite willing to work in meaningful activities. Her poor access to resources is likely to jeopardize her reproductive health. The next case study shows the importance of education and social networks.

Case Study 9.5: Risk-taking as a coping strategy in the face of vulnerability.

Tereza is a twenty-seven year old Sudanese woman refugee of the Azande tribe. During our interview she had just completed her Bachelor of Laws at Makerere University, Kampala. She is the third born (out of twelve) of a refugee couple in Kiryandongo refugee settlement. Amidst my congratulations upon this achievement (which was no mean achievement for a refugee woman in Uganda), she informed that she couldn't practice as a Lawyer in Uganda because she has not done the Diploma in Law Practice, a pre-requisite for law practice in Uganda.

When asked why, Tereza has a long story to tell concerning the numerous problems she and her family have suffered due to being refugees. However, before she continued with the story, she pointed out that the man responsible for paying the fees for her Law degree fees at Hugh Pilkington Trust has refused to pay for her diploma claiming she will not practice Law in Uganda since she was a Sudanese refugee. And that if she wants to practice law in Uganda, she should "become a Ugandan". "I want to tell you madam that after this man told me this I felt so bad, even now I have a Ugandan passport because I have seen I have to fight for myself. Even a friend of mine, she is also a refugee, got a Ugandan passport and now she is in the States, she is the one trying for me for school fees. But for me now I cannot go anywhere because of this baby, where can I leave him? And even his father, I do not know whether he is serious. O.K he gives money for rent and food but even it is not enough some times. He gives 300, then I pay 120 rent per month so for two months madam you can see the food, the baby at times he may fall sick and here everything one has to pay. The baby's father goes for two months and comes for just a few days. He works for ADRA and they move all over Uganda. Right now they have a project they are working on in southern Sudan. His mother is an Acholi and his father is Madi of Sudan, but Madam it is not good to say one is Sudanese because people will know you are a refugee. You may see me here but you don't know how I am suffering. About marriage, we have not talked about that one but I have seen I have to work hard for this baby".

Tereza is Azande by tribe. The Azande belong to the Bantu ethnic groups unlike the other African tribes in Sudan such as Kakwa and Kuku. They are ethnically closer in appearance, language and culture to the Bantu tribes of some parts of Congo and southern Uganda. However, this did not help. The Azandes were a minority in Kiryandongo refugee settlement. This appears to have resulted in refugees shunning their produce such as brewed alcohol.

"Madam in the settlement, refugees drink from fellow tribe people. I also tried to make pancakes, you know like the ones we make in Sudan, may be you have seen them in the camp. But they were not buying. Acholi women managed to sell their alcohol because there are many Acholis in the camp".

Tereza came to the settlement with six siblings and her uncle's son from Congo. Their parents sent them to Uganda because they heard the schools were good. Their parents remained in Democratic Republic of Congo (DRC) because her mother had a back problem. She states that her mother had a total of 17 children, seven of who died as babies. Their eldest sister is a nun currently serving in Cairo. Before she left for Cairo, she was with the Comboni Sisters at Mbuya in Kampala. Before leaving she placed her siblings under the care of one of the Comboni Sisters at the Settlement in Kiryandongo. This Sister was supposed to provide for the children in matters related to their education, for instance, scholastic materials. Despite this trust in the sister, she one day told Tereza to look after herself and her siblings. She discouraged Tereza from running to her every time there was a problem.

This new attitude prompted them to stop seeking help from the sister. Good enough some of the younger girls had been taken to a Catholic mission in Karamoja by their Nun sister before she left for Cairo. This left Tereza with only two brothers to look after. Due to the challenges in refugee settlement, the younger brothers (12 and 10) would skip school one or two days in a week and would go to do leja leja (piece work).

"We left Congo because my sister the nun had promised to get us to school. In fact when we came, she organized and they built a house for us behind the Catholic Mission in the camp near the transit camp. Everything was on me. I worked with the sisters at the nursery school but I was not happy. My sister managed to send me to Aboke Girls in senior three. I completed Senior Four. But I did not want to be a pioneer for Senior Five for they were just starting it. When the results of Form Four came I had passed very well in first grade. Sister Jovanina got me a place in Namugongo Secondary School. You know the school. It was so good but the girls had so much money they would look at me and say that I call myself a refugee because I want to get free money from UNHCR (they thought I was a Muganda). Before her transfer to Cairo, our sister had helped put my younger sisters in Morilem Girls Catholic School in Karamoja for primary education. During the holidays between my Form Four and Senior Five I worked as a nursery teacher at the Comboni nursery school at the settlement. My salary was Ug shs 20,000 per month. Though not much to speak of, I was at least able to help buy the necessary scholastic requirements for the boys. I also was able to buy soap for the home and second hand clothes, which we were not getting from Inter-Aid (UNHCR implementing partner). The problem came when I had to leave and go to Namugongo, a school in Kampala. We had to send for our mother, who was with my father in Dungu refugee camp in DRC (in a place called Koko) to come and look after the home as the children would be on their own. Mother came in 1995. With financial and social support of Sr. Jovanina, I also joined S 5 in second term (It was not possible for me to leave home before mother came). Meanwhile the three girls in Karamoja also completed their Primary seven. Fortunately they were given UNHCR bursaries and proceeded to Masindi Secondary School which is near Kiryandongo refugee settlement".

Because it was a child headed household, their household was treated as a vulnerable household and was placed on 100% food rations. However, being on 100% rations was just theoretical. The food was never on time and when it came, the maize was always in grain form needing money before it could be milled. The beans required fuel wood and long hours of cooking. These children could hardly raise money to grind the maize grain. In addition, there was need for money to purchase soap, salt and clothes and vegetables. The situation proved even more difficult when Tereza shifted to her new school in Kampala. Their mother who had since joined them was not of much help since she suffered from back and leg problems.

Despite this, when she came "family members became happy and some things changed". She had friends, old Italian friends including Combonis, her former teachers. These were quite helpful; they would send her some money, which she used on family needs and bought materials for her own business. (She makes handicrafts, as she cannot dig due to her back problem).

"It was at this time that I started concentrating on my studies". "Madam, things can be very difficult without social support". "All our relatives had scattered, some were in Congo and others were in Central Africa". Mother made handicrafts, which she sold to the Comboni sisters in the settlement. She also made pancakes and bread for sale to the community. Their father (64) joined them in 1997 and started growing onions, tomatoes and cabbages, which he sold at Bweyale Market. At this point the food situation of the home improved. Father bought fish and meat and they had vegetables from the garden improving on the food monotony. In addition the children received pocket money from their father of at least Ug Shs 5,000 every term.

The "A" level results were released in early 1998 and Tereza had passed very well despite the odds. She was admitted to Makerere University for a four-year degree course in Law. Luckily, the Hugh Pilkington Fund sponsored her. She was a resident of CCE Hall but she had to quit "so as to share the scholarship" with the younger siblings who were in lower classes. She moved to a cheaper place on Gayaza Road past Mpererwe. Sadly the priest who used to send mother money passed away. This worsened the economic situation as mother continued to depend solely on handicrafts. It was important that Tereza chipped in because unlike earlier times, the siblings were growing and making huge demands which mother alone could not meet. While at Namugongo, she had made friends with an Acholi girl who had invited her to her home in Kansanga to meet her parents. Tereza reports that her friend's parents liked her very much and helped her a great deal. Meanwhile at Makerere when things got so rough her friend's mother took her on as a house girl during vacations. She worked as a house girl, got free accommodation and food and was paid 30,000 per month. "These people were so good to me, they actually surprised me with a graduation party, upon my graduation". Though petty, she also engaged in several income-generating activities such as selling second hand clothes to university girls (where they named me Auntie Ngoye – Luganda word for clothes); She walked as a vendor from shop to shop selling her mother's knitted and crocheted table cloths, and washed cloths for neighbors. Unfortunately she suffered depression. "I am very grateful to Dr. Sylvia Tamale a senior lecturer in the faculty who gave me her shoulder to cry on". Meanwhile the staff not having first hand information of her case accused her for not attending lectures and spending time elsewhere. "They did not take time to find out the nature of my problems. And every time I tried to tell them, they dismissed it as false. Madam, that is why I am very grateful to Tamale, had it not been for her perhaps I would not be here. I also thank God for not failing exams, I did all my course work and assignments on time".

Tereza did not suffer any form of physical violence, but she had enough psychological trauma as an unaccompanied minor head of household. However, she says she witnessed violence in the settlement in form of fights and rape. According to her, the main points where women experienced violence was at the boreholes. She also noted that young teenagers got pregnant through rape and that the recourse was caning of boys and girls for misbehavior as "there is no money in the settlements"

Currently Tereza has a boyfriend working with Adventist Development and Relief

Agency (ADRA) with whom she had a baby boy who is now six months old. The boyfriend currently maintains her and the baby. However, it is not quite clear if the relationship will result into marriage. According to her, she entered into this relationship as suggested by the Officer at Hugh Pilkington that she should become a Ugandan if she hopes to practice Law in Uganda. Meanwhile she has sent for her mother to help her with the baby while she looks for work.

During a follow up interview, Tereza asked me to pray for her because her family was going to receive important guests. The guests happened to be her boyfriend who is also the father of her son. They were making an introductory visit to Tereza's home in the settlement with a view to paying the mandatory fines for making Tereza pregnant and then to proceed with introductions and bride wealth negotiations. This was good news and I promised I would pray for her. Indeed luck was on her side. The job she had applied for as a UN Volunteer (UNV) had materialized. At the writing of this report Tereza is UNV in Afghanistan.

The above case illustrates the complex nature of refugee situations. As the study illustrates, risk taking was pursued as a form of coping mechanism. This was done by Tereza's parents when they dispersed the children to Uganda and by Tereza when she posed as a Ugandan. Tereza assumed the responsibility of looking after her siblings, not because she had no parents, but displacement had dispersed them. It is quite possible that coupled with UNHCR assistance, the social support (her sister the nun) though meager could have been a propelling factor for Tereza and siblings to seek refuge in Uganda. The parents meanwhile sought refuge in northern DRC. At the face of it, the refugee situation appears to make parents 'unconcerned' about what happens to their children when in actual fact this is not the case. The discussions held with the parents indicated that Tereza's mother was a sick woman and her back problem could not allow her to move easily. Her father equally felt responsible for his wife, the more reason for remaining with her in DRC. The children were encouraged to go to Kiryandongo primarily because of the education facilities in Uganda. The fact that her parents over emphasized education (her mother having been a primary teacher) can be seen in the determination Tereza had to seek it. She faced many obstacles such as the need to raise income for herself and her siblings. She did this in all sorts of ways; she even opted to leave the hall of residence so as to share the money with her family. When she finally graduated, she could not work, as the prerequisite for law practice in Uganda is a Diploma in Law Practice. Her former sponsors could not sponsor her and they even appeared to be discouraging her by suggesting she should become a Ugandan. But because she was so keen in settling down into a stable marriage and continue to help her family, she felt that falling in love and getting pregnant would do it; it almost did not. It was indeed after her son was about two years that the boyfriend and his family initiated marriage negotiations. For Tereza the coping strategy was to get a Ugandan passport and is currently serving as a UN Volunteer in Afghanistan. She is now in a position to help her family. I have confined myself to the two case studies of the refugee girls, but there are many more refugees who fall under this category of vulnerability and who have no social support whatsoever.

9.6 Concluding remarks

Gender relations among the Acholi

The study established that gender roles are extremely differentiated. However, in refugee settings, even when men did men's work such as digging (which is given more value) they did not perform any of the women's work, except in very exceptional cases such as taking a sick child to the health center. This aspect needs to be appreciated by the settlement planners. The 'loss' of men's work such as fishing, hunting and blacksmithing, enticed them into excessive alcohol consumption whose end results were illicit behaviors and engaging in gender-based violence.

The Acholi marriage code, which emphasizes negotiations and the payment of bridewealth before sanctioning marriage was not followed most of the time and this marginalized women further. Women were taken 'for free' as it were, only to be abandoned in the process. Many women were victims of this irregular arrangement in the settlement, which they referred to as "take now, pay later". There were several cases of elopement, particularly because of the breakdown in the socio-cultural arrangements as a result of displacement. Moreover the position of a woman in a marriage was consolidated on the number of children she bore, which also determined the size of land she would be given by her father in law and husband. Furthermore in Kiryandongo, the size of the allocated land depended on the number of people in the household. It is highly probable that land and fertility were directly linked.

The lack of flexibility in some ideological issues made women more marginalized. Women were not permitted to negotiate or 'borrow' land for use. They had to depend on men for this. The cases in which men were absent meant that women would not carry on their livelihood activities with ease because of this bottleneck, which frustrated the women's efforts towards self-reliance.

Gender roles

Irrespective of the fact that they were confronted with many gender roles including digging, formerly a male activity, women refugees seemed to appreciate the fact that they could now dig. They also looked forward to the day they would return to Sudan and dig. Digging is the initial preparation of land for cultivation. Culturally in the Sudan and in several other African countries, it is usually the men who make the initial land clearing and digging before giving way to women to plant, weed and harvest. As long as this remained a male activity, it meant that the women had to depend on the men for subsistence farming which yielded both food for family consumption and for sale for income.

Water collection and firewood gathering were the most labour consuming, most tiring and drudgery of all the roles. Women spent most of their time performing these tasks at the expense of their leisure activities, rest and development.

At times they walked long distances and spent days looking for firewood. This was always done at the expense of care for their children. The several activities including survival strategies and the rigid gender division of labour appear to have influenced childbearing with main purpose of getting the children to help with domestic chores.

Water collection points proved to be arenas for violence and marginalization. The waterbed recession during the driest months of the year led to long queues at the water points. For the women, it meant waking up as early as 4 in the morning to beat the long queues. This problem was aggravated by a breakdown of the 16 boreholes in the settlement, which were not repaired due to lack of mechanics to repair and spare parts in the country. Had the refugees been encouraged to own and operate the water boreholes at the inception of the settlement, may be the result would have been different.

Livelihood security

The perception that refugees are a short-lived phenomenon is erroneous as it influences unsuitable policies. For example, refugees are not permitted to cultivate coffee, cotton and even tobacco despite their long stay in exile in Uganda. Yet these are the cash crops from which people derive an income. Restricting refugees from participating in the cultivation of cash crops perpetuates their poverty and increases their dependency on humanitarian aid. The mainstay of the refugees was subsistence farming from which they expected to get food for home consumption. The anticipated surplus would be for sale to obtain cash for other personal needs such as radios, blankets, clothing, shoes and meat. However the surplus, maize in this case, was very difficult to depend on as the prices kept fluctuating to the refugees' disadvantage. At the beginning of the refugee programme at Kiryandongo, the size of the land given out to refugees might have seemed adequate. However due to the fact that households have multiplied through population increase and given that there are no use of scientific methods in the subsistence farming, land productivity is reducing. Already some parts such as Ranch 18 are so rocky; nothing grows well there. This brings us to the issue of food security.

It was noted that food security was influenced by the non-food demands of the refugees. The notion that refugees sold the surplus did not arise. In many cases when refugees had a need to satisfy they sold whatever food they had. However, men tended to sell their entire foodstuff, while women kept a little food supply to be consumed. As long as avenues of raising income remain scarce, it is difficult to see how food security can be enhanced in refugee settlements.

Bweyale trading center has offered livelihood options to the refugees. While the government refugee policy insists on residence in the settlements, the creation of Bweyale trading center by mostly refugees on the Kampala–Gulu highway is a clear case where the government refugee policy becomes flexible. It also indicates that refugees, if given chance, can be successful. Sudanese refugees own more than half the shops in Bweyale. Men and women refugees undertake highly differentiated activities in the trading centre and the nearby market. The centre is also a stop over for the commuting buses from the north to Kampala and back.

The stopover gives opportunity for the women to sell their food items, such as fruit, roasted cassava and potatoes, groundnuts, simsim, pancakes and live chicken. Having said this it should be noted that only a few refugees participate in these activities.

Health care, violence and vulnerability

Poor soils, withdrawal of food rations and a lack of proper and awareness of weaning foods, contributed to the death of children under five. These deaths were not always reported to the officials, for fear of losing entitlements. However, the graves could be seen on the settlements graveyard and in the homestead compounds. The nutrition improvement policies of spending days at the health centre were not friendly to women who had many roles to complete.

The interface analysis of health care interventions shows the weaknesses in the approach and its failure to succeed due to the various power points not taken into consideration at the inception of the project. For instance, the refugee health centre is within the catchment area of the main general hospital only a few kilometers away. May be it would have been better and more cost effective for the government and UNHCR to refurbish the general hospital with a view to taking over the health management of the refugee caseload.

Lastly, we have noted that violence against women in the settlement abounds. The vulnerability of women and girls to sexual and physical abuse has been noted by way of case studies. The isolation of the refugees in settlement makes them even more vulnerable to ignorance. They can neither access radio nor newspaper and cannot socialize with others to get to know what is taking place in the world beyond Kiryandongo. The refugee programme did not appear to have clear guidelines of the unaccompanied children. These children therefore become even more vulnerable to the precarious situation of refugee life in the absence of a protection mechanism.

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[1] The New Vision September, 1995
[2] Acholi is singular as well as plural
[3] Personal communication Professor Sabrino December 1997 at RSC, Oxford.
[4] The LRA attack left 50 refugees dead and many displaced. The New Vision 20 July 2002, The Monitor 23 September 2002.
[5] Nursing Officer, Masindi District Hospital
[6] Interview with Sr Josephine, Kyatiri Orphanage Hoima (real name used with permission).
[7] Nakivale settlement accommodates refugees of various nationalities such as Somalis, Kenyans, Banyamulenge and Rwandese. Before 1994, it accommodated the majority of Rwandese refugees in Uganda then.

10

Conclusions

10.0 Introduction

This study may not have elicited entirely new concepts about power and gender relationships as they affect the livelihoods security and productive health among refugee women and how they respond to these processes. It has nevertheless attempted to critically analyse the existing concepts and how they are applicable in situations of armed conflicts and forced migration in Uganda and the Great Lakes Region of Eastern Africa.

The study has reconfirmed that armed conflict and forced displacement of populations account for a large proportion of the world's refugees, the majority of who are women and children. Forced displacement disrupts the wellbeing and protection of individuals and predisposes them to insecurity and powerlessness. Forced migration renders women and girl refugees in particular, vulnerable to abuse, as they easily fall victim to sexual and other gender-based violence (Seifert, 1994). For example, the study supplemented Musse's observation in which 192 sexual abuse cases against Somali refugees over a four-month period in the Kenyan refugee camps were documented (Musse, 1996). The study has reaffirmed that war, often accompanied by economic breakdown with a loss of homes and income, is likely to contribute to the spread of STDs including HIV / AIDs. It has been observed that apart from STDs and HIV / AIDS, violence against women in post conflict situations, the refugee experience exposes the already vulnerable women to other injustices such as marginalization in the distribution of resources and in decision- making concerning the day to day affairs of the refugee settlement.

The study confirmed reports of rebel attacks on Imvepi refugee settlement in Arua District, involving the death of one refugee girl and the abduction of eight others in 1997. Many similar incidents have occurred in Ikafe settlement in Aringa County in Arua District (Payne, 1998). Similarly, the study reinforced dozens of other reports which have corroborated the incidence of sexual and gender-based violence, especially targeted against women and girls, not only during overt conflict, but also in post-conflict situations and in refugee camps .

Some of the arguments I raised in Chapter 2 concern the on-going women's movement debates in regard to the subordination of women and how this constraints the access to resources. The study has noted that international refugee policies as well as local government policies increase gender biases. There is a tendency for the refugee programmes to cater for the practical needs as opposed to strategic needs which would ensure their transformation . I positioned the issue of reproductive health in the context of power and gender under conditions of conflict and displacement, with special reference to the problematic conceptualization of African households and livelihoods and to the institutional regimes of humanitarian aid, especially to refugees. constrains the access to resources. I argued that the experience cannot be universal. Hence, I opted to situate my own position within the Third World Women Feminism whose struggle is against both poverty and subordination for survival and respect (Johnson-Odim, 1991; Mohanty, 1991), while being cautious of the fact that the experience is not homogeneous, and that some women are worse off than others. I also examined the inappropriate nature of the welfare policies, based on the modernization paradigm, which target women in their role as mothers and which I find inadequate in addressing the strategic needs of women. Another issue that I raised, was the difficulty associated with conceptualizing the household and the decision-making process within the prevailing theories on households that do not fit the African household. Given the conceptualization shortfall, I instead opted to approach the woman refugee as the unit of analysis situated within the context of the household and the wider environment.

10.1 Theoretical Reflections

Actor-oriented approach

In most of the discussion in this report, I have used Norman Long's 'actor-oriented approach' to explain the behavior of refugees and those charged with their care and management. Among other things, Long argues that "… all actors exercise some kind of 'power' or room for manouvre, even those in highly subordinate positions" (Long, 2001:17). Humanitarian interventions present an arena of struggle in which access to resources such as land, water, food, education and health care become the focus of dynamic interactions among different social actors. I was able to witness and confirm first hand this phenomeonon for most part of the research methodology, I was a participant observer. I therefore used the actor-oriented (interface analysis) approach to understand the complex relationships and strategic actions of the actors. While the central component of the approach is the concept of agency, I have in addition used several other concepts associated to actor analysis to explain the relationships and processes studied. Concepts such as room for manouvre, social domain, lifeworld, arena and power have been employed to describe the 'landscape' and agency (even though many of them have overlapped with the gender analytical tools I have used to supplement the actor-oriented analysis). Hilhorst (2000:223), notes that actor-orientation does not focus on single individuals but acknowledges that agency emerges from social processes. Thus, I have analyzed individuals in the form in which they have mediated and interpreted certain socially-based material and cognitive phenomena and through their relationships with other social actors.

In analyzing this process, I have consistently used the concept of social actors to argue that they have agency in that they are knowledgeable and capable. I have argued that refugees as social actors use their agency relationally with others to negotiate new positions and or try and maintain old positions of power and authority or even subjugation as they pursue their projects. An appropriate example is the way most men deliberately refuse and loath performing duties and activites perceived by society as women's roles while at the same time how women are prepared to compromise and help their men in subsistence farming to keep peace.

Room for manouvre refers to the social space actors have (or do not have) to enable their projects succeed. I have used this concept to examine such spaces available to the actors for the realization of their projects or the factors that limited this realization. In the study I was able to identify and elucidate actors' perceptions and attitudes towards certain aspects of the intervention through the way they were negotiating space for themselves by enrolling others in their own projects. I have used the concept of lifeworlds to refer to the life experiences, values and norms and meanings individuals attach to their lives. The use of this concept goes beyond livelihood. The concepts arena and social domains have been applied interchangeably to refer to the social and symbolic boundaries that people define and uphold. Although such domains are not cultural givens (Long, 2001:241), in my study I found them nevertheless clearly demarcating the activities and space for refugees, especially according to their gender. The interface analytical perspective was useful in as far as the analysis of social actors at the meso level was concerned. However, I found that such analysis did not properly elucidate the processes at the household level which were so crucial for the study, and hence my supplementing the analysis purposively with gender analytical perspectives.

Gender analytical tools

The gender analytical tools used were derived from the Harvard Analytical Framework (Overholt *et al*, 1985) and included the following: gender division of labour and workload, access to and control over resources, participation in decision making and refugees' perceptions. However, this framework is not without weaknesses. It overlooks the importance of the contextual (macro) factors that influence the specific gender relations. It also does not adequately address the issue of power in gender relations. Because of this, I supplemented the analysis with the application of power and gender ideology, which I have used quite extensively throughout this study. This was helpful in that it allowed the analysis to extend beyond the micro level as well, and enabled me to analyze and understand the 'gendering' and often asymmetrical nature of relationships, both within the family and in other 'interface' situations. I have therefore used the concept of 'power' often as repressive and suppressive, as it was perpetuating or increasing gender inequalities. However, depending on the context, it also has an empowering positive aspect as in, for example, when certain forms of knowledge had a liberating effect. My usage of gender ideology (at the micro, meso and (inter)national levels) was to address analytically within a gender perspective the socio-cultural beliefs, norms, values and perceptions of the actors including the refugees, the health providers, UN and NGO staff and to examine the international and national policies

(including humanitarian policies) to detect the way the gender ideological perceptions and values might have shaped the design and implementation of the health programmes and the specific responses by the refugees towards the programmes.

10.2 Key Findings

Using research questions as guides, this section summarizes the key findings of earlier chapters.

On the question of international and national approaches and policies to health in general and reproductive health in particular

Briefly, the study shows how the national health policies have developed and evolved in Uganda. These policies were originally modeled along the western models and an attempt to implement them within the Primary Health Care (PHC) strategy has been made since the Alma Ata Declaration in 1978 and the Bamako Initiative. During this period, reproductive health policies have focused mainly on the reproductive functions of women and their children while health programmes have focused on maternal and child health.

However, the implementation of those policies were greatly hampered by poverty, poor economic performance and slow development particularly in the 1980 decade. As a result of the United Nations concern about the population trends including high mortality, morbidity and high fertility and to address this problem, the International Conference on Population and Development held in Cairo in September 1994 initially came up with the concept 'reproductive health'. The main goals set out in this concept were to focus on the total life cycle of women and to increase the participation of men in issues of reproductive health. The concept was further emphasized by featuring prominently in the Fourth World Conference on Women (FWCW) held in Beijing in 1995.

In Uganda the implementationof reproductive health policy was further adversely affected by several years of bad politics, total economic decline, and near anarchy, and near destruction of infrastructure and by the time the NRM government took over, there was hardly any health policy to speak of. Macrea *et al*, note that "the physical infrastructure was in a state of near collapse as a result of neglect and direct war-damage; the majority of health facilities had been looted of supplies and equipment" (Macrea *et al* 1996:1097). The dominant response by the national and international health organizations after the NRM take over has been an attempt to restore the health system to the pre-1970 levels of functioning and to add selective primary health care interventions. Although this approach has expanded the pre-conflict health systems and its assumption that wide spread access to primary health care could be achieved without reforming the financing and provision of secondary and tertiary care has been deffective. The rehabilitation of the infrastructure has been done at the expense of human resource capacity building. For example, the study shows that many health centres are operated by poorly qualified personnel.

The reproductive health policy framework instituted as a rehabilitation measure is guided by: the National Health Policy, the National Population policy; the National Guidelines for Reproductive Health, and the National Adolescent Reproductive Health Policy. Although the above policy framework is in place, it has not been very effective because "the rehabilitation programmes did not serve to increase national or local capacity for health policy design, implementation and management. By concentrating a significant proportion of capital funds on the rehabilitation of physical structures, improvements in access to health services were largely restricted urban areas and rural trading centres." (*ibid*:1100).

The study findings indicate that despite government policy and effort to bring healthcare services closer to the people, the health care system is still basically therapeutic and curative in nature and is generally urban-based. This is evidenced by the fact that highly skilled health professionals are predominantly urban based. The majority of health units in the rural areas are to be found in trading centres away from the rural communities. As a general rule Government hospitals tend to be associated with the district headquarters, which in turn are located in urban centres. In general only NGOs such as church missionaries have tried to locate their hospitals in rural areas, as is the case with Maracha Catholic Hospital in Arua district.

The study also indicated that in the health sector in several districts, reproductive health is implemented within the maternal and child health / family planning (MCH / FP) programmes, which target mothers and their babies. Although there were also reproductive health programmes for men, women who were non mothers and adolescents, the reproductive health sessions I visited did not include any men. Male refugees approached health units to seek treatment for STIs and occasionally for condoms, which they used not so much as a family planning measure but as a barrier for STIs and HIV / AIDS (chapter 8).

Although there has been concerted effort to implement the reproductive health approach recommended during the international conferences deliberations in Cairo and Beijing (UN 1994; UN, 1995), and the Millennium Development Goals (MDGs) this effort remains limited to urban centres and is also limited in the activities. For instance, there were no Pap smear facilities and cancer detecting equipment in rural health units (chapter 6). The refugee youth demand for condoms was high and yet the supply was unreliable (chapter 8). It was also noted that there was only one reproductive health organization specifically targeting adolescents, *the Naguru Teenage Information Centre* in Kampala. Having said this I must add that the HIV / AIDS programmes have established several centres in Uganda, which offer free condoms, treatment for opportunistic infections, counseling services, homecare, and Anti Retroviral Therapy (ARVs).

In Chapters 5, 6 and 7, we have examined some macro and micro factors, which have profound influence on the provision of health care in Uganda. We have specifically noted the after-effects of *coup detats* and civil wars and the associated civil and political instabiltiy, bad governance and social adjustment policies (SAPs) (Adedeji, 1999), have had a particularly constraining effect on effective provision of health care.

Chapter 4 has demonstrated how, since the mid 1950s, Uganda has been a refugee hosting country due to its geographical location in the Great Lakes Region (GLR). Although not all refugees are within the legal humanitarian assistance framework, as some of them opt to self-settle in various parts of Uganda, there is no doubt that the extra caseload of these refugees has placed additional strain on the already over-stretched health services. We have noted that women are particularly affected by this overloaded health system as they bear the brunt of sickness, either to themselves or as care givers to the rest of the family. This situation is regerattably aggravated by the HIV/AIDS pandemic.

Some of the issues raised in Chapter 2 concern patients with complicated illness who travel long journeys to hospitals in search of specialized attention, but because many are poor and short of financial resources and therefore cannot afford to pay the necessary ancillary hospital expenses, are unable to access the specialised treatment required. Some such cases do not even attempt to travel to the hospitals, and resign themselves to die in the village settlements. In Chapter 7, I have specifically observed that health for all will be difficult to achieve in a situation such as obtais in Uganda where the human resource is scanty. The health provider/population ratios are very lopsided (Chapter 6). Nurse aides and untrained individuals operate many of the rural health units, which should be operated by more qualified personnel.

I have argued that given these unfavourable circumstances including increasing poverty levels, protracted internal conflicts, and dependency on donor funding, the well-intentioned ongoing international proclamation to achieve health for all may not be fulfilled in the near foreseeable future. This tends to imply that there has been failure by those concerned to arrive at the correct formula for health provision in specific areas of the world and in specific conditions, such as those in refugee settlements, health for all is still as elusive now in Uganda as it was a decade ago and the situation os likely to be aggrevated by the high population growth in Uganda (Chapter 6). The evidence can be discerned from the maternal and infant mortality rates in Uganda (UDHS, 2000/1), where infant mortality rate (IMR) is as high as 88 per 1000 live births and maternal mortality rate (MMR) stands at 505 per 100,000 live births. Moreover many practioners have argued that the MMR coould be several times higher.

On the question of the institutional and organizational characteristics and practices of the health care programmes in Uganda and the refugee settlements, the study has unearthed some interesting observations.

The study shows that health care provision is done along a hierarchical arrangement starting with Health Centre Grade II to V up to the National Referral Hospital . The implementation of health care programmes has particularly been affected by decentralization and devolution of certain responsibilities from Central to Local government. This process has resulted in the creation of health sub districts (HSDs) centres in an effort to take health services closer to the people in the rural areas. The study established the existence of HSDs. The study has established that thses HSDs are beset with many problems including lack of both financial and human resources.

For instance, the HSD at Rhino Camp was found to be operating without a medical doctor and anesthetist. It also did not have blood supply facilities.

A disturbing observation is that the Health Policy is silent about refugee health. This implies that the health of refugees and of those caught in emergency situations is not considered as requiring specific attention out of the ordinary. Although refugee health might appear to be similar to that of the local residents in normal non-refugee settings, the initial influxes and the mode of the refugee settlement demand that special arrangements for refugee health care be made (Chapter 7). The study established that this special requirement was left entirely to the UNHCR, which has established parallel health structure for the sole use of refugees in the settlements. These health centres were well equipped and the staff well remunerated. However, the study did note that the refugee health centres in the districts of Masindi and Arua also benefited from the MoH vertical programmes of the Essential Drugs Programme and Expanded Immunization programmes. The study shows that despite the recent government decentralization policy, the refugee administration is still the business of central government (Chapter 7).

Much as the MoH has established guidelines for reproductive health programmes (Chapter 6), these guidelines do not indicate properly how the implementation should be done. For instance, the study found that the implementation of 'traditional' maternal and child health and family planning (MCH/FP) is the approach being implemented (Chapter 8 and 9). While the reproductive health programmes were 'one off' projects, such as the UNFPA-funded reproductive health project in Rhino camp conducted during the late 1990s (Chapter 8).

The study established that in the non-refugee areas of Uganda awareness of and the prevention of STD/HIV/AIDS received maximum attention, which was not the case in the refugee settlements, where such awareness was quite low (Chapters 8 and 9).

In summary the study observed that the implementation of the health sector is multisectoral and is the duty not only of the Ministry of Health, the NGO faith- based hospitals, but also the informal sector including the private for profit hospitals, the health clinics and drugstores as well as the traditional medicine sector. Due to the HIV/AIDS pandemic, many international organizations such as USAID, CARE, AIM and Marie Stopes have funded the implementation of several reproductive health related and HIV/AIDs projects in Uganda.

An interesting finding of the study is that healthwise the refugees appear to have been better taken care of than the host population in the surrounding villages. For example, Rhino camp with a population of about 25,000 refugees had 4 health units (2 at Grade III and 2 at Grade II). Similarly Kiryandongo with slightly more than 10,000 people had one health unit (Grade III). The distances to the health centres ranged from less than half a kilometre to maximum 5 kilometers in Rhino Camp. This compares to situations where host populations may have one health centres per 50,000 people and walking distance can as long as 30 kilometres.

We concluded therefore, that refugees get better health care than their hosts. In similar situations in Kiryandongo, the refugees in Ranch 1 and some areas of 37 access the health center easily as it was within easy proximity. However, the refugees in Ranch 18 have to travel up to 10 kilometers and more to attend health care. Long distances notwithstanding, it can be argued that on the whole, the refugees have been afforded excellent health care in copmarison to that afforded to the host population. (Chapters 8 and 9).

The question is: what effect if any has this reasonably good health service had on the reproductive health behaviour?

The study indicates that the good refugee health care services have motivated refugees to produce more children at very little cost (Chapter 8). It is not clear if, at the end of the day, the refugee parents would be able to educate and feed their children, especially within the framework of the self-reliance strategy (SRS) (Chapter 4).

On the question of refugee perception of reproductive health and how the new situation of refuge has changed their socio-cultural expectations, practices and coping mechanisms - The study makes th following conclusions

In Chapter 1, it was noted that the concept of reproductive health carried different meanings and connotations to women, men and adolescents, and that, in general, these different interpretations had something to do with survival. Women desired that their children survive while men were anxious about avoiding STIs and accessing incomes. Adolescent girls, on the other hand, wished they could get sanitary towels to enable them attend school during menstruation while boys were anxious about impregnating girls. There were therefore, variations in perception of reproductive health and its benefits.

Overall, however, the study shows that Sudanese refugees have a pronatalist attitude. The majority of the refugees have a propondarance for raising large families who they believe to be a gift from God. It was also observed revealed that this tendency could be heavily influenced by the war in southern Sudan, which has left thousands upon thousands dead and the natural desire to replenish themselves. Moreover, high fertility rates appeared to also be influenced by desire for status accorded to women with many children as well as the cutomary policy of giving more commodity supply entitlements such as land, and other provisions to women with larger families.

Sexually transmitted infections (STIs) including HIV/AIDS

The study shows that the available STI / HIV programmes focus a great deal on the use of condoms to prevent STI infection and not so much aimed at addressing the vulnerability of women in general and girls in particular in terms of sexual exploitation and unwanted pregnancies. The dispensing of contraceptives including condoms to adolescents appears to be biased by the health provider's attitudes. In this case, the health provider's 'projects' frustrate the main project (Chapters 8 and 9).

The use of condoms by the very few adult males was purely for protection against STIs and HIV, while the adolescent males was for protection against pregnancy and disease. The study shows that government anti-HIV/AIDS programmes and campaigns in the media, and drama in the communities did not get to the refugee settlements. The refugee population was kept unaware of the risks of having unprotected sex.

In addition, the current approach to reproductive health issues in the refugee settlements ignores the salient issues of gender-based violence and physical abuse. Violence against women and girls was widespread in both refugee settlements. Given the risk for sustaining HIV/AIDS and STI and unwanted pregnancy and the accompanying psychosocial trauma, this aspect did not receive much attention in the refugee programmes at the time of this study. The two case studies of sexual abuse and violence, which involve project staff, indicated in Chapter 8 help to illustrate the differences in interests between the UNHCR and the Implementing Partner. Furthermore, they show the vulnerability of adolescent girls (and women) to abuse and they also point to the non-existence of a mechanism for addressing these issues.

Marriage, households and gender roles

The study indicates that the traditional marriage patterns formerly practiced by the refugees in their original communities are eroding and giving way to short-lived and unsanctioned unions. This has been blamed partly on poverty, which incapacitates prospective husbands from affording to pay bridewealth. Another cause was identified as a breakdown in the family set up and relations caused by displacement, which led to family members seeking refuge in different refugee settlements and/or countries. In such situations, marriage has tended to be engaged in as a coping mechanism and as a way of avoiding the stigma of being single. The study shows that in an effort to evade the payment of bridewealth, many young couples have decided to elope.

Marriage divorce among refugees is quite common, but significantly invisible as the divorced couples soon find and make new relationships. Another significant change in the marriage institution is that most refugees marry before bridewealth is paid and promise to pay when they get back to Sudan. This lack of traditional financial commitment tends to marginalize women who are in many cases abandoned with their children by their uncommited spouses. And there is no mechanism to redress these issues in the settlements because of the fragmentation of the clan system.

It was established that a refugee household was a complex unit. Households were deliberately formed and sometimes inflated in size in a bid to maximize allocation of resources such as land, food rations, and non-food items for survival purposes. Some husbands to the several wives in the several households, and in some cases several settlements, kept trotting from one household to another and from one settlement to another. Eventually this made husbands dependent on the women for survival, as they had no time or were not willing to work on their own land since they were assured of food and shelter from their several wives. This phenomonon meant that most households were effectively headed by women (Chapters 8 and 9).

This headship of household by women was, however, limited to a few responsibilities, such as provision of food, health care and the education of children. Where major issues, such as determination of bride wealth, sale of livestock, the borrowing of land, and other decisions that are traditionally made by men, women were generally overlooked.

Whereas women were willing or were forced by circumsatnces to do men's work, the study confirmed that men loath to do women's work. This negative attitude by men towards everyday routine chores which they abandoned to women in turn led to the abandonment of house headship power to women. This situation is augmented by the practice of UNHCR allocation of household requirements to the women tended to make the men frustrated and led them to drink more and to become violent (Chapter 8 and 9). The study also established that there was a direct relationship between livelihood and reproductive health. Women's extensive and hard work in refugee situations motivated them to having more children to help them with domestic work.

The study established that, although more than 90% of pregnant women in Rhino Camp attend antenatal care, less than 35% of them deliver in hospitals. This is not very different from the national figure of 38% of assisted births (UDHS, 2000/1). The question arises as to why only about a third of these women who attend antenatal clinics chose to deliver in the hospitals, which are within easy reach, and the rest prefer to deilver in their homes. The study established that TBAs are very crucial in the reproductive health process and conduct most of the deliveries in the settlements because home deliveries are associated with the social cultural customs, which must be observed when babies are being born (Chapter 8). In particular, the way the placentas are disposed of is a crucial factor. All health units in the settlements have specially made placenta incinerators, but the refugees consider incinerating of placentas a breach of the customs and values of the predominant ethnic groupings, such as the Dinka and the Nuer. These socio-cultural taboos of refugees need to be respected and there is therefore the need to study the cultural practices, norms and beliefs that surround reproductive health issues of the specific population for which reproductive health programmes are designed.

On the question of the role of power/gender relations at household and community level in influencing the utilization of reproductive health services in refugee contexts, the study has the following observations.

The study discovered that gender relations played a crucial part in the acceptance and use of contraception. For example, it was observed that only a small number (35) of women refugees in Rhino Camp settlement use family planning. Even then, this is done discretely and without the knowledge of their husbands. This is because the husbands in the refugee settlements were vehemently opposed to family planning (Chapters 8 and 9) for reasons we have aleady covered in this summary. Another point at which power manifests itself was at the interface between the refugees and the health providers.

In some cases, the power-wielding nurses and midwives appeared to be a stumbling block in the way women access health care. For example, many expectant women were scared of ' being cut and sutured' during delivery simply because the refugees were of the opinion that midwives deliberately 'cut' women in labour in order to speed up the delivery and get over and done with it.

Settlement Policy as factor in livelihoods and survival strategies

The study noted that refugee settlement policy negatively impacted the livelihoods and the gender roles of refugees. The existing settlement law for refugees controls their mobility (Box 8.1) to the extent that it has led to the destruction of the surrounding environment by way of drastically reducing forests and tree coverage (Chapter 9). The study identified two major problems within the social domain of women refugees associated with firewood and water collection as the long distances travelled and considerable amount of time taken to gather and collect these items (Chapter 8 and 9). Kiryandongo was experiencing both water shortage and scarcity of firewood. Although Rhino Camp did not appear to have problems with firewood, as it was fairly abundant, the study established that it will soon dwindle due to the charcoal trade. Women refugees had to strategize to deal with these roles and it affected their livelihoods. They were obliged to decide on what to cook in order to save on the fuel wood even if their choice of food item was not necessarily the best for the children and themselves. Water points were observed to be points of struggles and sources of violence where some individual bullies tried to jump the queues.

Needless to say, it was noted that the collecting of firewood and water impinged on the women who had to attend to their gardens, income-generating activities or the children and their own self-improvement. Thus, there was a direct relationship between gender roles and livelihood strategies. Moreover, apart from the endless queues at the boreholes points the study identified lack of water storage facilities as another problem that needs attention. Refugee settlement policy did not appear to be sensitive to many other supplies that could help the women fulfil their gender roles uniformly. For example, whereas in some refugee settlements, women were targeted for energy saving stoves, the women in Kiryandongo had not benefited from such innovations. The study identified more gender roles for women than for men and yet men have more livelihood options than women. Men were quite active in income-generating activities associated with cash. Only as a coping mechanism, did men barter their labour for food. Women, on the other hand, tended to a variety of crops, which they could consume as well as sell.

Education and Reproductive Health

The study elucidated evidence that even when free education was provided for all primary going refugee children (Chapter 8 and 9), not all the children attended school and the majority of those not attending were girls. There were several reasons given for this non-attendance, but the most outstanding reasons given related to gender roles, poverty, menstruation, teenage pregnancy and violence.

Primary teachers and NGO staff and workers, such as drivers on contracted projects, were noted to be among the sexual abusers of the young girls (case 8.2). The response by security organizations like the police to such reported abuses was quite negative and discouraging in some cases. In one particular incident, the response of the Police was to instruct the perpetrator (the driver) to pack his things and proceed to Kampala. There was clear lack of machinery within the refugee settlement for protecting and offering justice to the injured and the wronged girls. To add insult to injury, in almost all cases, the the parents would agree that matters should be settled culturally instead of insisting that the law takes its course.

Regrattably, the study noted that many girls are taken advantage of through meaningless gifts of sweets or were simply raped. Those charged with refugee care and management, did not take appropriate actions even when they are aware of the problems because they wanted to protect their jobs and projects. For instance, they would rather not extend a contract for a driver than ensure that he supports the wronged girl (case 8.8) or they would rather transfer the policeman than to make sure the impregnated woman receives support.

One more interesting thing about education for girls in refugee settlements was that sex education started late while refugee children started going to school at a later age, which contributed to the girls dropping out early. When refugee girls start primary 1 at an advanced age, e.g. at 9, this means that by the time they get into puberty stage at about 11 or 12, they would still be in the lower classes of primary school. When they compare themselves with the host population where children usually start going to school at six, they get discouraged and drop out of school opting to get married, a virtue emphasized by their parents. Another factor that led to refuge schoolgirls dropping out early was the issue of sanitary towels and lack of toilets separation. Teenage girls felt embarrassed when they had to share the toilets with boys especially during menstruation. Equally as important, the girls claimed they missed school for as many as three to four days each month due to lack of protective sanitary wear during menstruation (Chapter 8).

On the question of the factors that contribute to 'gender neutral' planning and implementation of reproductive health programmes in refugee situations and how these can be changed

In practice, the policies are gender neutral, with the exception of UNFPA funded reproductive health programmes that are dealing with the female genital mutilation in Kapchorwa in Eastern Uganda. However, examining the existing policies closely, there is nothing to suggest that gender is considered during the formulation and implementation of programmes.

At the policy level, the UNHCR had gender sensitive policies (Chapter 2). However in practice the Implementing Partners did not appear to implement UNHCR preferred policies.

As I indicate in Chapter 8, the refugee programme in Rhino Camp was only just considering hiring a gender person even after several years of implementing UNHCR programme. It was clear that the UNHCR did not adequately supervise and monitor the programmes on the ground. In addition, even the locally conceived policies such as the SRS, the gender element was missing most likely because there was no gender incorporation at the formulation stage. The MoH policies were not gender sensitive either. This shows that the government and the international community are yet to come to grips with gender mainstreaming.

As a possible solution to the problem, the study has recommended that health policies should be gender mainstreamed and the staff of the implementing partners including the technical experts should be gender trained and sensitized so as to be gender responsive.

10.3 Implications of the study

I wish to conclude by summarising some of the implications of this study pertaining to the international and national reproductive health policies, gender relations and livelihood security.

First, it has been observed that international health policies do not always translate into operational health programes. While local governments strive to formulate policies, their implementation faces a myriad constraints including financial and human resource. The study found out that although the infrastructure of the health centre for the host population in the rural areas had been refurbished, they lacked the equipment and professional staff to run them. And yet the refugee health centres in isolated areas were well staffed and better remunerated. The study identified the disparity as being not only uneconomical, but also capable of creating bad relationship between the host population and refugees. Perhaps a programme could have worked whereaby the staff in refugee health centres could also work in hospitals for host populations. The lesson learnt is that even if it were possible that Third World countries that depend on donor funding may not be in a position to state their real needs in order not to get compromised in their chances of getting project funding, there is need to conduct needs assessments to learn from would be consumers what they really want instead of imposing on them what was perceived as the need.

Secondly, although the 1990s saw the term gender and development (GAD) gaining prominence over women in development (WID) with respect to developmental strategies in the Third World countries, the mainstreaming of gender in policies appears to still be a challenge for most organizations. Even in cases where the policies have been 'gendered', their implementation could pose a challenge as a result of gender irresponsive staff. GAD should look at both men and women as key players but with different roles, needs and entitlements in the development process. This aspect ought to be comprehended by the individuals assigned the task of implementing refugee health policies.

GAD links the relations of production with relations of reproduction since it takes into consideration all aspects of the women's lives based on social construction of production and reproduction as the basis of women's subordination. In this study, I established that women gain a higher status and more privileges if they produce many children and particularly boys.

Furthermore, the GAD approach also emphasizes the necessary role of the state in enabling the acquisition of advancement opportunities, such as, education, employment, health to women and girls. Although the government is operating affirmative action geared at the education of women and thier inclusion in the Local Councils up to Parliament, the study established that advancement of refugee women and girls is constrained by several obstacles, most important of which is the gender stereotyping and ascribing marriage to girls even before they are of age. There were similar attitudes across the whole spectrum of the refugee population. Men were eager to get bridewealth from their daughters so as to educate the sons. This attitude could be a function of the general poverty in refugee situations. Improvement of refugee livelihoods through skill development, micro finance and education are some of the ways that could change such attitudes. The patriarchal nature of the household, I feel, can be changed progressively through affirmative action through sets of empowering processes, such as education, participation in leadership and decision making roles for the women and girls.

Thirdly, the study shows that the magnitude of the impact of gender relations on reproductive health at the household level has not yet been adequately understood. Practically, all women refugees were illiterate, they could neither read nor write. They also belong to highly patriarchal societies with clearly established gender norms and values in which they have been socialized. Upon displacement, there are no programmes for their emancipation (apart from the education of their children which is skewed in favour of boys). The UNHCR offers the basic needs such as shelter, healthcare, water, and so on. This caters for the practical needs of the women refugees, but does not improve on their subordinate position; it leaves the gender relations at status quo. In other words, these women would not have changed one bit from what they were before they fled Sudan. The study concludes that UNHCR, the host government and the NGOs have not tackled the strategic needs that transform the position of women.

Fourthly, the study shows that as long as the security status of women is highly dependent on their capacity to bring forth children (particularly male children), then efforts to curb this process may not bear fruit. In addition, when the life of a newly born baby is not guaranteed, as is the case in many underdeveloped countries like Uganda and Sudan, it is difficult for any rational parent not to want to have as many children as possible. On the other hand, if child survival were guaranteed, and women's lives empowered so as to reduce their dependency on children for access to resources, such as allocation of land, or depending on them during old age, it is probable that parents may seek to have fewer children.

Fifthly, the refugee settlement policy perpetuates unintended gender inequalities. The

Women have to spend long hours looking for firewood. Most do not have improved heat saving stoves' technology to reduce the demand for firewood for cooking. The location of the settlements in secluded places makes it difficult for women to get out into the 'other world' because of their gender roles and yet men find it easier to seek permission and leave the settlements for education and employment. While outside the settlements, refugee men are exposed to more knowledge, employment and politics. Women, on the other hand, cannot even afford dry battery cells to enable them listen to educative radio programmes. They are constantly cut off from the outside world and do not get the intellectual stimulation their men get. Furthermore, women are not provided with adult appropriate literacy lessons (the few programmes offerred tend to act as hindering impediments). There is a high drop out rate for girls in primary schools, teenage pregnancies abound, and only very few girls make it to secondary classes in which case they are confronted with sponsorship problems.

10. 4 Looking into the Future

It is not possible to predict the end of forced migration and refugee situations especially in the Great Lakes Region. As long as armed conflicts persists in the region, there will always be a sizeable number of displaced people who will depend on others for their survival. The management of displaced persons and the provision of humanitarian assistance to refugees in Africa is likely to be around for many generations to come and should be reassessed with a view to generating better gender sensitivity polices, whose implementation will ensure that the strategic need of refugees are being considered.

The study has demonstrated that even though the Uganda government boasts of and indeed has tried to put in place a national gender policy, there is very little to prove for the policy existence in the health services implementation at the periphery. And much as the UNHCR has stressed People Oriented Planning (POP) (UNHCR, 1990), in addition to attempting to implement several policy measures taken to ensure gender sensitivity and increased levels of women participation in the refugee camps and settlements as recommended by Geneva, there is a great need for UNHCR to monitor and to insist on the stringest implementation of gender sensitive programmes by the implementing partners. There is the need for proper selection and engagement of implementing partners who are really gender sensitive. I recommend the use of a gender assessment guide such as one recommended by Gianotten, et al., (1994). Such assessments would yield information concerning the gender incorporation and to the practicability of some policies in our Great Lakes Region. It should be feasible to conduct such assessments in this, now historically well known potentail refugee area and such data should be stored in assessment banks and be retrieved for use as and when needed.

10.5 On the Need for Further Research

This study has attempted to look at the processes that reproduce and perpetuate gender inequalities in refugee situations with particular emphasis on humanitarian assistance (health and reproductive health care) and gender relations at the household level and the wider community.

The study has also highlighted and attempted to examine the changing gender relations and livelihood security in refugee settings. Obviously the study could not go as deep as possible into all the issues highlighted. It is therefore hoped that more research will be addressed to some of the issues such as the question of the linkage between empowerment of refugees, fertility and the gender gap. Much more indepth work need to be done on the refugee women survival tactics and strategies as well as mechanisms that need to be put in place to ensure successful education for the girl child at least up primary seven level. It is possible to generate programmes that will attract men refugees to keep to and play their expected roles of heading their households instead of abandoning their duties to women. There appear to be a lot of areas that need further research and study.

Bibliography

Adatu, F. (2005) 'The Challenge of Tuberculosis in Women and Children': *The New Vision.* May 3, p. 31.

Adedeyo, A. (1995) 'An African Perspective on Bretton Woods' in: M. Haq, R. Jolly, P. Streeten and K. Haq (eds) *The UN and the Bretton Woods Institutions New Challenges for the Twenty First Century.* London: Macmillan. pp.60-82.

Adebayo, A. (1999) 'Structural Adjustment Policies in Africa' in: *International Social Science Journal.* Vol. 1, Issue 162, pp.521-528.

Adepoju, A. (ed) (1997) *Family Population and Development in Africa* London: Zed Books. pp.1-24.

Adepoju, A. and C. Oppong (eds) (1994) *Gender, Work and Population in Sub Saharan Africa*. London: James Currey.

Afshar, H. and B. Agarwal (eds) (1989) *Women Poverty and Ideology in Asia – Contradictory Pressures Uneasy Solutions* Basingstoke and London: Macmillan.

*Africa Watch/Women's Rights Project (*1993) Vol. 5, No. 13.

Africa Watch/Women's Rights Project-Divisions of Human Rights Watch '*S*eeking Refuge, Finding Terror – The widespread rape of Somali women refugees in North Eastern Kenya', October, 1993. Vol. 5, No. 13.

Ager, A. (1999) *Refugees, Perspectives on the Experiences of Forced Migration*. London: New York, Pinther.

Akosua A. A. (2004) 'Whose Unmet Need'? Dis/Agreement About Child Bearing Among Ghanainan Couples' in: Signe Arnfred (ed) *Rethinking Sexualities in Africa.* Uppsala: Nordic African Institute.

Albrecht, L. and R. M. Brewer (eds) (1990) *Bridges of Power: Women's Multi cultural Alliances.* Philadelphia: New Society Publishers.

Anderson, M. B. and P. J. Woodrow (1993) 'Reducing Vulnerability to Drought and Famine" in: J. O. Field. (ed) *The Challenge of Famine: Recent Experience, Lessons Learnt.* West Hartford: Kumarian Press.

Anderson, M., F. Bechhofer and J. Gershuny (1994) *The Social and Political Economy of the Household.* Oxford: Oxford University Press pp. 2-5,20-21.

Anderson, B. and P. J. Zinsser (1989) *A History of their own: Women in Europe. From Pre-History to the Present.* Vol.1, New York: Harper and Row Publishers.

Arce, R. and N. Long (1992) 'The Dynamics of Knowledge. Interfaces between bureaucrats and peasants' in: Long, N and A. Long (eds) *Battlefields of knowledge; The interlocking theory and practice in social research and development.* London and New York: Routledge. pp. 211-245.

Arua District Health Work Plan 1997/98, Health Planning Unit, Entebbe.

ARROW (1996) Arrows for change: women's and gender perspectives in health programs. May 1996 Vol. 2 No.1 Kuala Lumpur, Malaysia.

Asthana, S. (1994) 'Primary Health Care and Selective PHC Community Participation in Health and Development' in: Phillips, D. and Yola Verhasselt (eds) *Health and Development.* London: Routledge. pp. 182-196.

Atkinson, R. (1999) *The Roots of Ethnicity: The Origins of the Acholi.* Kampala: Fountain Publishers.

Atkinson, R. (1998) *The Life Story Interview* . London and New Delhi: Sage Publications. Qualitative Research Methods Series 44.

Bankoff, G., G. Frerks and D. Hilhorst (eds) (2004) *Mapping Vulnerability Disasters, Development and People*. London: Earthscan.

Bantebya, G. (1997) 'Treatment seeking behaviour among poor urban women in Kampala, Uganda'. Unpublished Ph.D. Thesis. University of Hull.

Bandarage, A. (1984) 'Women in Development: Liberalism, Marxism and Marxist Feminism' *Development and Change*. 15 pp 495-515.

Baerends E. A. (1994) *Changing Kinship, Family and Gender Relationships in Sub-Sahara Africa*. Women and Autonomy Series, Leiden University.

BBC Report on 3rd January 2001 by Laura Faulton. The report was about expatriates for WFP in Angola. It concerned their inability to check the real situation leaving everything to local staff while they themselves drove around in Pajeros and Land Cruisers and were paid thousands of dollars.

Beechy, V. (1979) "Some notes on female wage labour in the capitalist production" in: B.S. Sharon and J.L. Papart (eds) *Patriarchy and Class: African women in the home and the work force.* Boulder Colorado: Westview Press.

Benneit, O., J. Bexley and K. Warnock(eds) (1995) *Arms to fight: Arms to Protect- Women speak out about Conflict.* London: PANOS.

Beneria, L and S. Feldman (eds) (1992) *Unequal burden: Economic crises, Persistent Poverty, and Women's work*. Boulder Colorado:Westview. pp.26-48.

Berthianume, C. (1995) Do we really Care? *Refugees*, II, 100. pp.10-13.

Black, R. (1994) 'Livelihoods under stress: a case study of refugee vulnerability in Greece' in: *Journal of Refugee Studies* Vol. 7, Vol. 4 pp.360-377.

Booth, D. (ed) (1994) *Rethinking Social Development Theory, Research and Practice*. Harlow: Longman Scientific and Technical.

Booth, D. (1996) 'Development research: From Impasse to a New Agenda' in: Schuurman and J. Frans (eds) *Beyond the Impasse: New Directions in Development Theory*. London and New Jersey: Zed Books Ltd.

Bouta, T. and G. Frerks (2002) *Women's roles in conflict prevention, conflict resolution and post conflict reconstruction literature review and institutional analysis*. The Hague: Ministry of Social Affairs and Employment.

Bozerup, E. (1970) *Women's Role in Economic Development*. London: George Allan and Unwin.

Bradley H. (1989) *Men's Work, Women's Work*. Cambridge: Polity Press.

Braidotti, R., E. Charkiewicz, S.Hausler and S. Wieringa (1994) *Women, the Environment and Sustainable Development; Towards a Theoretical Synthesis*. London: Zed Books Ltd.

Byrne, B. (1995) 'Gender, Conflict and Development' Vol. 1 Overview *BRIDGE*

Bryceson, D. F. (1995) 'Gender relations in rural Tanzania: power politics or cultural consensus? in: Creighton, C. and C.K. Omari (eds) *Gender, Family and Household in Tanzania*. Avebury: Aldershot. pp 37-69

Brydon, L. and S. Chant (1993): *Women in the Third World: Gender Issues in Rural and Urban Areas*. Hants: Edward Elgar Publishing Ltd.

Bunch, C. and R. Carrillo (1990) 'Feminist Perspectives on Women and Development' in: I. Tinker (ed) *Persistent Inequalities* NewYork: Oxford University Press. pp.70-82.

Bunch, C. (1990) 'Making Common Cause, Diversity and Coalitions' in: Lisa Albrecht and Rose M. Brewer (eds) *Bridges of Power: Women's Multi cultural Alliances* Philadelphia: New Society Publishers. pp.49-50.

Butler, J. (1990) *Gender Trouble: Feminism and the Subversion of Identity*. New York: Routledge.

Butt, A. (1952) *The Nilotes of the Anglo-Egyptian Sudan and Uganda*. London: International African Institute

Callamard, A. (1992) 'Refugee Assistance, Repatriation and Development: A Gender Analysis' Paper Presented at the Conference on First Country of Asylum and Development. Malawi 8-14 June.

Caldwell, J.C. (1975) 'Education as a Factor in Mortality Decline: An Examination of Nigerian Data' in: *Population Studies*, Vol. 33, No.3 pp. 395-399.

Caldwell, J.C., and L.T. Ruzicka (1978) 'Demographic Levels and Trends' in: Cleland, J., C. Scott and D. Whitelegge (eds), *The World Fertility Surveys: An Assessment* . Oxford: Clarendon Press. pp.741-772.

Camus-Jacques (1989) 'Refugee Women: The Forgotten Majority' in: Loescher, G. and L. Monahan (ed) *Refugees and International Relations*. New York: Oxford University Press.

Caplan, P. (1982) *Cultural Construction of Sexuality*. London: Tavistock.

Carby, H. (1982) 'Schooling in Babylon' in: Hutchinson (ed) *The Empire Strike Back: Race and Racism in Britain* London: Sage Publications.

Centre for Reproductive Law and Policy (CRLP) 'Displaced and Disregarded: Refugees and their Reproductive Rights'. http://www.crlp.org/pub_art_refugees.html Downloaded October 2001.

Chambers, R. (1983) *Rural Development: Putting the last first*. London: Longman.

Chambers, R. (1989) ' Introduction' *Vulnerability, Coping and Policy*. Institute of Development Studies, University of Sussex.

Chambers, R. (1997) *Whose Reality Counts? Putting the first last*. London: Intermediate Technology Publications.

Chant, S. (1997) *Women Headed Households: Diversity and Dynamics in the Developing World*. London: MacMillan Press Ltd. pp. 1-29.

C:/ WINDOWS/TEMP/ eud C.273. htm. 20 February 2002.

Cowley, P (1997) "Medicine practice in Uganda since 1890' . A paper presented at the Uganda Society 21 October 1998.

Crabtree, B.F and W. Miller (eds) (1992) *Doing qualitative Research: Research Methods for Primary Care* Vol.3. Newbury Park: Sage Publications.

Creighton, C. and C.K. Omari (eds) (1995) *Gender, Family and Household in Tanzania.* Avebury: Aldershot.

Crisp, J. (1999) 'Who has counted the Refugees? UNHCR and the politics of numbers'. *New issues in refugee research*: Working Paper No. 12 Geneva: UNHCR.

Coquery-Vidrovitch, C. (1997) *African Women A Modern History*. Oxford: Westview Press. pp. 9-2, 34-44.

Daley, P. (1989) 'The Exodus of refugees from Rwanda and Burundi: An analysis of the root causes'. A study commissioned by the Refugee Studies Programme, University of Oxford.

Daley, P. (1991) 'Gender Displacement and Social Production: Settling Burundi Refugees in Western Tanzania' *Journal of Refugee Studies* Vol. 4, pp. 248-266.

Davies, S. (1993) 'Are Coping Strategies a Cop out?' *IDS* Bulletin University of Sussex. pp. 60-72.

Demographic Health Survey, Kenya 1998.

Demographic Health Survey, Tanzania 1999.

De Haan, L.J. (2000) 'Globalisation, Localisation and Sustainable Livelihood'. *Sociologia Ruralis* 40/3 pp. 339-365.

Dehlot, C. (1994) 'Reproductive and Mental Health of Rwandese Displaced Women' in: UNIFEM/UNICEF (eds) *Reproductive and mental health issues and girls under situation of war and conflict in Africa.* Nairobi: UNICEF. pp. 7-22.

De Beauvoir, S. (1990) 'Woman as Other' in: S. Ruth (1990) *Issues in Feminism*. Mt View CA: Mayfield.

De Waal, A. (1989) *Famine that Kills: Darfur, Sudan 1984 – 1985* Oxford: Clarendon Press.

Devoe, P.A. (1993). 'The Silent Majority: Women as Refugees' in R. S. Gallin, A. Ferguson, and J. Harper (eds) *The Women and International Development Annual*, Vol. 3. Oxford: West View Press.

Dick, B. and S. Simonds (1983) 'Refugee Health Care: similar but different' in: *Disasters* 1983 Vol. 7 April 1983 pp. 291-303.

Diderichsen, F *et al* (2001) 'The Social Basis of Disparities in Health' in: Evans, T., M. Whitehead, F. Diderichsen, A. Bhuiya and M. Wirth (eds) *Challenging Inequalities in Health From Ethics to Action*. Oxford: Oxford University Press. pp. 13-22.

Dixon, M.(1980) *Women in Class struggle*. San Francisco: Synthesis Publications

Donor News 'Focus on Development' Vol 3 No 2 July –September 2003. pp. 7-13.

Duffield, M. (2000) 'Humanitarian Conditionality: Origins, Consequences and Implications of the Pursuit of Development in Conflict' in: Loane, G. and T. Schumer (eds) *The Wider Impact of Humanitarian Assistance: The case of Sudan and the Implications for European Union Policy*. Baden-Baden: Nomos verlagsgesellschaft. pp. 97-128.

Duffield, M (1998) 'Post-Modern Conflict: War Lords, Post – Adjustment States and Private Protection' *Civil Wars* Vol. 1 No 1 pp. 65-102.

El Bushra, J. and E. P. Lopez (1999) *Development in Conflict: The Gender Dimension*. Oxford: OXFAM.

Ellis, R. (1994) 'Help for single parent Refugee families' *Refugees*, 1/95, pp. 21-24.

Ellis, F. (1998) 'Household Strategies and Rural Livelihood Diversification' *Journal of Development Studies* Vol. 1 No. 1 October 1998 pp. 1-38.

Ellis, F. (2000) *Livelihoods and Diversity in Developing Countries*. Oxford: Oxford University Press.

Elson, D. (1992) 'From survival strategies to transformation strategies: Women's needs and structural Adjustment'. in: L. Beneria and S. Feldman (eds) *Unequal Burden: economic crises, persistent poverty, and women's work*. Boulder: Westview Press. pp. 26-48.

Engberg, L.E. (1996) 'Finding A Livelihood Alternative: An Example of Family Resource Management in Action' in: L.E Engberg, J. Varjonen and H. Steinmuller (eds) *Family Resource Management Issues*. pp. 151-155. Paris: International Federation for Home Economics.

Engle, K. (1992) 'International Human Rights and Feminism: When discourses meet'. in: *Michigan Journal of International Law* 85 pp. 517-610.

Esteva, G. (1993) 'Development' in: Sachs, W. (ed) *The Development Dictionary: A Guide to Knowledge as Power*. London: Zed Books Ltd. pp.6-25.

FAO (1997) *Rome Declaration on World Food Security and World Food Summit Plan of Action.* Rome: FAO

Forbes Martin, S. (1992) *Refugee Women.* London and New Jersey: Zed Books Ltd.

Fonow, M. and J. Cook (1991) 'Back to the future: a look at the second wave of feminist epistemology and methodology' in: Fonow, M and J. Cook, (eds) *Beyond Methodology: Feminist scholarship as lived Research* Bloomington: Indian University Press.

Fonow, M. and J. Cook (eds) (1991) *Beyond Methodology: Feminist Scholarship as Lived Research* Bloomington: Indian University Press.

Fontana, A. and Frey, J.H. (1994) 'Interviewing: The Art of science' in: N.K Denzin and Y.S.Lincoln (eds) *A Handbook of Qualitative Research.* Thousand Oaks: Sage Publications.

Foucault, M. (1978) *The History of Sexuality*. Vol.1 London: Allen Lane.

Foucault, M. (1980) *Power/Knowledge: Selected Interviews and Other writings 1972-1977* (edited by Colin Gordon and translated by Colin Gordon, Leo Marshall, John Mepham and Kate Soper) Brighton: The Harvester Press.

Fowler, A. (1998) 'NGOs and Globalization of Social Welfare: Perspectives from East Africa' in: J. Semboja and Ole Therkildsen (eds) *Service Provision Under Stress In East Africa*. London: James Currey. pp.51-65.

Friedman, H. (1979) 'Household Production and the National Economy: Concepts of the Analysis of Agrarian Formation' *Journal of Research Studies,* Vol. 7, No.2. pp.158-184.

Frerks, G.E. (1991) *Participation in Development Activities at the Local Level: Case Studies From a Sri Lankan Village.* PhD. Thesis, Wageningen Agricultural University.

Frerks, G. (2000) 'Recreating coherence through the perspectives of conflict and disaster: the role of coping capacities'. Paper for the World Congress for Rural Sociology Rio de Janeiro.

Gasper, D. (1997) *Logical Frameworks: a critical assessment.* Working Paper No. 278. The Hague: Institute of Social Studies.

Gaya, M (1944) 'The construction of Asiatic hospitals in Kampala' letter dated 21 June 1944 (Uganda archives, Entebbe–July 2003).

Gianotten, V., V. Groverman, E. Walsun and L.Zuidberg (1994) *Assessing the Gender Impact of Development Projects. Case Studies from Bolivia, Burkina Faso and India.* London: Intermediate Technology Publications.

Giddens, A. (1993) *Sociology*. Cambridge: Polity Press.

Giddens, A. (1984) *The Constitution of Society. Outline of the Theory of Structuration* Cambridge: Polity Press.

Giles, W., H. Moussa and P. Esterik (eds) (1990) *Development and Diaspora: Gender and the Refugee experience.* Ontario: Artemis Enterprises.

Girma, K. (1991) 'The Agonies of Displacement: Ethiopian Women Refugees in Khartoum, Sudan.' *Geojournal,* 23.2, 1991. pp. 99-106.

Gittins, D. (1993) *The Family in Question.* London: The MacMillan Press Ltd.

Golola, M. (2001) 'Decentralization, Local Bureaucracies and Service Delivery in Uganda' United Nations WIDER Discussion Paper No. 2001/115 October 2001.

Golombok, S. and R. Fivush (1994) *Gender Development.* Cambridge: Cambridge University Press.

Goldsworthy, D. (1988) 'Thinking Politically about Development' in: *Development and Change* Vol. 19. No. 2. pp. 505-530.

Goffman, E. (1961) *Asylums. Essays on the Social Situation of Mental Patients and Other Inmates.* London: Penguin Books.

Gorman, R. (1985) 'Private Voluntary Organizations in Refugee Relief' in: E. Ferris (ed) *Refugees in World Politics.* New York: Preager. pp. 82-103.

Government of Uganda and Uganda AIDS Commission (2004) *The Orphan and Vulnerable Children Policy* (Draft).

Goyens, P., D. Porignon, E. Mugisho Soron'gane, R. Tonglet, P. Hennart and H. Louis (1996) 'Humanitarian Aid and Health Services in Eastern Kivu, Zaire: Collaboration or Competition?' *Journal of Refugee Studies* Vol.9, No.3.

Green, A. (1992) *An Introduction to Health Planning in Developing Countries.* Oxford: Oxford University Press.

Green, A. (2004) 'Have health sector reforms strengthened PHC in Developing Countries?' In: *Primary Health Care and Development.* 5, pp. 289-295.

Guyer, J. I. (1981) 'Household and Community in African Studies' *African Studies Review.* Vol. xxiv No 2/3 June/September.

Guyer J. I. and P. E. Peters (1987) 'Conceptualizing the Household' in: *Development and Change.* Vol. 18, No. 2. pp. 197-214.

Halsema Ineke van (1991) *Housewives in the Field; Power, Culture and Gender in a South–Brazilian Village*. The Netherlands/ Paises Bajos.

Hammersley, M. (1990) *The Dilemma of Qualitative Method*: *Herbert Blumer and the Chicago Tradition*. London and New York: Routlege.

Handbook on Uganda, 1913

Hansen, H. B. and M. Twaddle (eds) (1988) *Uganda Now: Between Decay and Development*. London: James Currey.

Hardon, A. (ed) (1996) *Reproductive Rights in Practice*: *A feminist report on the quality of care* London and New York: Zed Books Ltd.

Hartmann, H. (1981) "The Unhappy Marriage of Marxism and Feminism: Towards a More Progressive Union" in: Sargent, L. (ed) *The Unhappy Marriage of Marxism and Feminism*. London: Pluto Press

Harrell-Bond, B. E. (1986) *Imposing Aid, Emergency Assistance to Refugees*: Oxford: Oxford University Press.

Harrell-Bond (1999) 'The Experience of Refugees as Recipients of Aid' in: Ager, A. (ed) *Refugees' Perspectives on the Experience of Forced Migration* London: Cassell. pp. 137-168.

Harrell-Bond, B. E. & Wim Van Damme (1997) 'The Health of Refugees: Are Traditional Medicines the Answer?' in: *Curare* Sonderband/Special Issue 11/97 Women and Health

Hewitt, T. (1992) 'Developing Countries: 1945-1990' in: Allen, T. and A. Thomas (eds) *Poverty and Development in the 1990s.* Oxford: Oxford University Press. pp. 221-37

Hilhorst, D. and G. Bankoff (2004) 'Mapping Vulnerability' in: Bankoff, G., G. Frerks and D. Hilhorst (eds) (2004) *Mapping Vulnerability Disasters, Development and People*. London: Earthscan

Hilhorst, D. (2000) *Records and Reputations: Everyday Politics of a Philipine Development NGO*. Wageningen: Pousen and Looyen. Ph.D. Thesis.

Hilhorst, D. (2003) *The Real World of NGOs Discourses, Diversity and Development.* Ateneo De: Manila University Press.

Hombergh, H. van den (1993) *Gender, Environment and Development – A guide to the literature.* Utrecht: International Books.

Holborn, L. (1975) *Refugees: A Problem in our Time- The Work of the United Nations High Commissioner for Refugees 1951-1972.* New Jersey: Scarecrow Press Inc.

Hollway, W. (1994) 'Separation, Integration and Difference: Contradictions in a Gender Regime' in: Radtke, L. and H. Stam (eds) *Power/Gender: Social Relations in Theory and Practice.* London: Sage Publications.

Horst, C. (2003) *Transnational Nomads How Somalis cope with refugee life in the Dadaab camps of Kenya.* Ph.D. Thesis. University of Amsterdam.

Hulme, D. and M. Edwards (eds) (1997) *NGOs, States and Donors. Too Close for Comfort*? New York: St Martins Press.

Human Rights Watch (1997) 'The Scars of Death- Children abducted by the Lords Resistance Army in Uganda'.

Human Rights Watch/Africa Human Rights Watch: Children's Rights Project.

Human Rights Watch (1997) A Human Rights Watch Report Vol. 9, No. 1 (G).

Humm, M. (1989) *The Dictionary of Feminist Theory*. London: Billing and Sons Ltd.

Hyndman, M.J. (1996) 'Geographies of displacement: gender, culture and power in UNHCR refugee camps, Kenya' Ph.D Thesis. University of British Columbia.

Hyndman, M.J. (1997) 'Refugees, Self Management and the Question of Governance' In: *Refugee*, Vol. 16, No. 2: pp. 16-22.

Indra, D. (ed) (1999) *Engendering Forced Migration: Theory and Practice.* New York and Oxford: Berghan Books.

Inter-agency Field Manual on Reproductive Health in Refugee Situations.

International League in Human rights (1985)'Uganda after Amin: A case of Displacement and Discrimination against the Banyarwanda Population'. New York.

International Federation of the Red Cross and the Red Crescent (IFRC) (1999) *Vulnerability and capacity assessment: An international Federal Guide.*

International Federation of the Red Cross and the Red Crescent (2002) *World Disasters Report* pp. 205-207.

Iyun, B. (1994) 'Health Care in the Third World: Africa' in: Phillips, D. and Yola Verhasselt (eds) *Health and Development*. London: Routledge. pp. 249 -257.

Jaspars, S. and J. Shoham (1999) 'Targeting the Vulnerable: A Review of the Necessity and Feasibility of Targeting Vulnerable Households' in: *Disasters* 1999, 23(4) 359-372.

Jiggins, J (1986) Women and Seasonality: coping with crisis and calamity' in: *IDS Bulletin* 17 (3) pp. 9-18.

Johnson, H. (1902) *The Uganda Protectorate* London: Hutchinson

Johnson, D. (2003) *The Root Causes of Sudan's Civil Wars.* Kampala: Fountain Publishers.

Jones, S. (1985) 'Depth Interviewing' in: Walker, R. (ed) *Applied Qualitative Research.* Guildford and King's Lynn: Great Britain Biddles Ltd.

Kabaka of Buganda (Sir Mutesa II) (1967) *Desecration of my Kingdom*. London: Constable.

Kabeer, N. (1991) *Gender Production and Wellbeing: Re-thinking the Household Economy*. Institute of Development Studies Discussion Paper No.288. University of Sussex.

Kabeer, N. (1999) 'From Feminist Insights to an Analytical Framework: An Institutional Perspective of Gender Inequality' in: Kabeer N. and R. Subrahmanian (eds) *Institutions, Relations and Outcomes: Framework and Case Studies for Gender - Aware Planning* New York: St Martins Press Inc.

Kabeer, N. (1994) *Reversed Realities Gender Hierarchies in Development Thought* London and New Delhi: Verso.

Kabeer, N. and R. Subrahmanian (eds) (1999) *Institutions, Relations and Outcomes: Framework and Case Studies for Gender Aware Planning.* New York: St Martin Press Inc.

Kabonesa, C. (1999) 'Factors that influence condom use among women and men in Kabarole District'. Ph.D. Thesis. University of Illinois.

Kabushenga, H. M. (1985) 'Changing Economic and Gender Patterns among the Peasants of Ndejje and Sseguku in Uganda' Ph.D. Thesis.

Kamukama, D. (1997) *Rwanda conflict: its Roots and Regional Implications.* Kampala: Fountain Publishers.

Kamya, M.R. (2002) Ndeezi G., Gasassira A., P. Rosenthal, G. Dorsey, S. Staedke and F. Zicker: 'Increasing Antimalarial Drug Resistance in Uganda and Revision of the National Drug Policy'. Research results www.who.int/tdr/research/findreps/no63.html downloaded 7 May 2005.

Kapadia, K. (1995) *Siver and her sisters. Gender, Caste and Class in rural South India* Delhi: Oxford University Press.

Kapwepwe Mishambi Julius, Millenium Development Goals: Progress Report for Uganda *Policy Review Newsletter* Vol. 3, Issue 4, 2004: p.5.

Karugire, S. (1980) *A Political History of Uganda.* Nairobi: Heinemann.

Kathina Juma, (1998) 'Action Research Project on Women and Reproductive Health in Post Crisis Situations in Africa: The Case of Refugee Women in Kenya' A Project Commissioned by the Medical Anthropology Unit and the Institute of Development Research (InDRA) University of Armsterdam.

Kayizzi-Mugerwa, S. (1996) *Uganda: Security, credibility and market development*. SIDA.

Kazibwe, S. (2002) 'Combining Vision and Leadership': The Centre for African Family Studies. Second Conference on NGO Partnerships for Reproductive Health in Africa in Nairobi, 16 to 18 April, 2002. www.cafs.org/confsup.html downloaded 7 May 2005.

Keen, D. (2001) 'War and Peace: What is the difference?' *International Peace -Keeping* 7 No. 4. pp. 1-22.

Kelly, N. (1989) W*orking with Refugee Women: A Practical Guide* UN Geneva

Kiapi Matsamura, E. (2005) 'Mother to Child Transmission of HIV defies prevention efforts' Inter Press Service News Agency. February 5.

Kibreab, G. (1988) *Africa's Refugees,* Trenton: World Press

Kibreab, G. (1993) The Myth of Dependency Among Camp Refugees in Somalia' *Journal of Refugee Studies* Vol. 6 No 4.

Kibreab, G. (1995) 'The African Refugee Regime With Emphasis on North Eastern Africa: The Emerging Issues' in: H. Adelman (ed) *Legitimate and Illegitimate Discrimination: New Issues in Migration.* Toronto: York Lanes Press.

Kibreab, G. (1995) 'Eritrean Women Refugees in Khartoum, Sudan 1970-1990.' *Journal of Refugee Studies* 8 (1) pp.1-25.

King, M. (1966) *Medical Care in Developing Countries.* Oxford: Oxford University Press.

Kirumira, E., A. Katahoire, A. Aboda, and K.Edstrom (1993*) Study on Sexual and Reproductive Health in Ugandan Women.* Supported by World Bank and SIDA.

Krietzer, L. (1998) 'The Experiences of Refugee Women in the Planning and Implementation of Program at Bududuramu Camp, Ghana'. MA Thesis, University of Calgary.

Kulman, J.W (1990) *Asylum or Aid: The Economic Integration of Ethiopian and Eritrean refugees in the Sudan.* Ph.D. Thesis Vritje University Amsterdam.

Kwesiga, J. C. (2002) *Women's Access to Higher Education in Africa: Uganda's Experience*. Kampala: Fountain Publishers.

Kyadondo, D. (2000) Evaluation of reproductive health project 'Support to Reproductive Health Including Family Planning for Sudanese Refugees in Rhino Camp Refugee Settlement, Arua District, Uganda'.

Lammers, E. (1999) *Refugees, Gender and Human Security: A Theoretical Introduction and Annotated Bibliography*. Utrecht: International Books.

Langseth, P. and J. Mugaju (eds) (1996) *Post-Conflict Uganda: Towards an effective Civil Service*. Kampala: Fountain Publishers.

Laws of Uganda (1964) 'The Control of Alien Refugees Act'.

Lehman, D. (1986) 'Two path of Agrarian Capitalism, or a critique of Chayanovian Marxism' in: *Comparative Studies in Society and History* Vol. 28 No 4.

Lewis, J. (1999) *The meaning of ' vulnerability' in Development in Disaster- prone places.* London: Intermediate Technology Publications. pp. 3-11.

Lindsey, C. (2001) *Women Facing War ICRC Study on the Impact of Armed Conflict on Women*. Geneva: International Crescent of the Red Cross.

Lorber, J. (1994) *Paradoxes of Gender* New Haven: Yale University Press.

Lincoln, Y.S and E.G. Guba (1985) *Naturalistic Inquiry* London: Sage Publications.

Long, N. and M. Villarreal (1996) 'Exploring development interfaces: from the transfer of knowledge to the transformation of meaning' in: Schuurman, F. (ed) *Beyond the Impasse: New Directions in Development Theory*. London and New Jersey: Zed Books. pp. 140-168.

Long, N. and A. Long (eds) (1992) *Battlefields of Knowledge; The interlocking theory and practice in social research and development.* London and New York: Routledge.

Long, N. (1999) "The multiple Optic of Interface Analysis" UNESCO Background paper on interface analysis.

Long, N. (1989) *Encounters at the Interface* Wageningen Studies in Sociology 27.

Long, N. (2001) *Development Sociology: actor perspectives*. London and New York: Routledge.

Longman Dictionary of Contemporary English. New Edition. Harlow:Longman.

Longwe, S. (1991) 'Gender Awareness: the Missing Element in the Third World Development Projects' in: Wallace, T. and C. March (eds) *Changing Perceptions Writings on Gender and Development*. Oxford: Oxford University Press.

Lofland, J. and L. Lofland (1984) *Analyzing Social Settings*, Belmont: Wordsworth.

Lwanga-Lunyiigo, S. (1998) 'Uganda's Long Connection with a problem of Refugees from the polish Refugees of world War II to the present' in: Pinycwa, A. (ed) 1998 *Uganda and the Problem of Refugees.* Kampala: Makerere University Press.

MacDonald, J. (1995) *Primary Health Care, Medicine in its Place* London: Earthscan Publications Ltd.

Mackintosh. M. (1981) 'Gender and Economics, The Sexual Division of Labor and Subordination of Women', in: Young, K., C., *et al* (eds) *Of Marriage and the Market: Women's Subordination in Internationally and its Lessons.* London: Routledge and Kegan Paul.

Malkki, L. H. (1995) *Purity and Exile: Violence, Memory and National Cosmology among Hutu Refugees in Tanzania.* Chicago and London: University of Chicago Press.

Makanya, S.T. (1990) 'Rural Mozambican Women in refugee camps in Zimbabwe: a case study of issues of assistance'. Paper presented at the Expert Group Meeting on Refugee and Displaced Women and Children Vienna Austria.

Mair, L. (1972) *An Introduction to Anthropology* London: Clarendon Press.

Marshall, C. and G. Rossman (1995) *Designing Qualitative Research.* London: Sage Publications.

Mazur, R. E. (1988) 'Refugees in Africa: The role of sociological analysis and plans' in: *Current Sociology* 36/2 Summer pp. 43-60.

Mbilinyi, M. J. (1972) 'The New Woman and Traditional Norms in Tanzania: In: *The Journal of Modern African Studies* 10 (1972) pp. 57-72.

Mbilinyi, M. (1992) 'Research Methodologies in Gender Issues' in: R. Meena (ed) *Gender in Southern Africa: Conceptual and Theoretical Issues* Harare: SAPES Books.

Mcspadden, L. A. and H. Moussa (1993) 'I have A Name: The Gender Dynamics in Asylum and Resettlement of Ethiopian and Eritrea Refugees in North America'. *Journal of Refugee Studies* Vol 6 No 3. pp. 203-255.

Mead, M. (1975) 'On Freud's View of Female Psychology' in: Strause, J. (ed) *Women and Analysis.* New York: Grossman.

Medecins Sans Frontiers (1997) *Refugee Health: An Approach to Emergency Situations.* London and Basingstoke: Macmillan.

Melvern, L. (2000) *A People Betrayed: The Role of the West in Rwanda's Genocide.* London: Zed Books Ltd.

Meena, R. (ed) (1992) *Gender in Southern Africa Conceptual and Theoretical Issues*: Harare*:* Sapes Books.

Middleton, J. (1965) *The Lugbara of Uganda.* London: Holt, Rinehart and Winston.

Mies, M. (1986) *Patriarchy and Accumulation on a World Scale* London: Zed Books Ltd.

Millet, K. (1972) *Sexual Politics.* London: Abacus.

Miller R. L. (2000) *Researching Life Stories and Family Histories.* London and New Delhi: Sage Publications.

Miller, W. and B. F. Crabtree (1992) 'Primary Care Research, a multi method typology and qualitative road map' in: Crabtree B.F and W. Miller (eds) *Doing qualitative Research: Research Methods for Primary Care* Vol.3. Newbury Park: Sage Publications.

Ministry of Health (1993) *White Paper on Health Policy: Update and Review,* 18 October.

Ministry of Health (1994) *Sexual and Reproductive Health Minimum Package for Uganda* Department of community Health Reproductive Health Division Kampala.

Ministry of Health, (2003) *Statistical Abstract* MoH Resource Centre

Ministry of Health, (2002) *National Adolescent Health Policy*

Ministry of Health (1999) *Health Policy* 1999-2004.

Ministry of Health, (2004) Statistical Abstract. *MoH Resource Centre.*

Ministry of Finance and Economic Planning '*Background to the Budget 2002*'

Ministry of Finance, Planning and Economic Development: Poverty Monitoring and Analysis Unit, *The New Vision*, Wednesday, January 26, 2005: p.5, Article: 'Analysis of Poverty Reduction Strategies'.

Mohammed, P. (1995) *Writing Gender into History: The Negotiations of Gender Relations Among Indian Men in Pre- Indenture Trinidad Society, 1917-47* London: James Currey.

Mohanty, C.T. (1988) 'Under Western Eyes: Feminist Scholarship and Colonial Discourse' in: *Feminist Review* No 30, Autumn 1988.

Molnos, A. (ed) (1973) *Culture, sources, materials for population planning in East Africa: Beliefs and practices.* Vol. 3. Nairobi: East African Publishing House.

Molnos, A. (1972-74) *Review of Social Culture Research 1952-72*. Nairobi:East African Publishing House.

Molnos, A. (1968) *Attitudes towards family planning in East Africa*. (Germany)

Molyneux, M. (1985a) 'Mobilization without emancipation? women's interests, state and revolution in Nicaragua' *Feminist Studies* 11, No.2, pp. 226-254.

Moore, H. (1988) *Feminism and Anthropology*. Minneapolis: University of Minnesota Press.

Moore, H. (1994) *A Passion for Difference. Essays in Anthropology and Gender*. Cambridge: Polity Press.

Moser, C.O.N. (1993) *Gender Planning and Development – Theory Practice and Training*. London and New York: Routledge.

Mtshali S (2002) *Household Livelihood Security in Rural KwaZulu-Natal, South Africa.* Ph.D. Thesis. Wageningen University.

Mugisha, J. (2005) 'Bundibugyo has 20% HIV/AIDS Prevalence Rate', *The Monitor*, Wednesday, February 9.

Muhiribidi, S.(1994) 'Speech on the occasion of the official opening of short course on refugees' in: Hall, N. (ed) *Working with Rural Refugees: A short course of training of Camp Refugee workers in southern Africa* Harare: School of Social Work/SATARI.

Mula, R. (1999) *Coping with Mother Nature: Household's Livelihood Security and Coping Strategies in Situation of Counting Disaster in Tarlac, Philipines* Ph.D. Thesis. Wageningen University.

Mulumba, D. (1984) 'Rwandese Refugees' Attitudes Towards Repatriation' BA (SWSA) Dissertation. Makerere University.

Mulumba D. (1998) 'Women and Reproductive health in Post–Crisis Situations in Africa, the Case of Mvepi Refugee Settlement, Arua District'. A project Commissioned by the Medical Anthropology Unit and the Institute of Development Research (InDRA) University of Armsterdam.

Mulumba, D. (1998) 'Refugee Women and the Traumas of Encampment in Uganda' In: *East African Journal & Human Rights* Vol. 5, No 1.

Mulumba, D. (2002) 'The Women Movement and Conflict Resolution in Uganda' in: Tripp, A.M and J.C. Kwesiga (eds) *The Women's Movement in Uganda History, Challenges and Prospects*. Kampala: Fountain Publishers.

Mupedziswa, R (1994) 'Planning for Repatriation of Mozambique Refugees with Particular Reference to Vulnerable groups: Some Practical Considerations' in: Hall, N. (ed) *Working with rural Refugees: A short course for the training of Camp Refugee workers in Southern Africa*. Harare: School of Social Work SATARI.

Murindwa, R. (1994) 'People's Anti-colonial struggles in Kigezi under the Nyabingi Movement, 1910–1930' in: Mamdani, M. and J. Oloka-Onyango (eds) *Uganda: Studies in the Living conditions, Popular Movements and Constitutionalism*. Vienna: JEP.

Murray, S. F. (1999) 'Maternal Mortality: Piecing Together the Jigsaw' *RCM Midwives Journal* May, 2(5) pp. 152-154.

Museveni, K. Y. (1997) *Sowing the Mustard Seed: The struggle for Freedom and Democracy in Uganda*. London: MacMillan.

Musse, F. (1996) 'Women Victims of Violence–Rape in Kenya's Refugee Camps'. Geneva: UNHCR.

Mushanga M.T (1973) 'Nkole of South Western Uganda' in: Molnos, A. (ed) (1973) *Culture, sources, materials for population planning in East Africa: Beliefs and practices*. Vol. 3, Nairobi: East African Publishing House. pp. 174-186.

Musisi, Nakanyike (1991) 'Women, elite polygyny' and Buganda State Formation' *Signs: Journal of Women in Culture and Society* 16 No. 4 pp. 757-786.

Nabuguzi, E. (1998) 'Refugees and Politics in Uganda' in: Pinycwa, A. (ed) (1998) *Uganda and the Problem of Refugees.* Kampala: Makerere University Press.

Neema, S. (1994) Mothers and Midwives: Maternity Care Options in Ankole, Southwestern Uganda. Ph.D. Thesis.

Niehof, A. and L. Price (2001) *Rural Livelihod Systems: A conceptual framework*. Wageningen: UPWARD series on rural livelihoods No. 1.

Ntozi, J. P. M. and J. B. Kabera, (1992) 'Women's status and high fertility Culture in Uganda. A case study in South West Uganda' in: UNDP *Women, Population and Development.* New York: UNDP.

Ntozi, J. P. M. (1995) *High Fertility in Rural Uganda: the Role of Socioeconomic and Biological Factors.* Kampala: Fountain Publishers.

Nyaba P.A. (1997) *The Politics of Liberation in South Sudan*. Kampala: The Fountain Publishers.

Nuijten, M. (2001) 'The Burden of Kinship: Transnational Networks and the inheritance of land in a Mexican Family' in: Anderson J. A & M. Breusers (eds) *Kinship structures and enterprising Actors: Anthropological Essays on Development.* Wageningen: Ponsen and Looyen.

Oakley, A. (1972) *Sex, Gender and Society* London: Temple Smith.

Obbo, C. (1980) *African Women: Their Struggle for Economic Independence*. London: Zed Books Ltd.

Obbo, C. 'East African Women, Work and the Articulation of Dominance' In: Tinker, I. (ed) *Persistent Inequalities Women and World Development* Oxford: Oxford University Press.

Obbo, C. (1980) *African women: Their struggle for Economic Independence*. London: Zed Books Ltd.

Obbo, C. (1988) *The Roots of Instability in Uganda.* Kampala: New Vision Printing and Publishing.

Odim, J. C. (1991) 'Common Themes different contexts Third world women and feminism' in: Mohanty, C., A. Russo and L. Torres (eds) *Third World Women and the Politics of Feminism* Bloomington: Indiana University Press.

Okin, S. M. (1979) *Women in Western Political Theory*. Princeton: Princeton University Press.

Okin, S. M. (1995) 'Inequalities Between the sexes in different cultural context' in: Nussbaum, M. and J. Glovern (eds) *Women, Culture and Development: a Study of Human Capacities.* Oxford: Clarendon Press. pp. 274-297.

Okonofua, F.E. and R.C. Snow (eds)(1999) 'The Impact of Family Planning on Women's Lives: Findings from the Women's Studies Project in Mali and Zimbabwe' *African Journal of Reproductive Health* Vol. 3, No. 1.

Oloka-Onyango, J. (1996) 'The Plight of the Larger Half: Human Rights, Gender Violence and the legal Status of Refugee and Internationally Displaced women in Africa' *Denver Journal of International Law and Policy* Vol 24, No2/3 Spring 1996 pp. 349-394.

Omari, C. K. (1995) 'Gender, Family and household'. In: Creighton, C. and C.K. Omari, (eds) *Decision Making and the Household: Case Studies from Tanzania*. Aldershot: Avebury. pp.203-220.

Orach, C., G. Bukenya and N. Mbona (1994) "Morbidity and Mortality among Hospitalized Sudanese Refugees in West Nile District of Uganda" *Tropical Health*, Vol. 4 No.3 December, 1994 pp. 16-17.

Ortner, S. and A. Whitehead (1981) *Sexual Meanings: The Cultural Construction of Gender and Sexuality*. Cambridge: Cambridge University Press.

OXFAM (1995) Uganda Profile. Kampala:OXFAM.

OXFAM (1996) *Uganda Strategic Plan.*

Overholt, C. *et al.* (1985) *A Casebook. Gender roles in Development Projects.* West Hartford: Kumarian Press.

Parker,C.A.A. (1995) *UNHCR and Refugee Women: Rebuilding a Future Together.* Geneva: UNHCR.

Payne, L. (1998) *rebuilding communities in a refugee settlement a case book from Uganda.* Oxford: OXFAM.

Pearson, R., A. Whitehead and K. Young (1984) 'Introduction – The Continuing Subordination of Women in the Development Process' in: Kate Young, Carol Wolkowitz and Rosylyn McCullagh (eds) *Of Marriage and the Market women's subordination internationally and its lessons.* London: Routledge and Kegan Paul. pp. ix - xix.

Phillips, D. and Yola Verhasselt (eds) *Health and Development.* London: Routledge.

Pinycwa, A. (1998) *Uganda and the Problem of Refugees.* Kampala: Makerere University Press.

Pirouet, L. (1988) 'Refugees in and from Uganda in the Post-Colonial period' in: Twaddle and Hansen (eds) *Uganda Now Between Decay and Development* Nairobi: Heinemann.

Population Reports Series J, No. 45 Family Planning Programs.

Price, P. (1994) 'Maternal and Child Health Care Strategies' in: Phillips, D. and Yola Verhasselt (eds) *Health and Development.* London: Routledge. pp. 138-155.

Prunier, G. (1995) *The Genocide in Rwanda* Kampala: Fountain Publishers.

Radke, L. and H. Stam (1994) *Power/Gender: Social Relations in Theory and Practice*. London: Sage Publications.

Rathbeger, E. M. (1990) 'WID, WAD and GAD: Trends in Research and Practices,' *The Journal of Developing Areas* Vol. 24 No 4 pp. 489-502.

Razavi, S. and Miller C. (1995) 'From WID to GAD: Conceptual Shifts in Women and Development Discourse' United Nations Research Institute for Social Development (UNRISD) Geneva: O.P.I.

Reinharz, S. (1992) *Feminist Methods in Social Research*. New York: Oxford University Press.

Rey, F. (2001) 'The Complex Nature of Actors in Humanitarian Action and the Challenge of Coordination' in: *Humanitarian Studies Unit. Reflections on Humanitarian Action, Principles, ethics and Contradictions*. London: Pluto Press.

Richardson, L. (1990) *Writing Strategies: Reaching diverse Audiences.* Newbury Park and London: Sage Publications. *Qualitative Research Methods* Vol. 21.

Ritu, V. (2001) *Gender, Land and Livelihoods in East Africa: Through Farmers' Eyes*. Ottawa: International Development and Research Center.

Rogers, B. (1980) *The Domestication of Women: Discrimination in Developing* Societies. London: St. Martin's Press.

Rosaldo, M.D. and S. Lamphere (1974) *Woman, Culture and Society*. Stanford: Stanford University Press.

Roscoe, J. (1911) *The Baganda: An Account of their Native Customs and Beliefs*. London: Macmillan.

Rubin, P. E. (1975) *The Social Psychology of Bargaining and Negotiation*. New York: Academic Press.

Rudie, I. (1995) 'The significance of eating: Cooperation, Support and Reputation in Kelantan Malay Households' in: K.J. Wazir (ed) '*Male' and 'Female" in Developing South East Asia.* Washington D.C.: Berg Publishers. pp.227-247.

Ruth, S. (1990) *Issues in feminism*. Mt View, CA: Mayfield.

Sacks, K. (1979) *Sisters and Wives* Urbanna University of Illinois Press

Sarantakos, S. (2001) *Social Research.* London: Macmillan

Sargent, L. (1981) 'New Left women and men: The honeymoon is over' in: Sargent, L. (ed) *Women and Revolution: A discussion of unhappy marriage of Marxism and Feminism*.London: Pluto Press.

Sargent C.F. (1982) *The Cultural Context of Therapeutic Choice.* London: Reidel Publishing Company.

Schuurman, F. (ed) (1993) *Beyond the impasse: New Directions in Development Theory*. London and New Jersey: Zed Books Ltd.

Scott, C.V. (1995) *Gender and Development Rethinking Modernization and Dependency*. Boulder: Lynne Rienner Publications.

Schrijvers, J. (1986) *Mothers for life: motherhood and marginalization in the North Central Province of Sri Lanka.* Den Haag: Eburon Delft.

Schrijvers, J. (1993) *The Violence of 'development': a choice for intellectuals.* Utrecht: International Books.

Seifert, R. (1994) 'Mass Rapes in Bosnia-Herzegovina and Elsewhere: A pattern of Cultural Destruction' in: *War Against women - the impact of violence on gender relations*. Swiss Peace Foundation report of the Sixth Annual Conference 1994.

Semboja, J. and Ole Therkildsen (eds) (1998) *Service Provision Under Stress in East Africa*. London: James Currey.

Sen, A. (1981) *Poverty and Famine: An Essay on Entitlement and Deprivation*. Oxford: Clarendon Press.

Sen, A. (1990) 'Gender and Cooperative Conflicts' in: Tinker, I (ed) *Persistent Inequalities Women and World Development.* Oxford: Oxford University Press.

Sen, A. (1995) 'Gender inequality and theories by Justice' in: Nussbaum, M. and J. Glover (eds) *Women, Culture and Development- A study of Human Capacities.* Oxford: Clarendon Press. pp. 259-273.

Sen, G. and C. Grown (1985/87) *Development, Crises and alternative Visions: Third World Women's Perspectives.* London: Earthscan.

Shahrashoub, R. and C. Miller (1995) *From WID to GAD*. United Nations Research Institute for Social Development. Occasional Paper.

Silberschmidt, M. (1999) *Women forget that we are the Masters- Gender Antagonism and Socioeconomic change in Kisii District, Kenya.* Ph.D. Thesis. Nordiska Afrikanstitutet.

Simonds, S. (1983) 'Refugee Camps, maternal and child health: key issues' in: Jellife and Jellife (eds) *Advances in International Maternal and Child health* Vol. 3 Oxford: Oxford University Press.

Sivandan, A. (1990) 'All that melts into air is solid: the Hokum of the new times' *Race and Class* 31, No 3 pp. 1-30.

Smyth, I, and C. Harris (2001) 'The Reproductive Health of Refugees: Lessons Beyond ICPD 10' *Gender and Development.* Vol. 9 No. 2 July pp. 10-21.

Stamp, P. (1990) *Technology, Gender and Power in Africa* . Ottawa: International Development Research Centre

Stewart, F. (1992) 'Can adjustment progammes be the interest of women?' in: Afshar, H. and C. Dennis (eds) *Women and Adjustment Policies in the Third World*. London: Macmillan.

Stockard, J. and M. Johnson (1992): *Sex and Gender in Society* New Jersey: Simon and Schuster Company. pp.111-131.

Stolen, K. A. and Mariken Vaa (eds) (1991) *Gender and Change in Developing countries.* Norwegian University Press.

Strauss, A. and J. Corbin (1990) *Basics of Qualitative Research: Grounded Theory and Procedures and Techniques* London and New York: Sage Publications.

Srizhak, E.F. and C. Harris (1993) Sex, Lies and the International Law" *Refugee Participation Network* 15 September. pp. 21-22.

Sztucki, J. (1989) 'The Conclusions on the International Protection of Refugees Adopted by the Executive Committee of UNHCR Program' In: *International Journal of Refugee Law* Volume 1 No. 3.

Swift, J. J. (1989) 'Why are rural people vulnerable to famine?' Institute of Development Studies *IDS* Vol. 20 No 2 pp. 8-15.

Tamale, S. (1999) *When Hens Begin to Crow Gender and Parliamentary Politics in Uganda*. Kampala: Fountain Publishers.

Tamale, S. and J. Oloka-Onyango (1997) "Forced Displacement and Gender Violence in Uganda: the case of refugee Women" A research paper written on a project of Displacement and Gender Violence in a Refugee Camp and Supported by a Grant from the Netherlands Embassy, Kampala

Tashokkori, A. and C. Teddie (1998) *Mixed Methodology: Combining qualitative and quantitative approaches.* London and New Delhi: Sage Publications. Applied Social Research Methods Series Vol. 46.

Tinker, I. (ed) (1990) *Persistent Inequalities: Women and World Development* Oxford: Oxford University Press.

Townsend, J. (1995) 'Gender Studies: whose agenda?' in: Schuurman, F. J. (1995) *Beyond the Impasse- New Directions in Development Theory*. London: Zed Books Ltd. pp. 169-186.

Thirkell, A. (1995) 'The community Development Program in Ikafe Sudan's refugee settlement, Aringa County Northern Uganda' OXFAM

The UN 1951 Convention Relating to the Status of Refugees Geneva:UN

The UN 1967 Protocol Relating to the Status of Refugees Geneva:UN

The OAU (1969) Organization of African Unity Convention Governing the Specific Aspects of Refugee problems in Africa. UNHCR

The Republic of Uganda (1997) *The Local Governments Act and the Local Government Amendment Act*, 1997.

The New Vision 3 March 2002 ' Trading food for sex' by Audrey Gillian and Peter Moszynski.

The New Vision , 20th August 2002. Article on Refugee attack by Lords Resistance Army.

The New Vision Friday 5th. September 2002. Article concerning the transfer to Kiryandongo of refugees from Achol Pii.

The Republic of Uganda, (1999) *Sexual and Reproductive Health Package for Uganda.* Ministry of Health, Kampala: Earnest Publishers.

The Republic of Uganda (1998) *Women and Men in Uganda Facts and Figures* Entebbe: Government Publishers.

The Republic of Uganda (1996) Ministry of Finance and Economic Planning.

The US Committee for Refugees (1991) The Banyarwanda Refugees in Uganda.

The World Bank *World Development Indicators 2001 and idem the little Data Book 2001*.

Tripp A. M. (2000) *Women and Politics in Uganda.* Oxford: James Currey.

The U.S Committee for Refugees (1997). *World Refugee Survey*.

The U.S Committee for Refugees (2002). *Refugee Reports.*

Twigg, J. and M. Bhatt (eds) (1998) *Understanding vulnerability: South Asian Perspectives.* Colombo: Intermediate Technology and Publication.

Turner, S.T (2001) *Barriers of Innocence – Humanitarian Intervention and Political Imagination in a refugee camp for Burundians in Tanzania*. PhD Thesis. International Development Studies, Roskilde University.

Ubels, J. (1989) 'Irrigation Systems as social interfaces: Towards understanding of irrigation development as an interactional process' in : Long, N (ed) *Encounters at the interface: a percepective on social discontinuities in rural development.* Agricultural University Wageningen 1989.

Uganda Bureau of Statistics (2002) *Population and Housing Census Results*

Uganda Demographic and Health Survey 2000-2001.

Uganda Handbook 1936.

Office of the Prime Minister (2003).*Uganda's Refugee Policy and Practice* Department of Disaster Preparedness and Refugees. Kampala

UNAIDS (1995) *Guidelines for HIV Interventions in Emergency Settings* Geneva: UNAIDS

UNAIDS (1997) *Refugees and AIDS* Geneva:UNAIDS

UNAIDS (2002) *Fighting AIDS related stigma in Africa.* Geneva: UNAIDS

UNAIDS (2003) *Report on the Global HIV Epidemic*. Geneva: UNAIDS.

UNIFEM/AFWIC (1996) *Legal Status of Refugee and Internally Displaced Women in Africa*. Nairobi: Space Sellers Limited.

UNIFEM/UNICEF (eds)(1994) *Reproductive and mental health issues and girls under situation of war and conflict in Africa.* Nairobi: UNICEF.

UNICEF (1994) *The State of the Worlds Children* New York*:* UNICEF.

United Nations Development Programme (2003) Human Development Index New York:UN.

UNFPA/GoU: *Fourth Country Programme* (1997-2000).

UNHCR (2001) Refugee Statistics Sub - Office Kampala.

UNHCR (2002) Refugee Statistics Sub - Office Kampala.

UNHCR (2003) Refugee Statistics Sub - Office Kampala.

UNHCR (2004) Refugee Statistics Sub - Office Kampala.

UNHCR (1980). *UN General Assembly Resolution: Relating to Refugee and General Displaced women* Document NO.A/CONF.94/35 December 1980 New York: UN.

UNHCR (1988). *Handbook on Procedures and Criteria for Determining Refugee Status* Geneva: UNHCR Publication.

UNHCR (1998) *Strategy Paper Self Reliance for Refugee hosting Areas in Moyo, Arua and Adjuman Districts 1999-2002.*

UNHCR Sub-Office Kampala '98/ UGA/LS/403' Report UNHCR/PTSS, Mission Report 95/20

UNHCR (1982) *Handbook for Emergencies.* Geneva: UNHCR.

UNHCR (1990) *Policy for Refugee Women* Geneva: UNHCR.

UNHCR (1991) *Guidelines on the Protection of refugee women.* Geneva: UNHCR.

UNHCR (1994) *People Oriented Planning at Work: Using POP to improve UNHCR Programming.* Geneva:UNHCR.

UNHCR (1995) *Sexual Violence Against Refugees: Guidelines on Prevention and Response.* Geneva: UNHCR.

UNHCR (1999) *Country Operations Plan* UGANDA.

UNHCR (1999) *Inter-Agency Field Manual* (citing WHO – World Health Day- Safe Motherhood – 1998).

UNHCR/WFP (1991) *Guidelines for calculating Food Rations for refugees, in collaboration with WHO*. Geneva: UNHCR.

United Nations (1997) *Convention on the Elimination of all forms of Discrimination Against Women.* New York: United Nations.

United Nations Security Council (2000) *Resolution 1325* (www.peacewomen.org/un/sc/1325.html) downloaded in January 2004.

United Nations (1999) IASC working group xxxvi Meeting Background paper 'Mainstreaming Gender in the Humanitarian Response to Emergencies' Rome April 1999.

United Nations (2000) *Beijing +5 Review Document.*

United Nations (1985) *The Nairobi Forward-Looking Strategies for the Advancement of Women.* New York: United Nations Publication.

United Nations (1994) *The Report of the International Conference on Population and Development.* New York: UN.

United Nations (1995) *The Beijing Declaration and the Plan of Action* Santa Rosa: Free Hand Books.

US Committee for Refugees (1997) *World Refugee Survey.* Washington DC: American Council for Nationalities Service.

US Committee for Refugees (2002) *World Refugee Survey* Washington DC: American Council for Nationalities Service.

Visvanathan, N. *et al,* (eds) (1997) *The Women, Gender and Development Reader*. London: Zed Books Ltd.

Villarreal, M. (1994) *Wielding and Yielding: Power subordination and gender identity in the context of a Mexican Developement Project.* Ph.D. Thesis Wageningen University.

Villarreal, M. (1992) "The Poverty of Practice: Power, Gender and Intervention from an Actor-Oriented Perspective' in: N. Long and A. Long (eds) *Battlefields of Knowledge: The Interlocking of theory and Practice in Social Research and Development.* London and New York: Routledge.

Voutira, E. 1996 "The Language of Humanitarian Emergencies and Idioms of Intervention" Draft Paper For The Wider Project On complex Humanitarian Emergencies, International Development Center, University of Oxford.

Voutira, E. and B. Harrell-Bond (1995) 'In search of the locus of trust, the social world of the refugee camp' in: Daniel, E. and J. Knusden (eds) *(Mis) Trusting Refugee Narratives.* Berkeley: University of California.

Voutira, E., Nasreen Mahmoud, Eva Oestergaard-Nielsen, Aitor Urquiola, Shaun Whishaw-Brown, Hong-Won Yu (1995) *Improving Social and*

Gender Planning in Emergency Operations. Refugee Studies Programme, University of Oxford.

Walker, R. (ed) (1986) *Applied Qualitative Research*. Guildford: Great Britain Biddles Limited.

Webster, A. (1989) *Introduction to the Sociology of Development* London: The Macmillan Press. pp.41-62.

Webster, C. (ed) (1993) *Health Care in the Third World* London: Open University Press.

West, C. and D. Zimmerman (1987) 'Doing Gender' In: *Gender and Society,* 1 No. 2 pp. 125-151.

Weighill, L. (1997) 'ICARA II - Refugee Aid and Development' Oxford: Refugee Studies Programme.

Whitehead, M. (1990) *Inequalities in Health. The Health Divide*. Harmondsworth: Penguin.

Whitehead, A. and H. Bloom (1992) 'Agriculture' in Ostergaard, L. (ed) *Gender and Development: A Practical Guide* . London and New York: Routledge.

WHO (1978) *Alma Ata – Primary Health Care* Geneva: World Health Organization.

Wieke van der Velden (1991) *Silent Voices Gender, Power and Household management in Rural Varanasi, India.* Ph.D. Thesis. Vrije Univeristy.

Wim Damme, van (1998) *Medical assistance to self- settled refugees Guinea*, 1990-96 Ph.D. Thesis. Antwerp: ITG Press.

Wijbrandi, J.B. (1986) *Organised and Spontaneous settlement in Eastern Sudan: two case studies on integration of rural refugees.* Work Document V-86/1.

Wilk, R. and R. Netting (1984) 'Households: Changing Farms and Functions' in: Netting, R. M., R. Wilk and E. J. Arnourd (eds) *Households: Comparative and Historical Studies of the Domestic Group*. Berkely:University of California.

Wilson, K.B. (1994) "Internally Displaced Refugees and Returnees From and in Mozambique" *SIDA Studies on Emergencies and Disaster Relief*, Report No. I, 20.

Wolf Bleek (1976) *Sexual Relationships and Birth control in Uganda a case study of rural Town Dissertation* Universiteit Van Amsterdam.

World Bank Discussion Paper No 356 1997 *Evaluating Health Projects – Lessons from the Literature* Washington.

Wollstonecraft, M. (1975) *A vindication of the rights of woman* edited by Poston, C.H. NewYork: W.W.Norton.

Women's Commission for Refugees and Children News Fall / Winter 1999/ Number 22.

Women's World ISIS WICCE No 19-20 February 1989.

Women's World No 35 2000.

www.ugandadish.org/collaborators.shtml, downloaded 7/5/05.

www.measuredhs.com/countries/country.cfm, downloaded 12/1/2004.

Yin, R. K. (1994) *Case study Research Designs and Methods: Applied social research method series*. Vol.5 London: Sage Publications.

Young, K. and C. Moser (eds) (1981) "Women and the Informal Sector", *IDS Bulletin* 12(3) University of Sussex.

Young, H. (1999) 'Public Nutrition in emergencies: An Overview of Debates, Dilemmas and Decision Making'. *Disasters,* 1999, Vol. 23 No. 4. pp. 277-291.

Young, K., C. Wolkowitz & R. McCullagh (eds) (1981) *Of Marriage and the Market: Women's Subordination in Internationally and its Lessons*. London: Routledge and Kegan Paul.

Zetter, R. (1988) 'Refugees, repatriation and root causes' In: *Journal of Refugee Studies* Vol 1 No. 2 pp. 99-106.

Zetter, R. (1991) 'Labeling Refugees: Forming and Transforming a Bureaucratic Identity' *Journal of Refugee studies* 4 No.1 pp. 39-62.

Zetter, R. (1996) 'Refugee Survival and NGO assistance: Mozambican refugees in Malawi' *Community Development Journal* 31 No.3. pp. 214-229.

Zetter, R. (1999) ' International perspectives on refugee assistance' in: Ager, A. (1999) *Refugees, Perspectives on the Experiences of Forced Migration*. London: New York, Pinther.

Zolberg, A., A. Suhrke and S. Aguayo (1989) *Escape from Violence: Conflict and the Refugee Crisis in the Developing World*. Oxford: Oxford University Press.

Zwi, A. and A. Mills (1995) 'Health Policy in Less Developed Countries: Past Trends and Future Directions' In: *Journal of International Development.* Vol. 7 No. 3 pp.299-328.

Summary

This study is an actor-oriented and gender analysis of the social relations, livelihood security and reproductive health of Sudanese refugees in Uganda. It is based on fieldwork in two refugee settlements, namely, Rhino Camp in Arua district and Kiryandongo in Masindi district. Although a gendered study, the focus is on women refugees who bear the brunt of the hardships and challenges of reproductive health in refugee situations. In this study I sought to find out how women refugees, who, while starting off at a less privileged position, respond to the various complex dynamics of political, social, economic and gender arrangements which connote power relations. Apart from the intra household relations, I studied the women refugees' encounters with the several actors involved in the provision of humanitarian aid, and how they use their agency to interpret and make meaning before responding to development interventions. The refugee assistance programme in both refugee settlements provided a useful development intervention, which I subjected to inquiry.

From an actor-oriented and gender perspective, I examined government refugee policies and humanitarian policies and programmes with a view to establishing how the actual institutional arrangements reproduce and perpetuate gender biases in the refugee reintegrating process. The actor-oriented approach starts with the premise that social actors have agency and they reflect upon their experiences and what happens around them and use their knowledge and capabilities to interpret and respond to development. One way to recognize the characteristics of diversity and inequality is to focus on the actors. This was done by a careful analysis of every day activities and social interactions by the several social actors in their own domains including the households, the health centres and hospitals, UNHCR, local and central government officials and implementing partners. Because social actors and human agency are socially constructed, I in addition adopted a gender analysis perspective because individuals have socially constructed identities. These identities influence the position and the kind of strategies open to the individuals in the various hierarchies, which they occupy. Gender relations in a given socio-cultural setting are shaped by ascribed positions of an individual according to sex, age and other attributes like level of education, etc. A gender analysis was applied in every event including human interactions and encounters.

Chapter 1 introduces the problem, the rationale, the research motivation as well as the objectives of the study. Chapter 2 is about theories and concepts used in the analysis of the study. It reviews the phases of the evolution of the feminist movement and discusses the actor-oriented and gender analytical framework. The last part of the chapter reviews the literature on concepts used in the study. Chapter 3 introduces the research questions and the methodology considerations. Grounded Theory was chosen as a general methodological approach. Data were collected by household survey and case study analysis. The former was done to obtain a general understanding of the socio-economic characteristics of refugees in settlements. The in-depth case study analysis was done to bring to light the 'hidden' voices of vulnerable refugees and their coping mechanisms.

A total of 13 case studies were analyzed and documented.

Chapter 4 describes the history and management of refugees and displacement in Uganda. The discussion looks at the pre-independence migration and Second World War refugees, the contemporary refugees in Uganda and their subsequent management by the Uganda government and the UNHCR. The last part of the chapter discusses armed conflict and internal displacement in Uganda. Chapter 5 analyzes the international and national health policies. The main health policy is premised on the Primary Health Care (PHC) strategy. Reproductive health policies derive their scope from the deliberations of the ICPD conference in Cairo in 1994. The study indicates that there is a gap between policy and practice due to several constraints including bad politics, structural adjustment programmes, chronic poverty and HIV/AIDS pandemic. Chapter 6 examines the organizations and programmes dealing with reproductive health in Uganda. It notes how the Anglican and Catholic missionaries introduced western health care to Uganda, before the government played a crucial role to ensure a healthy population. Partnerships focusing on reproductive health including HIV/AIDS have been established between Ministry of Health, the UN and several NGOs. The study has established that despite the effort to implement reproductive health policies in rural areas the main reproductive health programmes still target maternal and child health.

Chapter 7 explores the study area and the host environment. It examines the social, economic and political situation of Uganda. The geographical position of the country makes it susceptible to refugee influxes. A cursory look at the social and economic indicators compounded by the protracted war in northern Uganda helps one to conclude that Uganda is vulnerable and lacks the capacity to absorb large influxes of refugees. Chapter 8 and 9 enter the life world of women refugees in Rhino Camp and Kiryandongo. The chapter discusses the nature of the social relations and the gender arrangement patterns and how these are disrupted during refuge. The traditional pattern of male head appears to be disrupted by the UNHCR policy of distributing resources to refugees irrespective of gender. This included land. While ownership of land by women was empowering, it nevertheless created gender conflicts. It also acted as a catalyst to human reproduction seeing as the size of land to be allocated depended on the number of members in a household. We saw that humanitarian polices do not take into consideration the indigenous knowledge of the refugees. Pregnant refugee women are discouraged from using any form of 'traditional' medicine. Equally, pregnant women deliver majority of their babies with TBAs as opposed to the professionally trained midwives. The vulnerability of adolescent refugees girls raises concern. Several teenage girl refugees are exploited and some are sexually abused. The Implementing Partner lacks a gender policy and does not adequately respond to issues of vulnerability which result into exploitation and gender based violence and poor access to resources. The several case studies documented in these chapters show the vulnerability of refugee girls and women to male violence of a physical and sexual nature. They also indicate the lack of redress mechanism. The food insecurity in Kiryandongo leads to malnutrition and mortality among the under 5s. This was a result of poor soils; inefficient farming methods, and the fact the refugees sold their food crops to buy other necessities of life.

The infant deaths then catapulted the need to replenish oneself. Chapter 10 is the conclusion. In this chapter I recap the theoretical reflections as well as the key findings and outline some implications of the study on gender relations, livelihood security and reproductive health of refugee women. I also identify measures that must be put in place in order to ensure gender sensitivity during the implementation of what are already gender-sensitive policies.

Samenvatting

Deze studie is een actor- en genderanalyse van de sociale relaties, bestaanszekerheid en reproductieve gezondheid van Sudanese vluchtelingen in Uganda. Het is gebaseerd op veldwerk in twee vluchtelingenkampen, namelijk Rhino Camp in Arua District en Kiryandongo in Masindi District. Hoewel het een genderstudie betreft, ligt de nadruk op vrouwelijke vluchtelingen die de grootste problemen en uitdagingen op het gebied van reproductieve gezondheid ondergaan als vluchteling. In deze studie heb ik geprobeerd uit te zoeken hoe vrouwen beginnend op een minder bevoorrechte positie, omgaan met de complexe machtsverhoudingen en de bestaande politieke, sociale, economische en genderrealiteiten. Naast de relaties binnen de huishouding heb ik onderzocht hoe vrouwen zich verhouden tot de verschillende actoren die humanitaire hulp verschaffen en hoe zij hun *agency* gebruiken om te antwoorden op ontwikkelingsinterventies en deze te duiden. De ontwikkelingsinspanning in de hulpprogramma's voor vluchtelingen in beide kampen vormde een geschikte invalshoek voor het onderzoek.

Op basis van een actor- en genderbenadering heb ik het vluchtelingenbeleid en de programma's van de overheid en humanitaire organisaties onderzocht om vast te stellen hoe de huidige institutionele arrangementen een gender *bias* reproduceren in het proces van reïntegratie. De actorbenadering gaat er van uit dat sociale actoren *agency* hebben, over hun ervaringen nadenken en hun kennis en bekwaamheden inzetten om aan bepaalde ontwikkelingen het hoofd te bieden. De nadruk op actoren is één bepaalde manier om diversiteit en ongelijkheid te onderkennen. Dit is gedaan door een zorgvuldige analyse te maken van de dagelijkse activiteiten en sociale interacties door de verschillende sociale actoren binnen hun eigen domein, zoals de huishouding, gezondheidscentra en ziekenhuizen, UNHCR, en in het contact met de ambtenaren van de lokale en centrale overheid en uitvoerende partners. Omdat sociale actoren en menselijke *agency* sociaal worden geconstrueerd, heb ik daarnaast het genderperspectief gekozen, omdat individuen nu eenmaal sociaal geconstrueerde identiteiten hebben. Deze identiteiten beïnvloeden de positie en strategieën die de individuen volgen in de verschillende hiërarchieën, waar zij onderdeel van uitmaken. Genderverhoudingen worden in een bepaalde sociaal culturele context meestal gevormd door toegeschreven posities van een individu naar gelang sekse, leeftijd en andere eigenschappen zoals onderwijs niveau. Het genderperspectief is toegepast bij elke bestudeerde gebeurtenis zoals menselijke interacties en ontmoetingen.

Hoofdstuk 1 behandelt de vraagstelling, de rationale, de motivatie en de doelstellingen van de studie. Hoofdstuk 2 gaat over de theoriën en concepten die in de analyse worden gebruikt. Het bekijkt de evolutie van de feministische beweging en bespreekt een actorgericht en gender- analytisch raamwerk. Het laatste onderdeel van dit hoofdstuk loopt de literatuur door ten aanzien van de concepten die in de studie worden gebruikt. Hoofdstuk 3 introduceert de onderzoeksvragen en de methodologische overwegingen. De *grounded theory* is gekozen als de algemene methodologische benadering. Gegevens zijn verzameld door middel van een *survey* onder de huishoudens en een analyse van de *casestudies*. De *survey* is gedaan om een algemeen begrip te krijgen van de sociaal-in

economische omstandigheden van de vluchtelingen in de kampen. De diepergaande *casestudies* zijn gekozen om licht te werpen op de "verborgen stemmen" van kwetsbare vluchtelingen en hun *coping mechanisms*. In totaal zijn 13 *casestudies* gedocumenteerd en geanalyseerd.

Hoofdstuk 4 beschrijft de geschiedenis en het management van vluchtelingen en ontheemden in Uganda. De discussie begint bij de migratie van voor de onafhankelijkheid en bij de vluchtelingen ten gevolge van de Tweede Wereldoorlogen en vervolgt met de hedendaagse vluchtelingen in Uganda en op welke wijze zij behandeld worden door de overheid en de UNHCR. Het laatste onderdeel van dit hoofdstuk gaat in op het gewapende conflict in Uganda en het verschijnsel van de interne ontheemden. Hoofdstuk 5 analyseert het internationale en nationale gezondheidsbeleid. Het voornaamste gezondheidsbeleid is gebaseerd op de primaire gezondheidszorgstrategie. Reproductief gezondheidsbeleid is vooral afgeleid van de overwegingen op de ICPD conferentie in Cairo in 1994. De studie toont aan dat er een gat zit tussen beleid en toepassing ten gevolge van verschillende beperkingen met inbegrip van slecht bestuur, structurele aanpassingsprogramma's, chronische armoede en de HIV / AIDS pandemie. Hoofdstuk 6 onderzoekt de organisaties en programma's op het terrein van reproductieve gezondheidszorg in Uganda. Het hoofdstuk beschrijft hoe Amerikaanse en katholieke missionarissen westerse gezondheidszorg in Uganda introduceerden, lang voordat de overheid een cruciale rol ging spelen om een gezonde bevolking te waarborgen. Samenwerkingsverbanden op het terrein van reproductieve gezondheids zorg en HIVAIDS zijn opgezet tussen het Ministerie van Gezondheid, de Verenigde Naties en verschillende NGO's. De studie heeft vastgesteld dat ondanks pogingen reproductieve gezondheidszorg in de rurale gebieden uit te voeren, de voornaamste reproductieve gezondheidsprogramma's nog steeds gericht zijn op moeder- en kindzorg.

Hoofdstuk 7 verkent het gebied onder studie en de zogenoemde gastomgeving. Het gaat in op de sociale, economische en politieke situatie van Uganda. De geografische positie van het land maakt het vatbaar voor de toestroom van vluchtelingen. Een vluchtige blik op de sociale en economische indicatoren die ernstig verslechterd zijn door de langdurige oorlog in noord Uganda, maakt al snel duidelijk, hoe kwetsbaar Uganda is en dat het de capaciteit mist grote stromen vluchtelingen op te vangen. In hoofdstuk 8 en 9 betreden we de *lifeworld* van de vrouwelijke vluchtelingen in Rhino Camp en Kiryandongo. Het hoofdstuk bespreekt de aard van de sociale relaties en genderpatronen en beschrijft hoe deze ontwricht raken tijdens de vlucht. Het traditionele patroon van mannelijk leiderschap schijnt te worden verstoord door het beleid van de UNHCR om hulpbronnen te verdelen onder vluchtelinge ongeacht hun gender, met inbegrip van land. Hoewel landbezit van vrouwen *empowering* is, heeft het desondanks genderconflicten veroorzaakt. Het heeft ook de menselijke voortplanting gestimuleerd, omdat men zag dat de grootte van het stuk land dat werd toegewezen afhing van het aantal gezinsleden. We zagen ook dat men bij de uitvoering van het humanitaire beleid de inheemse kennis van de vluchtelingen niet in beschouwing nam. Zwangere vluchtelingen- vrouwen worden bijvoorbeeld ontmoedigd om enigerlei vorm van traditionele medicijnen te gebruiken. Op een zelfde wijze bevallen zwangere vrouwen

meerderheid met behulp van traditionele *birth attendants* in tegenstelling tot professioneel getrainde vroedvrouwen. De kwetsbaarheid van tienermeisjes in de kampen baart veel zorgen. Verschillende vluchtelingen *teenagers* worden geëxploiteerd en een aantal seksueel misbruikt. De uitvoerende organisatie ontbeert een duidelijk genderbeleid en weet niet op de juiste wijze te reageren op deze kwestie van kwetsbaarheid, hetgeen weer resulteert in uitbuiting en *gender-based violence* alsmede een slechte toegang tot hulpbronnen. De verscheidene *case studies* beschreven in deze hoofdstukken tonen de kwetsbaarheid van vluchtelingen meisjes en vrouwen aan voor fysiek en seksueel geweld door mannen. Ze tonen ook aan dat er bijna geen manieren zijn om hier tegen in te gaan. De bestaande voedselonzekerheid in Kiryandongo leidt bovendien tot ondervoeding en sterfte onder kinderen beneden 5 jaar. Dit is een gevolg van arme bodems, inefficiënte landbouwmethoden en het feit dat vluchtelingen hun voedselgewassen weer verkochten om in andere levensbehoefte te voorzien. De kindersterfte leidde op zijn beurt weer tot een behoefte aan gezinsuitbreiding. In hoofdstuk 10 presenteer ik de conclusies. In dit hoofdstuk vat ik de theoretische beschouwing en de belangrijkste bevindingen samen en schets ik de implicaties van de studie ten aanzien van de genderverhoudingen, bestaanszekerheid en reproductieve gezondheid van vluchtelingen vrouwen. Ik identificeer ook de maatregelen die moeten worden getroffen om voldoende gendersensitiviteit waar te borgen bij de uitvoering van het genderbeleid.

Appendices

Appendix 1 Research Questionnaire for survey

Demographic and Personal Profile

1. Age…… 2. Sex: Male / Female (tick appropriately)

2 Religion (Catholic, Protestant, Pentecostal, Animist Muslim, Other – specify) (tick appropriately)

3. Marital Status (Married / Single / widowed / Separated / Divorced) (tick appropriately)

4. In case you are married, state age at marriage…….....……

5. Do you have any children? (tick) Yes / .NO

6. If answer to 6 is yes how many children have you had in total?
Alive …….....…..
Dead …….. State when and cause of death
…….....……

7. How many children did you have in Sudan before fleeing to Uganda?
…….....…

8. Are you Head of Household? (tick) Yes / No

9. What is the number of individuals in your household?
…….....……..
Are you in a polygamous setting? Yes / No
If yes how many wives do you (or your husband) have? …….....……

12. Status: Registered / Self- settled (tick)

13. When did you seek refuge in Uganda? Year / Month …….....…….

14. Education: Level of education including profession if any …….....……

Employment and Livelihood activities

15. What was your source of livelihood in Sudan? …….....……

16. What is your main source of income? (tick) [salary and allowances, remittances, humanitarian aid, sale of farm produce, sale of livestock and chicken, local brew, casual

labor, income generating activities – trade, poultry, rabbit rearing, mats, blacksmith, pottery, etc, other (specify)] ……

17. Kindly estimate how much money you get per month? Ug Shs ……

18. Please itemise how you spend your money per month (food, health care, scholastic material, clothes, toiletries, parrafin, other (specify). ……

19. What problems (if any) have you experienced while undertaking the above mentioned activities? (eg land acquisition, marketing, credit facilities, marginalization, heavy work load, mobility, etc) ……

Reproductive health (women only)

Pregnancy and childbearing
Where do you attend antenatal care during your last pregnancy? (tick) (health centre/elsewhere)
Where did you deliver your last child? (health centre/home/TBA) ……
In case you do not deliver at the health centre, please state where giving reasons.
……
What problem have you faced during pregnancy and childbirth? ……
What steps have you taken to overcome them? ……
Have you ever had a miscarriage Yes/No (tick appropriately)
In case yes, how did you manage? ……

Sexually transmitted infections (STIs) and HIV/AIDs (All refugees)
Have you suffered from STIs in the refugee settlement? Yes/No (in case yes, syphilis, gonorrhea, others- specify) ……
28. In case yes, how was it treated? ……
29. Was the spouse treated as well? Yes/No
30. Explain if you have encountered any problems in accessing STI treatment? …
29. What is HIV/AIDS? ……
30. What causes of HIV/AIDS? ……
31. Are you involved in any STI/AIDS programs? Yes/No
32. If yes, which ones and at what level?……

Family Planning
33. What is family planning? ……
34. Which family planning methods do you know? ……
35. Of these methods, which ones have you used? ……..
In case you have used any family planning methods, what was the supply source? …….. .
What problems have you encountered while trying to access contraceptives? ……
What sort of problems have you encountered with child spacing? ……
How have you over come them? ……

Perceptions – reproductive health needs

40. What, in your opinion, are the major reproductive health needs of women and men in the settlement/parish? ……
41. What could be the causes of the reproductive health problems? ……
42. Suggest 3 ways in which these problems could be overcome? ……
43. What are the likely obstacles limiting women from participation ……

Gender relations

44. Describe gender roles of men and women in Sudan in your ethnic grouping ……
45. Describe the changes in the gender roles of men and women since becoming refugees. ……
46. Can we go through your daily activities please? (Gender activity profile) ……
47. What problems do you encounter as you undertake these activities? ……
48. How do you cope with the problems? ……

Gender- Based Violence

49. Have you been a victim of gender-based violence? Yes/No (tick appropriately)
50. If yes, kindly discuss the circumstances leading to this incident. ……
51. Who came to your rescue during the incident? ……
52. What is your main problem(s) now? ……
53. How were the perpetrators treated? ……
54. Were you satisfied with the treatment? Yes/No (tick appropriately)
55.In case no, why not?
……
56. Suggest ways in which the treatment could have been better. ……

Vulnerability

57. Are you an unaccompanied refugee (or one with special needs such as aged, disabled? Yes/No
58. In case yes, describe (if any) the problems you have experienced in the settlement?
……
59. How have you dealt with the problems? ……
60. Kindly make any suggestion how you would like your situation to be improved.
……

Appendix 2 Research Questionnaire (Adolescents)

Demographic/ Personal Profile

1. Date of birth ……2. Country of Birth …….....……
3 Male / Female (tick appropriately). 4. Religion …….....……
5. Are you Head of Household? Yes / No (tick appropriately).
6. If under 15 mention how many siblings you have and your own position in your family: ….....…….

Education:
7. Do you attend school? Yes / No. 7. In case yes, state whether primary / secondary / other (specify) ……. …….
8. Who pays your school fees (UPE, UNHCR, other-specify) …….....……
9. Please explain the problems (if any) you have encountered in accessing education. …….
10. If not attending school explain reasons why not. …….....……

Girls only
11. Have you started getting your periods? Yes / No (tick appropriately). 12. In case yes, starting age. .....….
13. What hygienic lessons do you get and from which source? …….....……
14. How do you protect your self during menstruation? …….....……
15. If sanitary towels are used state source of money or towels. …….....……
16. What problems associated with menstruation have you encountered? ……...……
17. How have you tied to solve them? …….....……

All
Sex, contraception and Sexually Transmitted Infections
18. Have you been taught about menses, pregnancies, and STIs at school? Yes / No (tick appropriately)
19. Would you know if any girl in your school was forced by any man or boy to have sex? Yes / No
20. In case yes, what were the circumstances leading to this?. …….....……
21. How was the offended girl and the perpetrator treated? …….....……
22. Have you ever heard if any of the girls have tried to remove the pregnancy? Yes / No (tick appropriately)
23. If yes, how and under which circumstances? …….....……
24. Do you have sex with your friend? Yes / No (tick appropriately)
25. How do you prevent against making or becoming pregnant?. ……..….....……
26. What problems (if any) have you encountered during the access of contraceptives?. …….....……..
27. How have you tried to overcome these problems?. …….....……
28. Can you tell me some of the signs and symptoms of sexually transmitted infections?. …….....…….

29. How can one prevent these diseases? …….....……..……
30. How can HIV / AIDS be prevented?. …….....……

Income and livelihood activities

31. What is your source of income?. …….....……
32. What is the social support network available to you in the settlement?. …...……
33. What type of assistance do you get from the network?. …….....…
34. What problems you have experienced as an adolescent? ……..…….....….
35. Suggest possible ways how these can be minimized? …….....……

Appendix 3 Checklist - Key Informants

Health Providers (health units/hospitals)
Level of education
Position in the health unit.
Nature of services / programmes being at the health unit.
Government / NGO institution
State type of assistance from UNHCR
Management of:
Pregnancies and deliveries,
STIs including HIV / AIDS
adolescent reproductive health needs
Mortality and morbidity rates
Infertility and other gynecological needs (eg cancers, tumors, fibroids etc)
Male reproductive health needs
Sexual and gender-based violence
Problems encountered during service delivery and how solved
Mode of treatment and cost sharing
Problems associated with cost sharing
Suggestions for improvement

Traditional Health Provider (Traditional Birth Attendant)
Level of education
Years of practice
Source of training
Mode of management of labor and deliveries
Any maternal, child deaths and likely causes
Main problems presented by pregnant mothers and how they are solved
In your opinion, why do women prefer to have their babies with the assistance of traditional birth attendants?
Problems, if any, experienced in assisting women in labour
How are the above problems are overcome
Traditional birth control methods
Traditional treatment for STIs

OPM/ Local Government/ UNHCR/Implementing Partner
Settlement Commandant
1. Nature of problems in the settlement
2. Refugee policy
3. Livelihood security
4. Health problems
5. Reproductive health needs
6. Security and protection of refugees
7. Gender-based violence in the settlement and its management
8. Refugee welfare committees and gender composition
9. Pattern of settlement and social support systems

10. Gender roles in the settlement
11. Sources of income

Local Government
1.Local refugee policies
2.Working relationship with UNHCR, WFP, Implementing partners, NGOs and refugees.
3.Local health policy Vs inclusion of refugee caseload
4.Views on refugee utilization of district infrastructure

UNHCR/ Implementing Partner
1. Mission
2. Vision
3. Level of gender mainstreaming of the programmes
4. Programs under implementation
5. Associated implementational problems
6. Livelihood and income-generating activities
7. Collaborative partnerships
8. Sources of funds
9. Human resource policies

Appendix 4 Guide for FGDs (men, women and adolescents)

Men and Women
Major changes in gender roles
Mechanisms for addressing these changes
Livelihood strategies (land ownership and use, IGAs, food crops, food sale etc)
Gender relations
Health problems in general, reproductive health needs in particular
Problems faced (at household, at health centre, implementing partner, at district health units, the community)
Coping mechanisms
Major reproductive health needs of women in this settlement?
Make suggestions of overcoming them
Adolescents
Major reproductive health needs
Income and livelihood activities
Education
Gender and sexual relations
Vision

About the author

Deborah Mulumba was born in Bugema, Luwero in Uganda. After the completion of 'O' level, she proceeded to the UK where in 1972, she obtained the UK registration in General Nursing and Midwifery. After a few years of nursing and midwifery in the UK, Uganda and Kenya, Deborah attended Makerere University, Uganda, where she obtained BA degree in Social Work and Social Administration in 1984. In 1996 she obtained MA in Women Studies from the same University. In 1997 she was a Visiting Fellow at the Refugee Studies Centre (RSC) at Oxford University where she attended an introductory course in Forced Migration.

In 1999, Deborah won a four-year WOTRO (Netherlands Foundation for the Advancement of Tropical Research) scholarship to pursue her PhD studies at Wageningen University. The period between June 2000 and June 2004, she was a PhD candidate at Wageningen University and Research Centre.

She worked as a counsellor / social worker for the United Nations High Commissioner for Refugees (UNHCR) for ten years (1985-1994). She was project manager for a USAID-funded project for the demobilised soldiers in Uganda in 1995-1996.
Since 1998, Deborah has been lecturer at the Department of Women and Gender Studies, Makerere University, Kampala. Besides teaching, she is also a Research Associate with Makerere Institute of Social Research of Makerere University and has actively been involved in gender and forced migration- related research including research projects funded by Ford Foundation, UNIFEM, IDRC and SIDA / SAREC.

She is married to Stanley and they are blessed with five children and one grandchild.

Deborah has written about
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