SURGERY, MEDICAL AND PSYCHOSOCIAL REHABILITATION FOR VICTIMS OF WAR

Funded by the **United Nations Peacebuilding Programme**
Through United Nations Development Programme and the United Nations Office of the High Commissioner for Human Rights

Report on

"Response and Redress for Serious Crimes and Violations Resulting in Physical and Mental Injury in Acholi Sub-region, Uganda"

Implemented by AYINET

"Facilitating healing, restoring hope, dignity and building peace"

Supporting the

Government of Uganda's Peace, Recovery and Development Program (PRDP)

TABLE OF CONTENTS

List of Figures

List of Tables

Executive Summary

Victims of serious crimes and violations struggle and suffer for years. Their untreated war-related injuries are a painful reminder of the horrors they have lived through. The medical and psychological care AYINET provides is carried out to improve the quality of these peoples' lives and uphold one of their most fundamental rights – the right to health – the right to life. Providing medical and mental rehabilitation to victims of serious crimes and violations helps release their potential and enables them to move forward in their lives with dignity. It's uplifting to see someone who has been in anguish for years walk free from pain and stigma. As we work for justice and sustainable peace in Uganda, we must ensure we act to uphold the rights of, and provide care for, those who live with the physical and mental harms caused by the war.

This report presents a comprehensive overview of the support provided by the United Nations Peacebuilding Programme through United Nations Development Programme (UNDP) and the United Nations Office of the High Commissioner for Human Rights (OHCHR), Uganda in the healing of individual victims, their families and larger war-affected communities in Acholi in 2011-2012. With their financial support, AYINET provided 574 victims with a total of over 1,500 medical treatments and counseling sessions.

We believe in practical assistance to victims of serious crimes and violations, and we are pleased to partner with UNDP, Uganda and OHCHR, Uganda in this project that literally saved and transformed lives. We have seen the great need in Acholi, and we know there are more victims in need of assistance in the other war-affected sub-regions. I am hopeful that in the next phase of Peacebuilding Fund work, many more victims throughout northern Uganda who are in need of medical rehabilitation will receive the assistance they require and deserve.

Victor OCHEN, Executive Director, AYINET

African Youth Initiative Network (AYINET)

AYINET was founded in 2005 and is based in Lira, in the Greater North region of Uganda. The people of this region have been subjected to numerous ethnically-motivated armed conflicts and insurgencies. AYINET provides physical and psychosocial rehabilitation in the Greater North of Uganda for victims of brutalities suffered during the rebel Lord's Resistance Army (LRA) and Government of Uganda (GoU) hostilities over the last two decades. AYINET works in two critical areas: medical rehabilitation of those who have suffered serious violations, and the building and promoting of responsible youth leadership.

In the area of medical rehabilitation, AYINET has focused on those victims who have experienced the most serious physical and emotional harm. These are victims who have suffered physical injury and deformity due to physical trauma, maiming and torture, and who are in critical medical need of medical intervention and psychosocial support. AYINET's medical work is aimed at providing a more effective response to these victims with an emphasis on women and children; building safe, peaceful and healthy communities through victim empowerment; and strengthening a human rights culture. AYINET regularly carries out outreach to victims, assesses their needs, screens them and facilitates reconstructive surgeries (plastic and general), provides follow-up care, and offers psychosocial support.

Acknowledgement

This project was funded by the United Nations Peacebuilding Programme, an initiative supporting the Government of Uganda's Peace, Recovery and Development Plan to foster a lasting peace in northern Uganda. The support provided to victims of serious crimes and violations detailed in this report resulted from the efforts of many people. The UN Peacebuilding Programme generously contributed $ 150,000 to the project. Particular thanks to United Nations team members Birgit Gerstenberg, Katherine Liao, Lobegang Motlana, Richard Musunguzi, Florence Nakazibwe, Yagya Shahi and Fiona Shanahan. Our sincere thanks to Dr. Patrick Opio and the dedicated nurses and doctors of Ayira Health Center in Lira and St. Joseph Hospital in Kitgum for treating our patients. Thanks to Professor Dyan Mazurana and Teddy Atim Apunyu of Tufts University for their support and collaboration. Thanks to Dr. Thom R. Feroah and the Center for Global Health and Peacebuilding, USA for the matching grant of $ 40,000 that helped us reach and support more victims in other war-affected sub-regions. Thanks to Refugee Law Project of Makerere University.

AYINET staff who made this project a success includes Anna Grace Acia, Diana Grace Akello, Robina Akullo, Judith Amongi, Anna Aonyo, Vincent Ekola, Denis Ojok, Tony Omara, Richard Onen, and Jackson Opio. Jimmy Opio provided the data management and analysis and write up of this report.

Finally, we recognize and value the support from the Uganda's Ministry of Health through the District Local Government and government health centers where many of our patients received specialized medical care.

AYINET/UN PEACEBUILDING FUND PROJECT BACKGROUND

After two decades of conflict in northern Uganda that saw over 2 million people internally displaced, the need for rebuilding both the physical and psychosocial wellbeing of individuals and communities is clearly visible. The war between LRA and the government of Uganda resulted in human sufferings, where tens of thousands of children were abducted and recruited as child soldiers, and many more people died as a consequence of the war. The northern region of Uganda has been faced with natural disasters, armed conflicts and health emergencies (Ebola, hepatitis, HIV/AIDS, and now nodding disease syndrome) and acute poverty. People lost their relatives, friends, homes, and livelihoods. Emotional pain, grief, anger, and frustration are a daily part of many survivors' lives. To date, even as the war has gone silent in northern Uganda, there are still thousands of the persons who have been forcibly disappeared by parties to the conflict and whose fate is unknown. Many victims of physical injuries lack access to community and victim-centered health and psychosocial support and rehabilitation. Much of the post conflict development work ignores the most vulnerable, many of whom are victims of the most serious crimes and violations committed during the war.

Starting in 2011, the United Nations Peacebuilding Programme supported AYINET's project "Response and Redress for Serious Violations of International Humanitarian Rights and Grave Violations of International Humanitarian Law Resulting in Physical and Mental Injury in northern Uganda." The project's specific activities included:

Reconstructive Medical Assistance to Victims (Surgical and Non-surgical Treatments)

The program consisted of identifying, treating and enabling the rehabilitation of victims of serious violations of international human rights law (IHR) and grave violations of international humanitarian law (IHL) who have been physically maimed and harmed as a result of the crimes and violations. The program was aimed at victim and survivor's empowerment, contributing to building safe, peaceful and healthy post conflict communities, especially now that fighting has moved out of the Greater North and victims are resettling to their respective communities. The medical and psychosocial rehabilitation project benefited the patients who have suffered and are still suffering the brunt of horrific crimes committed against them. Furthermore, the project was intended to support other members of the family who have suffered as a consequence of the severe harm to their close-ones and family members.

Psychosocial Rehabilitation (Counseling)

The psychosocial aspect of the project was aimed at facilitating emotional healing and resilience within individuals, families, and communities. The goal was to enable people seriously injured and affected by the war to recover emotionally from the impact of war and see a possible future and way forward. The program was to empower the individuals and their communities to tackle emotional reactions and also create community cohesion that is essential for adaptation for victims with lifetime injuries (mutilations, amputations, etc.).

ASSESSMENT OF WAR-RELATED PHYSICAL INJURIES AND PSYCHOSOCIAL HARMS

This report presents data gathered by AYINET in its surgical and medical rehabilitation project between July 1st and December 31st 2011. Because this is an internal report intended for United Nations partners, pictures of victims' injuries and victims in various stages of recovery are provided to show the project's ability to address serious harms and restore functionality to victims. We selected pictures that both conveyed the realities of injuries people are suffering and ones that preserve the victims' dignity. All victims' photographs that appear within this report gave their consent to be photographed for medical and documentation purposes. The project's mandate was to provide medical care and rehabilitation to victims with grave injuries incurred during the hostilities between the Government of Uganda and the Lord's Resistance Army. Within the project timeframe, AYINET screened 574 victims from a total of 31 sub-counties across the six districts of Agago, Amuru, Gulu, Kitgum, Lamwo and Pader, in the Acholi sub-region of Northern Uganda. With some victims presenting multiple complications, AYINET registered a total of 589 physical injuries amongst the 574 patients. As part of the UN-PBF project, AYINET has facilitated medical treatment for 574 of the adults and children (100%) screened, with 85 of the victims (14.8%) still awaiting further assistance.

Cecilio, 82 at the time of interview, was tortured by the LRA in 1992:

"The LRA came to my house and set it on fire. They started beating me and cutting me with a panga. After some time, they turned me from my back to my stomach and started beating me again. They stripped my skin and went with it".

Cecilio lifts his shirt, exposing the hyper tropic skin scars. It appears as if his entire stomach has been burned, but the cause is actually the brutal torture. Within a year of his encounter with the LRA, he began to develop keloids, or bulky masses protruding from his skin. He went for treatment, but the pain kept coming back. And he 'got stuck', no longer able to turn his neck. Nineteen years after his torture, AYINET found Cecilio, still suffering from pain and immobility.

"The doctors released my contractures, the keloids and hyper tropic scars were excised and I was counseled. I came back completely someone new. I felt I had the ability and capacity to do work. I had good shape. I was productive in doing some of the domestic activities"

Walter, 14 at the time of interview, and his father, Patrick, began in 2002 to sleep in the bush to escape LRA attacks. As Patrick explained:

The bush became the only safe home for most of the locals around. But when hiding in the bush overnight, Walter got an infection in the leg. We don't know what bit him, but it started itching. There was a little wound, some liquid, and then it started swelling seriously. He couldn't afford to bend.

Patrick brought his son to the hospital. He thought the first treatment was working, but then the pain and swelling came back. Medications were not helping. The pain became too much for his son to bear, and so one morning, Walter said to his father, 'Father, you don't be surprised if you come back one day and find me dead because I can't contain this pain.' Patrick couldn't stand seeing his son in such a state. He felt helpless, and thought he should kill himself before having to watch his son die.

But nine years after the infection and swelling first appeared, Walter and Patrick were introduced to AYINET. The AYINET team brought him to a general surgeon, who slowly began peeling away the swollen skin. Walter's leg remains mostly immobile and he has to walk with a crutch, but he can move around on his own now and, most importantly, his pain has significantly reduced. Patrick describes:

"I was feeling too much pain in my heart. There was nothing I could do to save my son. AYINET came and picked me up from there. Now my son can walk and bend his knee, which was impossible before. He's not in pain like he used to be. Now I'm not thinking so much about his illness, and can think about his education. He is disabled, yes, but now I'm thinking about how I can take him to school".

Walter called our counselor and told him that his next need was education.

Although the war is now past, its lingering effects upon victims that sustained physical injuries and psychosocial harms continue to frustrate individual and community healing across Northern Uganda. Like hundreds of other patients treated by AYINET, Cecilio and Walter waited years for assistance.

With medical rehabilitation, Cecilio and Walter have been able to move beyond their debilitating pain and incapacity.

Methods of Implementation

Patient Mobilization

Patient mobilization involves outreach by AYINET staff, in particular medical health worker/doctors who reach out to victims/patients. This included travelling deep into the communities and identifying the victims, developing case records on them, conducting medical assessments, and collecting and compiling patients' health profiles which were submitted to the consultant doctors for review. AYINET has found that this process is a very reliable means to identify patients who have now relocated to their original home villages which are often more remote and isolated.

Psychosocial Care

Counselors are always present to work with victims, their families and communities to help with the screening process and provide each victim with basic counseling services. Even in cases where we cannot provide the necessary medical support, we always strive to provide counseling support. For those that we screen and find are in need of medical support that we can provide, we provide additional counseling services to the victims and their family members to ease their fears and reassure victims and their families that the services are indeed free. During their time in the hospital, our trained counselors were there to provide pre- and post-operational/surgery counseling to individuals and groups of patients. This helps to inform them of what is going to happen, enable them to discuss fears and concerns, and help build their confidence in the doctors. Most importantly, the counselors help to lessen their fears and build confidence in them that they will be supported all the way through their recovery.

Surgery Process

Upon AYINET's medical officers' confirmation of the patient's qualifications for specific categories of surgery, the victims/patients are prepared and transported to and from the identified surgical camp in the selected specialized hospitals suiting the patients' treatment needs (e.g., plastic surgery, orthopedics surgery, physiotherapy, burn units, reproductive health units etc.). The AYINET provides a variety of services during the surgery, including catering for their essential needs and welfare,

feeding, accommodation, counseling for ensuring proper care and follow-up care (pre, during and post operation) and paying for their medical and maintenance bills. Through the above process, AYINET helps to build confidence, trust and hope among patients, encouraging and supporting them to seek medical assistance. This bond of trust between AYINET staff and patients also enhances proper medical control, which ensures proper treatment and healing of the patients.

Follow-up

Follow-up is carried out by both counselors and clinical officers and is essential and enables AYINET to conduct on-going supervision and support visits to patients in their respective localities/villages. Through follow-up we are able to maintain proper medical control, encourage the family and community support system for the patients, and liaise with the community based health centers for further, effective post operation control/management. All these strategies are designed with a focus on the victims' right to health and mobilizing families and communities' holistic support towards victims.

Patient Demographics (at the Time of Consultation)

The PBF AYINET project showed 574 victims (44.4% females) from across six districts of Agago, Amuru, Gulu, Kitgum, Lamwo[1] and Pader districts; Agago district had the highest number of victims screened (32.2%) followed by Pader (27.9%), and last was Amuru with only 9.8%. Women were relatively more frequent in Amuru (57.1% of victims were female) and Kitgum (54.4% female) districts compared to Gulu (43.3% female) and Agago (30.3% female). Children are persons below 18 years and made up a significant proportion of victims, particularly in Amuru district (30.4%). Across the districts, Agago had the highest proportion of elderly (above 50 years) at 22.5% of victims mobilized (Table 1).

[1]Lamwo was left out of some analysis due to too few cases(3)

TABLE 1: BREAKDOWN OF VICTIMS SCREENED BROKEN DOWN BY SUB-COUNTIES

Count

District	Sub County		Sex		Total
			Male	Female	
AGAGO	Sub County	Adilang	56	29	85
		Arum	1	1	2
		Atanga	3		3
		Lapono	18	1	19
		Lira Palwo	3	1	4
		Omot	27	9	36
		Patongo	19	14	33
		Wol	2	1	3
	Total		129	56	185
AMURU	Sub County	Lamogi	10	12	22
		Pabbo	14	20	34
	Total		24	32	56
GULU	Sub County	Awach	18	5	23
		Bungatira	1	1	2
		Gulu MC	2	3	5
		Ongako	1	1	2
		Paicho	15	18	33
		Patiko	1	1	2
	Total		38	29	67
KITGUM	Sub County	Kitgum TC	3		3
		Lugoro		1	1
		Mucwini	1	1	2
		Namokora		5	5
		Orom	43	49	92
	Total		47	56	103
LAMWO	Sub County	Padibe West		3	3
	Total			3	3
PADER	Sub County	Acholibur	22	29	51
		Atiak	16	9	25
		Awere		1	1
		Lamiyo		1	1
		Lapul	1	3	4
		Latanya	5	8	13
		Lukole	5	2	7
		Pader TC	12	15	27
		Pajule	20	11	31
	Total		81	79	160

As represented in Table 2, the average patient age at the time of consultation was 36 years, with 36.6% between 18–35 years of age. 55.4% of the patients were married. Based on the project specifications by UN-PBF which only allowed the project to operate in Acholil, all the victims (100%) were Acholi (though it should be noted that many other ethnic groups and sub-regions in the Greater North of Uganda are suffering for serious physical injuries due to armed conflict). The majority of victims we screened (63.2%) had not attained any form of education, which parallels the fact that more than 80% of the victims are peasant farmers.

TABLE 2: DEMOGRAPHICS BY DISTRICT AT THE TIME OF CONSULTATION

		Agago	Amuru	Gulu	Kitgum	Pader	Total %
Sex (% female)		30.3	57.1	43.3	54.4	49.4	44.4
Age Group (%)	<=17	11.4	30.4	14.9	16.5	13.1	15.2
	18 - 35	33	23.2	52.2	28.2	43.8	36.6
	36 - 50	33	33.9	25.4	35.9	21.9	29.4
	>50 years	22.7	12.5	7.5	19.4	21.3	18.8
Marital Status (%)	Single	27.1	31.6	40.0	37.7	42.9	35.4
	Married	68.2	56.6	52.0	48.1	46.9	55.4
	Divorced	2.9	2.6	5.3	4.7	1.4	3.1
	Widow(er)		7.9	1.3	8.5	6.1	4.4
	Partner Missing	1.8	1.3	1.3	0.9	2.0	1.6
Education Level (%)	None	63.5	55.3	52.0	72.6	66.0	63.2
	Primary	26.5	38.2	19.7	14.2	32.0	31.9
	Secondary	10.0	6.6		7.4	2.0	4.7
	Tertiary				0.9		0.2
Occupation (%)	Peasant	82.9	81.6	74.7	83.0	85.0	82.2
	Civil servant	1.2			0.9	0.7	0.7
	Business	0.6					0.2
	Community Leader	1.2		2.7			0.7
	Student	3.5	14.5	6.7	0.9	1.4	4.4
	Pre-School	10.6	3.9	16.0	14.2	12.9	11.7

As this project was conducted in 2011, it had often been many years since the patients had originally sustained their injuries. Accordingly, the age demographics had changed significantly between the time of injury and the time of consultation. Table 3 evidences the age breakdown of patients at the time of injury. Three-quarters (74.4%) of the victims were below the age of 36 at the time they were injured, highlighting the conflict's disproportionate effect upon the youth in the sub-region. The fact approximately a third of all victims across the region were injured when they were children (under 18) further testifies to children being significantly impacted by the war.

TABLE 3: PATIENT AGE AT THE TIME OF INJURY

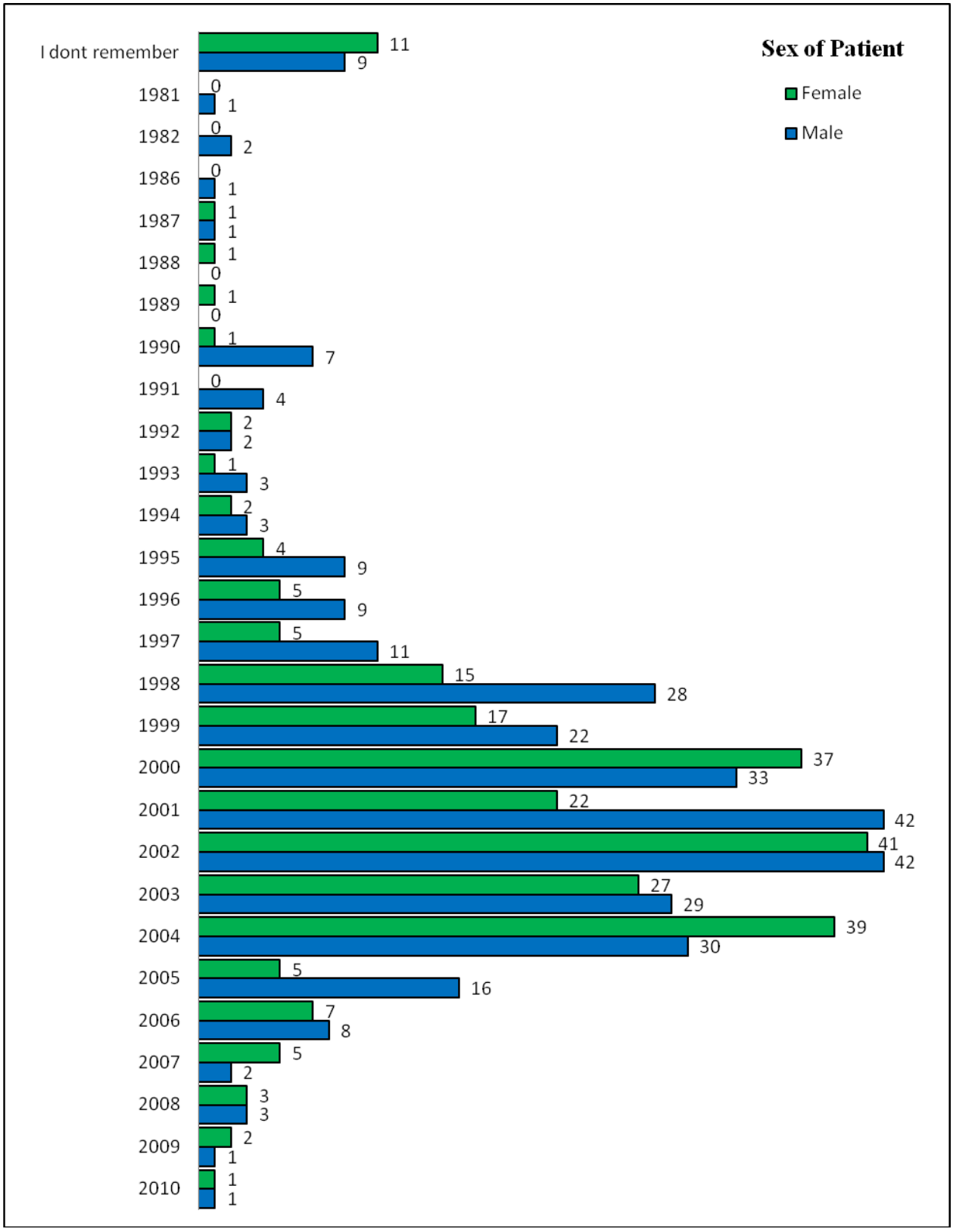
		Agago	Amuru	Gulu	Kitgum	Pader	Total %
Age Group (%)	<=17	34.1	28.9	36.0	29.2	38.8	34.0
	18 - 35	40.0	40.8	50.7	42.5	34.0	40.4
	36 - 50	16.5	28.9	12.0	24.5	17.0	19.2
	>50 years	9.4	1.3	1.3	3.8	10.2	6.4

PHYSICAL INJURIES

Year of Injury

At the time of consultation, the victims/patients were asked which year they sustained their injuries. The greatest prevalence of injuries occurred between the years of 2000 and 2004, reflecting the effects of the brutal campaign waged by the LRA in the sub-region at that time.

FIGURE 1: YEAR THE VICTIMS SUSTAINED INJURIES (574 Victims)



Nelson, 16 in 2012, was abducted at age 9 by the LRA in 2005:

'It was the 6th of May 2005 when I and 20 others were abducted by the LRA. The rebels took us somewhere far, and we were made to enter into a simple grass hut. Then they locked the door from the outside and set it on fire. The grass roof started to fall in because of the fire. The UPDF pulled down the door, but unfortunately some group members had already died. A helicopter gunship had followed the rebels. That was the only luck as to why some of us survived'.

Now seriously burned all over his body, Nelson cannot do any manual work because of his injuries. He attends secondary school, but suffers from a great deal of pain, and from the social stigma caused by the keloids on his face and the leaking from his wounds:

"When I go to school, sometimes these wounds discharge mucous. I find a lot of students trying to abuse me".

Paulina, 61 at the time of interview, was captured by a group of LRA fighters who severely beat her on her right breast. The breast became swollen and enlarged, and due to the constant pain, she went to a traditional practitioner (non-medical) who performed an Incision and Drainage (I & D) to remove the puss. The external wound appeared to have healed, so she lived with her injury for another five years until the nipple started itching. One year later a wound reappeared around the nipple, and began discharging liquid. Upon connecting with AYINET, she was in serious pain:

"The pain I had before made me feel like I wanted to go mad. Even to bend down and pick something was a problem. When AYINET brought me to the hospital, the doctor told me that one side of my breast had developed cancer. He had to cut off the breast to keep it from spreading. Some days I still feel pain, but other days I don't. Now I'm in recovery, and my family members are very strict that I follow the doctor's advice because they saw the pain I was in before. But soon I will begin to again make porridge like I used to".

Paul, 65 at the time of interview, was shot in the leg by the LRA in 1998.

"I was hospitalized about 4 months at Kalongo, but I could not afford treatment. They gave me wound nursing, but after all these months, I couldn't see any change. The doctors said that if it was going to be this way, better I go home. Meanwhile, my leg started rotting. I was going to the government health center for painkillers, but sometimes they didn't have any, so I had to buy them from a private clinic. But at some point I could not afford to pay. Lucky enough, I found AYINET".

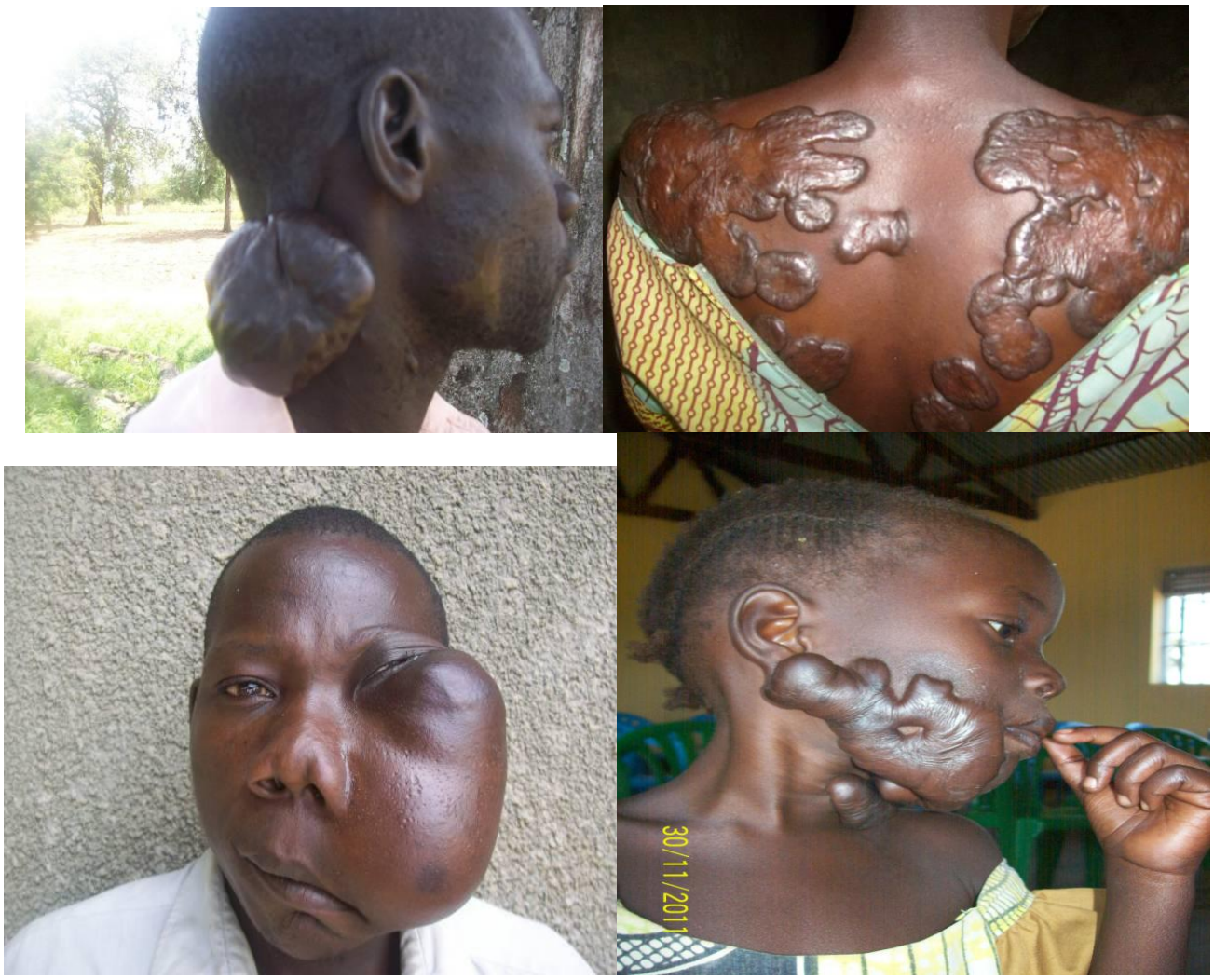
"Due to the severity of the injury, there couldn't be a way to operate. Only way out was amputation. I consulted back home and decided, yeah, let it be that way. From that time until now, I don't have pain anymore. I feel better. Much as I am somehow disabled and can't perform any gardening, I am happy that I can stay home and look after the kids. Now I'm just hoping for an artificial limb. I'm worried that the crutch might break at any time".

The 574 patients AYINET treated for the UN-PBF project presented a total of 589 injuries, with some having multiple complications needing sequential treatments. More than four out of every five patients (80.5%) required surgical operation(s). The most frequent presentations in need of surgery included: retained bullet and/or bomb fragments (23.4%); contractions of the fingers, elbows, neck and other webbed/burn-related complications (11.9%); vaginal fistulas due to rape, sexual abuse and forced early deliveries (5.4%); discharging hyper-tropic scars due to torture and/or gunshot wounds (5.3%); and chronic osteomyelitis due to bacteria or blood entering the bone (5.1%).

Stray bullets and bomb blasts had a particular impact upon those abducted by the LRA, as abductees were often put on the frontline in confrontations with government forces. The rebels were also known to set fire to IDP camps and villages, resulting in many burn-related injuries such as contractions, painful scars, and keloids. These injuries were found in greater concentrations among women and children, as they were more likely to be at the home, with children often retreating to the home in an effort to hide from the incoming rebels. AYINET also found many instances of rape and sexual abuse leading to pregnancies and birth-related complications, especially among young girls.

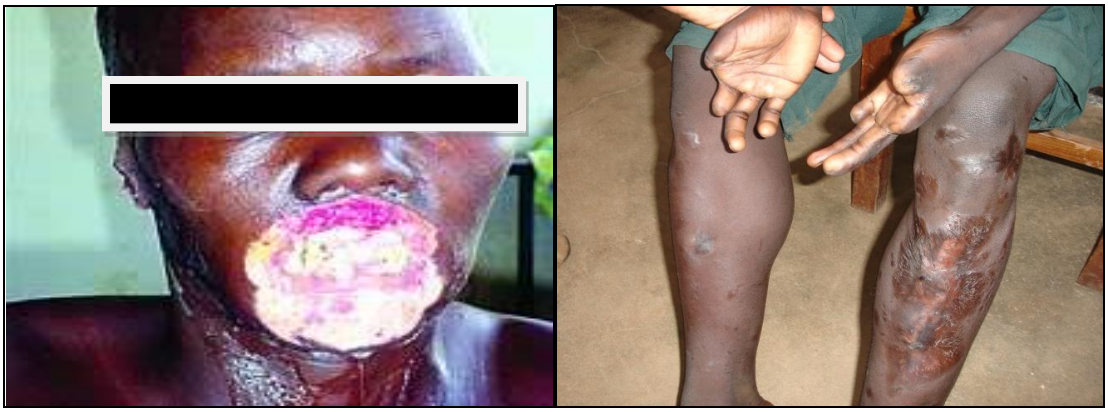
Patients with burn wounds and resulting contractions and bullet wounds (bottom right). Most of them feels their injuries are beyond repair.

Patients described the torture inflicted upon them, including severe beatings, being forced to crawl on their chests or walk on their knees over rocks, and carrying heavy loads for long distances resulting in painful swellings. These wounds, when not given medical attention, often expanded into enlarged deformities that brought both great physical suffering and social stigma.



Patients with keloids (above) and lymphoma (below) (scar tissue from wounds that becomes inflamed and painful and can result in deformity and restricted movement)

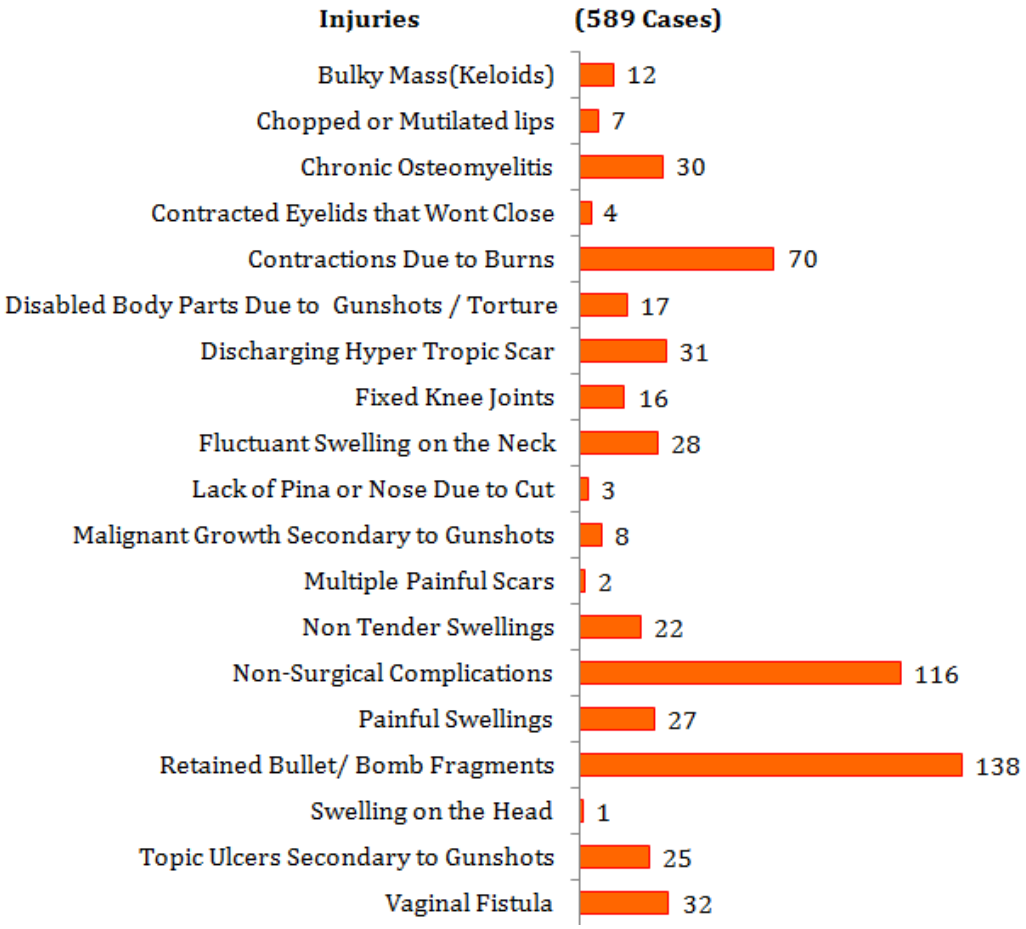
Patients reported that mutilation and torture was often used by the LRA as a means of punishment or to 'send a message' to local communities or the UPDF. Methods of torture and mutilation varied, but included physical beating, sometimes with weapons or other objects; sexual violence and rape; the cutting off of ears, noses and/or lips and body parts (predominately the victims were female); genital mutilation, including castration; and burning, among others. Physical complications resulting from mutilation and torture vary depending on the type of injury, but victims often suffered from chronic pain, disfigurement, impaired movement, permanent disability and in some cases, social ostracization. Some patients who had been victims of sexual violence also suffered from complications such as vaginal fistulas.



Patients like the above mutilated initially received emergency medical treatment only for the wound to heal, but remained with deformities. Most require multiple reconstructive surgical procedures and psychosocial support

The 116 non-surgical cases included prolonged pains due to torture, neck/back pains, headaches and sound-related complications as a result of explosions and gunshots, simple breakages and dislocations, and other war-related medical conditions.

FIGURE 2: TOTAL COMPLAINTS



(INJURIES)

Distribution of Injuries by District

The injuries were fairly evenly distributed throughout the districts of Acholi where the project ran. The top five injuries across the districts were foreign bodies (retained bomb fragments) (138), burn and contractures (70), fistula (32), discharging hyper tropic scar (31) and chronic osteomyelitis (30). Chronic osteomyelitis is an infection of the bone tissue resulting from fracture of the bones or secondary to gunshots which allows systemic infections where bacteria reach and inflame the bone tissues. Discharging hyper tropic scar is a complication when wounds heals with a scar and later bulges into malignancy. Most of the fistula cases we recorded in these districts were either caused by rape or early pregnancy with related complications.

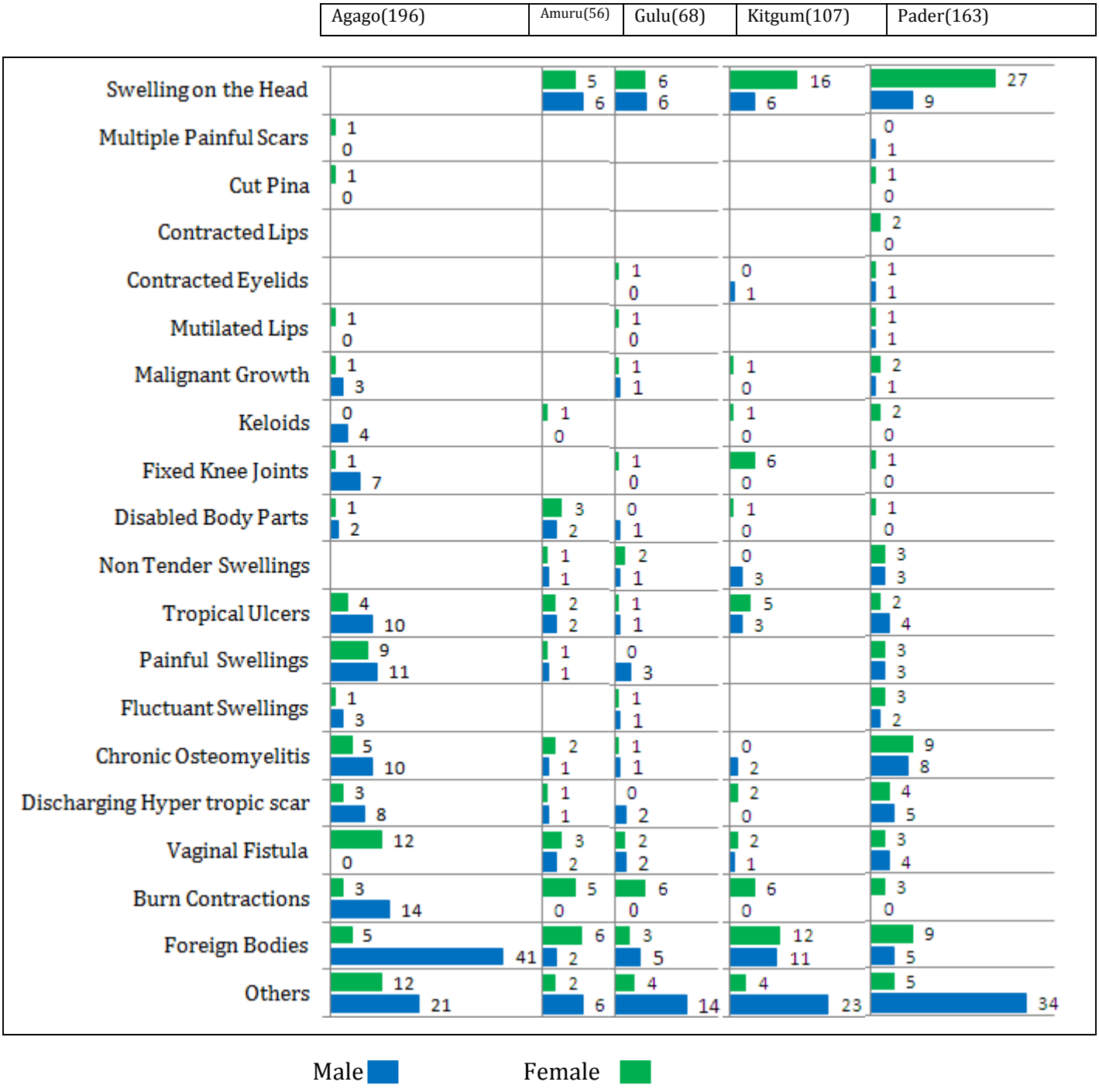
The top five frequent injuries showed increased prevalence in Agago district than in Amuru, Gulu and Pader (odds were 1.2, 1.03 and 1.5 respectively). Reduced prevalence in Amuru compared to Gulu and Kitgum districts, less chances in Gulu than in Kitgum (odds ratio= 0.9) but with increased prevalence in Kitgum and Gulu than in Pader (odds = 1.8, 1.6). These figures showed increased prevalence of the five top injuries in Agago and Kitgum districts compared their counterparts in the sub-regions.

Distribution of Injuries by Sex and District

In Agago district there were increased prevalence of foreign bodies (retained bomb fragments), Burn and contractures and discharging hyper tropic scars were more frequent in men than in women (odds ratio= 4.8, 2.2 and 1.2 respectively). Women were more likely to present osteomyelitis and fistula cases than men.

In Kitgum and Gulu districts, foreign bodies, burns and contractions were more likely to be reported by men than women. Meanwhile in Amuru and Pader districts men were less likely to report burn and contractures compared to women. Figure 3 below shows the breakdown of injures presented by victims broken down by district and sex.

FIGURE 3: DISTRIBUTION OF INJURIES BY SEX AND DISTRICT



Injuries by Sex

As depicted in figure 4B, non-surgical complications (26.9%), contractions due to burns (13.0%), and vaginal fistulas (12.6%) were the complaints most frequently presented by females. Among the males, retained bomb splinters/bullets (37.2%), non-surgical complications (15.1%), and contractions due to burns (11.7%) were the most recurrent. Notable differences across sex included the greater prevalence of chopped lips and cut pina amongst women. AYINET attributes this distinction to the fact that women would often scream or beg for the release of their children, husbands or relatives taken by the LRA. The rebels would retaliate by cutting off their lips for challenging their authority. The LRA also regarded pregnant women as a bad omen and would punish them by cutting off their lips, ears, nose or breasts. More frequently, women and girls were victims of rape and sexual abuse. Abducted pubescent girls and young women given to LRA commanders and soldiers as `forced wives' were routinely raped by their `captor-husbands,' forcibly impregnated and forced to give birth to the resulting children. Adult rebel commanders in their 50s raped and impregnated girls as young as 12 years-of-age. AYINET's work has documented that the majority of young women who were seriously wounded or killed in captivity by the rebels died as a result of their persistent refusal to engage sexually with their captors, which led to them being severely beaten, tortured, maimed (e.g., by having their breasts cut off), or killed.

The male victims were more likely to suffer from gunshots/bomb-related injuries and chronic osteomyelitis, as well as tropic ulcers and discharging hyper tropic scars resulting from gunshot wounds. AYINET believes, again, that this is explained by the fact that young men were often abducted and used for active combat. On many occasions, abducted male children were used as human shields for the more advanced fighters; children were put forward in battles and during forced marches, making them more vulnerable to ambushes and attacks by the government army, militias or other forces fighting the LRA. Additionally, males are often those forced to serve as porters, which resulted in injuries to their backs and chests. Finally, given that males comprised the majority of abducted LRA fighters, they were often severely beaten and tortured as part of their indoctrination into the LRA, or (less frequently) as a means of retaliation and punishment when they were captured by the Ugandan army.

FIGURE 4A: PRESENTED INJURIES BY SEX

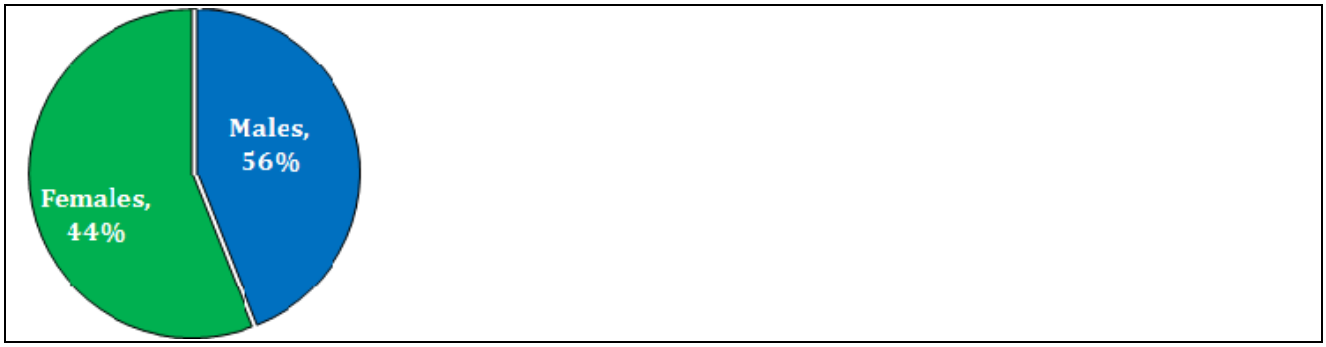
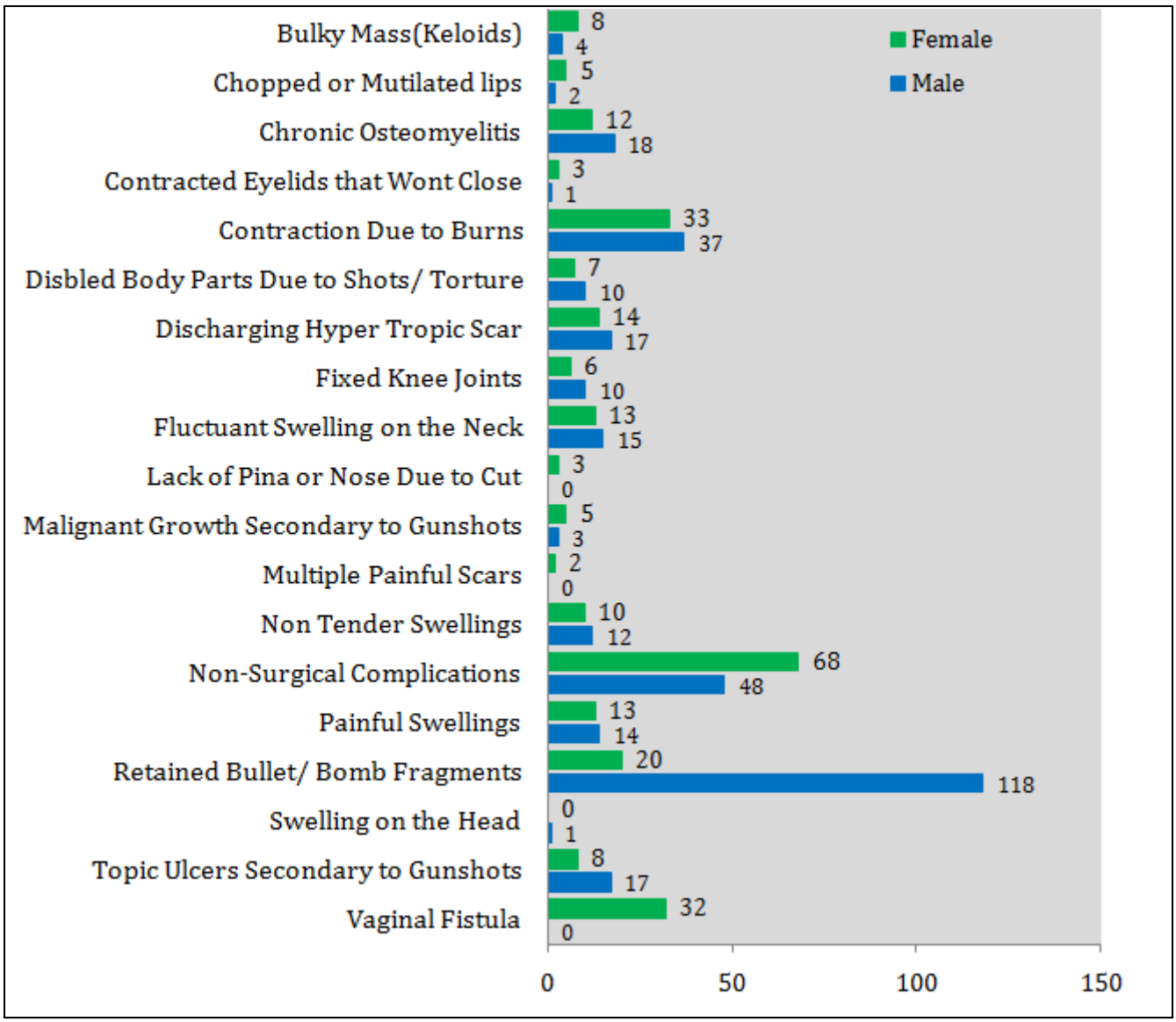


FIGURE 4B: PRESENTED INJURIES BY SEX (589 injuries)

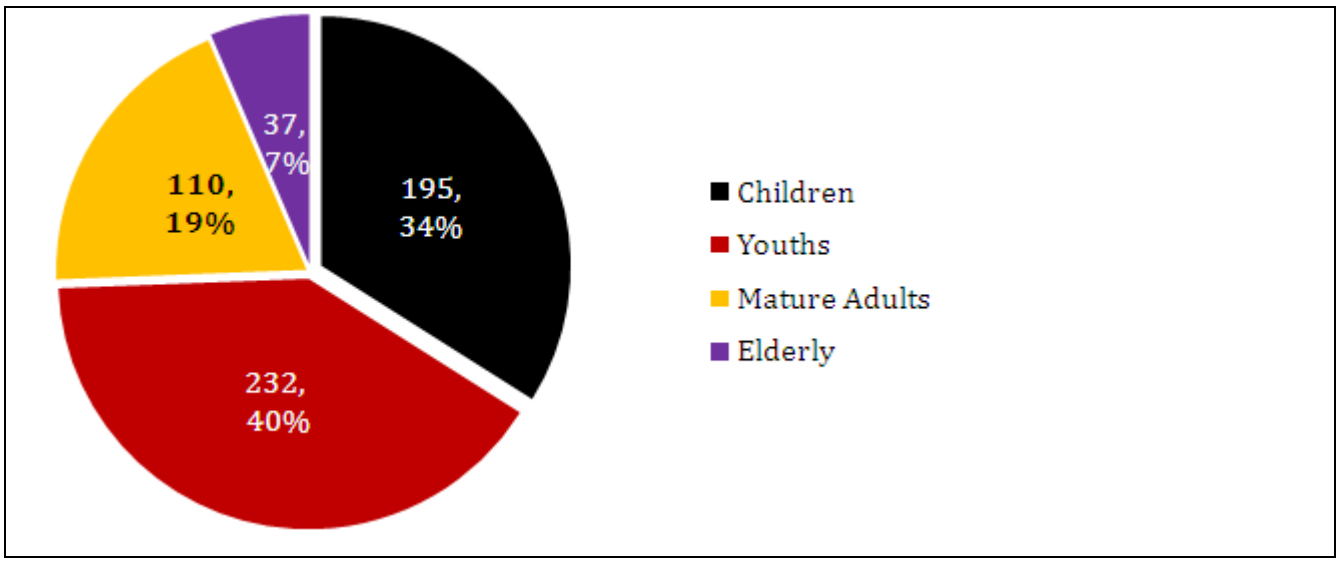


Injuries by Age Group

Figure 5A breaks the injuries down by age group *at the time* of injury to highlight those generations most affected by the conflict in terms of physical injuries. The youth group (between 18 and 35 years of age) comprised the greatest number of victims (40%) and presented the largest number of injuries in most categories.

Children (under 18s) were also heavily impacted, suffering 34% of all recorded injuries. They sustained the greatest number of keloids, malignant growths due to gunshots, and most prominently, contractions due to burns. Children suffered the majority of burn injuries because houses were often set ablaze by the rebels when they attacked camps for internally displaced persons. When people began to flee during the attacks, children would instinctively run into their grass-thatched huts seeking refuge only to be caught in the flames as rebels set the camps and huts on fire. AYINET also treated children for water burns (from boiling water) which they suffered when the mothers were away looking for food when they were in the IDP camps, or when the children were not properly monitored or protected from cooking fires and boiling water due to extreme congestion in the camps. The cases of malignant growths among children were all as a result of landmines and UXOs.

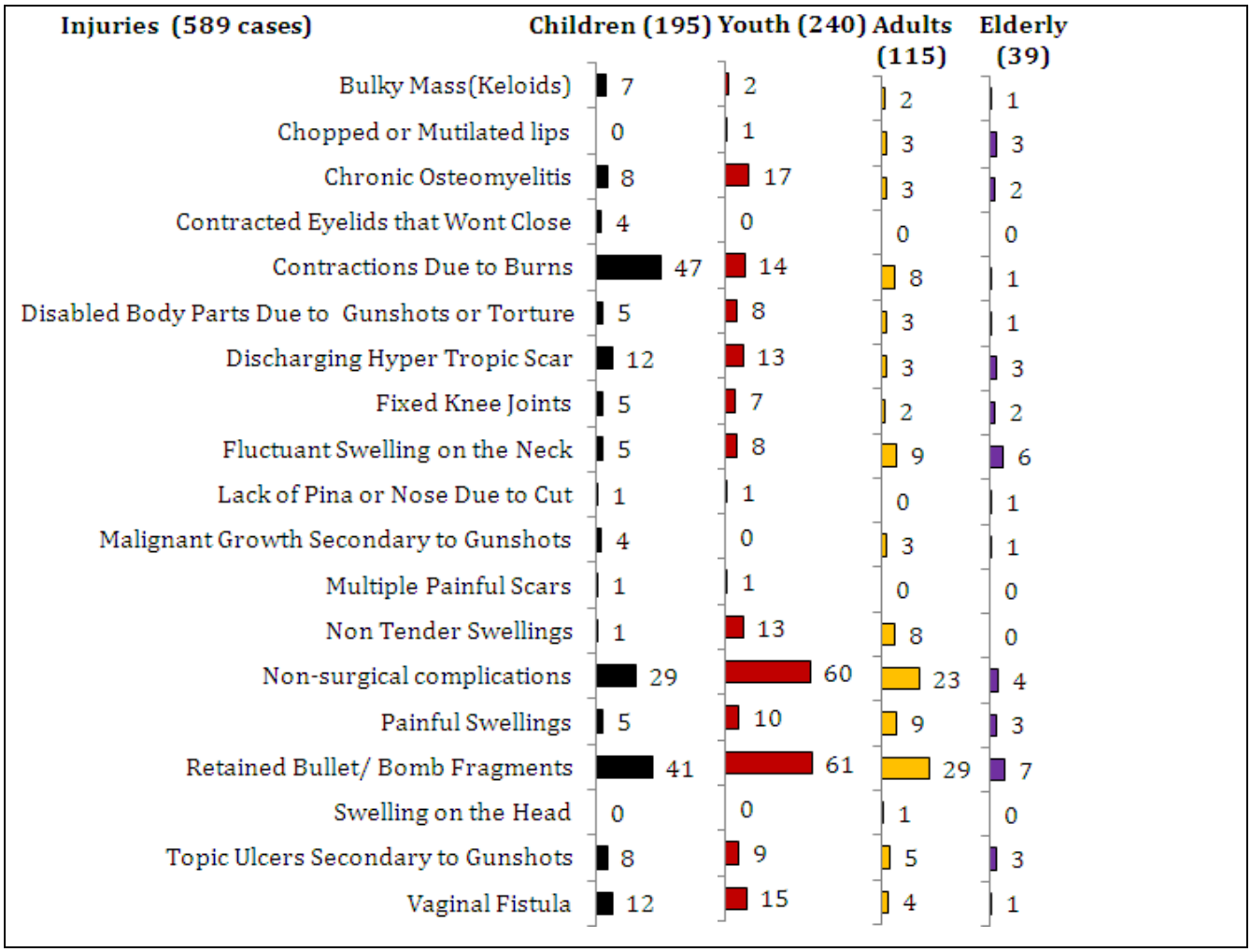
FIGURE 5A: PRESENTED INJURIES BY AGE GROUP (BASED ON TIME OF INJURY)



Adults and the elderly incurred more of the painful and fluctuant swellings associated with torture, and the adult and elderly females sustained the majority of cases of mutilated lips. The

LRA cut the women's lips to stop their screaming, and tortured the adults and elderly by beating them, forcing them to harm themselves or others, and by compelling them to carry heavy loads for long distances, often barefoot through the bush.

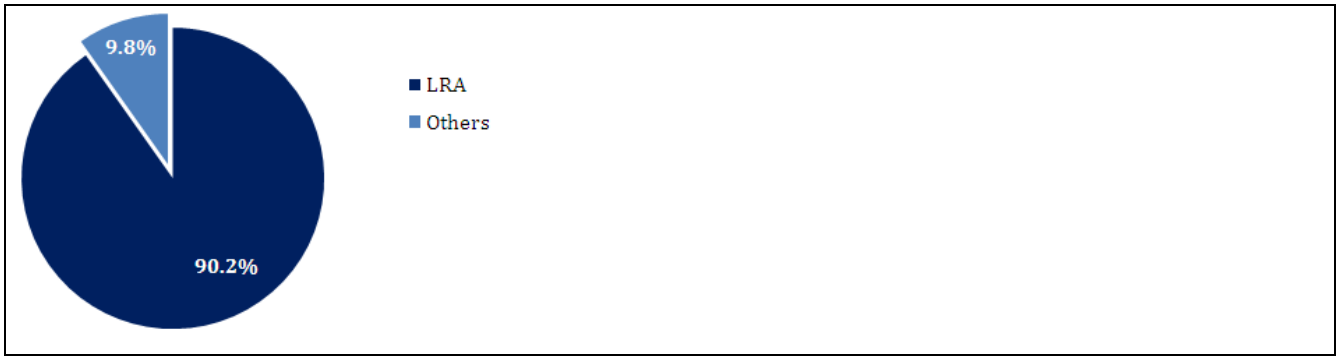
FIGURE 5B: PRESENTED INJURIES BY AGE GROUP (BASED ON TIME OF INJURY)



Attributing Responsibility

The vast majority of AYINET patients (90.2%) attributed responsibility for their injuries to the LRA (Figure 6).

FIGURE 6: WHOM DO YOU CONSIDER RESPONSIBLE FOR YOUR INJURY?



Abductions

More than half (53.3%) of the 574 patients screened were once abducted by the LRA. Of those that were abducted, the ratio of men to women was relatively even at 49.3% women and 50.7% men. Abductions however had strong significant relationships (sig. 0.000) with age groups; frequent abduction was reported by age groups of 18 – 29 years (32.7%), 30 – 39 (20%) and 13 – 17(9.5%). It should however be noted that ages 6 - 29 were significantly more likely to be abducted (60%), while ages above 60 and below 5 were significantly less likely to be abducted.

Of the abductees' age bracket 18 – 29, two thirds were women/girls, while 65.4% abducted within 13 – 17 age bracket were boys. In fact, boys formed greater proportions of abductions between 6 -17 (60.5%) at the time of the injury. Further, for our patients, time spent in LRA captivity ranged from as short as hours to longer than 10 years. A third of the patients spent less than six months while two thirds spent more than I year in abductions. Women within age bracket of 18 – 29 were more likely to spend up to 5 years in abduction, while older women were significantly less likely to spend more than three months in abduction.

TABLE 4: ABDUCTIONS BY SEX AND AGE GROUP

Total abductions at time of injury				Male abductions at the time of injury			
Age group	**Freq.**	**Percent**	**Cum.**	**Age group**	**Freq**	**Total**	**Percent.**
0-5	6	2	2	0 - 5	3	36	1.9
6-twelve	29	9.5	11.5	6-twelve	15	31	9.7
13-17	52	17	28.5	13 - 17	34	47	21.9
18-29	100	32.7	61.2	18 - 29	39	74	25.2
30-39	61	19.9	81.1	30 - 39	36	70	23.2
40-49	42	13.7	94.8	40 - 49	20	36	12.9
50-59	10	3.3	98.1	50 - 59	4	16	2.6
60-69	6	2	100.1	60 - 69	4	7	2.6
70+	0	0	100	70+		2	0
Total	306	100		Total	155	319	100

(A) (B)

Female abductions at the time of injury			
Age group	**Freq**	**Total**	**Percent.**
0 – 5	3	27	2.0
6-twelve	15	32	9.9
13 – 17	17	22	11.3
18 – 29	61	88	40.4
30 – 39	25	38	16.6
40 – 49	22	32	14.6
50 – 59	6	12	4.0
60 – 69	2	3	1.3
70+		1	0.0
Total	151	255	100.0

(C)

Abduction and physical injuries

Former abductees showed significant relationships with injuries by presenting multiple cases of swellings secondary to torture (76%), sexual abuses (at least 75% of sexual related abuses reported occurred during abductions), fixed knee joints secondary to torture and other related injuries compared to their non- abducted counterparts (compare 144 to 54 of the former mentioned cases). Burns and contractions, Keloids secondary to burns, and tropical ulcers were not very frequent among abductees. Foreign bodies and shrapnel were evenly distributed among both groups. More than five of every six boys/men within the age bracket of 13 – 40 years reported cases of retained bullet/fragment. Among females who experienced abduction by the LRA, 83.3% of those aged 18-49 reported being sexually abused, with up to two thirds (67%) reporting being within 18 – 39 years at the time of their abuse. Burns/contractions, swellings and other injuries were uniformly distributed among both abductees and non-abductees at both times.

Table 5 below shows the distribution of 310 injuries among the 306 abductees by sex.

TABLE 5: ABDUCTEE INJURIES BY SEX

Injuries by Sex of Person Abducted				
	Male		**Female**	
Injuries	freq.	Percent	freq.	Percent
Chopped Lips	1	0.6	4	2.6
Chopped Nose	0	0.0	2	1.3
Chronic Osteomyelitis	7	4.5	4	2.6
Contractures and Burns	8	5.1	9	5.8
Disabled Body Parts	2	1.3	7	4.5
Discharging Hyper Tropic Scar	5	3.2	6	3.9
Fixed Knee Joints	6	3.8	4	2.6
Fluctuant Swellings	10	6.4	10	6.5
Malignant Growth	2	1.3	3	1.9
Multiple Painful Scars	0	0.0	1	0.6
Non Tender Swellings	8	5.1	10	6.5
Non-Surgical Injuries	33	21.2	49	31.8
Painful Swellings	3	1.9	6	3.9
Retained Bullet/ Fragments	66	42.3	12	7.8

Sexual Abuse	0	0.0	24	15.6
Tropical Ulcers	5	3.2	3	1.9
Total	**156**	100	**154**	100

From table 4 above, most common injuries presented by male abductees were retained bullets (42.3%), swellings secondary to torture (12.8%) and other non-surgical injuries. Females frequently presented injuries due to sexual abuses (15.6%) and other non-surgical injuries.

PSYCHOSOCIAL HARMS

In addition to treating those patients presenting physical injuries, AYINET also screened victims of mental health within the targeted communities. AYINET identified 331 victims exhibiting psychosocial complications from 18 sub-counties distributed throughout the five districts of Agago, Amuru, Gulu, Kitgum and Pader, in the Acholi sub-region of northern Uganda (Figure 5). 316 of these 331 victims were also patients with physical injuries (analyzed above). The remaining 15 patients presented with psychosocial manifestations exclusively. The fewer overall psychosocial patients (compare 331 to 574 patients with physical injuries) should not be understood as indicative of a lower number of victims with psychosocial needs. Rather, due to the project mandate and available resources, AYINET was unable to screen all victims for psychosocial complications.

Of the 331 registered victims with psychosocial needs, AYINET provided sequential counseling sessions to 321 (97%). The small percentage (3%) of those not receiving counseling was typically due to the cost and challenge of meeting each patient individually. Whereas those patients being treated for physical injuries were gathered at a central location and then transported to the hospital, subsequent psychosocial counseling sessions required counselors to travel to distant locations to meet individual patients near their homes.

Unlike its analysis of physical injuries assessed based on the time of injury, AYINET is unable to accurately determine the onset time of any psychosocial harms affecting the patients. Their mental health may have been immediately impacted by an experience that coincided with a physical injury or it may have only manifested years later. As explained above, although most patients presented with physical injuries often exhibited psychosocial challenges, there were

also patients screened by AYINET that exhibited mental health complications in the absence of any discernible physical injuries. For these reasons, the proceeding examination is limited in its use of data regarding age to explain particular psychosocial harms.

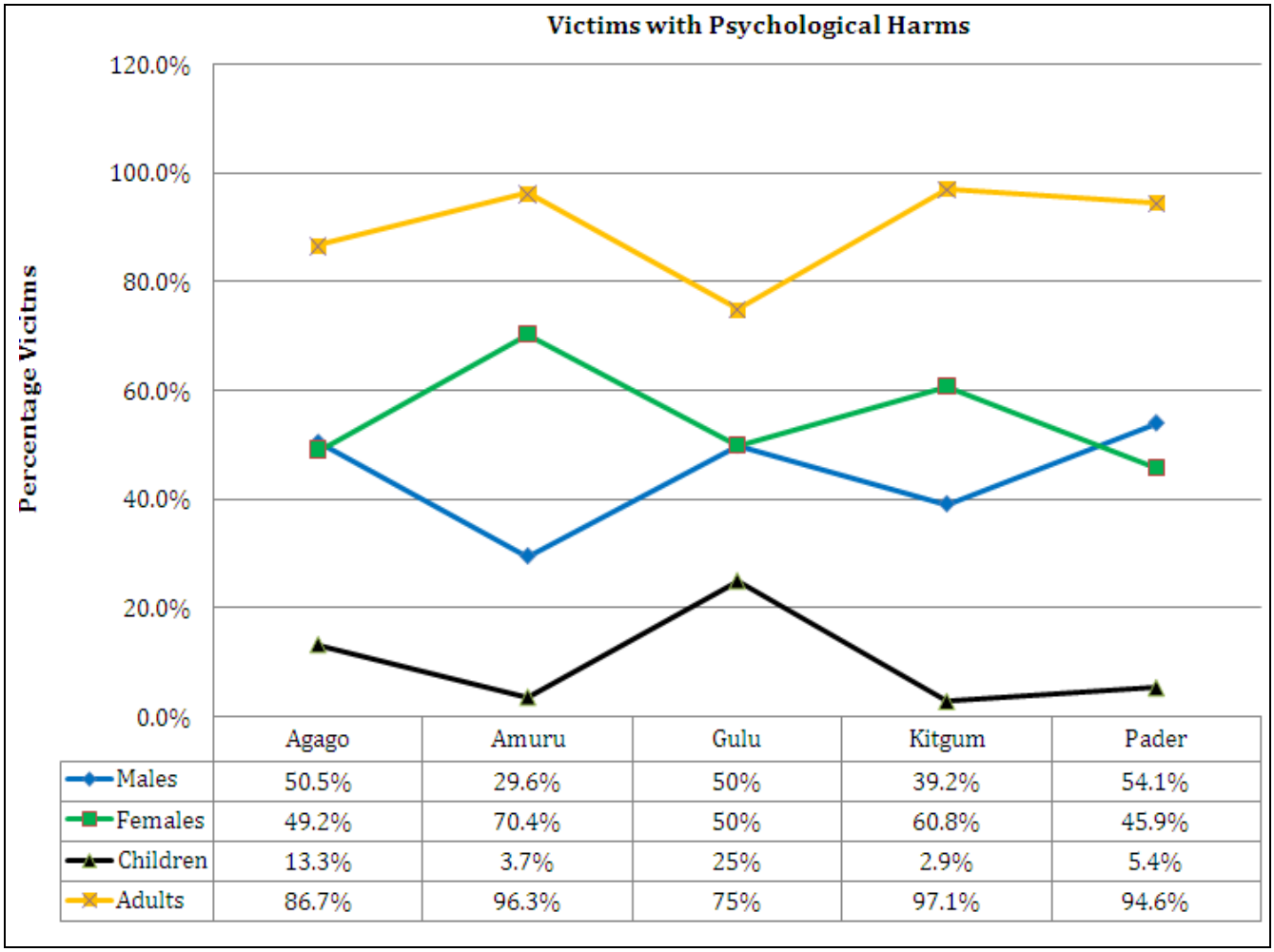
That said, AYINET believes that children tended to be less psychosocially affected than adults. When children were abducted, they were told that their parents, siblings and family members were all dead, and that they were all alone. They were indoctrinated by the LRA and often forced to kill. The normalization of this process for children often lessened their experience of guilt for any wrongdoings, and made them more willing to admit to what they had done. The exception, though, is the child who has been forced to kill a close family member or friend. In AYINET's experience, the trauma experienced by a child after beating his mother or father to death is profound.

Overall, mental health related complications were reported less in children. AYINET counselors believe this is because children at the time of their abduction had fewer societal norms inculcated in them; they took their traumatic experiences more like training than torture. Children later became a greater challenge to the community on return with the 'bush-mentality' traits.

Adults have been more likely to try and hide their transgressions, bearing the weight of their guilt internally. Men have been especially guarded, fearing the possibility of societal retribution or stigmatization. Female adults have been hesitant as well, but their reservations are often temporary, as they seek forgiveness and assistance after opening up.

Further, when communities experienced a rebel attack, the women were slowed or often left behind in their effort to try and save their children. In the process they witnessed the violence, as the men were more likely to be killed, kidnapped or flee towards refuge. Most women refused to abandon their loved ones, especially their children. When a child was abducted or attacked, these women would tend to blame themselves for not protecting the children, and therefore, the psychosocial manifestations arising out of such an event were often more with the adult women than the children themselves.

FIGURE 7: VICTIMS BY DISTRICT (AT TIME OF CONSULTATION)



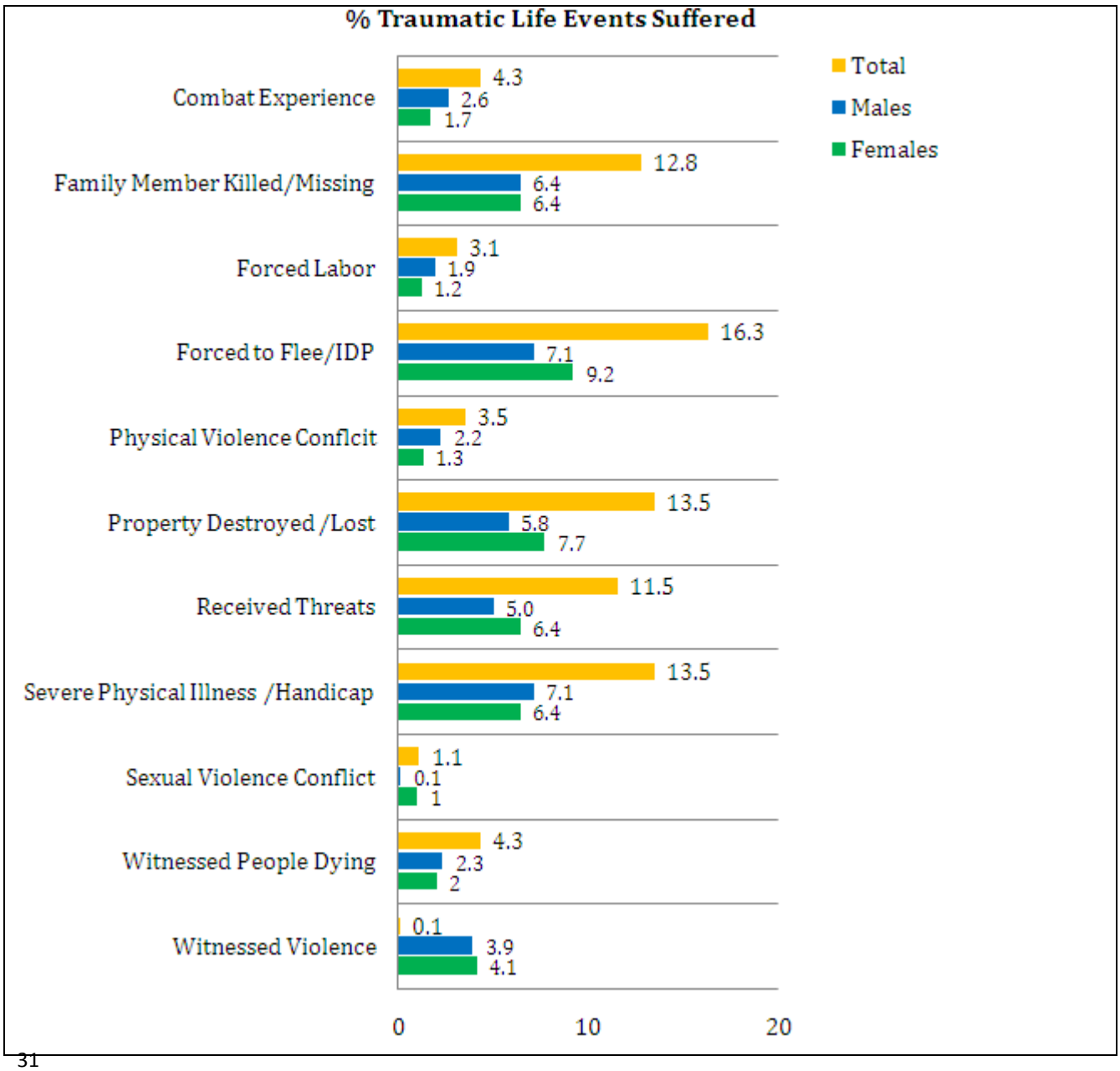
	Agago	Amuru	Gulu	Kitgum	Pader
Males	50.5%	29.6%	50%	39.2%	54.1%
Females	49.2%	70.4%	50%	60.8%	45.9%
Children	13.3%	3.7%	25%	2.9%	5.4%
Adults	86.7%	96.3%	75%	97.1%	94.6%

Experiences of Events

AYINET counselors documented their patients' stories, detailing their experiences of traumatic life events. These narratives were then used by AYINET counselors to assist in patient diagnosis and to begin conversations with patients around prioritization of needs and treatment options. The greatest proportion of patients (16.3%) mentioned having been forced to flee their homes, often having to 'night commute' and ultimately resettle in IDP camps. AYINET sees a close positive relationship between the phenomenon of being forced to flee and the subsequent loss and destruction of property, stalling of education, and decline in physical/mental health. Other patient's highlighted severe physical illness or handicap (13.5%), loss or destruction of properties and assets (13.5%), and family member killed or missing (12.8%), as the most frequent traumatic events inflicted upon them. Notably, instances of reported sexual violence reported as traumatic event are comparatively low at 1.1%. This is because when sexual violence results in

a serious, debilitating and life-threatening injury female are more likely to report the violence as they try and seek assistance. However, in cases where physical wounds are not apparent, due to high stigma regarding sexual violence throughout northern Uganda, females rarely come forward for mental health interventions to address the effects of the sexual violence. Typically, AYINET has found that victims of sexual violence were unlikely to report such experiences, due to potential stigma, as well as strong and wide-spread gender discrimination against women and girls, where they are denied access to information and do not have the right to be heard in social gatherings or often even within families or communities. Victims of sexual violence were more likely to acknowledge instances of sexual violence if it had resulted in complications that required physical treatment (fistula, HIV, birth complications).

FIGURE 8: TRAUMATIC LIFE EVENTS EXPERIENCED BY THE PATIENTS



Presenting Mental Health Complaints

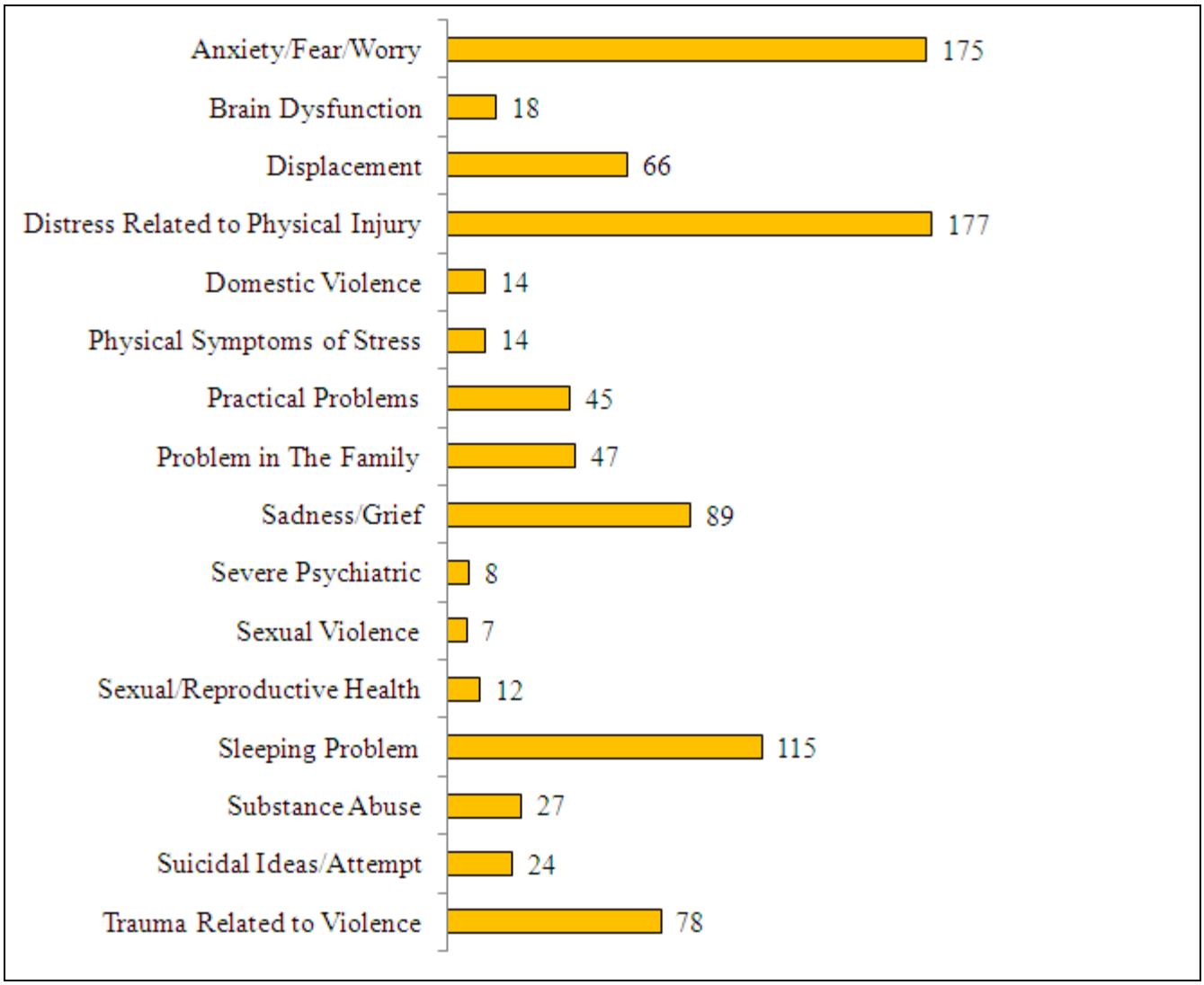
During the assessment period, 331 victims presented 916 complaints that impacted upon their mental health. AYINETS' mental health counselors noted from their one-on-one discussions with individual victims that the most frequent complaints were: distress related to physical injuries (19.3%); anxiety, fear and worry (19.1%); sleeping problems (12.6%); and sadness and grief (9.7%) (Figure 8). AYINET observed that during the war, many of its patients were forced to endure unbelievable suffering, including – among other experiences – parents bearing witness to the burning of their children; women, especially older women, being gang raped multiple times, as younger ones were often taken as forced wives by the aged commanders; mothers and fathers being forced to engage in sex acts with their sons or daughters as the other siblings watch; as well as victims being made to kill friends and loved ones (usually with axes, machetes and sticks), to cook loved ones alive, or to eat human flesh; and being forced to survive in the bush alone, abandoned, after extreme torture.

Patients often presented with anxiety, fear and worry from the very start of their discussion with AYINET counselors, even though their experiences were diverse. Some patients feared death, while others feared the challenges of living life. Many women mourned the loss of their husbands, while also worrying about the loss of the family breadwinner and its implications upon the future for them and their families in regards to access to shelter, health, food and education. This was even more the case for child-headed households. Ex-combatant returnees feared being identified by their community and hunted out of revenge for the misery befallen untold victims. Others feared revisiting past events, and so have thus far declined to return to their homes, remaining in the IDP camps. Some patients distrusted AYINET's counseling team, accusing them of being crime investigators rather than good Samaritans. The fear and guilt associated with recalling traumatic events helps to explain the frequency of anxiety exhibited by AYINET patients who were either victims or forced perpetrators of atrocities committed against innocent civilians.

AYINET attributes the high rate of sleeping problems to the fact that it was at night that most victims experienced flashbacks of traumatic events. Sadness and grief were largely due to the killing and loss of family members in both brutal and mysterious ways. This was exacerbated by the fact that patients were often unable to offer their loved ones a proper burial. Despite a high value being placed on traditional burial arrangements in these communities, victims were denied the opportunity to take such measures because they were constantly on the run, fearing

for their lives. Therefore, they were never able to complete their mourning cycle and pay their last respects to their deceased loved ones. Finally, torture during the war often contributed to a number of psychosocial challenges, as many clients were victims of violent abuse, physical beatings, and sexual violations.

FIGURE 9: PRESENTING COMPLAINTS (916 Cases)



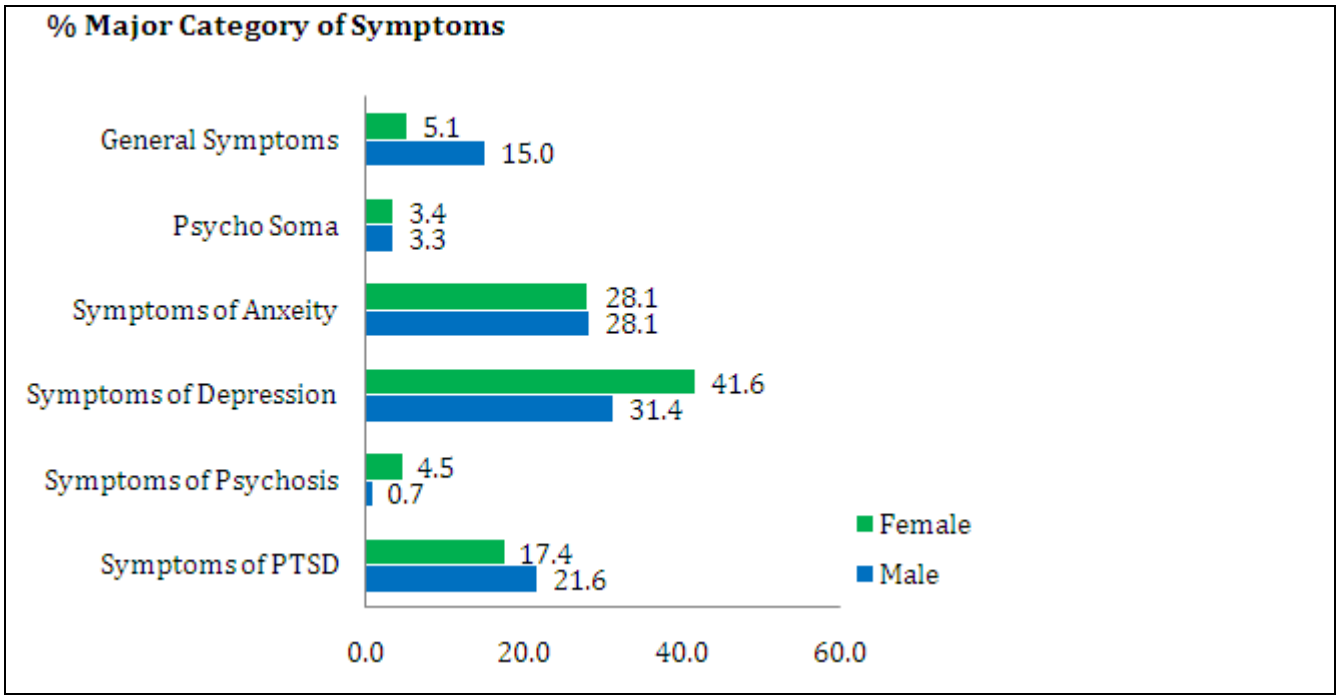
Major Symptoms of Psychosocial Harms

AYINET counselors were able to identify symptoms of depression (36.9%), anxiety (28.1%), and Post Traumatic Stress Disorder (PTSD) (19.3%) as the major symptoms of psychosocial harms suffered by both male and female patients. Sadness (19%), feelings of hopelessness (16.9%), and worthlessness (13.3%), which were captured under the heading of depression, were also frequently presented. Flashbacks and nightmares, often major causes of sleeping problems (third most frequent complaint, figure 8), were also major symptoms of PTSD.

AYINET found hundreds of victims describing their encounter with AYINET as 'God-sent'. These victims had often given up on life and were just waiting or wishing to die, convinced that no one cared about their suffering.

As depicted in Figure 9, notable differences between sexes were those presenting general symptoms (loss of appetite, low energy, irritability, etc.), where the proportion of males (15%) nearly tripled that of their female counterparts (5.1%). These males were most frequently presenting with a loss of energy or feeling of weakness.

FIGURE 10: MAJOR CATEGORIES OF SYMPTOMS BY SEX

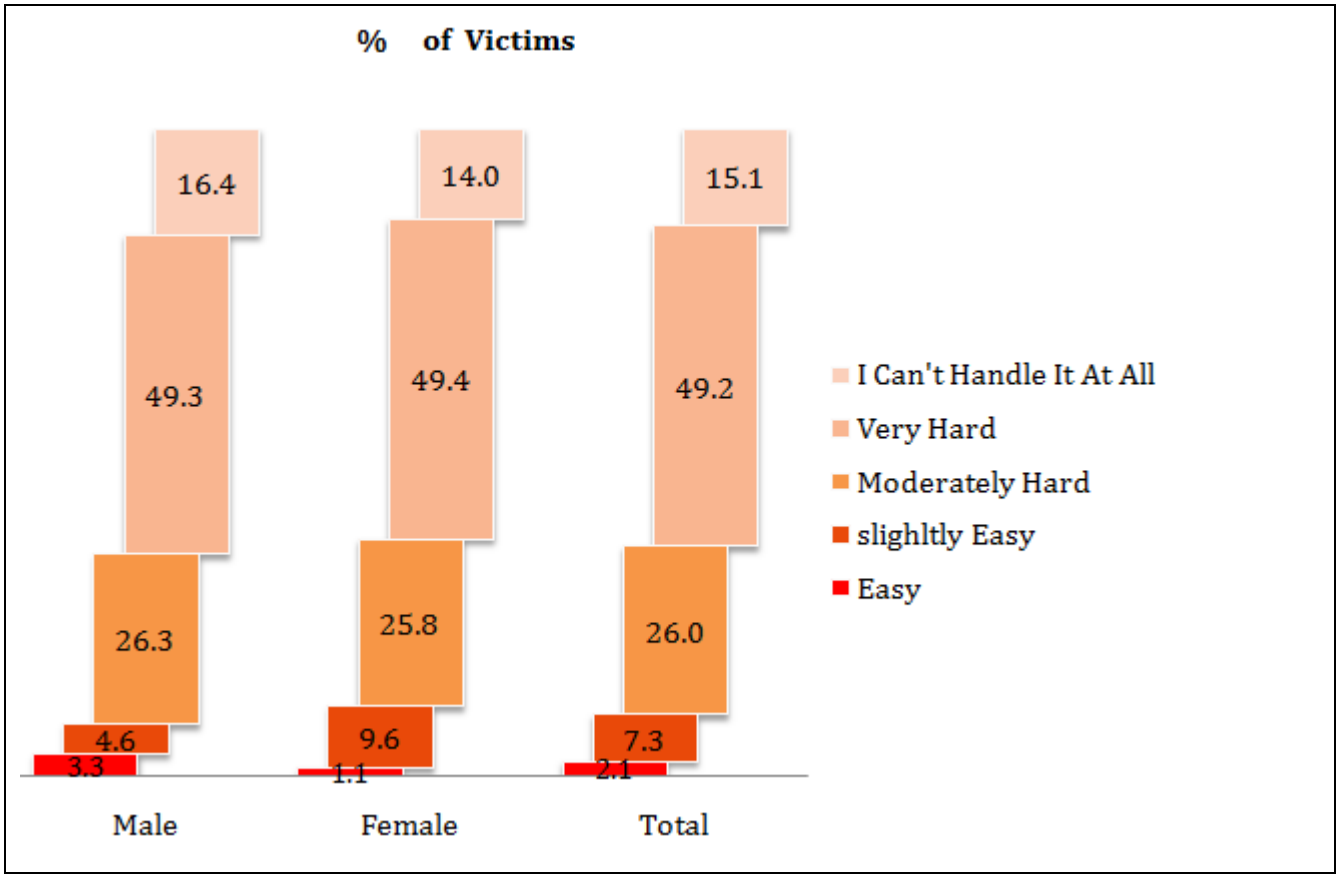


Severity of Complaints

When asked how heavy they felt their condition was, close to half (49.2%) of all patients confessed that their challenges were very hard, and almost two-thirds (64.3%) found their struggle to be either very hard or impossible to handle. As depicted in Figure 10, both males and females seemed to be relatively equal in their experience of such effects.

FIGURE 11A: SEVERITY

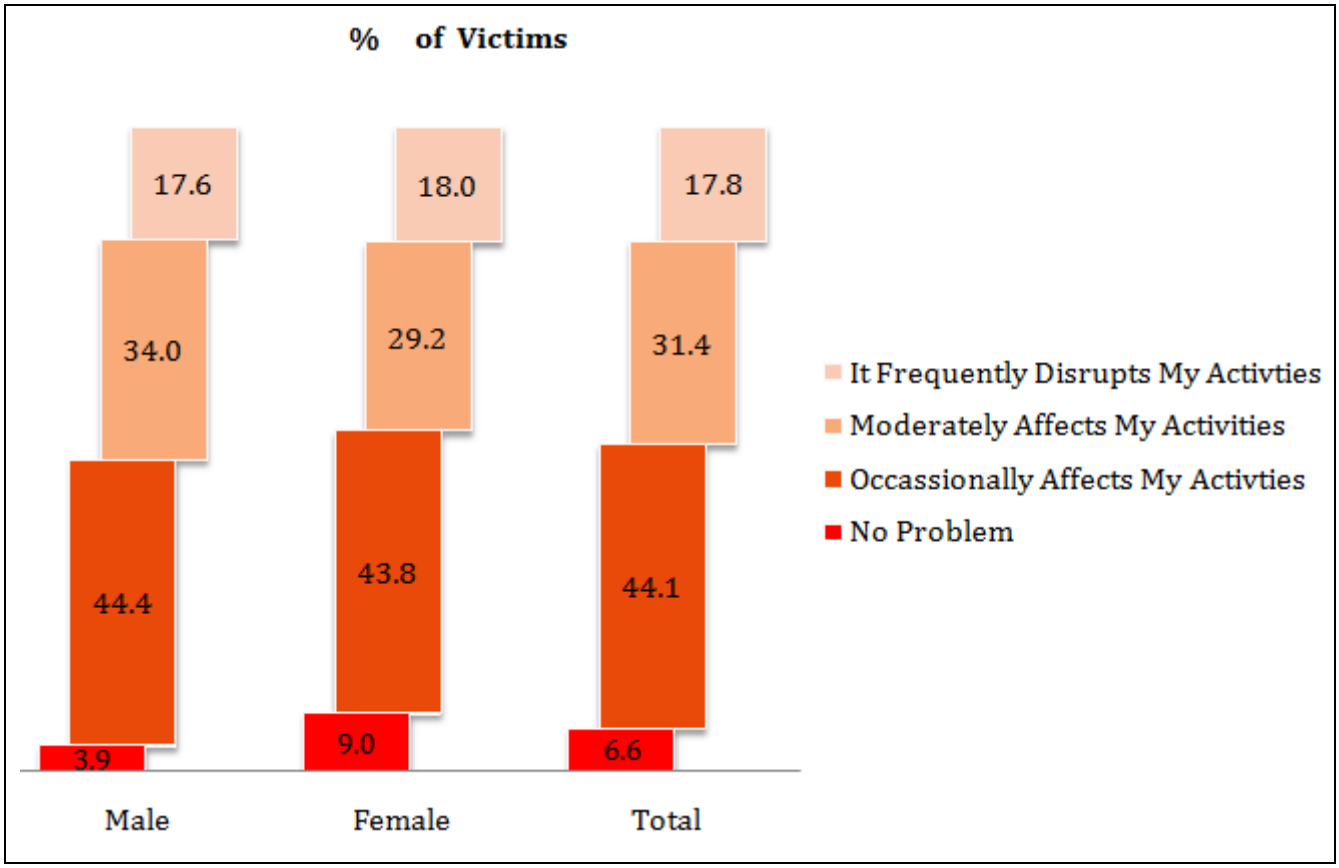
How heavy do you feel this situation/problem is for you?



Males and females also displayed similar characteristics in their response to whether their current challenges impacted their daily activities. There was some divergence, though, in the proportion of females admitting to having 'no problems' with their daily activities (slightly more than doubled their males counterparts at 9% compared to 3.9% of males). AYINET does not attribute this difference to females being less affected, but rather sees a distinction in the fact that women were typically the ones responsible for their families. These women, therefore, often ignored their pain and struggled from dusk till dawn to make sure food was put on the mat to feed their dependents, as men sat at home revisiting the topic of property and assets lost due to the LRA war.

FIGURE 11B: EFFECTS ON DAILY ACTIVITIES

How is it for you to carry out your daily activities?



Psychological harms generally affect the socio- economic wellbeing of the victims. The loss of respect by the society, isolation, stigma and feeling of worthlessness is the result of mental health related problems suffered. Women especially feel more challenged in their community to stay and feel accepted; this sometimes is made worst if these are sexually abused mothers having children born of rape who may never be accepted by their close relatives. Reduced productivity due to mental incapacity peaks the economic challenges. The extreme cases like psycho somatic situations lead to loss of income.

TREATMENT OF PHYSICAL INJURIES

Christine, 40 years old at the time of interview in 2012, was taken captive in 2002 by the LRA. She was subjected to brutal torture and was gang - raped in front of an assembly of LRA onlookers. She later became a forced wife to one of the rebel commanders. After more than two and a half years in captivity, she escaped during a UPDF attack (in mid-2004):

"After my escape, I found out that I had contracted HIV. I suffered serious abdominal pains and headaches. Actually I felt I was a few days to die. But then I connected with AYINET, and had an operation to relieve my stomach pains. The pains came back, so I was taken for a second operation. The very day I left the hospital that second time, that was the end of the pain. I have six dependents who were orphaned after the LRA killed my brother. So now I'm struggling with finding something to eat and paying for their schooling, but the pain is gone. AYINET has added me another 40 days".

John, 56 at the time of interview, was abducted by the rebels one night in 2002. They took him about 100 meters from his home, placed a gun against his face and shot him in the jaw. The bullet ripped off part of his tongue and shattered his jawbone. John spent the next six months in Kalongo Hospital, and with support from World Vision, was able to receive reconstructive surgery. Although the surgery was largely successful, the doctors could not keep the saliva in his mouth:

"I used to not come into the public. I couldn't even have time to chat with my friends. I was lonely, always worried. There was too much stigma. But then AYINET came to our community, and said they could help. After the operation, the saliva stopped flowing. From the time I came back, I've been talking, happy, feeling life so good".

Like Christine and John (and as indicated by Figure 1), the majority of victims survived with their physical injuries and psychosocial complications for years prior to AYINET's intervention. Patients voiced not only the pain and debilitation of living with such afflictions for so long, but the significant delay in treatment also exacerbated the extent of their injuries and ultimately led to greater impediments in the capacity and cost of rehabilitation. Moreover, there remain thousands of still unassisted victims who have lost hope of ever receiving medical care for their

injuries. Of the patients seen by AYINET, more than two thirds (70.7%) had not received any prior medical assistance for their respective injuries, despite several visits to government health centers and hospitals. This was not by choice. Many of the victims are very poor peasants who can hardly meet their daily domestic needs, let alone cover the medical expenses required to treat their complicated injuries. Of the relative few who did receive prior treatment (29.3%), five in six reported being treated by the GoU, although most were less complicated cases and virtually none of the patients (98.9%) received follow up care. Further, the fact that these patients were still in need of treatment for injuries sustained during the conflict highlights that the treatment they received was, at the very least, incomplete.

TABLE 6A: DID THE PATIENT RECEIVE MEDICAL HELP AT THE TIME OF INJURY

	Frequency	Percent.
No	406	70.7%
Yes	168	29.3%
Total	574	100%

TABLE 6B: IF YES, WHO PROVIDED THE MEDICAL ASSISTANCE*

	Frequency	Percent.
GoU	142	84.0%
NGO	6	3.6%
Private (self)	21	12.4%
Total	168	100%

***Medical assistance provided to 29.3% of the victims only**

AYINET's goal is to provide the necessary physical and psychosocial care for victims of serious crimes and harms arising out of the conflict between the GoU and the LRA in Northern Uganda.

Child burn victim after treatment has released her contraction

Figure 12A highlights the number of patients that have received complete treatment and those that await further assistance for their injuries. Figure 12B breaks down the completed and pending treatments by type of injury. The majority of surgical cases presented – including retained bomb fragments or bullets (138), contractions due to burns (70), discharging hypertrophic scars (31), and chronic osteomyelitis (30) – were supported with medical and surgical rehabilitation. Victims with double complications include fistula (30), disabled body parts (17), fixed knee joints (16), malignant growths (8) and mutilations (7), among others, although each was typically given basic counseling and non-surgical treatments.

FIGURE 12A: INJURIES AND IF RECEIVED TREATMENT BY AYINET

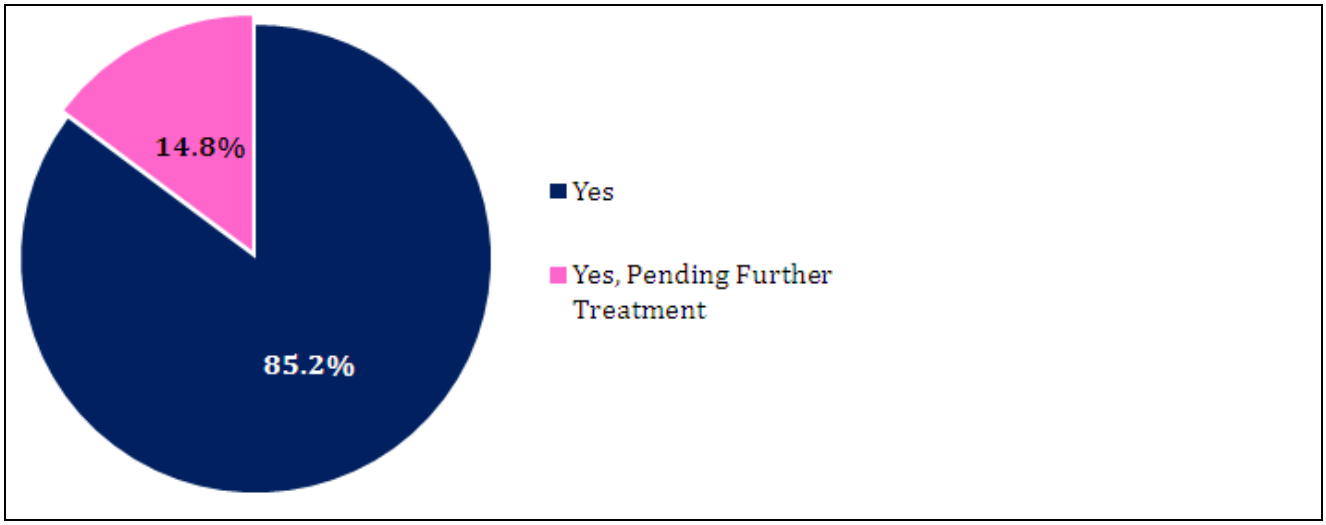


FIGURE 12B: INJURIES AND IF GIVEN TREATMENT BY AYINET (589 Cases)

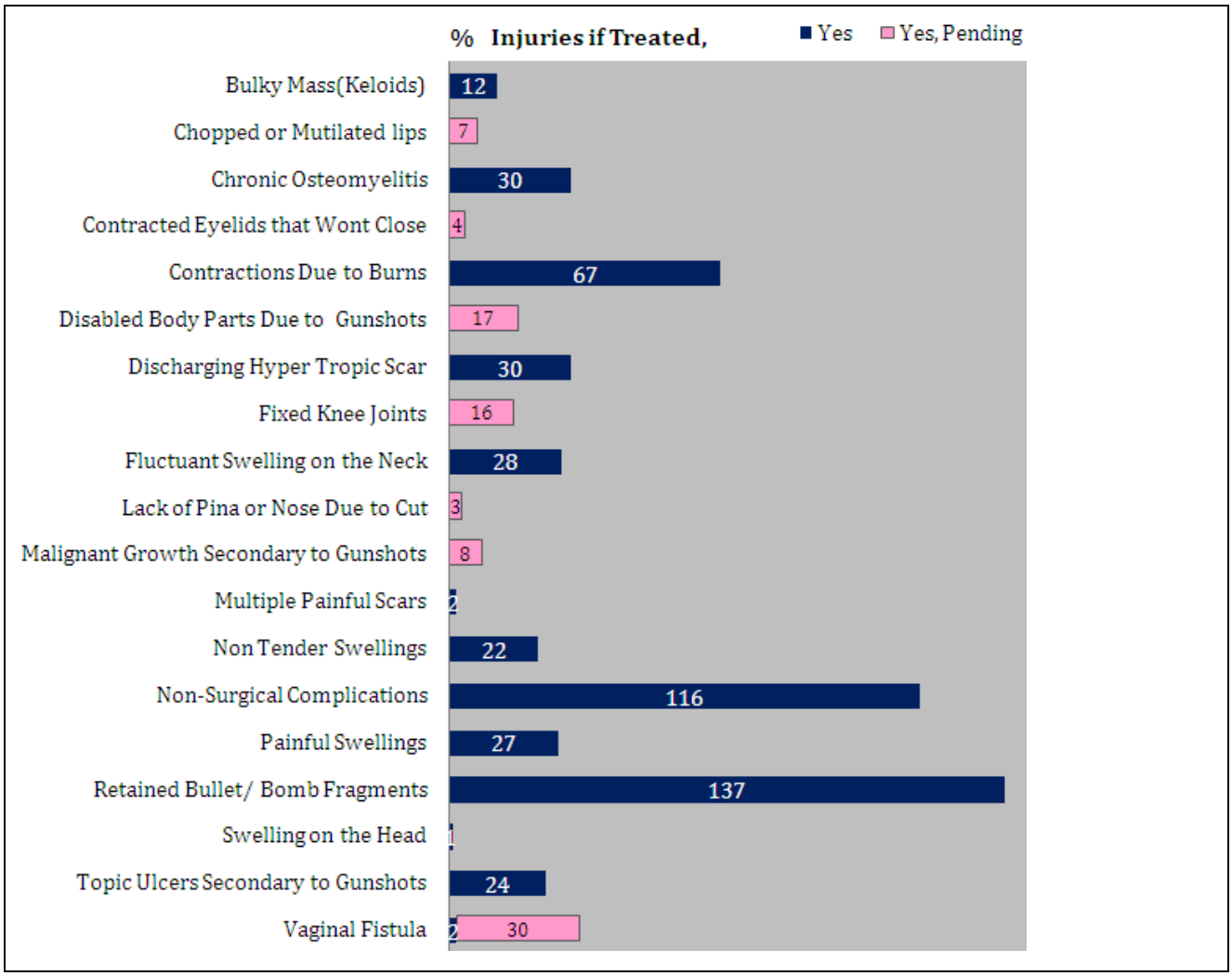
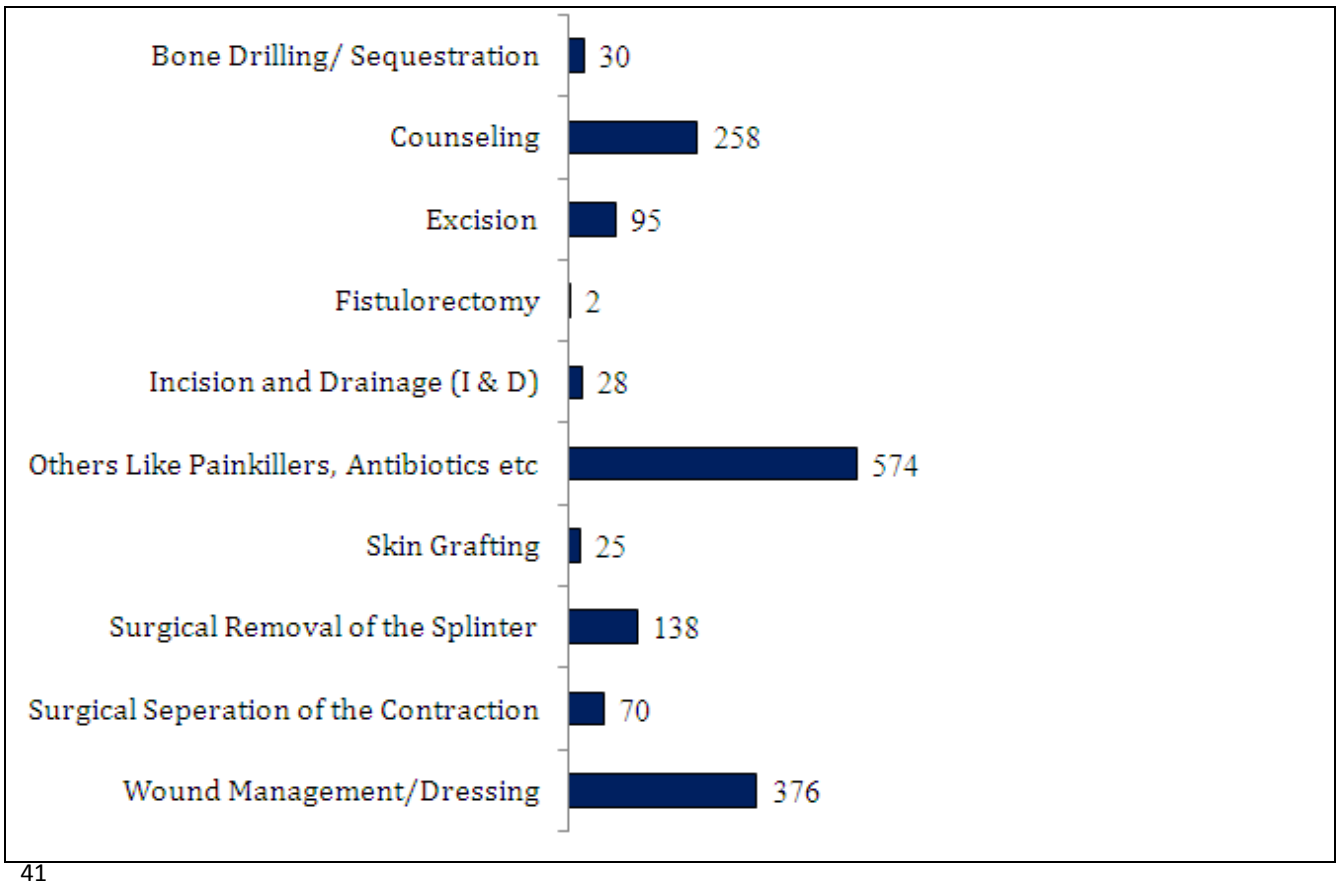


Figure 13 presents the types of medical treatment recommended by clinical medical officers and doctors that AYINET was able to offer to its clients. Each of the 574 victims was given laboratory investigations and applicable therapeutic medicines. A large proportion of the patients with physical injuries were given psychosocial counseling (316) and many also received basic counseling related to their physical health complications (258). 138 cases of retained bullets and bomb fragments were surgically removed, while 70 cases of contractions due to burns were surgically separated to reintroduce patient mobility. 30 cases of chronic osteomyelitis were addressed through bone drilling and sequestration, and excision was used to attend to multiple cases of discharging hypertrophic scars (31), painful swellings (27), non-tender swellings (22), keloids (12), multiple scars (2) and swelling on the head (1). Two young girls with fistula cases were also given fistulorectomy. At least 30 sexual abuse cases are already waiting for the services in our camp, we have already consulted the gynecologists who will conduct the medical rehabilitation and their treatment details shall be included in the next UN-PBF report. Almost all surgical treatments (96.9%) were given wound management and dressing, and all (100%) of the clients recovered from their procedures. Follow-up visits, health reviews and evaluations continue, but thus far no complications have been reported during the follow-up visits.

FIGURE 13: TREATMENT GIVEN (1596 medical treatments given to the 574 patients)



Treatment by Sex

Table 4 compares completed cases with those that still require additional treatment, broken out by sex. Of the 255 females screened, 196 (76.9%) received medical care to treat their underlying physical injury, while 293 of the 319 males (91.8%) received the same. This difference is largely explained by the fact that 30 cases of fistula repair were yet to be conducted, as the expertise and cost necessary for such a procedure were not readily available to AYINET (the treatment of those cases will occur within a few months after this report is presented). With those cases accounted for, the percentage of females completing treatment would rise to 88.6%, bringing it more in line with the percentage of males completing treatment.

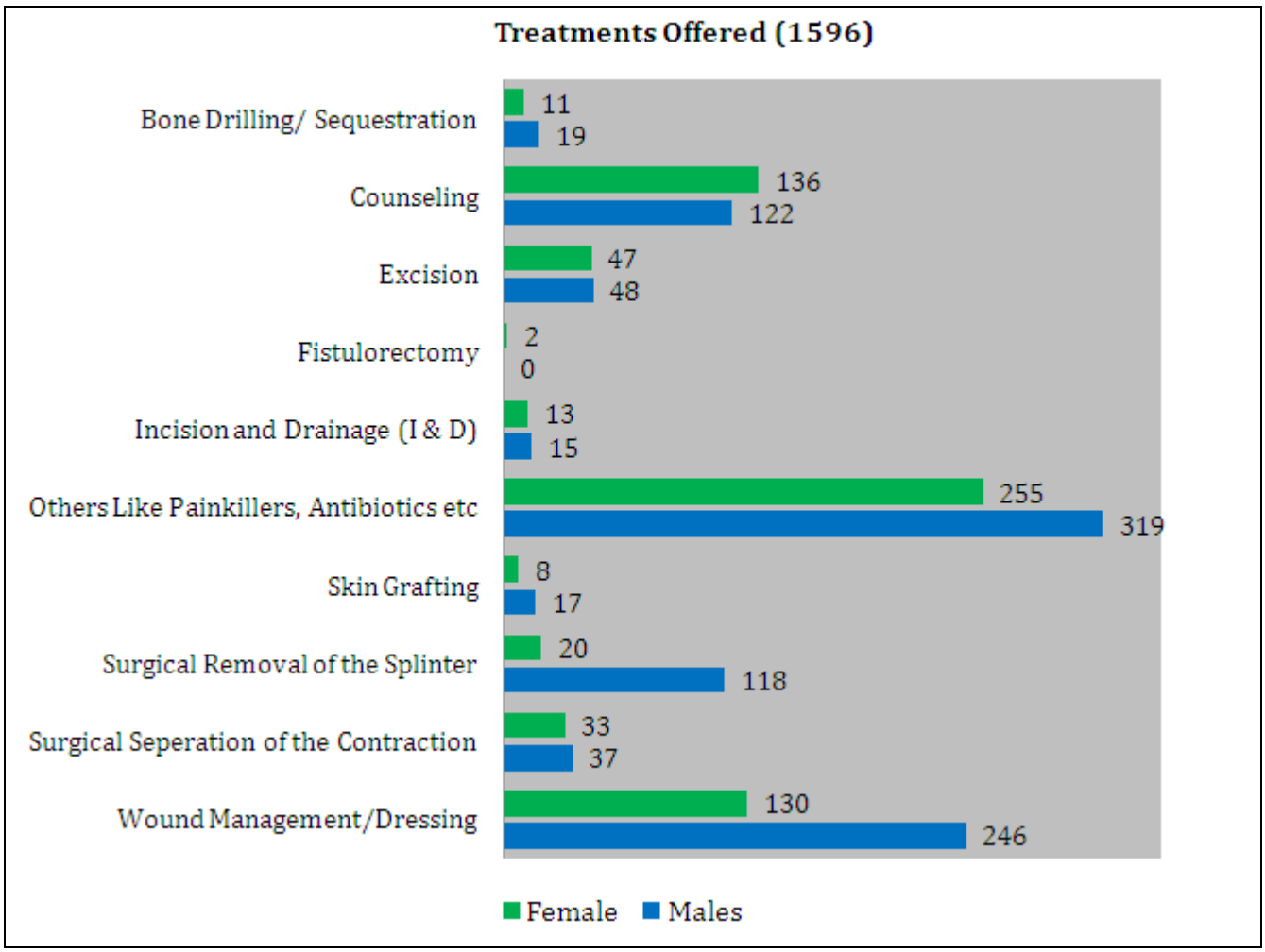
TABLE 7: TREATMENT BY SEX

	Sex of Victims		
If Treated	Females	Males	Total
Yes, Pending Next Treatment	59	26	85
	23.1%	8.2%	14.8%
Yes	196	293	489
	76.9%	91.8%	85.2%
Total	255	319	574

Figure 14 highlights the types of treatment required by AYINET patients, as well as what has been provided to them and approaches. 327 injuries were screened from the 319 male victims, of which almost nine out of every ten (293) received full medical rehabilitation. 262 injuries were screened from the females, of which three quarters (74.8%) received full treatment.

Notably missing from Figure 14 is the lack of treatment available for most cases of vaginal fistulas, disabled body parts, fixed knee joints and mutilations. This is due to the high monetary cost and sophisticated nature of each of these surgical operations, which is difficult to obtain in the country.

FIGURE 14: TREATMENT BY SEX (1596 Treatments)



Treatment by Age Group

Table 5A shows the age group breakdown of patients at the time of consultation. There were 87 children, 210 youths, 169 mature adults and 108 elderly victims screened during the project. AYINET has thus far been able to provide complete medical treatment to at least three quarters of all patients in each of the age groups.

TABLE 8A: PATIENTS TREATED BY AGE GROUP (at Time of Consultation)

	Age Group of Victims – 2011				
If Treated	Children <=17	Youths 18-35	Adults 36-50	Elderly >50	Total
Yes, Pending Next Treatment	21	28	20	16	**85**
	24.1%	13.3%	11.8%	14.8%	14.8%
Yes	66	182	149	92	**489**
	75.9%	86.7%	88.2%	85.2%	85.2%
Total	**87**	**210**	**169**	**108**	**574**

Table 5B re-examining patients treated from the various age groups based on the time the injury was sustained. This comparison sheds light not only upon the asymmetrical effect upon children and the youth throughout the conflict, but also upon the inordinate delay (from years to decades!) between the time of injury and the time of received treatment for the vast majority of patients.

TABLE 8B: PATIENTS TREATED BY AGE GROUP (based on Time of Injury)

	Age Group of Victims –then				
If Treated	Children <=17	Youths 18-35	Adults 36-50	Elderly >50	Total
Yes, Pending Next Treatment	29	32	15	9	**85**
	14.9%	13.8%	13.6%	24.3%	14.8%
Yes	166	200	95	28	**489**
	85.1%	86.2%	86.4%	75.7%	85.2%
Total	**195**	**232**	**110**	**37**	**574**

Figures 15A and 15B showcase treatment and pending treatment cases by age group. Those screened that were children at the time of injury presented with 195 injuries, 165 (84.6%) of which have since been treated. Youths (18-35) at the time of injury exhibited 240 injuries, 207 (86.3%) of which have since been treated. The mature adults (36-50) at the time of injury revealed 115 injuries, 98 (85.2%) of which have since been treated. And the elderly presented with 39 injuries, 28 (72.0%) of which have since been treated. These figures differ slightly from those in Table 5B above, as they represent total injuries (589) whereas the table above is based on total patients (574).

Patient receiving surgical care

FIGURE 15A: TREATED CASES BY AGE GROUP (Based on Time of Injury) (504cases)

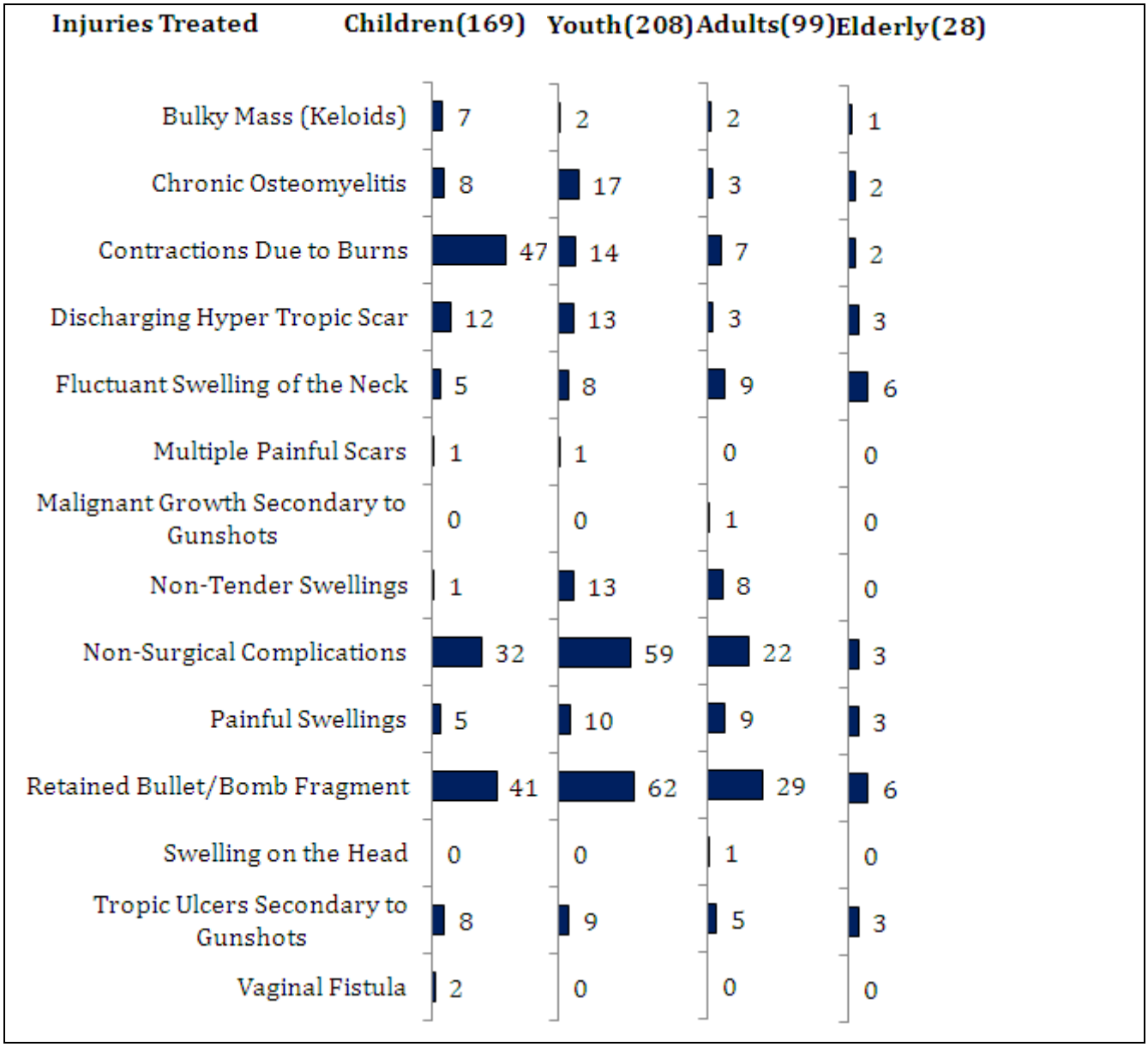
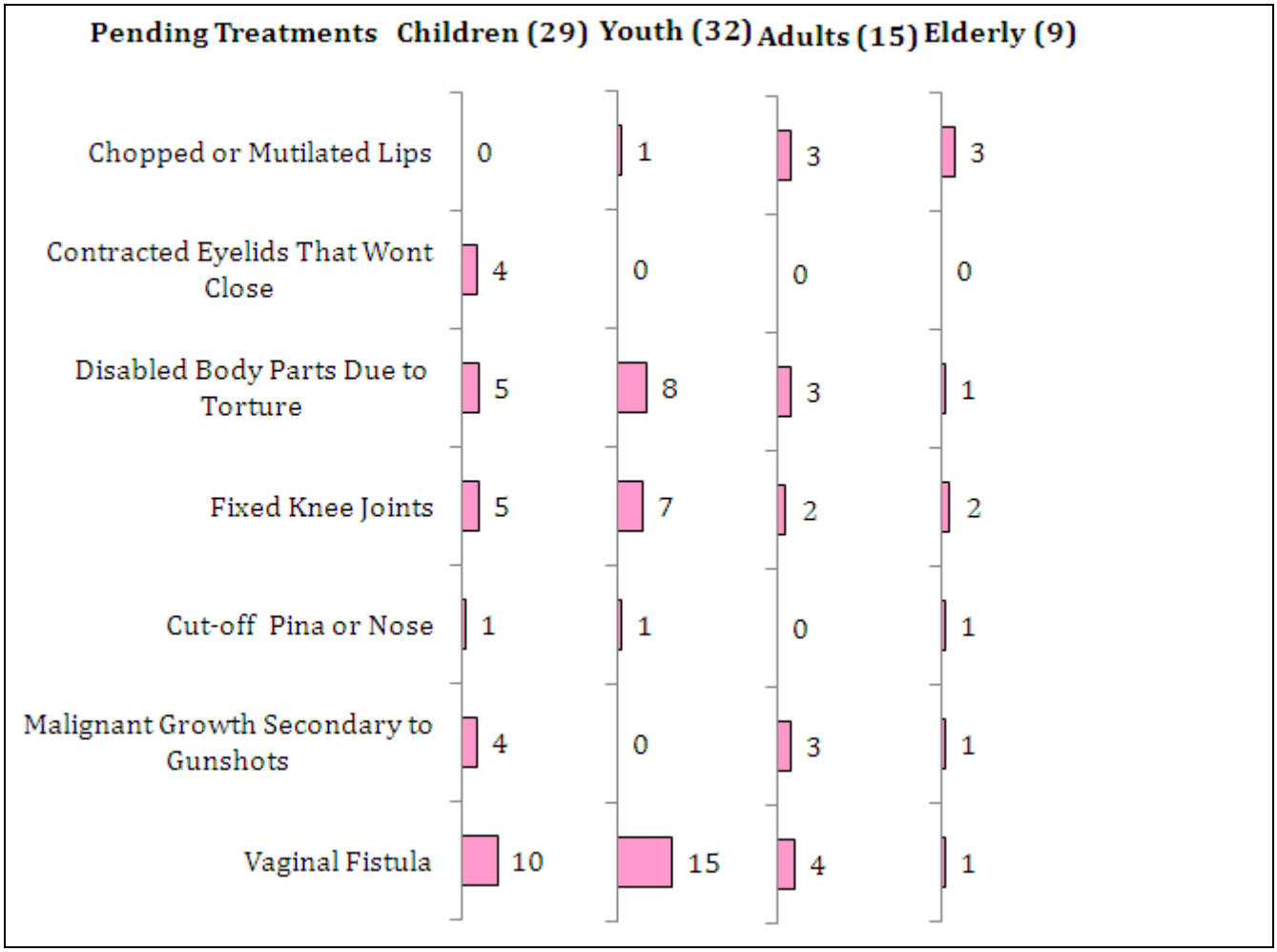


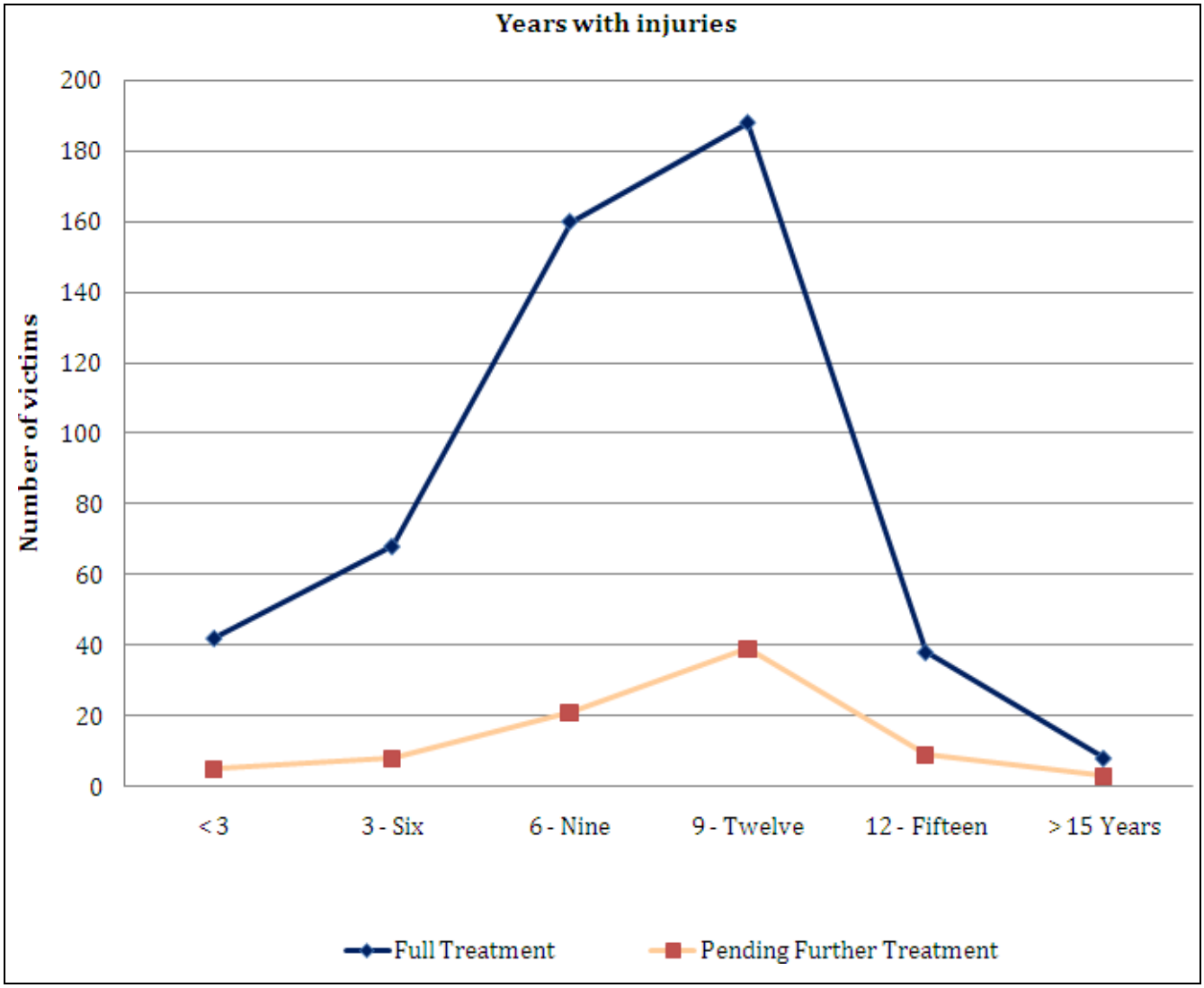
FIGURE 15B: PENDING TREATMENTS BY AGE GROUP (Based on Time of Injury) (85 cases)



Time between Injury and Treatment/Pending

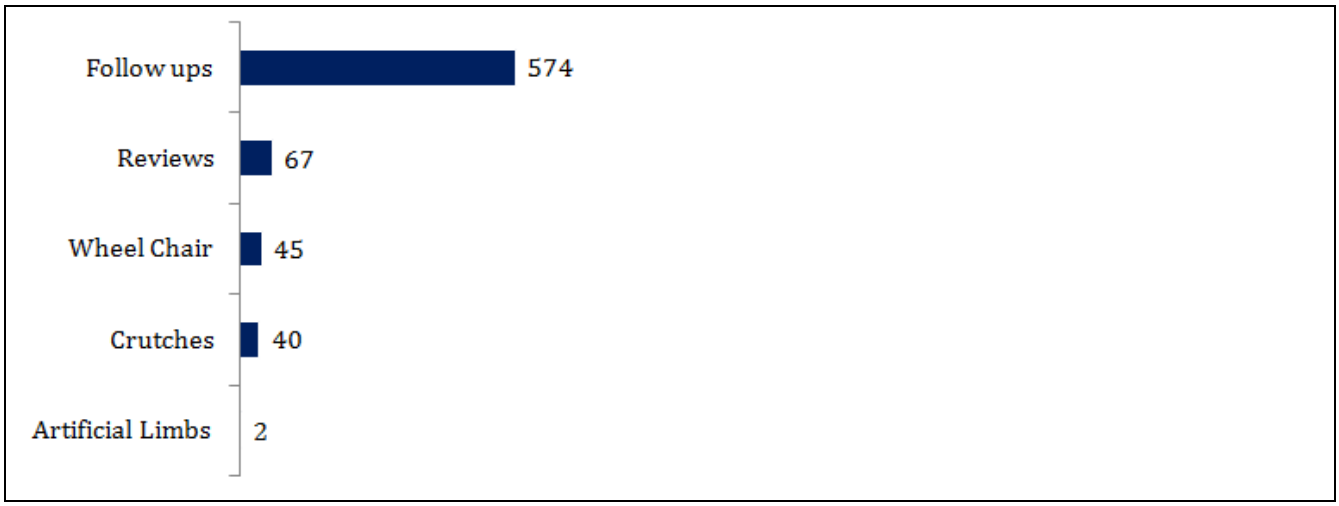
Figure 16 evidences the astounding length of time patients were forced to live with their injuries prior to receiving adequate medical care, with the average victim needing to wait 10.5 years. More than three-quarters (78.1%) survived with injures for greater than six years prior to treatment. For those still pending treatment, three-fifths have been waiting more than nine years, and 84.7% have waited more than six years. In the vast majority of cases, patient injuries only got worse with time.

FIGURE 16: AMOUNT OF TIME WITHOUT TREATMENT (through Dec 2011)



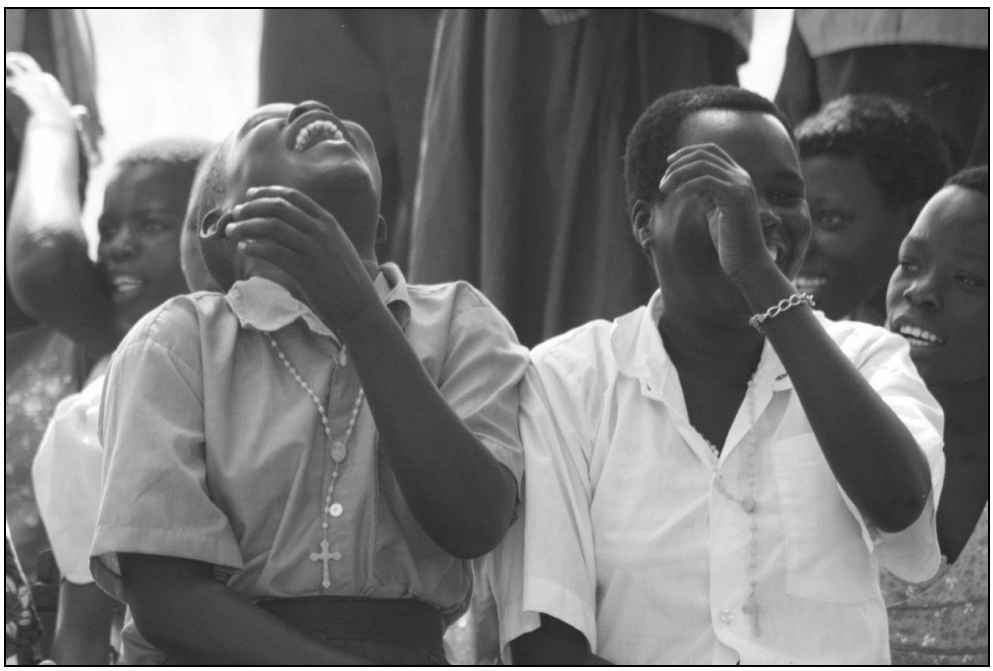
In addition to those surgical operations still pending (85), Figure 17 details AYINET's further recommendations for general and post-operation care required by the 574 victims assessed and treated (complete or partial) by AYINET. AYINET continues to conduct follow-up visits to patients who have recently been discharged from the hospital to assess their recovery. Placing a high value on post-treatment care, AYINET makes every effort to follow up with each of its clients to ensure that they adhere to proper wound management for the best possible recovery from their treatment. This has been found to be an important component of patient treatment, as most clients would abandon their wound care and contract secondary infections when not provided with active follow up.

FIGURE 17: FURTHER RECOMMENDATIONS



TREATMENT OF PSYCHOSOCIAL HARMS

AYINET firmly believes that physical healing and psychosocial wellbeing are mutually reinforcing. The team of AYINET counselors found that more than half of all patients (53.5%) exhibiting psychosocial harms were experiencing such challenges, at least in part, as a result of their physical injuries. In this way, treatment for a debilitating physical injury also has a healing effect upon a patient's psychosocial health. But even in the absence of a physical injury, AYINET mental health counselors strive to support their patients by listening to their stories and working with their patients to rediscover value in their lives.



Young women who received surgical treatment laugh during a group session with AYINET counselors

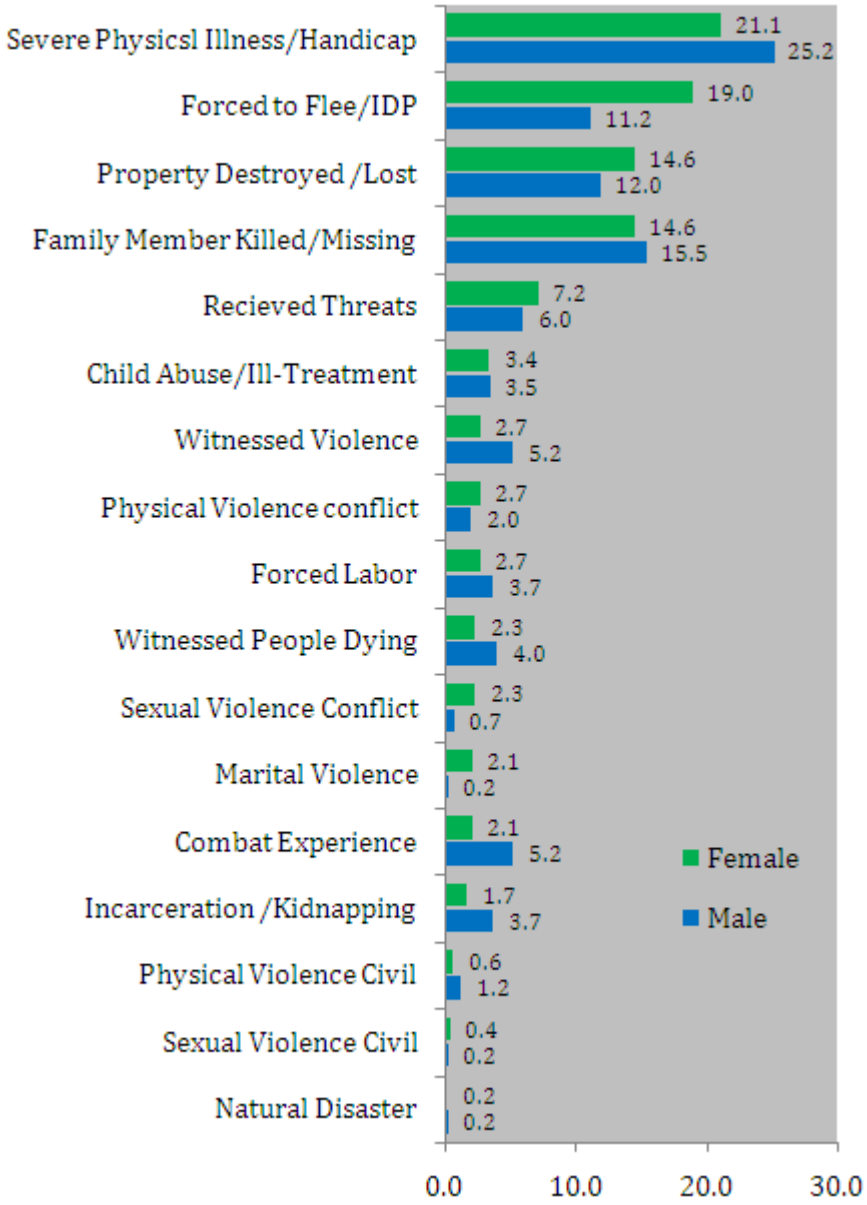
AYINET Counselor Jackson Opio explains,

We all have suffered differently. And focusing so much energy and worry can be debilitating. It affects productivity. It affects living. So we try to help patients attach value to what they have. We start by asking, 'What is your priority in sitting with me today?' They may talk about their physical injuries, or their material needs, and we try to help them, especially with physical rehabilitation. But in that session, we try to focus on their psychosocial wellbeing. We might ask the patient, 'Can you tell me anything that you are happy for?' And the patient may say, 'I'm glad to be alive.' Now that's quite a leg to stand on! And so we go from there.

Patients' Priorities

When asked by AYINET counselors to determine which three obstacles were presenting the greatest impediment to recovery, and which they would prioritize as most important to address, both male (25.2%) and female (21.1%) patients listed severe physical illness/handicap (23%) as their top priority. AYINET attributes these findings to the fact that physical disabilities are not only painful and limiting, but they also exacerbate the psychosocial harms being suffered by these victims. In addition to physical illnesses/handicap, being forced to flee/IDP (15.4%), killed/missing family member (15%) and loss/destruction of property (13.4%) were among the top impediments, with females placing more emphasis on the impact of being forced to flee/IDP than men (19.0% to 11.2%).

FIGURE 18: TOP EXPERIENCES OF THE PATIENTS

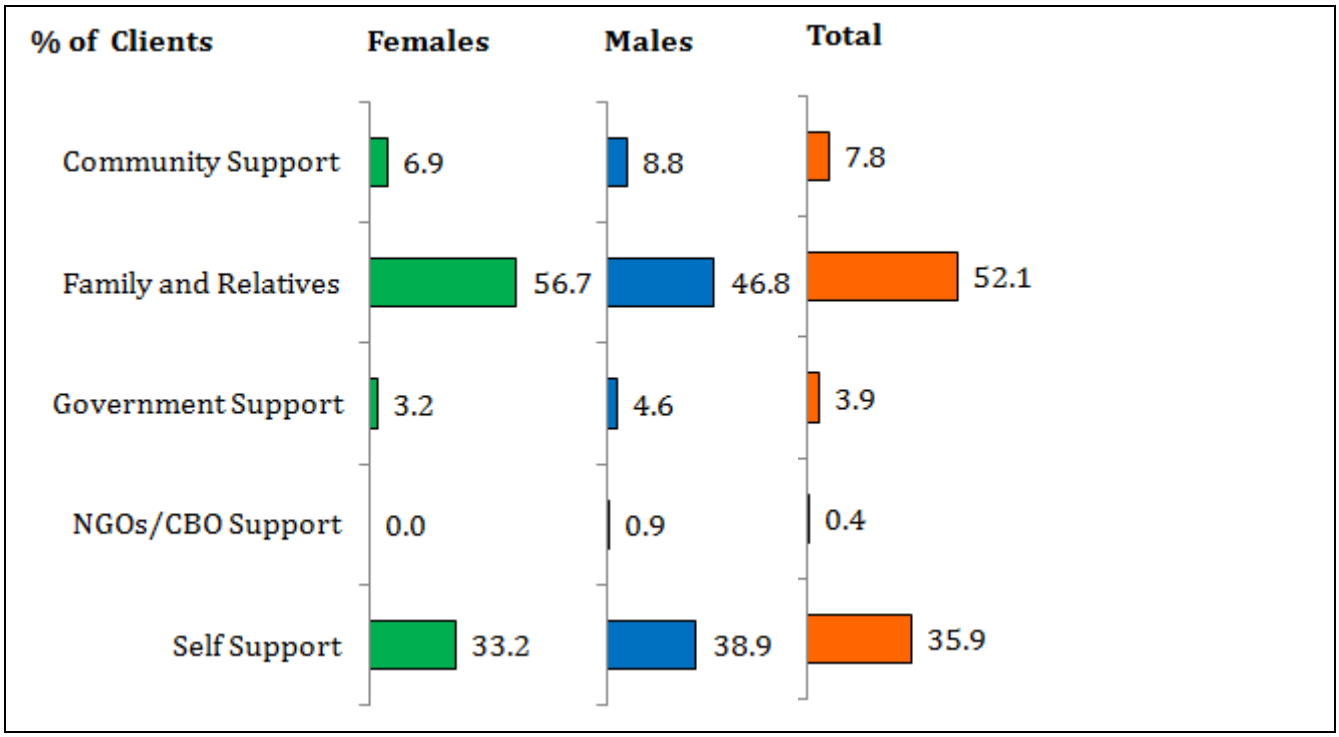


Functionality and Support for Patients

To better understand the severity of mental disability suffered by victims, and therefore the capacity of AYINET to support their psychosocial rehabilitation, AYINET counselors sought to assess patient response to areas of normal life. Encouragingly, almost half of the patients (41.9%) felt willing and able to seek support or services to enhance their situation (although that didn't necessarily imply that services were available). In seeking to understand what type of support network patients had to help them cope with their psychosocial challenges, AYINET counselors asked patients about support services in their communities. 88% of patients

identified either their families or themselves as their only available support. Less than 4% mentioned government services, and less than 1% looked to NGOs. We believe the reason why most of the victims don't count on NGOs is because there are very few NGOs focusing on medical rehabilitation of the victims in the region. Finally, as most of the victims are in the villages, they won't know of any services unless they are visited at their homes.

FIGURE 19: SUPPORT AVAILABLE TO CLIENTS



Goals of Counseling

AYINET counselors worked with their patients to mutually set goals for their counseling sessions. As depicted in Figure 20, building self-esteem (26%), improving stress management (19.8%) and restoring lost hope in life (12.9%) were the most frequently decided goals of counseling. These objectives reflect some of the major symptoms of psychosocial harms experienced by patients, including symptoms of depression, anxiety and PTSD (Figure 9). Notable differences in sex can be seen in the goal to restore lost hope in life, where the proportion of females (16.4%) almost doubled that of their male counterparts (8.4%). AYINET attributes this difference to the greater proportion of females exhibiting signs of depression (compare 41.6% females to 31.4% males, Figure 9).The counselors also set their own first plan of action based upon their assessment of each individual patient's needs. Figure 21 shows the restoration of hope (31.7%), establishment and development of self-esteem/confidence

(25.1%) and psychosocial health education (21.4%) as the top points of emphasis in the counselor's efforts to assist patient recovery and rehabilitation.

FIGURE 20: GOALS OF COUNSELING

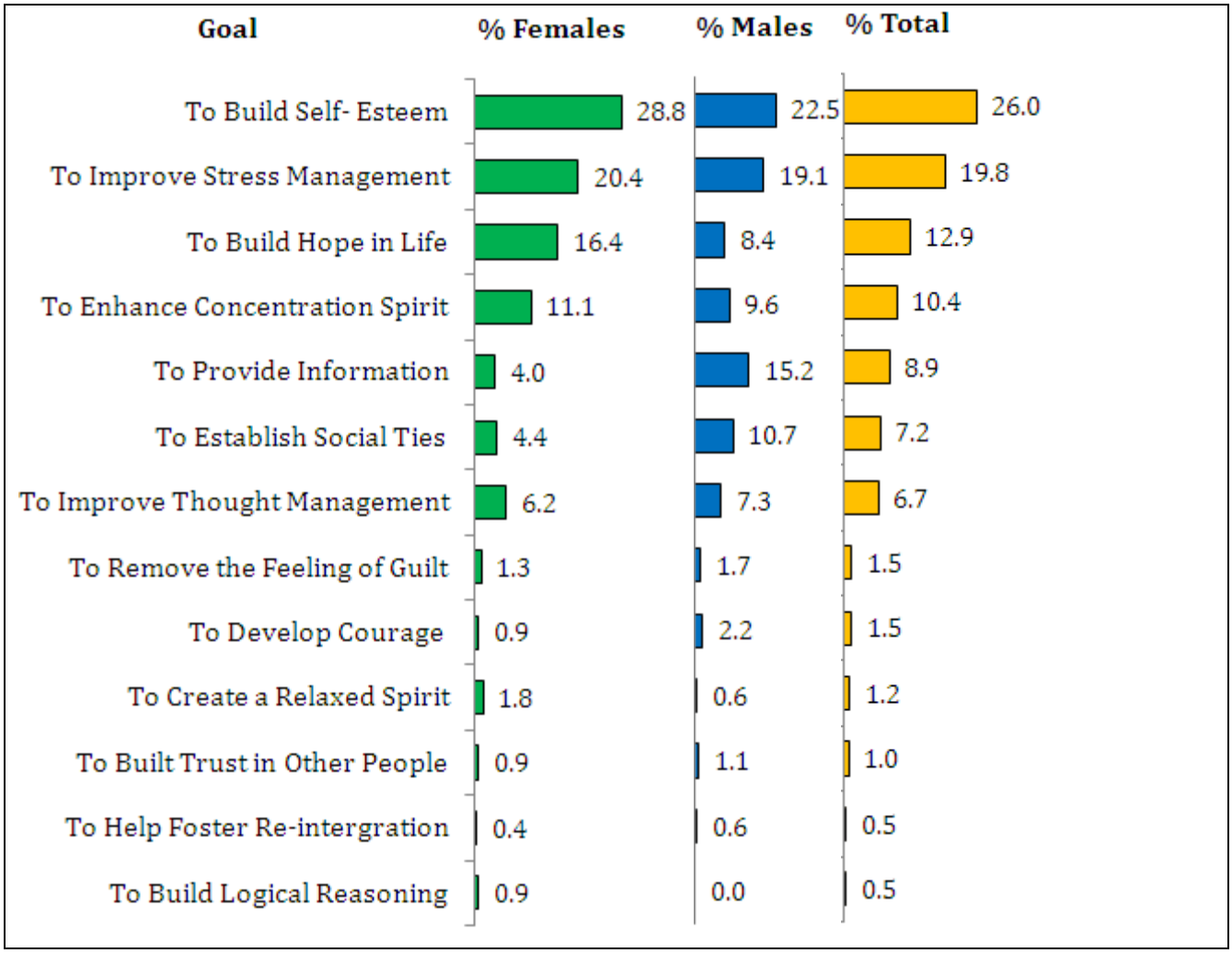
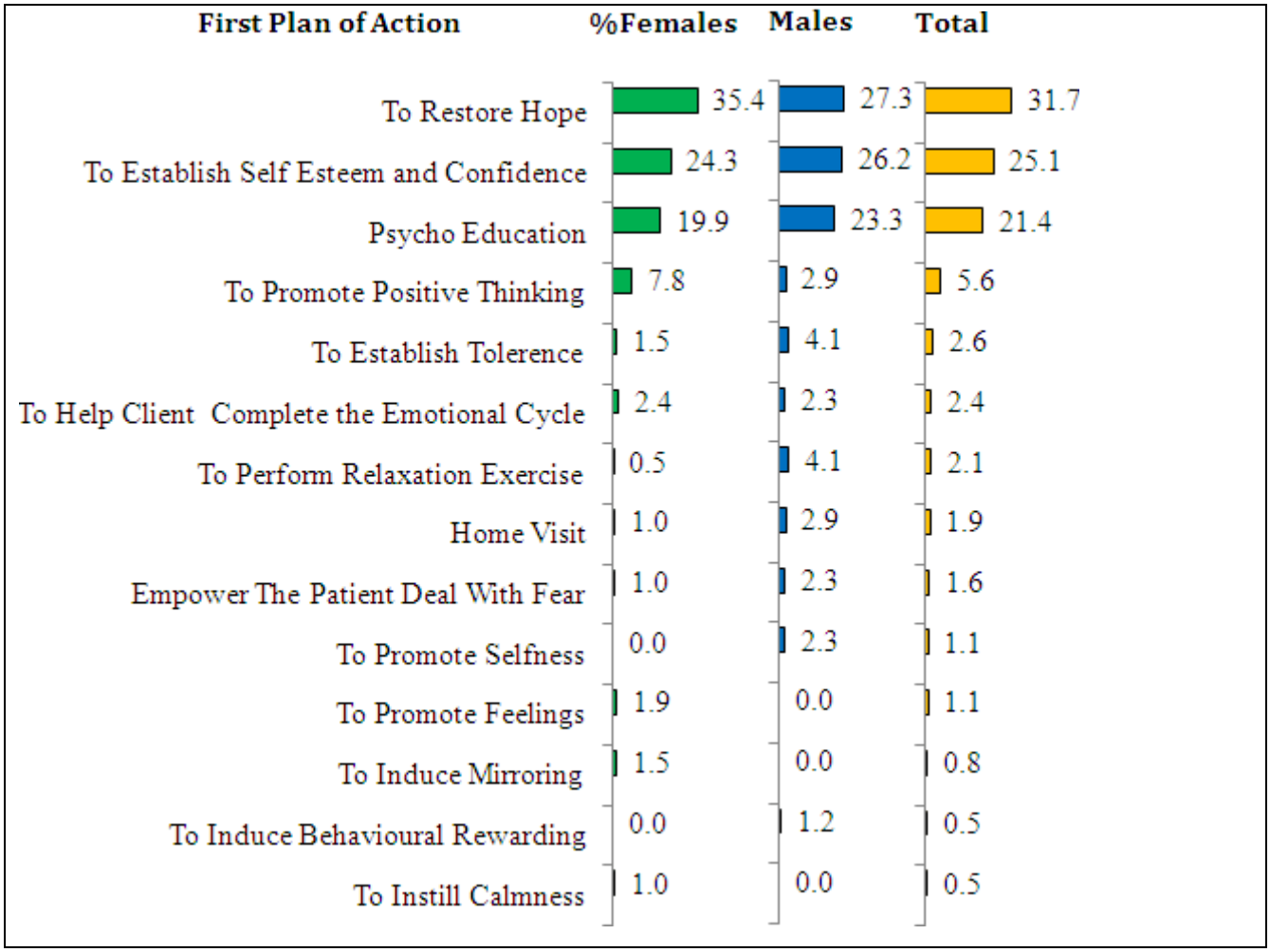


FIGURE 21: FIRST PLAN OF ACTION UNDERTAKEN BY COUNSELOR AND CLIENT/VICTIM



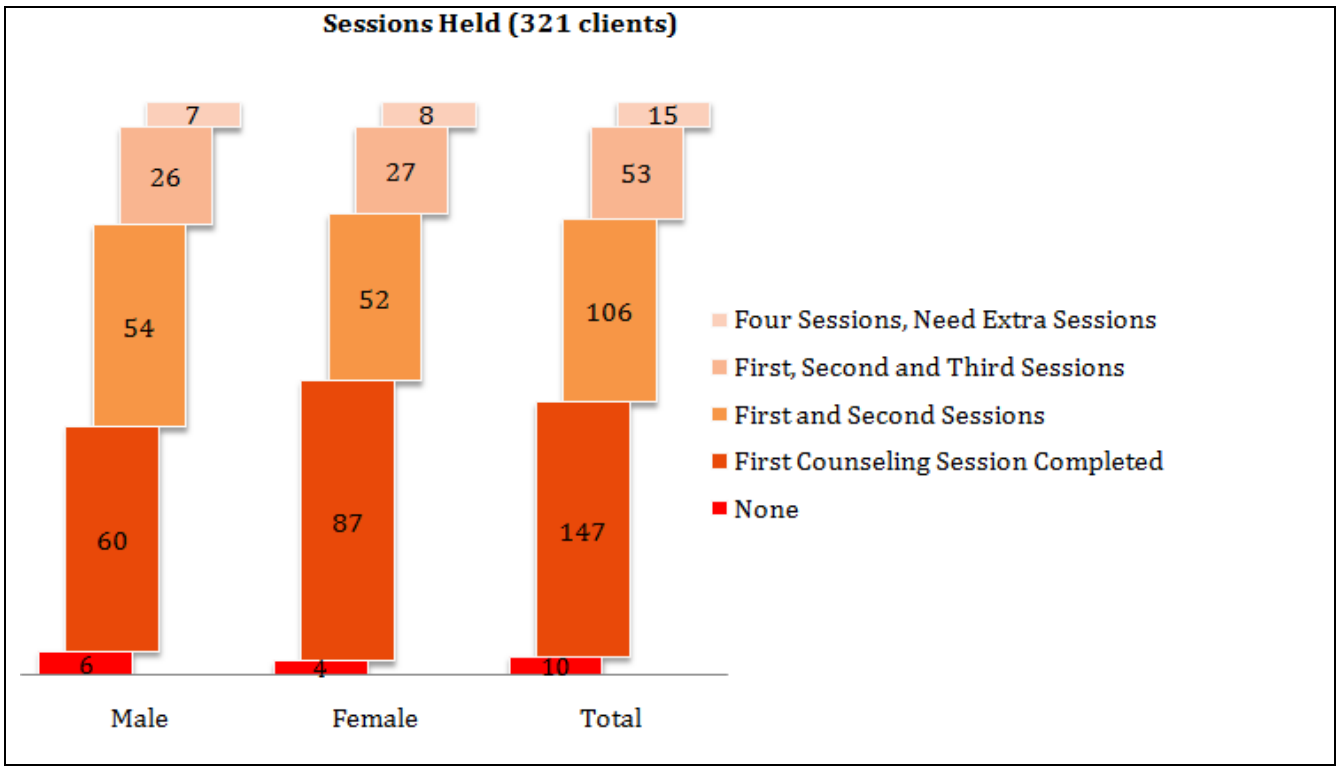
Counseling Sessions Held

The provisional number of counseling sessions to be held with each client has depended largely on the severity of psychosocial harms exhibited. The first sessions were usually very exploratory and covered the counseling goals and first plan of action to be undertaken by counselor and patient. At the time of writing, 578 counseling sessions had already been completed with 321 clients -- 147 clients had completed their first session, 106 completed their first and second sessions, 53 completed three sessions and 15 were in need of additional counseling after completing four sessions.

AYINET notes that patients with greater economic wellbeing and physical health typically had higher coping speeds than those less fortunate. Most of these (former) clients were already feeling better after the completion of their first and second sessions. With the exception of

those patients exhibiting extreme psychosocial harms (like psycho somatic symptoms), AYINET found that most of the more destitute patients would rather ignore their psychosocial challenges in the presence of a physical disability. AYINET believes that this is due to the challenges physical impediments place upon a patient's struggle to survive and accomplish his or her responsibilities. Such limitations, then, only serve to compound their manifestations of psychosocial harms. Therefore, the rehabilitation of one's physical health has been found to be the best mechanism to begin to address a patient's accompanying mental health complications.

FIGURE 22: SESSIONS HELD WITH CLIENTS



DIAGNOSES WITHOUT TREATMENT

Benedicto, age 45 in 2011, was abducted from his home in 2002:

"We were made to loot properties. I was carrying a bag of sugar, and was tied around the waist and to others in the group. Then there was a military ambush, and I was shot in the leg and then again in the shoulder. Amidst the fire exchange, it was difficult to tell if it was the LRA or the GoU".

The bullet in the shoulder blade never exited, and it continues to cause Benedicto a great deal of pain. AYINET took him in for an X-Ray, which showed the bullet to be deep, with fragments dispersed to multiple locations. The doctors determined that it was too dangerous to operate, and so there was nothing they could do but offer a short-term supply of painkillers.

"I used to rely much on agricultural produce, but now if I try to do it for longer hours, the pain is too much. It has impacted my domestic capacity. Alright, I'm a primary school teacher, but that money alone cannot be enough to support my dependents [Benedicto must take care of his wife, 4 children, and 3 children from his brother who was killed by the LRA".

For Benedicto, and the other remaining 85 patients, AYINET has been unable to offer complete medical rehabilitation. Each of the pending surgical cases requires extensive expertise, time and finances. After receiving counseling, laboratory investigations and other partial medical treatments (like antibiotics and painkillers), patients were unfortunately forced to wait again for proper surgical care. Thirty cases of vaginal fistula were pending gynecological repair, with only 2 women having received complete treatment. Seventeen patients with disabled body parts were awaiting physiotherapy and wheel chairs/artificial limbs. Sixteen patients with fixed knee joints were in need of orthopedic surgery. Eight patients with malignant growths secondary to gunshots and four patients with contracted eyelids were pending surgeries. Seven patients with mutilated lips and three patients with a lack of nose were awaiting plastic surgery.

MEDICAL REHABILITATION AS A FORM OF JUSTICE

Measures for Victims

AYINET Director Victor Ochen explained:

'People talk of justice for victims, but how can you realize justice when you have severe pain from torture or the stigma and pain of a fistula caused by rape? Creations of new courts, investigations into serious crimes committed, holding perpetrators accountable, victims' rights to remedy, these things are all important, but they may mean little if your health has been destroyed. Restoring victims' health must be a top priority in the work for justice, peace and development.' We must deliver justice beyond the court-room. Facilitate healings healing the hospitals and restore dignity; this is more practical human rights.

AYINET is committed to providing quality care to people who have suffered the worst harms as a result of the decades of conflict in the Greater North of Uganda. Believing in community-based care, AYINET not only works with local care providers whenever possible, but also galvanizes and rallies communities to join together in the reconstruction of the lives of their families and neighbors. Solidarity with victims and their families to realize their right to health is at the core AYINET's work.

There are very few locally-based organizations in Uganda that have taken AYINET's approach to systematically assist stigmatized, marginalized and hard-to-reach victims with serious injuries due to grave crimes and violations. AYINET sees its work as tightly interconnected to social justice. Other international organizations and actors working with victims of serious crimes and human rights violations often focus on legal justice, at times spending more energy and resources on bringing perpetrators to justice than on addressing the chronic medical and psychosocial needs of the victims of the perpetrators' crimes. AYINET concentrates instead on life-saving and life-altering interventions aimed at restoring victims' health, functionality and dignity.

Grace, a child victim of torture and mutilation, received medical rehabilitation and counseling that eventually enabled her to live without chronic pain and return to school

RECOMMENDATIONS

Based on the medical needs AYINET has documented, the following recommendations are presented to the Government of Uganda, Development Partners, the United Nations and national civil society partners:

1. Financial support for victims' medical and psychosocial rehabilitation and care should be prioritized and increased. Our finding shows that most of the victims have lived with chronic and debilitating pain for over 9 years and their untreated injuries worsen over time. It is imperative that the treatment of victims with serious injuries resulting from the conflict be prioritized. We estimate there are thousands of victims still in need of treatment throughout northern Uganda.

2. There is a need for increased and specifically earmarked funding for sexually related violence and injuries, as these injuries usually cost 5 to 10 times the amount of other injuries to successfully treat.

3. All Implementing Partners under PBF II should refer victims in need of medical assistance to AYINET and AYINET should be provided with the resources to care for those patients. In the past, AYINET has received many referrals, but has lacked resources to ensure proper treatment for all referrals.

4. There is a need to expand medical rehabilitation throughout northern Uganda, specifically including the sub-regions of Lango, Teso and West Nile, as thousands of victims in these areas remain injured, in pain and without treatment. There can be no factual or moral justification not expanding programming to other ethnic groups and sub-regions that have been significantly impacted by the LRA conflict.

5. All PBF II interventions in northern Uganda should coordinate with the Office of the Prime Minister, so that programs such as PRDP and NUSAF could complement areas where direct victims assistance is needed. This would also help strengthen response to victims' needs in the sub-regions of Lango, Teso and West Nile which are currently not catered for under PBF, yet which do require similar services that AYINET through the PBF is providing in Acholi.

6. There is a need for a comprehensive mapping of war victims from across northern Uganda. Such a mapping should include prevalence and incidence rates of serious violations and crimes and resulting harms among the different geographic, sex and age groups throughout the region; the services victims' need and what they have access to now; and any gaps between services and needs. A mapping is viewed by many victim-focused CSOs and government representatives, UN agencies and Development Partners as a needed resource that can provide accurate figures of persons suffering from various harms and the services they require. Such information would enable these actors to mainstream victim-centered programs into ongoing reconstruction and development programs.

Contact:

African Youth Initiative Network

(AYINET)

Plot 12, Otim Tom Road, Junior Quarter, P. O. BOX 981, Lira – Uganda.

Tel: **Mob**: +256772 539879, **Office**: +256473660170

Email: uganda@africanyouthinitiative.org, ed@africanyouthinitiative.org

www.africanyouthinitiative.org