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> The effect of the aggressive rapes left me with constant chest, back and abdominal pain. I get some treatment but still, from time to time it starts all over again. It was terrible (Woman discussing the effects of civil war during a Kamuli Parish focus group).

> Amongst the issues treated as private matters that cannot be regulated by international norms, violence against women and women's health are particularly critical. The essays in "Violence and Health" argue for the recognition of these as human rights issues (Peters & Wolper, 1995: 17).

**Abstract**[5]

This paper will describe the resulting long-term health needs of women war-torture survivors of the civil war years in Luwero District, Uganda. To do this sections of case studies from interviews carried out in Kikamulo Sub-County, Luwero, are utilised. The effects of gender-based violence and torture and its long term, severe and enduring impact on women's health will be highlighted. In 1994, the Centre for Health and Human

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rights at Harvard University led the first international conference on health and human rights. This recognised that human rights are an essential pre-condition for physical and mental health. Women's resulting health needs following war, including the urgent need for reproductive and gynaecological health services, are argued to be a fundamental human right which should be upheld through the legal mechanisms available. The paper suggests ways of assisting the women war survivors of Luwero and concludes that to be successful integrated health interventions for war-torture survivors need to be combined with the further collective legal, social and political empowerment of women and address the health inequalities and discriminations that exist.

*Keywords*: women, war, Uganda

## Introduction

Uganda has experienced civil wars since gaining independence in 1962. Between 1981 and 1986 gross violations of human rights occurred during the protracted bush war against Obote's regime[6]. This involved Museveni's army and had its starting base in Luwero District. Hence, this area, which became known as the Luwero Triangle, was particularly affected. Although Luwero is now relatively peaceful, research has shown the population still suffers physical and psychological effects (Musisi, Kinyanda, Liebling, Kiziri-Mayengo & Matovu, 1999). There is also an absence of literature on the treatment of women war-torture survivors in Uganda.

In 1998, Isis-WICCE, an international women's non-government organisation organised a Ugandan-led project with women war survivors in Luwero District. The funding was obtained from Medica Mondiale. A multidisciplinary team of health workers provided medical, psychological and gynaecological services to 237 war-affected women in Luwero. This intervention was provided by Isis-WICCE, African Psycare Research Organisation, APRO, including psychiatrists, social workers and psychologists, as well as members of the Counselling Service at Makerere University. APRO is a Ugandan-based organisation whose main function is to conduct research, training and provide mental health services, particularly to war-torture survivors in Uganda. The Association of Obstetricians and Gynaecologists of Uganda, AGOU, also provided screening and interventions. The first part of the intervention involved screening 48 women war survivors over a period of three days at a health centre in Kikamulo sub-county, Luwero. This screening involved an assessment of demographic information, experiences during the war and resulting effects, including post traumatic stress. This study found most of the women were tortured during the war, and 54.4% suffered sexual violence including rapes, being abducted as sex slaves, forced marriages to abductors, and other violations. Of the women screened 54.2% had post traumatic stress, as well as physical and gynaecological health difficulties as a result of their experiences. Women also experienced physical aches and pains, headaches, genital and abdominal pains, palpitations, chest pains, anxiety, lack of appetite and ulcers. The second part of the

[6] The war was fought between Milton Obote's army consisting of soldiers from Northern Uganda, mainly Langi and Acholi, with Museveni's National Resistance Army, largely comprising soldiers from the Baganda ethnic group. Between 300,000 and one million Ugandans were murdered during the second Obote regime, 1980-1985 (Uganda Resistance News, 1985). In 1984, it was estimated that the Ugandan army had killed between 100,000 and 200,000 people, most of whom were non-combatants (Washington Post, 1984

intervention comprised a qualitative analysis of the psychological consequences of war in 237 women. The third part of the intervention identified gynaecological effects and provided treatment for those affected. This project concluded:

> The effects of the war on the women have impeded their daily functioning and impacted on the low socio-economic development of this region despite massive infrastructural and economic rehabilitation efforts by the government (Musisi et al.1999: 4).

It also recommended:

> A psychotraumatic treatment programme be implemented as a matter of priority for these war survivors (Musisi et al. 1999: 4).

Women's experiences of sexual torture left them with very serious gynaecological and reproductive health needs and the same Isis-WICCE intervention project concluded:

> Since women were sexually targeted during the war, many of the crimes against them resulted in the damage of their reproductive organs or problems with sexually transmitted diseases including AIDS (AGOU, 1999: 4).

This intervention report was presented at a conference in Kampala and women who had been interviewed powerfully spoke out about their war experiences. Although the study was well received, proposals for services for these women war-torture survivors have not yet received funding as far as the authors are aware. Hence, this area of research was therefore pursued as part of a Ph.D.

This article focuses on key findings of this research in relation to the effects of sexual violence on women's health, the legal implications of these, and the relationship to women's future recovery (see Grown, Rao Gupta & Pande, 2005; Joseph, Williams & Yule, 2003; Liebling, 2003; 2004a; 2004b; Obbo, 1989).

**Fieldwork**

The fieldwork was carried out in Uganda between November 2000 and June 2001. The first three months were spent learning Luganda to intermediate level, the language of the Baganda[7] tribe and the largest single ethnic group two (Nzita Mbaga-Niwampa, 1997). As the researcher had been visiting and carrying out work in Uganda since 1992 she already had a good basic knowledge of Luganda. Most of the research participants spoke Luganda and, due to the sensitive nature of the research, it was important to be able to understand and speak as much of their language as possible. It was also important to ensure what was being said and translated was recorded as accurately as possible therefore native Luganda speakers were employed as research assistants to carry out translation and transcription.

Due to the large turn out of women during the previous project it had not been possible to carry out as many in-depth interviews as had originally been intended.

[7] The Baganda occupy the central part of Uganda, previously called Buganda province. They are a Bantu-speaking people said to have originated from the Congo.

Hence, the current research utilised in-depth interviewing of women war survivors with the aim of giving them the opportunity of narrating their experiences, survival strategies and views on what type of interventions were still required (Liebling & Ojiambo-Ochieng, 2000). During the first session the research process was fully explained to ensure full understanding of the implications of taking part and individual participants consented verbally or by signing a consent form. Several of the women involved were already known to the researchers through the previous Isis-WICCE intervention project.

In total 99 interviews were carried out. Interviews with women war survivors took place in five parishes in Kikamulo Sub-County, Luwero District and three were focused on in greater depth: Kamuli, Kasana and Wakayamba. The purpose of the study was explained in full to a woman local leader who then went to the parishes and asked for any women who wished to discuss their experiences during the war. As the interviews were very sensitive it was considered the most important factor in selection was that women identified themselves as willing to take part rather than attempting to attain 'representativeness.' Separate focus group discussions were held with women and men volunteers, for gender comparison purposes, and individual interviews were also carried out. In total 23 individual interviews were held with women in Kasana, Wakayamba and Kamuli parishes and 33 women took part in the focus groups. We discussed what took place during the war, the effects of their experiences, and views about current needs. All interviews were held in Luganda, together with a woman local leader, a co-researcher who translated the questions verbatim as the interviews were in progress.

A semi-structured interview schedule around the research themes was utilised but women were encouraged to narrate their experiences and follow-up prompts were used to explore important themes for women themselves. The woman co-researcher ensured that questions were understood correctly by checking this with the women themselves. The interviews were all taped and transcribed into Luganda and then English before analysis. This was carried out by a Social Scientist at Makerere University. Twenty-eight key informants were also interviewed in Kikamulo Sub-County and Kampala using a semi-structured interview schedule, in order to gain additional perspectives on women's war experiences, services developed and outstanding needs. Interviews were held with non-government organisations, health workers, human rights workers, community leaders, research assistants and a University Lecturer. The majority of these interviews were held in English, with the exception of a few, which were carried out in Luganda, together with the co-researcher translating. For the purposes of this paper, the women's stories are focused on but the key informants provided a wealth of knowledge that informed the broader study.

**Research questions**

These were in three thematic areas as follows:

1. What are Ugandan women's experiences of violence, rape and torture during civil war years in Luwero?
2. What are the effects of women's experiences and can these be understood in terms of debates about trauma, a predominantly western concept, and identity construction?

3. What are the resulting needs of women in terms of health policy, welfare and human rights and what are the implications for gender-sensitive services?

This article focuses on the third thematic area.

**Data analysis**

All interviews held in Luganda and English were taped and transcribed. Three Ugandan research assistants were employed to help with the fieldwork, translation and transcribing from Luganda to English. The interview transcripts were checked for accuracy and meaning. Both research assistants had worked on the previous Isis-WICCE project and therefore knew the participants and the area of research well. The English interviews were transcribed by the researcher and in total 99 interviews were analysed. A qualitative data analysis computer programme entitled Atlas Ti was utilised for assistance with data organisation and management. A broadly grounded theory approach, that views participants as experts and where themes are derived directly from the data, was adopted. Literature concerning women, violence, rape, and torture during war in Uganda (e.g. Isis-WICCE, 1998) and worldwide (e.g. Cockburn, 1998; Jacobs, Jacobson & Marchbank, 2000) was also drawn on. Using a critical perspective that took account of the historical and cultural context of the situation for women in Uganda, a conceptual framework was developed and continually refined on the basis of data obtained (Pidgeon & Henwood, 1996). A feminist approach was adopted for understanding the experiences of women war survivors that was firmly grounded within their social and cultural context. Whilst recognising women's extreme vulnerability to sexual exploitation and torture, the study aimed to provide further knowledge of their agency, resistance and action (see Anthias & Yuval-Davis, 1989; Lovell, 2003), as well as the processes used for collective empowerment.

Although full details will not be presented here, a gendered analysis of the data obtained demonstrated what took place in Luwero amounted to genocide and women were targeted due to their social, ethnic and national construction (see Lentin, 1997). The torture of men and women by the warring factions was an act of aggression against the Baganda tribe and women's bodies were central to these experiences (Scarry, 1985; Bakare-Yusuf, 1997). Concepts of militarism, nationalism and patriarchy also played a central role within the analysis. The total devastation of the social and economic infrastructure in Luwero was an attack on the culture and identity of the Baganda people fought on the bodies of local women and men. As Carolyn Nordstrom (1994) argues, because societies derive their specific form, their self-image and their definition of reality from cultural cohesion, its destruction is of outstanding importance.

The research went on to conclude that the war was a planned military strategy that caused destruction of the economic, social and cultural capital of the Baganda ethnic group. Obote's soldiers targeted practices, rituals and customs that embody cultural values. They caused sexual dishonour of Baganda women through sexual violence, abductions, rape, forced marriage and sexual slavery and sexual dishonour of men and women through forced incest. These war crimes can be understood as an attempted genocide (Liebling, 2005).

**The Health Consequences for Women War-Torture Survivors**

The vast array of health effects that resulted from women's war experiences was overwhelming. The previous study by Isis-WICCE found 'the most vulnerable and greatest casualties of the war were women and children' (Isis-WICCE, 1998). Of the 209 women seen 55% had gynaecological problems as a result of rape and sexual violence experienced during the war. These included fibroids, cancers, vesico vaginal fistulae, sexually transmitted diseases, infertility, prolapses, menstrual disorders, miscarriages, and perineal tears. Of 48 women screened for psychological and physical difficulties, 41.7% experienced chronic pelvic pains and 35.4% disclosed they were raped during the war. However this figure is likely to be much higher and Rosalind Lubanga in an earlier study in Luwero found out of 92 respondents 88% reported knowing someone who had been sexually abused and she estimated from focus groups held with women war survivors that between 50-70% could have been sexually assaulted during the war (Lubanga, 1998). Of these 48 women 81.3% suffered with musculo-skeletal aches and pains and 62.5% experienced chronic headaches. This paper highlights the reproductive and gynaecological effects on women by illustrating these particular sections of two narratives. It is important to note that their stories are a similar reflection of the experiences of other women war-torture survivors interviewed in Luwero.

**Jackie**

Jackie was a 34-year-old woman from Kasana Parish. She grew up in Luwero with her paternal aunt, as her mother left home when she was young. She received little education, as she was withdrawn from school by her father. The war started when she was 17 years old before she had completed primary education. She described what happened during the war:

> When we ran we lost all our property. After they told us that our father had been killed we continued running to Kiboga and Mummy almost died too. Daddy was shot dead and Mummy survived and is still alive today. When we returned, we found two people had been killed from our house and the skulls were still there. The iron sheets had been removed and taken to their detach.

She went on to say:

> When we came back we found soldiers had taken some girls and as they tried to run they came by our house. As the soldiers chased them they saw me and three of them raped me twice in succession.

Jackie became pregnant and later lost the baby. She said:

> I was greatly affected and I was taken care of using local traditional medicine. I healed well but they had left me pregnant and I contracted syphilis...I feel a lot of pain and a sore developed which hurts a lot and I itch around the private parts, which smell. I produced the baby and named her Samanya Agnes, 'I did not know Agnes', but she died at two years from diarrhoea and body swelling.

Jackie lost her father, several family members and friends during the war. She later married and had four children. Her husband beat her, refused to give her money for food or to educate the children. As Christine Obbo (1989) has also argued in the context of Uganda, Jackie's experiences caused destruction to her identity and loss of her role as a maintainer of social boundaries. However, she was able to take control of her life, leave this abusive relationship, obtain economic independence and establish a life for herself and her children. She had never taken legal action for what she experienced but she hoped to buy a piece of land of her own in order to settle.

The role of traditional beliefs is very important in Uganda and like Jackie; several women relied on traditional medicines for their difficulties and used traditional birth attendants to deliver. Within Baganda culture there is an expectation that women will continue to produce children but due to devastating effects on their reproductive health this is problematic. The damage to women's identities is immense within this cultural context (Obbo, 1989).

**Harriet**

Harriet was 40 years old and from Wakayamba. She had five children, grew up in Luwero and attended school until Senior 1. However, she became ill, which affected her schooling. She grew up with her grandma and described a happy childhood. Harriet got married in 1975 and when the war started she had two children and was pregnant with another child. Her husband was chosen for her.

Three of Obote's soldiers raped Harriet during the war.

> I was raped the first time when I was coming from Kampala. I had no identity card so they took me in to a small house in Bombo and three soldiers had turns with me.

Harriet went on to describe how badly her experiences had affected her and she developed abdominal pain. She was later raped again. This time she had just given birth and had to go looking for food in an area infested with soldiers. Harriet left her baby with her mother and whilst looking for food two Obote soldiers raped her again. Harriet described her problems:

> Ever since then, my tubes hurt a lot and when I went to the hospital they said my fallopian tubes had become 'shocked'. It actually took four years to produce another child after that one. But during the delivery the uterus came out too but it was put back. However, when I got pregnant again the uterus had to be removed completely.

Although Harriet had seen several doctors she still felt a lot of pain when she was having her period. Whenever she had sexual intercourse she suffered extreme internal pain and had also been infected with syphilis. Harriet explained that ever since the war she had lost the desire for sex. Hence, similarly to Jackie, her identity as a woman had been badly affected (see Obbo, 1989).

Harriet was the leader of Twekembe women's group and had taken legal action for her war experiences although this had been unsuccessful. She felt local women had become more empowered since the war ended and had entered leadership roles in government. Despite her difficulties Harriet became a local woman political leader within her community and assisted many other women. In these ways she reconstructed an alternative identity. She was able to reflect on the influential roles women had taken in Government since the war had ended.

Several other women interviewed had experienced similar effects and research analysis concluded that genital mutilation and rape caused considerable damage to women's reproductive organs (see Liebling, 2003; 2004a; 2004b, 2005). Women were infected with sexually transmitted diseases, including HIV/AIDS and the effects of their experiences resulted in chronic abdominal pain. The physical, psychological and social aspects of their experience of pain were closely enmeshed and directly impacted on their identities. As Gillian Bendelow (2000: 23) argues:

> In order to develop a more sophisticated model of pain, which locates individuals within their social and cultural contexts, a more sociological analysis is needed, not to replace the role of medicine or psychology, but to enhance our overall understanding of the complex phenomena of pain.

Priel, Rabinowitz & Pels (1991) put forward the view that people suffering pain need to find meaning for their symptoms as without it, despair and isolation may develop. Through the process of narrating their experiences during focus groups, women in the current study were able to give some meaning to their pain.

The Isis-WICCE intervention projects, as well as funding for the Ph.D. research and fund-raising by the Older Feminist Network South Wales, enabled time-limited specialist medical treatment for these women war survivors, as well as the establishment of an income-generating scheme. In March-April 2005 a small research grant obtained from Coventry University enabled further focus groups to be held with the same women and men, as well as follow-up interviews with key informants. The aims of this study were to evaluate the effectiveness of the income-generating scheme initiated and medical interventions previously held. These interventions have contributed positively to the further collective empowerment of women war-torture survivors in Luwero. This in turn has enabled women to make greater use of local health services. However, the women's need for specialist and sustained reproductive and gynaecological health care remains an urgent priority (AGOU, 1999; Liebling, 2005). Women war survivors interviewed in Luwero felt a holistic approach to their reproductive health needs would be of benefit. They expressed the wish for a specialist reproductive health intervention service including gynaecologists employed by Luwero District as well as global changes in health policy to provide gender-sensitive services for all women affected by war. Women interviewed felt their views should be included at all levels in the future planning and delivery of services. Women also expressed the view that sharing their painful experiences through the current research had enabled recognition and an end to the silencing of their urgent health difficulties and therefore improved access to appropriate treatment. Women also felt that increased access to income-generating schemes would further assist their ability to access appropriate healthcare.

**Redress and human rights**

Recourse to legal mechanisms in Uganda to prosecute the perpetrators and to bring compensatory treatment and resources to these women has been lacking. The Isis-WICCE Annual Report No 5 of 2005 acknowledges that the dual system of customary and statutory law in Uganda results in discriminatory practice against women (Isis-WICCE, 2005). Perpetrators are not brought to justice and women's voices are not heard. In consequence, a team from Isis-WICCE have assisted in a referral of the desperate situation in Northern Uganda to the International Criminal Court. This move could create more awareness of the significance of international law for the survivors in the central area of Uganda. They cannot approach the International Criminal Court as the violations in Luwero district occurred before 2002, but the potential of international rights' claims is still available.

**A Legal Claim: The Right to Health**

Could the women of Luwero expect state protection from the rape, mutilation, assault and torture they were subjected to during the years of 1981-86? And can they subsequently claim access to medical services to alleviate the long-term effects of their injuries? The first issue to consider is the nature of Uganda's international legal obligations at the time of the conflict in Luwero. Uganda did not ratify the International Covenant on Economic and Social and Cultural Rights (ICESCR) until 21 April 1987, and did not ratify the Convention on the Elimination of Discrimination against Women (CEDAW) until 21 August 1985, by which time the years of conflict were over. Similarly, the African Charter on Human and People's Rights (the African Charter) did not come into force until 1986, and Uganda ratified it on 10 May 1986. As human rights treaties cannot operate retrospectively, no claim can be made as against the government of Uganda for the years of violence.

**Access to health care services after the conflict**

After April 1987, Uganda has an obligation to protect its population's right to health care, and should take steps towards "the creation of conditions which would ensure to all medical services and medical attention in the event of sickness" (Article 12(2)(d) ICESCR). Can this international legal obligation assist the women of Luwero? The supervisory mechanism for the ICESCR consists of a requirement to report every 5 years to the UN Committee on Economic, Social and Cultural Rights. The Committee takes into account the socio-economic conditions and the state's available resources, but will consider also the interrelated features of availability, accessibility, acceptability and quality of health service provision (UN Committee on Economic, Social & Cultural Rights, General Comment 14, 2000).

Given the difficulties of Luwero as a remote, poor rural area, with women war survivors with specific mental and physical health needs, and a prevalence of HIV/AIDS, these measures are directly relevant to their requirements for health facilities. In fact, the Committee's General Comment No 14 goes on to indicate appropriate provision (in para 17) as:

> Equal and timely access to basic preventive, curative, rehabilitative health services and health education; regular screening programmes; appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, preferably at community level; the provision of essential drugs; and appropriate mental health treatment and care (UN Committee on Economic, Social & Cultural Rights: para 17).

All this in so far as it can be made available (given Uganda's restricted resources) must nevertheless be made equally available on the basis of Article 2.2 and 3 of the Covenant. Article 2.2 requires that the right to health will be exercised without discrimination of any kind, and this is an immediate legal obligation (unlike the full realisation of the right to health which will be achieved progressively).

If proposing that there is a violation of Article 12, it would be on the basis that a state was unwilling to use the maximum of its available resources for the realisation of the right to health, not that it was impossible to do so given its resources. A state would have to justify its position to the Committee that every effort had been made to fulfil its obligations. However, sadly, Uganda has a number of overdue reports for UN treaty bodies, and has in fact never produced its periodic reports for the Committee on Economic, Social and Cultural Rights. Without these reports, any assessment by the Committee of the progress and compliance of Uganda is inevitably lacking, and any monitoring role the Committee has is severely curtailed. Furthermore, there is no individual complaint system for groups of victims complaining of violations under the International Covenant on Economic, Social and Cultural Rights, so there is no direct enforcement under Article 12 for these groups.

Violence against women is deeply rooted in the structures of gender inequalities (see UNIFEM, 2007). It is also well documented that the inequalities in access to health care also remain a sign of discrimination against women globally (see WHO, 2001) and that there are also linkages between inequalities and other socioeconomic factors (i.e. OECD, 2003; UNFPA, 2003).

**The Convention on the Elimination of all forms of discrimination against women, CEDAW**

CEDAW adds a commitment to non-discrimination in access to health services under its Article 12 and provides further emphasis on standard-setting through the Convention and its application (eg. CEDAW, General Recommendation 24, 1999). CEDAW is concerned with equality of access to health care, and requires that a state 'prohibits all discrimination against women', 'establish legal protection of the rights of women', and 'take all appropriate measures to eliminate discrimination against women by any person, organisation or enterprise' (Article 2). All this must be done 'without delay', so this is not an obligation to be realised progressively by measured steps according to the resources of the country concerned, but an immediate requirement that health services are not discriminatory. Furthermore, states parties to CEDAW assume obligations to determine risks to women's health, and attempt to combat these through their health policies (Cook, 1994). This includes reproductive health services specific to women, and covers also protection and health services, including trauma treatment and

counselling, for women in 'especially difficult circumstances' such as those in situations of armed conflict (CEDAW, 1999).

The significance of CEDAW for the women of Luwero is recognition of their specific health needs. The obligation on Uganda is to take appropriate legislative, judicial, administrative and budgetary measures "to the maximum extent of their available resources" to ensure the women's right to health care. This includes taking into account barriers such as high fees, distance from health facilities, and stigma associated with a need for treatment for HIV/AIDS, rape and other sexual injuries. These specialist services are not currently available to the women of Luwero. There is an individual complaints procedure for individuals or groups of individuals, but this is only available where the country has signed the Optional Protocol to CEDAW. Uganda has not signed the Optional Protocol, and therefore individual complaints and the independent inquiry procedure (as a response to complaints) is not open to Ugandan citizens. The sole remaining enforcement mechanism is the submission of reports to the Committee on the Elimination of Discrimination against Women. Uganda has submitted twice to the Committee, and the Third Periodic Report is the most recent (The First and Second Periodic Reports of Uganda, 1992; Third Periodic Report, 2002). The report states the aim of:

> Equitable distribution of health resources….throughout the country, so as to provide all sections of the population effective access to the national essential health care package (CEDAW, 2002: 44).

However, it also acknowledges that:

> Women are less able than men to use health services, even when these are available….women have less access to money than men. Lack of money for transport is often the reason why women do not seek health services (CEDAW, 2002: 44).

The Committee on the Elimination of Discrimination against Women in its Concluding Observations on the Third Periodic Report of Uganda expressed concern at the poverty of rural women, and urged that they have full access to health services (CEDAW, 2002). It also recommended the establishment of counselling services for victims of violence, and training for health workers. The Committee noted the lack of means for women to enforce their rights, and recommended legal aid programmes be made available to enable women to demand enforcement of their rights. The Committee was particularly concerned that women who had been victims of violence, including abduction and sexual slavery, might see measures of redress and rehabilitation. Finally, the Committee recommended that Uganda ratify the Optional Protocol to CEDAW, to allow access to the complaints mechanism for CEDAW. These specific recommendations to the government of Uganda should be addressed in the Fourth Periodic Report to CEDAW. It is difficult to tell how far the recommendations impact on the policies of the government of Uganda, and the Fourth Periodic Report is still overdue. Yet the persuasive and insistent process of the Committee procedures, if maintained, can be another inducement to Uganda to comply. It is also worth noting that the government

of Uganda relies on international donors for aid, and this is pressure from another source to invest in health services according to international human rights obligations and standards (Cook, Dickens & Fathalla, 2003). Further, these obligations should be upheld through the Ugandan court system to allow recognition and redress, including provision for specialist health and counselling staff, and appropriate legal aid and advocacy programmes.

**The Regional Treaty: the African Charter (entered into force in 1986)**

The African Charter is a regional commitment to human rights for the member states of the African Union (previously the Organisation for African Unity) and sets a high standard. States "shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick" (Article 16). The right is to be enjoyed "without distinction of any kind" (Article 2), and is set in the context of the duties listed in Articles 27-29. Article 27(2) states that:

> The rights and freedoms of each individual shall be exercised with due regard to the rights of others, collective security, morality, and common interest.

The Charter emphasises the collective nature of these rights. However, the monitoring body, the African Commission on Human and People's Rights has taken a cautious role and has not provided anything like the same body of recommendations and comments to guide member states as have other human rights Committees. In fact, the African Commission is viewed as having been "hesitant in exercising these powers or creatively interpreting and developing them" (Steiner and Alston, 2000). This in combination with the principle of non-interference in the integrity and independence of other African member states has discouraged interventions. The Commission requires a state report every 2 years. Uganda, along with many other African states, has not reported regularly, and only one state report has been submitted to the Commission. The report on Uganda was considered in May 2000, at the 27th Session of the Commission. However, it is possible for the Commission to receive complaints, under Article 55 of the African Charter, from individuals, peoples, groups or from NGO's. Most individual complaints are in fact from NGO's on behalf of the victim group (African Commission on Human & People's Rights Decisions, 2005). This could be a mechanism used by the women of Luwero district to raise their complaint of a violation of their right to health, and to create further pressure through the Ugandan courts to uphold their claims.

**Conclusion: Suggestions for Ways Forward**

The sexual violence and torture experienced by women during the Luwero civil war years caused considerable damage to their reproductive organs and the effects of their experiences has resulted in chronic abdominal pain. Women were also infected with sexually transmitted diseases and left with serious gynaecological health problems, including HIV/AIDS (Obbo, 1989; AGOU, 1999; Liebling, 2004a; 2005). Women's reproductive powers were reshaped through multiple rapes, impregnation and destruction of foetuses Within Baganda culture there is an expectation women will continue to produce children but due to devastating effects on their reproductive health this is problematic. The physical, psychological and social aspects of women's experiences of

pain are closely enmeshed and impact directly on women's identities (see Obbo, 1989; Bendelow, 2000). However, through the process of narrating their experiences in the current study women reflected that they were able to break the silence about their urgent health needs as well as giving meaning to their pain.

The use of a local drama group; links with women's groups internationally and income-generating schemes in the current research have contributed positively to the further collective empowerment and positive growth of women war-torture survivors in Luwero (see Joseph, Williams & Yule, 2003; Liebling, 2005). This in turn has also enabled women to make greater use of health services. However, although limited specialist medical interventions have been implemented, women's need for specialist and sustained reproductive and gynaecological health care remains an urgent priority (Liebling, 2005).

The content of the right to health in ICESCR, CEDAW and the African Charter should lead to more adequate health service provision for the women of Luwero, if properly upheld. Enforcement should be strengthened at the international level and within the court system of Uganda. It is also possible to view a legal claim (e.g. a complaint to the African Commission) as exerting a political claim, which could pressurise the Uganda government to fulfil its legal obligations.

In addition laws must be accompanied by resource allocations, institutional regulations and guidelines and systematic training for officials who monitor and reinforce them (see UNIFEM, 2007).

However these claims are made, it is important to acknowledge that the health needs of women war-torture survivors must be addressed. The authors recognise that there is a need for multiple strategies working across different sectors at different levels (see UNIFEM, 2007). However, taking into account the women's views, we make the following specific policy recommendations for the women war survivors of Luwero (see Musisi et al. 1999; Liebling & Kiziri-Mayengo, 2002; Liebling, 2003: Liebling, 2004a):

1. There should also be specific health provision within the Ministry of Health's policies for Uganda and sustainable services should be developed for women war survivors that are integrated into the existing primary health care system (African Union, 2001; Liebling, 2004a; 2004b). It is recommended that there should be provision of a free mobile treatment service in Luwero, which includes specialised gynaecologists, obstetricians, and trained women counsellors that would be effective in reaching grassroots women who urgently need treatment. Services should utilise a holistic approach involving women in all stages of decision-making (see WHO, 2005). Indeed, the Department for International Development included 'universal access to reproductive health services by 2015' as a priority area for action (DFID, 2000: 32; Doyal, 2000).

2. The urgent need for holistic gender-sensitive services for women war-survivors and their families in Luwero District utilising empowerment principles and. integrated into existing primary health care systems, community and political support networks (Liebling, 2002: 13).

3. Income-generating activities and micro-finance schemes for women providing further collective empowerment and increasing access and uptake of existing

health services. Poverty reduction strategies in conjunction with specialist health programmes would improve the health outcomes for these women war survivors (see OECD, 2003).

4. Legal redress and compensation for the human rights abuses women suffered in Luwero should be actively pursued using group actions under international laws. Women's resulting health needs should also be viewed as a human rights issue (Short, 1997; Short, 1999) within the Ugandan court system.

5. Training and sensitisation programmes of government, local leaders and health workers in Uganda on the gendered effects of war and the services and policy changes that are required.

Achieving equity in health care requires a better understanding of gender needs and barriers linked to social structures and health systems (Gomez Gomez, 2002), efforts needed to improve the status of women and to allocate health resources according to economic ability (e.g. Okojie, 1994) and by paying attention to social exclusion (WHO, 2005). Health interventions should be based on long-term sustainable improvements in women's health and social, legal and political empowerment, rather than on time-limited external assistance (Grown, Rao Gupta & Pande, 2005) and should involve women at all stages of decision-making. It is only when these urgently required services are in place that these women can fully recover and continue to rebuild their lives.

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