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Centre for Children in Vulnerable Situations (CCVS)-Uganda

# Assessment report on mental health needs in Kitgum and Pader Districts

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## ACRONYMS

| | |
|---|---|
| CCVS | Centre for Children in Vulnerable Situations |
| GBV | Gender-based violence |
| FDG | Focus group discussion |
| KII | Key informant interview |
| MHPSS | Mental health and psychosocial support |
| PHC | Primary Health Care |

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## EXECUTIVE SUMMARY


The main purpose of the assessment was to map out the current needs for mental health support and rehabilitation services within the districts of Kitgum and Pader, and was intended to achieve the following specific objectives; (1) assess the mental health needs of the population, get insights into attitudes and knowledge on mental health, for whom (target groups) and in what places (locations); (2) collect relevant data and information on the current mental health interventions and resources, and how they are responding to the needs of the population; and (3) develop specific and reasonable actionable recommendations for ways in which gaps and bottlenecks can be addressed regarding mental health support and rehabilitation.

The assessment adopted a descriptive and cross-sectional study design. The study used a total sample size of 436 respondents (222 women and 214 men). Specifically, 300 respondents participated in a survey, 120 respondents participated in FGDs and 16 respondents were key informants. The study adopted both probability and non-probability sampling approaches with simple random, purposive and convenience sampling techniques used to obtain at least an unbiased information. Collection of findings was made easy by the use of a semi-structured questionnaire, FGD and key informant interview tool. Triangulation (quantitative and qualitative) analysis methods was applied to obtain information that was rich to inform the study. Excel was used to provide a descriptive analysis of the findings.

Findings from the assessment showed that, on average, 90% of the respondents strongly recommended a need for MHPSS services in their communities, connecting the most common causes of mental health problems to substance and alcohol abuse (15.9%), the effect of the LRA insurgency (13.2%), witchcraft (6.7%) and contagious diseases such as HIV (6.0%). Trauma was mentioned as the most common mental health problem within communities at 54.6% (respectively 70.6% in Kitgum District and 38.6% in Pader District), followed by substance and alcohol abuse at 17.6% (respectively 6.6% in Kitgum District and 28.6% in Pader District), and depression at 15.0% (respectively 17.4% in Kitgum District and 12.6% in Pader District). The most highly expectant MHPSS interventions in the two districts, according to the respondents, included psychological counselling (34.7%), psychotropic medication (10.0%) and livelihood support (35.3%).

Following the above findings, the following recommendations were made:

1. CCVS-Uganda will continue to offer counselling and guidance services to clients in the new project areas of operation; and
2. Both individual and group counselling services will be provided to the communities in Kitgum and Pader Districts.

Lessons learned from the practice of mental health in Lango Sub-Region will be transferred to Acholi-sub region to support CCVS-Uganda following its consistency with findings in Kitgum and Pader Districts. They include, CCVS-Uganda continuing to collaborate with the local leaders, health workers, youth leaders and cultural, among others, in its systemic approach of providing MHPSS services. With evidence of the data presented categorically between men and women, gender mainstreaming will be a component of CCVS-Uganda's gender analysis and programming, and CCVS-Uganda will ensure its partnership with other MHPSS partners are strengthened in and out of the field. It will also be necessary to provide trainings on PSS and continuous sensitisation and psychoeducation to stakeholders and the communities to improve of the knowledge on mental health and its referral systems, the Organisation shall incorporate gender mainstreaming in its gender analysis and programming.

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# 1. INTRODUCTION

## 1.1 Background

The World Health Organization published its Mental Health Global Action Plan in 2013 indicating that one out of four people will be affected by a mental health disorder at some point in their life. Scholars have estimated that one out of four families have at least one household member with a mental health disorder (MacKenzie, Kesner, Ball & Caddick, 2016). Moreover, mental health problems are on the rise and, by 2030, depression will become the leading cause of disability worldwide (World Health Organization, 2013).

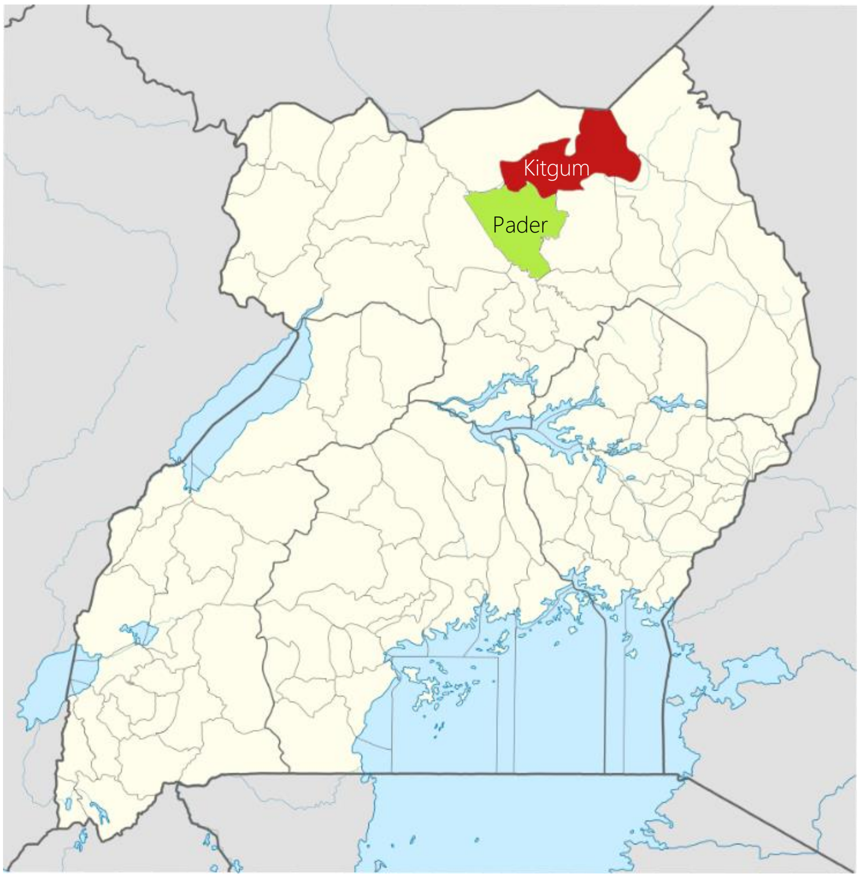
The burden of mental health disorders is disproportionally higher in low- and middle-income countries (LMICs), with 75 to 80 percent of all people with mental health problems living in these countries (MacKenzie et al., 2016; World Health Organization, 2017). Studies have also shown that the burden is also higher in countries affected by war and armed conflict. Recent studies estimate that about one out of five people suffer from mental health disorders in post-conflict settings (Charlson et al., 2019). The psychosocial consequences of war and armed conflict can unfold on both the short and long term, potentially threatening human rights, peace and development (Inter-Agency Standing Committee, 2007). Specifically, in the context of Northern Uganda, the psychological impact of over twenty years of armed conflict on individuals, families and communities is still continuing up to today. These effects become evident in the number of war-related physical injuries and mental health problems in Northern Uganda (Advisory Consortium on Conflict Sensitivity, 2013; Internal Displacement Monitoring Centre, 2014). Additionally, the breakdown of communities and social networks because of war, displacement and high poverty rates in Northern Uganda caused – and still cause – increased psychological stress in individuals, families and communities, resulting in a high prevalence of various mental health problems (e.g., trauma, depression, anxiety, complicated grief, ambiguous loss), social challenges (e.g., stigmatization of former child soldiers and victims of sexual violence), alcohol abuse, domestic and gender-based violence, and family breakdowns (Okello & Hovil, 2007; Vindevogel et al., 2011). Furthermore, the impact of war and armed conflict onto the social fabric of communities could potentially evoke the risk that long-term tensions in communities, which form the silent background of the conflict-related events, may resurge again and potentially cumulate into new violence and armed conflicts.

About three quarters of people suffering from mental health disorders and challenges have no access to MHPSS support, especially in low- and middle-income countries (LMICs) in which 75 to 90 percent do not receive services (Murray et al., 2015; World Health Organization, 2013). This is also the case in Northern Uganda where, despite high rates of mental health disorders due to collective violence (ranging between 25 and 67 percent [Mboyah, 2008; Ministry of Health, 2017; Mugisha et al., 2015]), there is a serious lack of (specialized) MHPSS support services because of, amongst other reasons, a lack of qualified counsellors and psychotherapists to support individuals, families and communities to deal with these problems (Mazurana, Marshak, Opio, Gordon & Atim, 2014) and many aid organizations closed office after the overt collective violence came to an end (Denov & Lakor, 2017; Internal Displacement Monitoring Centre, 2014). Consequently, a high burden remains for persons experiencing mental health problems, their families and communities in post-war Northern Uganda.

## 1.2 Assessment objectives

The main objective of the assessment was to map out the current needs for mental health support and rehabilitation services within the districts of Kitgum and Pader (see Map 1).

*Map 1: Kitgum and Pader District*[1]




[1] Adjusted from OpenStreetMap contributors. (2017, June 25). Kitgum District in Uganda. Retrieved from https://commons.wikimedia.org/wiki/File:Kitgum_District_in_Uganda.svg

### *1.2.1 Specific objectives*

Specifically, the assessment was undertaken to:

1. Assess the mental health needs of the population, get insights into attitudes and knowledge on mental health, for whom (target groups) and in what places (locations);
2. Collect relevant data and information on the current mental health interventions and resources, and how they are responding to the needs of the population; and
3. Develop specific and reasonable actionable recommendations for ways in which gaps and bottlenecks can be addressed regarding mental health support and rehabilitation.

# 2. METHODOLOGY

## 2.1 Study design

A descriptive and cross-sectional research study design was used to conduct the mental health needs assessment to obtain information concerning the current mental health needs and available mental health services of the people in Kitgum and Pader Districts. An extensive literature review about Kitgum and Pader Districts were undertaken to assess the specific areas to be included in the assessment. A cross-sectional research study was executed and a triangulation approach (i.e., methodological and data triangulation approaches) was employed to check data reliability and validity.

## 2.2 Study population

The study considered the following categories of respondents: (1) community members, (2) teachers, (3) health facilities' staff, (4) local leaders, (5) district officials and (6) opinion leaders from the sampled districts of study.

### *2.2.1 Geographical scope, time and location*

The study population covered the districts of Kitgum and Pader. Three (3) Sub-Counties from Kitgum, namely Mucwini, Orom and Lagoro, and three (3) Sub-Counties from Pader, namely Acholi bur, Pajule and Angagura, were selected by simple random sampling from a list of six purposively selected Sub-Counties. The same sampling strategy was applied to the Parishes and villages of study within the selected Sub-Counties.

## 2.3 Sampling procedure and techniques

This study used both probability and non-probability sampling approaches. According to Sekaran and Bourgie (2016), probability sampling designs are used when the representativeness of the sample is of importance in the interests of wider generalizability. The study adopted simple random sampling as recommended by Amin (2005) because the method avoids bias. In non-probability, the study adopted purposive and convenient sampling techniques because the study also included people that are critical for research (i.e., key informants).

More specifically, the following sampling techniques were used:

1. *Survey:* Each member of the population had an equal chance of being included in the sample. From the villages that were randomly selected, our mobilizers (LC1's) consulted a register of

members living within that village. The enumerator would spin a pen, which landed onto a specific name on the register who automatically qualified as our respondent. On completion of the interview of the first respondent selected, another spin was then done by the enumerator and the process continued until we met our targets for each village;

2. *Focus-group discussions (FDGs):* Various categories of respondents were included in the FDGs, such as teachers, household members, Village Health Teams, LC's (especially 1 and 2), youth leaders, members of women and male groups within the communities, health care providers and opinion leaders. The respondents had varying socioeconomic, demographic and geographical characteristics, such as age (from young adults to elders), gender, various target communities, various levels of education, living alone and living with family members (various family sizes), working and not working, and various marital statuses; and
3. *Key informant interviews (KII):* Psychiatric Nursing and Clinical Officers, District and Sub-County leaders, school leaders and mental health focal persons were selected purposively based on their knowledge on mental health needs in Kitgum and Pader Districts.

A total sample size of 436 respondents (Kitgum, n=218; Pader, n=218) provided a representative sample size for the needs assessment clearly described in the tables below. Lot Quality Assurance Sampling (LQAS) method (i.e., random sampling) was considered to map out the mental health needs of the targeted population. This is because it measures access, quality, use, health seeking behaviour and perception of the population regarding mental health.

## 2.4 Data collection methods and instruments

Quantitative and qualitative data was collected to provide rich and qualitative information from the analysis of the data. The data sources of the assessment included:

4. *Survey*[2]*:* A semi-structured survey was administered to obtain data. The semi-structured tool was built in tablets using a mobile application for data collection, Kobo Collect;
5. *Focus-group discussions (FDGs)*[3]*:* Focus group discussions (N=12; (Kitgum, n1=6 groups and Pader, n2=6 groups) and opinions and experiences on mental health needs, resources and practices in the communities were sought. The FGDs were conducted as follows:

[2] Refer to Appendix A.
[3] Refer to Appendix B.

- In each Sub-County, one group was composed of community household members and one group was composed of opinion leaders, local leaders, health facility staff and school staff;
- Each focus group consisted of 10 participants and discussions lasted for a maximum of one hour and thirty minutes; and
- Group discussions were conducted focusing on places like schools, communities and health facilities, and Sub-County headquarters. One data collector gathered the notes in hard copy while the group discussion was facilitated by another data collector;

6. *Key informant interviews (KII)[4]:* Sixteen (16) key informant interviews were conducted with participants selected purposively based on their knowledge on mental health needs and mental health in Kitgum and Pader Districts. Of these, twelve (12) were selected on Sub-County level and four (4) on District level. The data collector gathered the notes in hard copy; and
7. *Scientific reviews from the previous studies on the effect of the LRA insurgency.*

#### *2.4.1 Data collectors*

Trained data collectors selected from Kitgum and Pader Districts collected data with the support from mobilisers in the target areas. In its background, the two (2) days training and assessment aims were clarified, ethical principles and code of conduct including do's and don'ts, assessment methodology and data management, provision of basic counselling to respondents that were expected to break down among other critical areas during the training on the practical use of the tools. A pilot was conducted within Kitgum town among 24 persons (F=16; M=8) to provide corrective measures to re-framing some of the key questions in the survey questionnaire.

During data collection, tablets were used to collect survey data which was on a daily basis uploaded to the repository with the help of the M&E Officer upon its review every evening.

### 2.5 Data analysis

The aggregated data in the project repository was exported to Excel for verification of its completeness and accuracy, and coded, cleaned and analysed. Qualitative data was collected through FGDs and KII instruments to provide an in-depth understanding of respondent's behaviour and reasons surrounding such behaviour (see 2.4). Two (2) feedback meetings with data collectors (Kitgum=1 and Pader=1) were

[4] Refer to Appendix C.

conducted to minimise errors in data entry, to identify preliminary findings and to address the challenges noted during data collection.

Survey data was analysed at two levels, namely at

1. univariate level that involved generation of summary (frequency) tables and graphs; and
2. bivariate level that involved cross tabulations of variables.

In addition, discourse and content analyses techniques were used to analyse notes from FDGs and KIIs. Words, tones, reflections and opinion shifts during the discussions, frequency and intensity of comments, specifics, trends and iterations were typical of the data analysis. The content analysis technique was used to describe and interpret the quantitative findings from the survey data.

Tables, charts and respondent quotes and opinions of the respondents were used to describe the findings.

## 2.6 Ethical considerations

Permission to conduct the study was obtained from the District Health Officer (DHO) and the Chief Administrative Officer (CAO) of Kitgum District and Pader District for the respective areas of the survey.

Informed consent was sought from each respondent; their privacy and confidentiality of information obtained were safeguarded throughout the course of the study because names were not needed during the study and their participation in the study was voluntary. In addition, the data collectors ensured that the responses of each interviewee were confidential and were not shared with other interviewees in any location. Collected records were also submitted to the repository on a daily basis and no records of submitted data could remain in the tablets. In the event that some responses caused psychological discomfort (secondary trauma) to the data collector, the collector disclosed the nature of the case and sought for advice without disclosing the interviewees' personal information.

## 2.7 Study constraints and limitations

The assessment is constrained by the following limitations:

- In a few instances, respondents allocated inadequate time during the key informant interviews because of busy schedules;
- The study covered a small sample size which could undermine the generalizability of the study findings. However, a triangulation of data sources, including reviews of previous studies, survey data, and focus group discussion and interview transcripts, was utilized to increase the credibility of the study findings;

- The time frame allocated for data collection was rather short which had an impact on the quality of information collected;
- Very few mental health practitioners participated in providing situational analysis of mental health needs and resources in Kitgum and Pader Districts. The discrepancy between the approved and filled positions of mental health providers in the health facilities is high and findings would not provide the most accurate data for the study; and
- Few data collectors were used to support in the assessment in the distant areas of data collection. However, a manageable target was allocated to them.

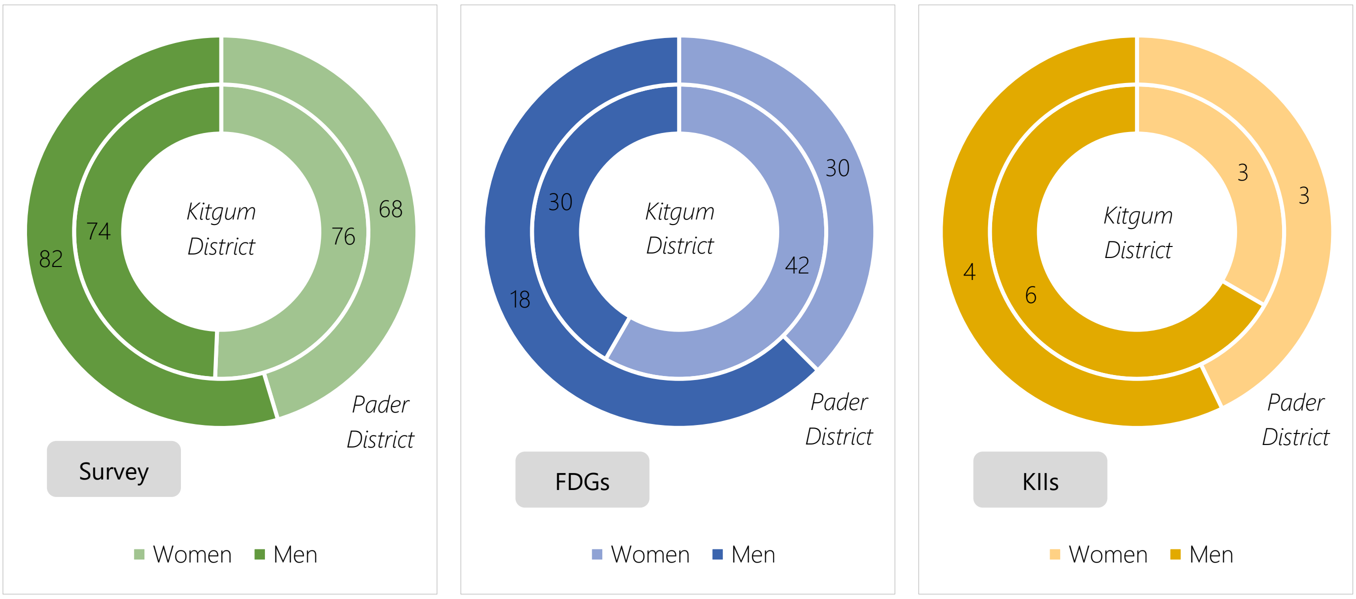
# 3. FINDINGS AND INTERPRETATIONS

## 3.1 Respondent characteristics

A total of 436 respondents (222 women and 214 men) took part in the mental health needs assessment in Kitgum and Pader District. Specifically,

- The survey was based on a total sample of 300 respondents. On average, 48.0% of the respondents who participated in the survey in Kitgum and Pader District were females and 52.0% were male respondents *(see Table 1)*;
- The needs assessment also considered responses from key informants (KIs; n=16 and comprised of 6 women and 10 men) and focus discussion groups (FGDs; n=120 which comprised of 72 women and 48 men); and
- In total, 49.0% of the male respondents and 51.0% of the female respondents in both Kitgum and Pader Districts participated in the surveys, FGDs and KIIs *(see Charts 1 to 3)*.

*Charts 1 to 3: Number of participants who took part in the survey, FDGs and KIIs*




The assessment was conducted in Kitgum and Pader District with three (3) sub-counties selected from each district. In Kitgum District, the Sub-Counties of Mucwini, Orom and Lagoro were selected. In Pader District, the Sub-Counties of Acholi Bur, Pajule and Angagura were selected.

*Table 1: Number of participants who took part in the survey*

| Row labels | # of women | % of women | # of men | % of men | # total | % average |
|---|---|---|---|---|---|---|
| Kitgum District | 76 | 52.8% | 74 | 47.4% | **150** | **50.00%** |
| Lagoro | 14 | 9.7% | 26 | 16.67% | **40** | **13.33%** |
| Mucwini | 47 | 32.6% | 32 | 20.51% | **79** | **26.33%** |
| Orom | 15 | 10.4% | 16 | 10.26% | **31** | **10.33%** |
| Pader District | 68 | 47.2% | 82 | 52.6% | **150** | **50.00%** |
| Acholi-bur | 19 | 13.2% | 23 | 14.74% | **42** | **14.00%** |
| Angagura | 17 | 11.8% | 18 | 11.54% | **35** | **11.67%** |
| Pajule | 32 | 22.2% | 41 | 26.28% | **73** | **24.33%** |
| **Total** | **144** | **100.0%** | **156** | **100.00%** | **300** | **100.00%** |

### *3.1.1 Age*

In Kitgum District,

- 28.9% of the female respondents were aged between 18-24 years old, 34.2% were aged between 25-34 years old, 17.1 % were aged between 35-49 years old, and 19.7% were 50 years and above; and
- 21.6% of male respondents were aged between 18-24 years old, 32.4% were aged between 25-34 years old, 31.1% were aged between 35-49 years old and 14.9% were 50 years and older.

In Pader District,

- 27.9% of the female respondents were 18-24 years old, 23.5% were aged between 25-34 years old, 32.4 % were aged between 35-49 years old, and 16.2% were 50 years and above; and
- 15.9% of the female respondents were 18-24 years old, 28.0% were aged between 25-34 years old, 35.4 % were aged between 35-49 years old, and 20.7% were 50 years and above.

*Table 2: Respondents' age*

| Age bracket | Kitgum District | | | | | | Pader District | | | | | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Female* | | *Male* | | *Total* | | *Female* | | *Male* | | *Total* | | *n* | *%* |
| | *n* | *%* | *n* | *%* | *n* | *%* | *n* | *%* | *n* | *%* | *n* | *%* | | |
| 18-24 years | 22 | 28.9% | 16 | 21.6% | 38 | 25.3% | 19 | 27.9% | 13 | 15.9% | 32 | 21.3% | **70** | **23.3%** |
| 25-34 years | 26 | 34.2% | 24 | 32.4% | 50 | 33.3% | 16 | 23.5% | 23 | 28.0% | 39 | 26.0% | **89** | **29.7%** |
| 35-49 years | 13 | 17.1% | 23 | 31.1% | 36 | 24.0% | 22 | 32.4% | 29 | 35.4% | 51 | 34.0% | **87** | **29.0%** |
| >50 years | 15 | 19.7% | 11 | 14.9% | 26 | 17.3% | 11 | 16.2% | 17 | 20.7% | 28 | 18.7% | **54** | **18.0%** |
| **Total** | **76** | **100.0%** | **74** | **100.0%** | **150** | **100.0%** | **68** | **100.0%** | **82** | **100.0%** | **150** | **100.0%** | **300** | **100.0%** |

### *3.1.2 Marital status*

In Kitgum District,

- 71.1% of the female respondents were married, 6.6% were separated, 15.8% were single, 6.6% are widowed and none of them were divorced; and

- 70.3% of the male respondents were married, 2.7% were separated, 24.3% were single, 2.7% were widowed and none were divorced.

In Pader District,

- 70.6% of the female respondents were married, 10.3% were separated, 14.7% were single and 4.4% widowed and none were divorced; and
- 1.22% of the male respondents were divorced, 79.3% were married, 19.5% were single and none were separated or widowed.

*Table 3: Respondents' marital status*

| Marital status | Kitgum District | | | | | | Pader District | | | | | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | *Female* | | *Male* | | *Total* | | *Female* | | *Male* | | *Total* | | **n** | **%** |
| | *n* | *%* | *n* | *%* | *n* | *%* | *n* | *%* | *n* | *%* | *n* | *%* | | |
| Divorced | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 0 | 0.0% | 1 | 1.2% | 1 | 0.7% | **1** | **0.3%** |
| Married | 54 | 71.1% | 52 | 70.3% | 106 | 70.7% | 48 | 70.6% | 65 | 79.3% | 113 | 75.3% | **219** | **73.0%** |
| Separated | 5 | 6.6% | 2 | 2.7% | 7 | 4.7% | 7 | 10.3% | 0 | 0.0% | 7 | 4.7% | **14** | **4.7%** |
| Single | 12 | 15.8% | 18 | 24.3% | 30 | 20.0% | 10 | 14.7% | 16 | 19.5% | 26 | 17.3% | **56** | **18.7%** |
| Widowed | 5 | 6.6% | 2 | 2.7% | 7 | 4.7% | 3 | 4.4% | 0 | 0.0% | 3 | 2.0% | **10** | **3.3%** |
| **Total** | **76** | **100.0%** | **74** | **100.0%** | **150** | **100.0%** | **68** | **100.0%** | **82** | **100.0%** | **150** | **100.0%** | **300** | **100.0%** |

### *3.1.3 Level of education*

In Kitgum District,

- 14.5% of the female respondents didn't attain any kind of education, 64.5% attained primary education, 18.4% mentioned "O" level education, 1.33% attained "A" level tertiary/college/university level of education; and
- 5.4% of the male respondents didn't attain any kind of education, 50.0% attained primary education, 23.0% mentioned "O" level education, 5.44% of male respondents attained "A" level education and 16.2% mentioned tertiary/college/university level of education.

In Pader District,

- 14.7% of the female respondents didn't attain any kind of education, 57.4% attained primary education, 22.11% mentioned "O" level education, none attained "A" level education and 5.9% mentioned tertiary/college/university level of education; and
- None of the male respondents didn't attain any kind of education, 56.1% mentioned primary education, 26.8% mentioned "O" level education, 2.44% of male respondents mentioned "A" level education and 14.6% mentioned tertiary/college/university level of education.

Table 4: Respondents' level of education

| Level of education attained | Kitgum District | | | | | | Pader District | | | | | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | | Male | | Total | | Female | | Male | | Total | | n | % |
| | n | % | n | % | n | % | n | % | n | % | n | % | | |
| None | 11 | 14.5% | 4 | 5.4% | 15 | 10.0% | 10 | 14.7% | 0 | 0.0% | 10 | 6.7% | **25** | **8.3%** |
| Primary | 49 | 64.5% | 37 | 50.0% | 86 | 57.3% | 39 | 57.4% | 46 | 56.1% | 85 | 56.7% | **171** | **57.0%** |
| "O" level | 14 | 18.4% | 17 | 23.0% | 31 | 20.7% | 15 | 22.1% | 22 | 26.8% | 37 | 24.7% | **68** | **22.7%** |
| "A" level | 1 | 1.3% | 4 | 5.4% | 5 | 3.3% | 0 | 0.0% | 2 | 2.4% | 2 | 1.3% | **7** | **2.3%** |
| Tertiary | 1 | 1.3% | 12 | 16.2% | 13 | 8.7% | 4 | 5.9% | 12 | 14.6% | 16 | 10.7% | **29** | **9.7%** |
| **Total** | **76** | **100.0%** | **74** | **100.0%** | **150** | **100.0%** | **68** | **100.0%** | **82** | **100.0%** | **150** | **100.0%** | **300** | **100.0%** |

### 3.1.4 Religion

In Kitgum District,

- 23.7% of the female respondents mentioned Anglican, 68.4% mentioned Catholic and 7.9% mentioned SDA; and
- 23.0% of the male respondents mentioned Anglican, and 1.4% mentioned Seventh-day Adventist Church (SDA).

In Pader District,

- 27.9% of female respondents mentioned Anglican, 66.2% mentioned Catholic and 5.9% mentioned SDA; and
- 20.7% of male respondents mentioned Anglican, 74.4% mentioned Catholic, , 1.2% mentioned Muslim 2.4% mentioned Pentecostals and 1.2% mentioned SDA.

Table 5: Respondents' religion

| Religion | Kitgum District | | | | | | Pader District | | | | | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Female | | Male | | Total | | Female | | Male | | Total | | n | % |
| | n | % | n | % | n | % | n | % | n | % | n | % | | |
| Anglican | 18 | 23.7% | 17 | 23.0% | 25 | 16.7% | 19 | 27.9% | 17 | 20.7% | 36 | 24.0% | **61** | **20.3%** |
| Catholic | 52 | 68.4% | 56 | 75.7% | 36 | 24.0% | 45 | 66.2% | 61 | 74.4% | 106 | 70.7% | **142** | **47.3%** |
| Muslim | 0 | 0.0% | 0 | 0.0% | 21 | 14.0% | 0 | 0.0% | 1 | 1.2% | 1 | 0.7% | **22** | **7.3%** |
| Pentecostals | 0 | 0.0% | 0 | 0.0% | 15 | 10.0% | 0 | 0.0% | 2 | 2.4% | 2 | 1.3% | **17** | **5.7%** |
| SDA | 6 | 7.9% | 1 | 1.4% | 53 | 35.3% | 4 | 5.9% | 1 | 1.2% | 5 | 3.3% | **58** | **19.3%** |
| **Total** | **76** | **100.0%** | **74** | **100.0%** | **150** | **100.0%** | **68** | **100.0%** | **82** | **100.0%** | **150** | **100.0%** | **300** | **100.0%** |

## 3.2 Definition of mental health problems

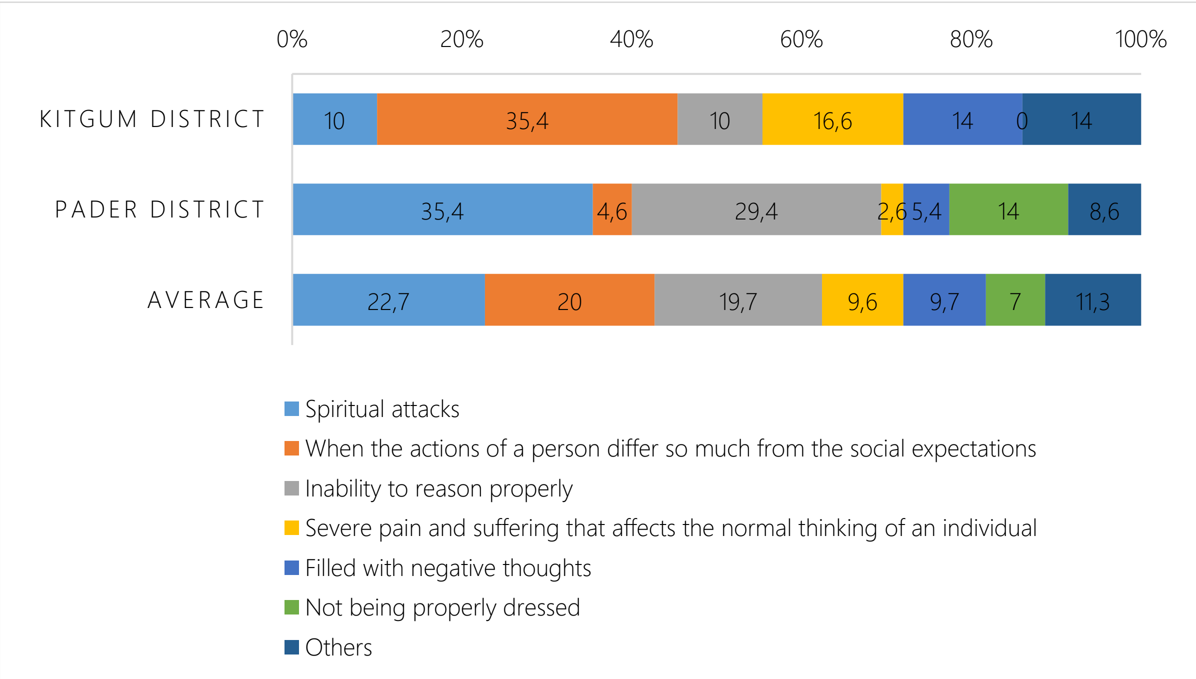
Different respondents provided their understanding of the term "mental health problems", and Chart 4 summarises the various responses provided of their understanding on mental health problems.

According to the assessment, on average, 22.7% (respectively 10.0% in Kitgum District and 35.4% in Pader District) mentioned spiritual attacks as a key definition of mental health problems, 20.0%

(respectively 35.4% in Kitgum District and 4.6% in Pader District) mentioned that it is when the actions of a person are different from the social expectations, followed by the inability to reason properly at 19.7% (respectively 10.0% in Kitgum District and 29.4% in Pader District).

Other definitions of mental health problems according to the assessment included the following; severe pain and suffering that affects the normal thinking of an individual at 9.6% (respectively 16.6% in Kitgum District and 2.6% in Pader District), being filled with negative thoughts at 9.7% (respectively 14.0% in Kitgum District and 5.4% in Pader District), not being properly dressed pointing towards 7.0% (respectively 0.0% in Kitgum District and 14.0% in Pader District) and 11.3% on average for other definitions with 14.0% in Kitgum District and 8.6% in Pader District respectively.

*Chart 4: Definition of mental health problems (in %)*




When asked during a KII, a male respondent in Kitgum District quoted

> *"When the moods, thoughts and behaviour of a person are affected, we say it is a mental health problem."*

He added that mental health has grown a priority today but little attention is given to it by both the key players, and the victims because most people have associated it to poverty and witchcraft despite government efforts to strengthen health facilities with psychotropic drugs and health workers to manage cases at the health centres. However, outreach programmes organised by health workers often do not cover MHPSS services.

Furthermore, an FDG composed of local, cultural and religious leaders including the community members in the sub-county of Acholi Bur, Pader District, referred to the following quote as the definition of mental health problems:

> *"Irrational and un-matching words while speaking, unsettled and restless caregiver madness/insanity."*

Other FDGs in the sub-counties of Pajule (Pader District) and Orom (Kitgum District) referred to mental health problems as having a bad social life such as wearing balanced trousers and mini-skirts by the youth, a type of dressing the communities have associated with taking marijuana for boys and prostitution for girls. They also pointed to an uncoordinated way of speech, while other respondents described some behaviour exhibited by some musicians as mental health problems, for example tattooing all the body parts and wearing dreadlocks. Some responses pointed towards doing unproductive things like youth sitting at the road side the whole day, failure to cope with educational roles at school and home, aggressiveness and displaying epileptic symptoms.

### 3.3 Main causes of mental health problems

While the respondents provided overwhelming and underlying causes of mental health problems, the majority mentioned that they had not taken a positive outlook to life and had not gained the confidence to re-engage in community activities during FDGs across Kitgum and Pader Districts. Many reported not being in position to deal with their problems because of a reduced sense of confidence and social cohesion as a result of the past LRA insurgency.

A respondent at Pajule HC IV (Pader District) explained that it is a common practice for the community members to refer persons with mental illnesses to the cultural leaders because the community perceives spiritual healing to be associated with rituals. He further reported that while he attempts to manage some of the patients with mental illness and refers the severe cases, people in the community tend to ignore health facility support and prefer cultural ways of rehabilitating persons by performing rituals to victims that are presented with demonic spirits *(cen)*. Community members believe that mental health services can only be received at the national referral mental hospital but lack of resources makes accessing these services very difficult. He added that there is need for massive awareness campaigns to sensitize communities on mental health and its referral systems to curb the concerns surrounding knowledge and referral attitudes by the communities. In addition, a male focal district official in Kitgum District stated that

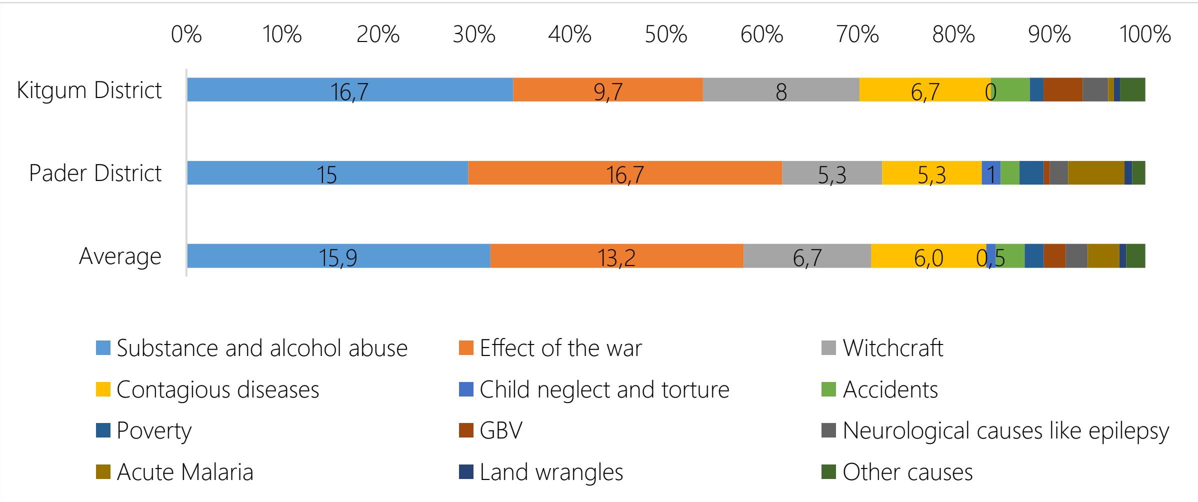
> *"we barely have any information onto how to uplift our shame and raise our self-esteem again. No one shares with us here at work about dangers of isolating*

> *ourselves, keeping in thoughts without being productive. No one tells us we should be integrated and our young boys have resorted to a high consumption of alcohol and substance as a way of coping to effects of the past LRA war."*

This was consistent with quantitative findings from the community and the key causes of mental health problems within the communities of study are explained as follows *(see Chart 5 below)*:

- On average, 15.9% (respectively 16.7% in Kitgum District and 15.0% in Pader District) of the respondents mentioned substance and alcohol abuse was the most important cause of mental health problems, followed by the effect of the war at 13.2% (respectively 9.7% in Kitgum District and 16.7% in Pader District), 6.7% (respectively 8.0% in Kitgum District and 5.3% in Pader District) pointed towards witchcraft and 6.0% (respectively 6.7% in Kitgum District and 5.3% in Pader District) indicated contagious diseases such as nodding syndrome and HIV; and
- Other causes included, on average, 0.5% (1.0% in Pader District only) mentioned child neglect and torture, 1.5% (respectively 2.0% in Kitgum District and 1.0% in Pader District) mentioned accidents, 1.0% (respectively 0.7% in Kitgum District and 1.3% in Pader District) mentioned poverty, 1.2% (respectively 2.0% in Kitgum District and 0.3% in Pader District) mentioned gender-based violence, 1.2% (respectively 1.3% in Kitgum District and 1.0% in Pader District) mentioned neurological cause like epilepsy, 1.7% (respectively 0.3% in Kitgum District and 3.0% in Pader District) mentioned (acute) malaria, 0.4% (respectively 0.3% in Kitgum District and 0.4% in Pader District) mentioned land wrangles while 1.0% (respectively 1.3% in Kitgum District an 0.7% in Pader District) mentioned other causes.

*Chart 5: Main causes of mental health problems (in %)*



In the FDGs, the effect of the war, witchcraft and alcohol and substance abuse were mentioned by the majority of the participants as the main cause of mental health problems within communities. However, substance and alcohol abuse, according to a KI respondent, has been used by persons affected by mental health problems as a coping mechanism to the torture that people are going through as a result of the effect of the past LRA war in the region of Northern Uganda. Therefore, some or all of the above causes could have resulted into the nature of mental health problems, as tabulated below *(see Table 6)*.

The Kitgum District mental health focal person was joined by the Pader District mental health focal person in expressing the low level of awareness of community members on mental health. They estimated that on average fifty (50) clients are received at the health facilities on a daily basis in Kitgum and Pader Districts through referrals and outreaches but there are no trained counsellors to psychologically support the clients. The District focal person of Pader added that most people attribute mental health to be a myth; something traditional or spiritual and they believe that the health workers cannot do much to support recovery.

## 3.4 Common mental health problems

The tabulated analysis below (see Table 6) is an extract of the nature of the common mental health problems in Kitgum and Pader Districts according to the assessment;

- Respondents mentioned trauma as the most common mental health problem at 54.7% (respectively 35.3% in Kitgum District and 19.3% in Pader District), followed by substance and alcohol abuse at 17.7% (respectively 3.3% in Kitgum District and 14.3% in Pader District), and depression at 15.0% (respectively 8.7% in Kitgum District and 6.3% in Pader District);
- Other mental health problems within the communities included; anxiety at 6.0% (respectively 2.0% in Kitgum District and 4.0% in Pader District), Neurological epilepsy at 6.0% (respectively 0.7% in Kitgum District and 5.3% in Pader District), and symptoms of psychosis at 0.7% in Pader District only.

*Table 6: Common mental health problems*

| | | | **Which kind of mental health problems do you think are common in your community?** | | | | | | **Total** |
|---|---|---|---|---|---|---|---|---|---|
| | | | *Trauma* | *Substance and alcohol abuse* | *Depression* | *Anxiety* | *Neuro-logical epilepsy* | *Symptoms of psychosis* | |
| **District** | *Kitgum* | *n* | 106 | 10 | 26 | 6 | 2 | 0 | **150** |
| | | *%* | 70.6% | 6.6% | 17.4% | 4.0% | 1.4% | 0.0% | **100.0%** |
| | *Pader* | *n* | 58 | 43 | 19 | 12 | 16 | 2 | **150** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | % | 38.6% | 28.6% | 12.6% | 8.0% | 10.6% | 1.4% | **100.0%** |
| **Total** | | *n* | 164 | 53 | 45 | 18 | 18 | 2 | **300** |
| **Average** | | % | 54.6% | 17.6% | 15.0% | 6.0% | 6.0% | 0.7% | **100.00%** |

Because of the increasing manifestation of the mentioned mental health problems, the assessment finding also confirmed that gender-based violence (GBV) is on the rise within families according to a statement from a male opinion leader and a retired civil servant in Mucwini Sub-County. He quoted

> *"Our communities are experiencing a big number of unsettled marital relationships among couples and reasons stem from loss of property and lives during the LRA war, a deep hole the men of Mucwini Sub-county have failed to cover and as a result women are running away to reside in the neighbouring Lamwo settlement in search of free humanitarian livelihood items distributed by the partners and UNHCR and as a result men are being treated as "useless "by their own wives because they are finding it hard to provide to their families."*

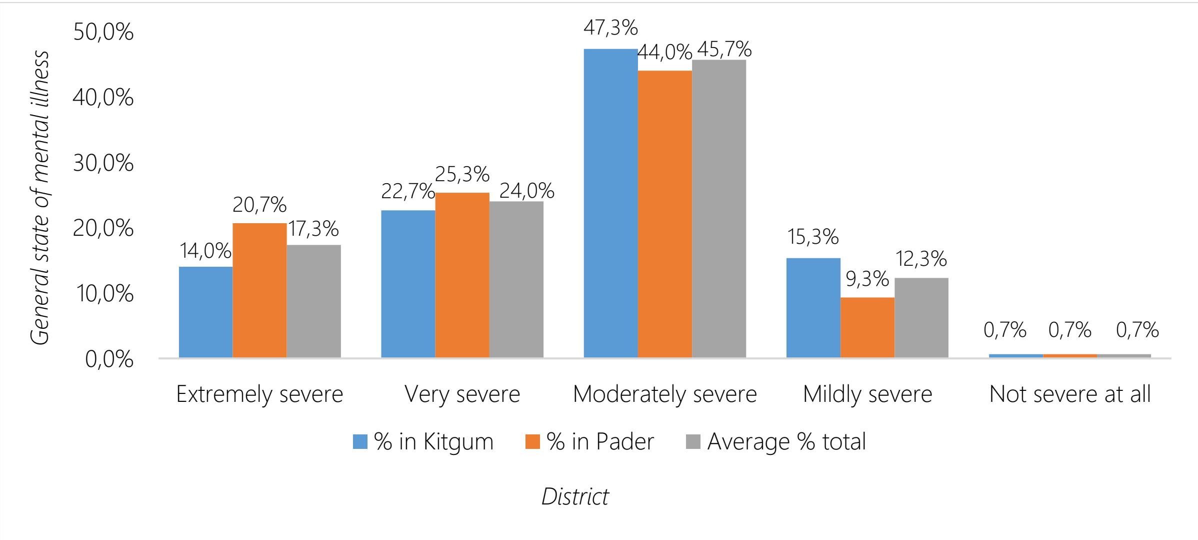
He added that the prevalence of mental health problems varied considerably between men and women, with the majority females having had mental health problems compared to the males. The difference between the sexes was mainly due to the higher observable prevalence of the symptoms such as very low self-esteem, troubled relationships and difficulties at school/work resulting into attention difficulty, hyperactivity and impulsiveness according to a male KI from Kitgum District when asked about the high prevalence of mental health problems among females in comparison to males.

Much as some of the MHPSS service providers and the government have been of significance to the people in the districts of Kitgum and Pader in providing psychosocial counselling to specific communities in Kitgum and Pader Districts, the psychological consequences of the LRA war still appear to be very "fresh" according to a statement from District focal person for mental health. A victim of the war narrated

> *"The rebels set my hut ablaze and ordered me to carry a sack of potatoes and join the abductees. We moved in a group through the bush to an unknown destination. Life became really tough. They turned us into sex slaves; then men were used as messengers or child soldiers," remembers Ayenyo (not real name). After one year of torture, she was sent back home without harm, probably because of the baby she was carrying. But her experience there left her traumatized. She added that she cries a lot today and she goes through night mares and day dreams whenever she crossed the place that the LRA rebels arrested her from. "I saw people being killed, girls being raped together with her and other people molested. Those memories still haunt me."*

Interestingly, according to the district maternal health focal person of Kitgum District, the development projects in the two districts have not adequately integrated MHPSS into their interventions. She also suggested that there is need to incorporate mental health related community interventions for strengthening mental health and some social outcomes across social-ecological levels. Partner projects have not integrated basic counselling, mental health identification and referral pathways onto ongoing resources and training to maintain long-term outcomes, explicit attention to ethics and processes to foster equitable partnerships, and policy reform to support sustainable mental healthcare-community collaborations, emphasized the female KI respondent in Kitgum District Health Office. She added that the indoctrination of victims in the community is necessary in the communities that were grossly affected by the insurgency and integrating MHPSS into partner interventions could provide an exploration of social and psychological mechanisms through which better mental health can be achieved, and with focus particularly on the roles of men and women in the society. The psychological impact of indoctrination enables reintegration programs to more effectively address issues and serve the complex needs of formerly abducted people.

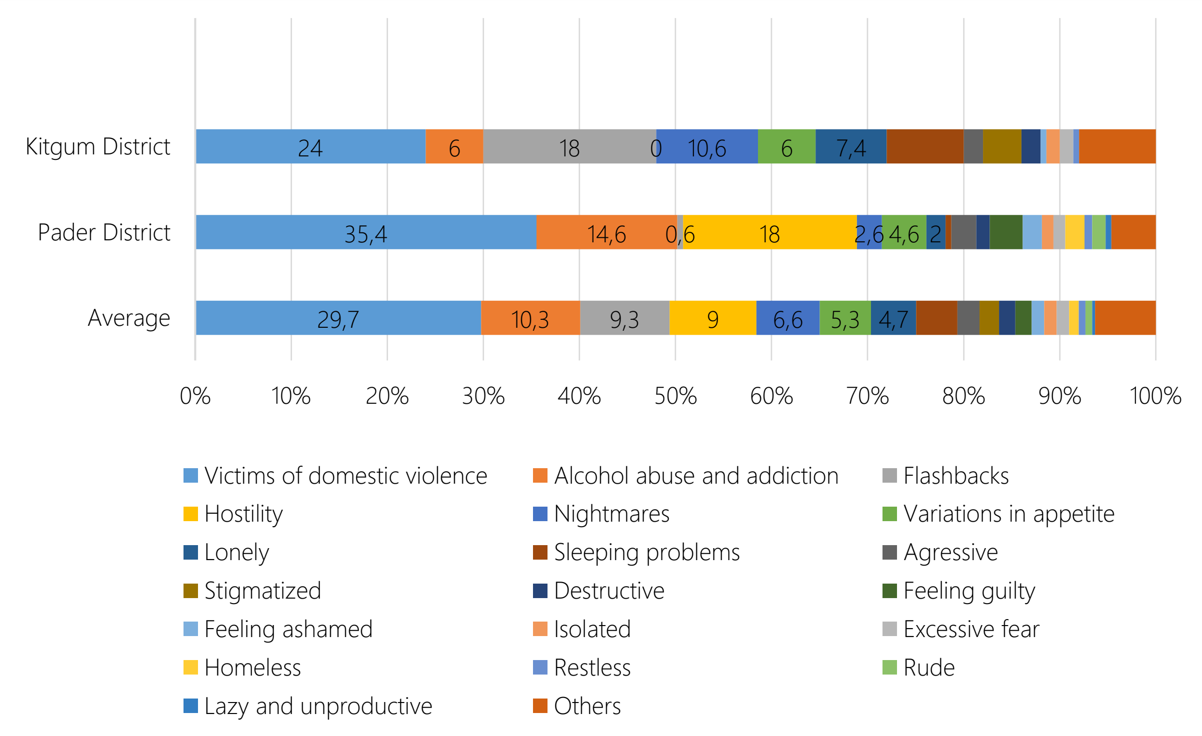
*Chart 6: Perceived general state of mental illnesses within communities (in %)*




The chart above gives a picture of the general state of mental illnesses in Kitgum and Pader Districts as follows; on average, 17.3% of the respondents (respectively 14.0% (F=11.8%; M=16.2%) in Kitgum District and 20.7% (F=20.6%; M=20.7%) in Pader District) mentioned that the general state of mental illness was extremely severe, 24.0% (respectively 22.7% (F=25.0%; M=20.3%) in Kitgum District and 25.3% (F=26.5%; M=24.4%) in Pader District) pointed to the state of mental health as very severe, 45.7% (respectively 47.3% (F=47.4%; M=47.3%) in Kitgum District and 44.0% (F=44.1%; M=43.9%) in Pader

District) revealed moderately severe, 12.3% (respectively 15.3% (F=15.8%; M=14.9%) in Kitgum District and 9.3% (F=7.4%; M=11.0%) in Pader District) mentioned mildly severe and 0.7% (respectively 0.7% (F=0.0%; M=1.4%) in Kitgum District and 0.7% (F=1.5%; M=0.0%) in Pader District) said not at all.

*Chart 7: Perceptions of key manifestations in someone who is mentally unwell (in %)*




The tabular analysis above provides evidence that majority of the people in Kitgum and Pader Districts are aware of the key manifestations of mental illnesses. Majority of the respondents perceive someone who is mentally unwell in the following ways:

- On average, 29.7% (respectively 24.0% in Kitgum District and 35.4% in Pader District) of the respondents mentioned being victims of domestic violence, 10.3% (respectively 6.0% in Kitgum District and 14.6% in Pader District) mentioned excess use and dependence on alcohol, 9.3% (respectively 18.0% in Kitgum District and 0.6% in Pader District) mentioned flashbacks, 9.0% (18.0% of respondents in Pader District only) mentioned hostility, 6.6% (respectively 10.6% in Kitgum District and 2.6% in Pader District) mentioned nightmares, variations in appetite at 5.3% (respectively 6.0% in Kitgum District and 4.6% in Pader District), 4.7% (respectively 7.4% in Kitgum District and 2.0% in Pader District) mentioned loneliness;
- Other important manifestations mentioned included sleeping problems at 4.3% (respectively 8.0% in Kitgum and 0.6% in Pader District); feelings of shame at an average 1.3% (respectively

0.6% in Kitgum District and 2.0% in Pader), being aggressive at 2.3% (respectively 2.0% in Kitgum District and 2.6% in Pader District), laziness and unproductiveness at 0.3% ((0.6% in Pader District only), being rude at 0.7% on average (1.4% in Pader District only); and

- There were other mentions as well such as isolation that pointed towards 1.3% (respectively 1.4% in Kitgum District and 1.2% in Pader District), excessive fear at 1.3% (respectively 1.4% in Kitgum District and 1.2% in Pader District), restlessness at 0.7% (respectively 0.6% in Kitgum District and 0.8% in Pader District), homelessness at 1.0% on average (2.0% of respondents in Pader District only), destructive behaviour at 1.7% (2.0% in Kitgum District and 1.4% in Pader District), stigmatization at an average of 2.0% with 4.0% in Kitgum District alone and guilt at 1.7% (3.4% in Pader District alone) among others at 6.5% (respectively 8.0% in Kitgum District and 4.9% in Pader District).

## 3.5 Assessment of mental health problems

### *3.5.1 Feeling afraid that nothing could calm the situation down*

According to the table below, majority of the respondents mentioned that in the last two weeks from the time of the interview they at least most of the time felt so afraid that nothing could calm the situation down, 32.3% (F=17.3%; M=15.0%) mentioned that they felt so afraid that nothing could calm them down in the last two weeks all of the time, 20.7% (F=9.3%; M=11.3%) pointed to most of the time, 12.7 % (F=6.0%; M=6.7%) said some of the time, 18.0% (F=8.3%; M=9.7%) mentioned a little of the time and 15.0% (F=6.7%; M=8.3%) mentioned none of the time. Furthermore, 0.3% of all males in Kitgum District said they did not know and 1.0% (F=0.3%; M=0.7%) refused to disclose the information.

The psychological difficulties that the people in Kitgum and Pader Districts are going through is affecting both men and women. In table 7 below, 52.0% of men compared to 48.0% of their female counterparts mentioned that they felt afraid that nothing could calm them down.

*Table 7: Feeling so afraid that nothing could calm the situation down*

| | District | | | | Total | |
|---|---|---|---|---|---|---|
| | *Kitgum* | | *Pader* | | | |
| | *n* | *%* | *n* | *%* | *n* | *%* |
| **All of the time** | **44** | **29.3%** | **53** | **35.3%** | **97** | **32.3%** |
| Female | 23 | 15.3% | 29 | 19.3% | 52 | 17.3% |
| Male | 21 | 14.0% | 24 | 16.0% | 45 | 15.0% |
| **Most of the time** | **20** | **13.3%** | **42** | **28.0%** | **62** | **20.7%** |
| Female | 10 | 6.7% | 18 | 12.0% | 28 | 9.3% |
| Male | 10 | 6.7% | 24 | 16.0% | 34 | 11.3% |
| **Some of the time** | **21** | **14.0%** | **17** | **11.3%** | **38** | **12.7%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Female | 13 | 8.7% | 5 | 3.3% | 18 | 6.0% |
| Male | 8 | 5.3% | 12 | 8.0% | 20 | 6.7% |
| **A little of the time** | **29** | **19.3%** | **25** | **16.7%** | **54** | **18.0%** |
| Female | 15 | 10.0% | 10 | 6.7% | 25 | 8.3% |
| Male | 14 | 9.3% | 15 | 10.0% | 29 | 9.7% |
| **None of the time** | **32** | **21.3%** | **13** | **8.7%** | **45** | **15.0%** |
| Female | 14 | 9.3% | 6 | 4.0% | 20 | 6.7% |
| Male | 18 | 12.0% | 7 | 4.7% | 25 | 8.3% |
| **I don't know** | **1** | **0.7%** | **0** | **0.0%** | **1** | **0.3%** |
| Male | 1 | 0.7% | 0 | 0.0% | 1 | 0.3% |
| **Refused to disclose** | **3** | **2.0%** | **0** | **0.0%** | **3** | **1.0%** |
| Female | 1 | 0.7% | 0 | 0.0% | 1 | 0.3% |
| Male | 2 | 1.3% | 0 | 0.0% | 2 | 0.7% |
| **Grand total** | **150** | **100.0%** | **150** | **100.0%** | **300** | **100.0%** |

The difference of the psychological difficulties faced by a sample population of men and women in Kitgum and Pader was statistically tested as shown below.

*Table 8: t-Test (paired two samples for means)*

| | Sex | Feeling afraid that nothing could calm them down |
|---|---|---|
| **Mean** | 1.48 | 4.143 |
| **Variance** | 0.250 | 0.525 |
| **Observations** | 300 | 300 |
| **Pearson Correlation** | 0.086 | |
| **Hypothesized Mean Difference** | 0 | |
| **df** | 299 | |
| **t Stat** | -54.656 | |
| **P(T<=t) one-tail** | 0.000 | |
| **t Critical one-tail** | 1.650 | |
| **P(T<=t) two-tail** | 0.000 | |
| **t Critical two-tail** | 1.968 | |

Hypothesis test:

- Ho: There is no significant mean difference in the psychological difficulties faced by the sample population of men and women in Kitgum and Pader Districts.
- Ha: There is a significant mean difference in the psychological difficulties faced by the sample population of men and women in Kitgum and Pader Districts.
- The observed two-tailed significance level is (0.000) <0.05, hence we reject the null hypothesis and conclude that there is a significant mean difference in the difficulties faced by the sample population of men and women in Kitgum and Pader Districts, who felt afraid that nothing could calm them down.

### *3.5.2 Feeling angry and out of control*

According to the table below, the majority of the respondents continued to mention that in the last two weeks from the time of the interview they at least most of the time felt so angry and out of control. Specifically, 29.7% (F=14.7%; M=15.0%) mentioned that they some of the time felt so afraid that nothing could calm the situation down in the past two weeks all of the time, 20.0% (F=9.3%; M=10.7%)

mentioned that they felt it most of the time, 14.0% (F=6.0%; M=8.0%) mentioned some of the time, 21.7% (F=11.0%; M=10.7%) mentioned that they felt so angry and out of control a little of the time and 13.3% (F=6.6%; M=6.7%) mentioned they felt that way none of the time. In addition, 0.7% (F=0.4%; M=0.3%) mentioned that they did not know anything, while 0.7% (all men) refused to disclose this information.

*Table 9: Feeling so angry and out of control*

| | District | | | | Total | |
|---|---|---|---|---|---|---|
| | *Kitgum* | | *Pader* | | | |
| | *n* | % | *n* | % | *n* | % |
| **All of the time** | **43** | **28.7%** | **46** | **30.7%** | **89** | **29.7%** |
| Female | 24 | 16.0% | 20 | 13.3% | 44 | 14.7% |
| Male | 19 | 12.7% | 26 | 17.3% | 45 | 15.0% |
| **Most of the time** | **31** | **20.7%** | **29** | **19.3%** | **60** | **20.0%** |
| Female | 15 | 10.0% | 13 | 8.7% | 28 | 9.3% |
| Male | 16 | 10.7% | 16 | 10.7% | 32 | 10.7% |
| **Some of the time** | **18** | **12.0%** | **24** | **16.0%** | **42** | **14.0%** |
| Female | 10 | 6.7% | 8 | 5.3% | 18 | 6.0% |
| Male | 8 | 5.3% | 16 | 10.7% | 24 | 8.0% |
| **A little of the time** | **30** | **20.0%** | **35** | **23.3%** | **65** | **21.7%** |
| Female | 14 | 9.3% | 19 | 12.7% | 33 | 11.0% |
| Male | 16 | 10.7% | 16 | 10.7% | 32 | 10.7% |
| **None of the time** | **26** | **17.3%** | **14** | **9.3%** | **40** | **13.3%** |
| Female | 13 | 8.7% | 7 | 4.7% | 20 | 6.6% |
| Male | 13 | 8.7% | 7 | 4.7% | 20 | 6.7% |
| **I don't know** | **0** | **0.0%** | **2** | **1.3%** | **2** | **0.7%** |
| Female | 0 | 0.0% | 1 | 0.7% | 1 | 0.4% |
| Male | 0 | 0.0% | 1 | 0.7% | 1 | 0.3% |
| **Refused to disclose** | **2** | **1.3%** | **0** | **0.0%** | **2** | **0.7%** |
| Male | 2 | 1.3% | 0 | 0.0% | 2 | 0.7% |
| **Total** | **150** | **100.0%** | **150** | **100.0%** | **300** | **100.0%** |

### *3.5.3 Feeling uninterested in things liked*

As reflected in the analysis table below, majority of the respondents mentioned that in the last two weeks from the time of the interview they at least most of the time felt so uninterested in things they used to like, that they didn't want to do anything at all. Specifically, 27.7% (F=12.0%; M=15.7%) mentioned that they felt so uninterested in things they liked in the past two weeks all of the time, 6.7% (F=3.4%; M=3.3%) mentioned it most of the time, 19.7% (F=9.7%; M=10.0%) mentioned that they some of the time felt so uninterested in things they liked in the past two weeks, 27.7% (F=14.0%; M=13.7%) mentioned that they felt it a little of the time and 15.0% (F=7.3%; M=7.7%) mentioned they felt that way none of the time. Furthermore, 1.7% (F=0.4%; M=1.3%) mentioned that they did not know anything and 1.7% (F=0.4%; M=1.3%) refused to disclose that they felt uninterested in doing things they liked.

*Table 10: Feeling uninterested in things liked*

| | District | | | | Total | |
|---|---|---|---|---|---|---|
| | *Kitgum* | | *Pader* | | | |
| | *n* | *%* | *n* | *%* | *n* | *%* |
| **All of the time** | **59** | **39.3%** | **24** | **16.0%** | **83** | **27.7%** |
| Female | 27 | 18.0% | 9 | 6.0% | 36 | 12.0% |
| Male | 32 | 21.3% | 15 | 10.0% | 47 | 15.7% |
| **Most of the time** | **12** | **8.0%** | **8** | **5.3%** | **20** | **6.7%** |
| Female | 5 | 3.3% | 5 | 3.3% | 10 | 3.4% |
| Male | 7 | 4.7% | 3 | 2.0% | 10 | 3.3% |
| **Some of the time** | **21** | **14.0%** | **38** | **25.3%** | **59** | **19.7%** |
| Female | 14 | 9.3% | 15 | 10.0% | 29 | 9.7% |
| Male | 7 | 4.7% | 23 | 15.3% | 30 | 10.0% |
| **A little of the time** | **31** | **20.7%** | **52** | **34.7%** | **83** | **27.7%** |
| Female | 17 | 11.3% | 25 | 16.7% | 42 | 14.0% |
| Male | 14 | 9.3% | 27 | 18.0% | 41 | 13.7% |
| **None of the time** | **22** | **14.7%** | **23** | **15.3%** | **45** | **15.0%** |
| Female | 11 | 7.3% | 11 | 7.3% | 22 | 7.3% |
| Male | 11 | 7.3% | 12 | 8.0% | 23 | 7.7% |
| **I don't know** | **3** | **2.0%** | **2** | **1.3%** | **5** | **1.7%** |
| Female | 2 | 1.3% | 2 | 1.3% | 4 | 1.4% |
| Male | 1 | 0.7% | 0 | 0.0% | 1 | 0.3% |
| **Refused to disclose** | **2** | **1.3%** | **3** | **2.0%** | **5** | **1.7%** |
| Female | 0 | 0.0% | 1 | 0.7% | 1 | 0.4% |
| Male | 2 | 1.3% | 2 | 1.3% | 4 | 1.3% |
| **Total** | **150** | **100.0%** | **150** | **100.0%** | **300** | **100.0%** |

### *3.5.4 Suicidal intensions*

The analysis *(see Table 11 below)* still continues to provide evidence that majority of the respondents mentioned that in the last two weeks from the time of the assessment that they at least most of the time did something, started to do anything or even prepared to end their lives. Specifically, 44.3% (F=21.0%; M=23.3%) said it happened all of the time, 19.3% (F=9.0%; M=10.3%) mentioned that they did it most of the time, 6.0% (F=2.3%; M=3.7%) did it some of the time, 8.7% (F=4.4%; M=4.3%) mentioned it happened a little of the time and 19.3% (F=11.0%; M=8.3%) mentioned they never felt that way at any time. Out of all the respondents, 2.3% (F=0.3%; M=2.0%) refused to disclose that they did something, started to do something or prepared to end their lives.

*Table 11: Suicidal intentions*

| | District | | | | Total | |
|---|---|---|---|---|---|---|
| | *Kitgum* | | *Pader* | | | |
| | *n* | *%* | *n* | *%* | *n* | *%* |
| **All of the time** | **86** | **57.3%** | **47** | **31.3%** | **133** | **44.3%** |
| Female | 42 | 28.0% | 21 | 14.0% | 63 | 21.0% |
| Male | 44 | 29.3% | 26 | 17.3% | 70 | 23.3% |
| **Most of the time** | **37** | **24.7%** | **21** | **14.0%** | **58** | **19.3%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Female | 18 | 12.0% | 9 | 6.0% | 27 | 9.0% |
| Male | 19 | 12.7% | 12 | 8.0% | 31 | 10.3% |
| **Some of the time** | **6** | **4.0%** | **12** | **8.0%** | **18** | **6.0%** |
| Female | 2 | 1.3% | 5 | 3.3% | 7 | 2.3% |
| Male | 4 | 2.7% | 7 | 4.7% | 11 | 3.7% |
| **A little of the time** | **5** | **3.3%** | **21** | **14.0%** | **26** | **8.7%** |
| Female | 4 | 2.7% | 9 | 6.0% | 13 | 4.4% |
| Male | 1 | 0.7% | 12 | 8.0% | 13 | 4.3% |
| **None of the time** | **13** | **8.7%** | **45** | **30.0%** | **58** | **19.3%** |
| Female | 9 | 6.0% | 24 | 16.0% | 33 | 11.0% |
| Male | 4 | 2.7% | 21 | 14.0% | 25 | 8.3% |
| **Refused to disclose** | **3** | **2.0%** | **4** | **2.7%** | **7** | **2.3%** |
| Female | 1 | 0.7% | 0 | 0.0% | 1 | 0.3% |
| Male | 2 | 1.3% | 4 | 2.7% | 6 | 2.0% |
| ***Total*** | ***150*** | ***100.0%*** | ***150*** | ***100.0%*** | ***300*** | ***100.0%*** |

### 3.5.5 *Feeling upset about any life event which made you avoid places, people, conversations or activities*

Majority of the respondents mentioned that in the last two weeks from the time of the assessment they at least most of the time felt so severely upset about any life event that they even tried to avoid places, people, conversations or activities. Specifically, 23.0% (F=10.7%; M=12.3%) said they felt so upset about any life event that made them avoid places, people, conversations or activities in the last two weeks all of the time, 35.7% (F=17.7%; M=18.0%) mentioned that they did it most of the time, 13.7% (F=7.3%; M=6.4%) did it some of the time, 13.7% (F=5.7%; M=8.0%) mentioned it happened a little of the time and 10.3% (F=5.3%; M=5.0%) mentioned they never felt that way at any time. A total of 3.7% (F=1.4%; M=2.3%) refused to disclose their answer to this question.

*Table 12: Feeling so upset about any life event which made you avoid places, people, conversations or activities*

| | **District** | | | | **Total** | |
|---|---|---|---|---|---|---|
| | *Kitgum* | | *Pader* | | | |
| | *n* | *%* | *n* | *%* | *n* | *%* |
| **All of the time** | **46** | **30.7%** | **23** | **15.3%** | **69** | **23.0%** |
| Female | 24 | 16.0% | 8 | 5.3% | 32 | 10.7% |
| Male | 22 | 14.7% | 15 | 10.0% | 37 | 12.3% |
| **Most of the time** | **32** | **21.3%** | **75** | **50.0%** | **107** | **35.7%** |
| Female | 17 | 11.3% | 36 | 24.0% | 53 | 17.7% |
| Male | 15 | 10.0% | 39 | 26.0% | 54 | 18.0% |
| **Some of the time** | **29** | **19.3%** | **12** | **8.0%** | **41** | **13.7%** |
| Female | 16 | 10.7% | 6 | 4.0% | 22 | 7.3% |
| Male | 13 | 8.7% | 6 | 4.0% | 19 | 6.4% |
| **A little of the time** | **26** | **17.3%** | **15** | **10.0%** | **41** | **13.7%** |
| Female | 9 | 6.0% | 8 | 5.3% | 17 | 5.7% |
| Male | 17 | 11.3% | 7 | 4.7% | 24 | 8.0% |
| **None of the time** | **14** | **9.3%** | **17** | **11.3%** | **31** | **10.3%** |

| | | | | | | |
|---|---|---|---|---|---|---|
| Female | 8 | 5.3% | 8 | 5.3% | 16 | 5.3% |
| Male | 6 | 4.0% | 9 | 6.0% | 15 | 5.0% |
| **Refused to disclose** | **3** | **2.0%** | **8** | **5.3%** | **11** | **3.7%** |
| Female | 2 | 1.3% | 2 | 1.3% | 4 | 1.4% |
| Male | 1 | 0.7% | 6 | 4.0% | 7 | 2.3% |
| **Total** | **150** | **100.0%** | **150** | **100.0%** | **300** | **100.0%** |

### 3.5.6 *Unable to carry out essential activities for daily living*

The analysis table below provides a tabular analysis and evidence that majority of the respondents mentioned in the last two weeks from the time of the assessment that they at least most of the time were unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, disinterests, hopelessness or even upset. Specifically, 32.3% (F=17.7%; M=14.7%) said they felt unable to carry out essential activities for daily living in the last two weeks all of the time, 34.0% (F=16.0%; M=18.0%) mentioned that they felt so most of the time, 8.7% (F=3.4%; M=5.3%) mentioned some of the time, 14.3% (F=6.3%; M=8.0%) mentioned it happened a little of the time and 9.3% (F=4.7%; M=4.7%) mentioned they never felt that way at any time. Out of all the respondents, 1.3% (all male) refused to disclose their answer to this question.

*Table 13: Unable to carry out essential activities for daily living*

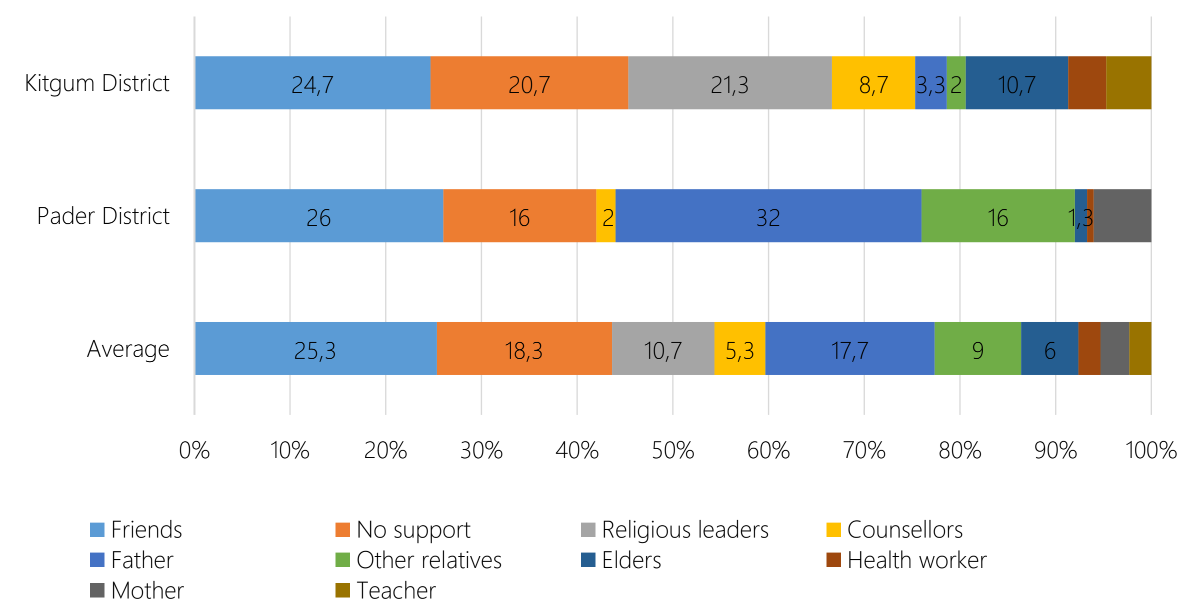
| | District | | | | Total | |
|---|---|---|---|---|---|---|
| | *Kitgum* | | *Pader* | | | |
| | *n* | *%* | *n* | *%* | *n* | *%* |
| **All of the time** | **53** | **35.3%** | **44** | **29.3%** | **97** | **32.3%** |
| Female | 33 | 22.0% | 20 | 13.3% | 53 | 17.7% |
| Male | 20 | 13.3% | 24 | 16.0% | 44 | 14.7% |
| **Most of the time** | **33** | **22.0%** | **69** | **46.0%** | **102** | **34.0%** |
| Female | 16 | 10.7% | 32 | 21.3% | 48 | 16.0% |
| Male | 17 | 11.3% | 37 | 24.7% | 54 | 18.0% |
| **Some of the time** | **15** | **10.0%** | **11** | **7.3%** | **26** | **8.7%** |
| Female | 6 | 4.0% | 4 | 2.7% | 10 | 3.4% |
| Male | 9 | 6.0% | 7 | 4.7% | 16 | 5.3% |
| **A little of the time** | **23** | **15.3%** | **20** | **13.3%** | **43** | **14.3%** |
| Female | 9 | 6.0% | 10 | 6.7% | 19 | 6.3% |
| Male | 14 | 9.3% | 10 | 6.7% | 24 | 8.0% |
| **None of the time** | **24** | **16.0%** | **4** | **2.7%** | **28** | **9.3%** |
| Female | 12 | 8.0% | 2 | 1.3% | 14 | 4.7% |
| Male | 12 | 8.0% | 2 | 1.3% | 14 | 4.7% |
| **Refused to disclose** | **2** | **1.3%** | **2** | **1.3%** | **4** | **1.3%** |
| Male | 2 | 1.3% | 2 | 1.3% | 4 | 1.3% |
| **Total** | **150** | **100.0%** | **150** | **100.0%** | **300** | **100.0%** |

## 3.6 Sources of support for MHPSS

### *3.6.1 Common sources of support for persons with mental health problems*

Key sources of support according to the respondents included elders, friends, father, relatives, religious leaders and counsellors as shown by the high percentage distribution in the chart below as the most common sources of support for mental health problems.

*Chart 8: Common sources of support for persons with mental health problems in the past 12 months (in %)*




From the chart above, there were numerous mentions for sources of support for persons with mental health problems by respondents in the past twelve (12) months:

- Of the total percentage of respondents in Kitgum and Pader Districts, on average, the following key sources were mentioned with 25.3% of the respondents (respectively 24.7% in Kitgum District and 26.0% in Pader District) pointing to friends, 17.7% (respectively 3.3% in Kitgum District and 32.0% in Pader District) mentioned their father, 10.7% (respectively 21.3% in Kitgum District and 0.0% in Pader District) mentioned religious leaders, 9.0% (respectively 2.0% in Kitgum District and 16% in Pader District) mentioned other relatives, 6.0% (respectively 4.7% in Kitgum District and 0.0% in Pader District) mentioned elders and 5.3% (respectively 8.7% in Kitgum District and 2.0% in Pader District) mentioned counsellors as the most important sources of mental health support to persons with mental illnesses;
- A large 18.3% (respectively 20.7% in Kitgum District and 16.0% in Pader District) mentioned there is no support; and

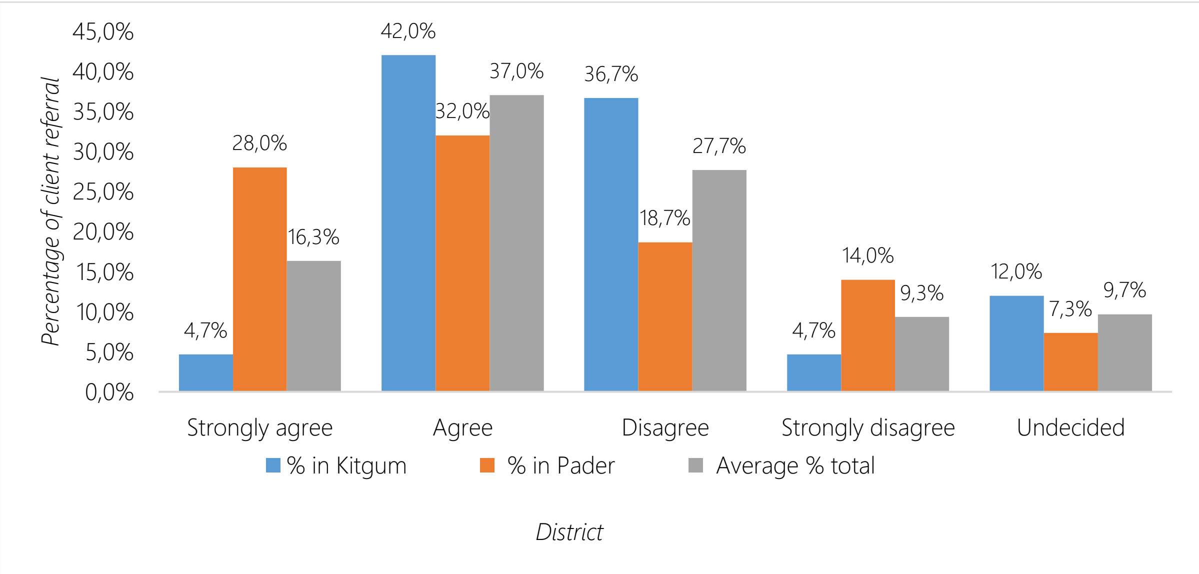
- Respondents also said that, on average, 3.0% (6.0% in Pader District only) mentioned mothers, 2.3% (4.7% in Kitgum District only) mentioned teachers and 2.3% (respectively 4.0% in Kitgum District and 0.7% in Pader District) mentioned health workers.

### *3.6.2 Client referral system*

From the chart below, client referral systems in both Kitgum and Pader Districts were viewed by respondents in the following ways:

- On average 16.3% (respectively 4.7% in Kitgum District and 28.0% in Pader District) strongly agreed to the existence of a client referral system, 37.0% (respectively 42.0% in Kitgum District and 32.0% in Pader District) agreed, 27.7% (respectively 36.7% in Kitgum District and 18.7% in Pader District) disagreed and 9.3% (respectively 4.7% in Kitgum District and 14.0% in Pader District) strongly disagreed; and
- 9.7% (respectively 12.0% in Kitgum District and 7.3% in Pader District) were undecided.

*Chart 9: Client referral system within the community (in %)*

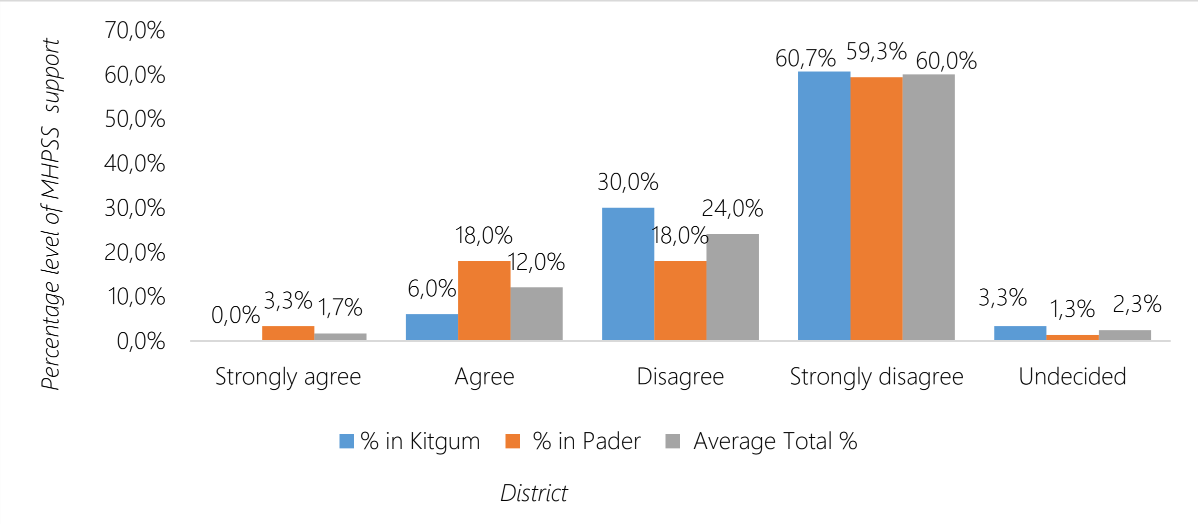



According to respondents in Kitgum and Pader Districts, TPO, HealthRights International, Government and other service providers like Care International in Kitgum District, Food for the Hungry and local leaders such as LC1 and opinion leaders have been key players in strengthening client referral of persons for mental health services, however, mixed reactions from the responses generated in the chart above show more efforts are still needed to strengthen the referral system for case management.

### 3.6.3 Current level of support and need for MHPSS services

According to the analysis chart below, respondents in Kitgum and Pader Districts recommended a need for stronger mental health support. This was also emphasized during the FGDs and KIIs.

*Chart 10: Current level of mental health support services*

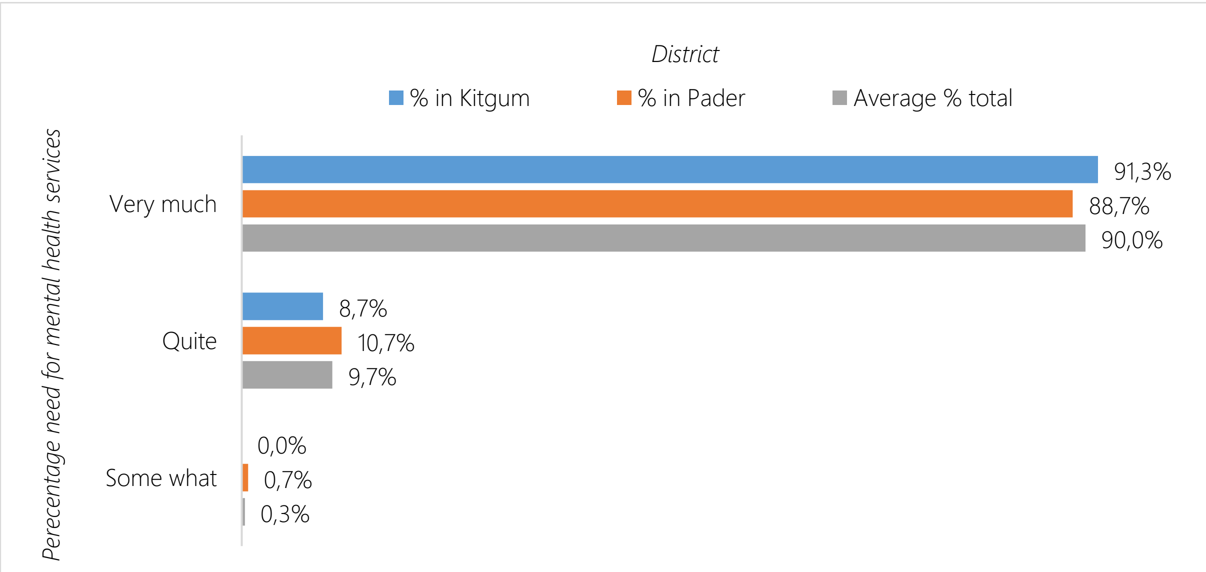



At least the majority of the respondents mentioned that there wasn't enough support for persons with mental health problems within the communities, namely, on average 1.7% (3.3% in Pader District only) strongly agreed that there is enough support for persons with mental health problems, 12.0% (respectively 6.0% in Kitgum District and 18.0% in Pader District) agreed to the existence of enough support to persons with mental health problems, 24.0% (respectively 30.0% in Kitgum District and 18.0% in Pader District) disagreed, while a high 60.0% (respectively 60.7% in Kitgum District and 59.3% in Pader District) thought that MHPSSMHPSS services are not sufficiently available. In addition, 2.3% (respectively 3.3% in Kitgum District and 1.3% in Pader District) were undecided. In an interview with a key informant respondent in Mucwini Sub-county headquarters, a male leader commented that

> *"we are the ones on ground and we still have fresh memories and bad thoughts of the LRA insurgency, and we see support only being directed to the refugees in the nearby Lamwo settlement. Very little was done to support our very own people in attempts to heal from our wounds and yet Mucwini is where there were mass killings. I personally survived because blood covered all over by body while I slept amidst killed people. There could have been some attempt by the Government and other few partners but we know the reality. Our wounds are still very fresh because almost everyone here is now an orphan."*

In terms of mainstreaming mental health into the national system, a male key informant at Pajule HC IV expressed his dissatisfaction on how the ten (10) percent of the budget allocated to MHPSS activities and support supervision are diverted towards clearing utility bills. In addition, health workers attached to the mental health department are not part of budgeting and planning at the facility level. Lack of resources to support awareness raising led to a huge knowledge gap regarding mental health and psychotropic medicines are inadequately available in the facilities. According to the district maternal and child health focal person of Kitgum District, all the above factors affect the mental health service delivery in Kitgum and Pader Districts, resulting in an increasing rate of mental health symptoms within the area.

*Chart 11: Need for mental health services provided by CCVS-Uganda*




To a greater extent the communities of Kitgum and Pader Districts emphasized a stronger need for CCVS-Uganda to provide mental health services as follows:

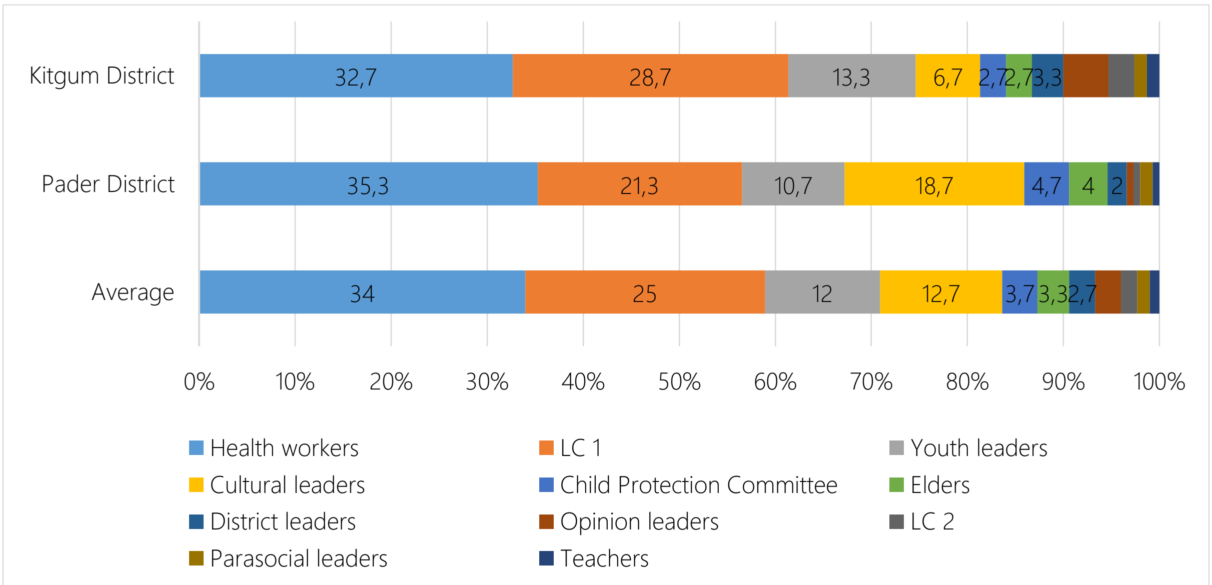
- As shown in the chart above, on average an overwhelming 90.0% (respectively 91.3% in Kitgum District and 88.7% in Pader District) very much see a need for CCVS-Uganda to provide mental health services;
- 9.7% (respectively 8.7% in Kitgum and 10.7% in Pader District) on average said the mental health services are quite needed; and
- 0.3 % (0.7% in Pader District only) on average said the communities somewhat needed the services.

The stronger need for mental health services was consistent with the findings on the thoughts of the community people on the current levels of support provided to the communities in Kitgum and Pader Districts by the current and proposed MHPSS actors in the two districts as shown in Charts 8 and 12.

### *3.6.4 Key stakeholders with whom CCVS-Uganda can cooperate*

From the chart below, findings revealed that amongst other stakeholders, local leaders, cultural leaders, health workers and youth leaders could play key cooperative roles to support CCVS-Uganda in its provision of mental health services.

*Chart 12: Key stakeholders with whom CCVS-Uganda can cooperate (in %)*




As indicated in the table above,

- On average, 34.0% (respectively 32.7% and 35.3% in Kitgum and Pader Districts) mentioned health workers, 25.0% (respectively 28.7% and 21.3% in Kitgum and Pader Districts) mentioned LC1, 12.7% (respectively 6.7% and 18.7% in Kitgum and Pader Districts) pointed to cultural leaders, while an average of 12.0% (respectively 13.3% and 10.7% in Kitgum and Pader Districts) mentioned youth leaders as key stakeholders with whom CCVS-Uganda can collaborate; and
- Other categories of stakeholders mentioned to be relevant in strengthening the work of CCVS-Uganda included the following, on average, 3.7% (respectively 2.7% and 4.7% in Kitgum and Pader Districts) mentioned CPCs, 2.7% (respectively 3.3% and 2.0% in Kitgum and Pader Districts) said district leaders can continue to cooperate with CCVS-Uganda in

implementing its work, 3.3% (respectively 2.7% in Kitgum District and 4.0% in Pader District) mentioned elders, 1.7% (respectively 2.7% in Kitgum District and 0.7% in Pader District) mentioned LC2, 2.7% (respectively 4.7% in Kitgum District and 0.7% in Pader District) mentioned opinion leaders, 1.3% (respectively 1.3% in Kitgum District and 1.3% in Pader District) mentioned para-social workers, and 1.0% (respectively 1.3% in Kitgum District and 0.7% in Pader District) mentioned teachers as a reliable source of cooperation and strengthening the work of CCVS-Uganda.

In a discussion with the focal person for mental services in Pader District, Pajule HC IV, he commented that

> *"Most local leaders, health workers and youth leaders are very relevant during case management providing support in client identification, referrals and offering basic counselling to clients."*

This is consistent with the finding that most respondents preferred local leaders (LC1, LC2, youth leaders) and health workers as shown on the quantitative analysis in the table above.

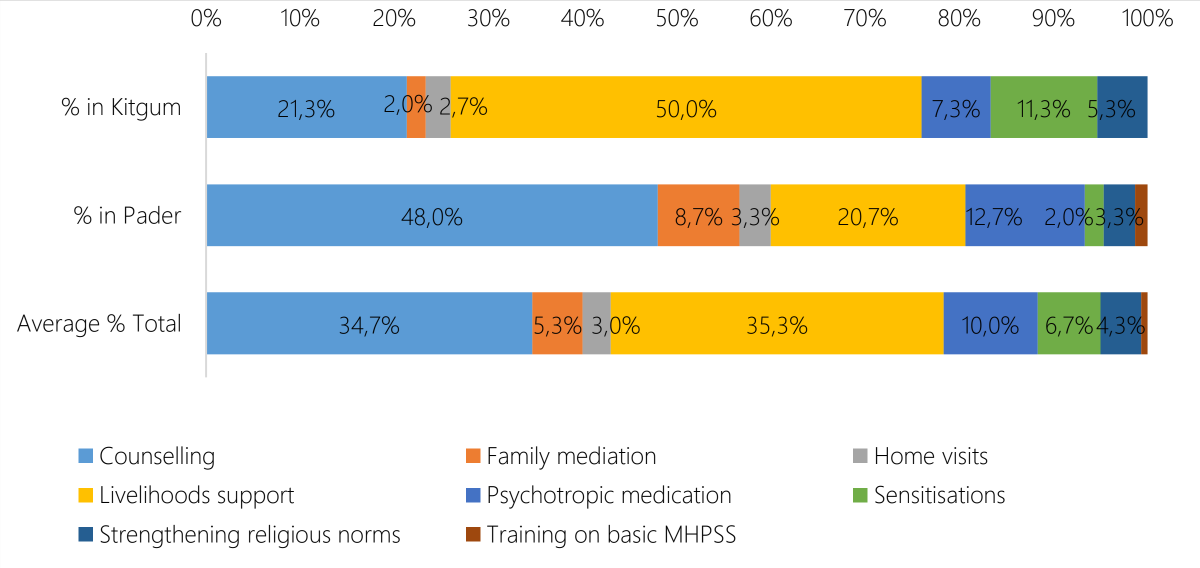
### *3.6.5 Expected MHPSS services*

The chart below clearly provides an analysis of the specific and relevant mental health support services recommended by the communities in Kitgum and Pader Districts to persons who are experiencing mental health problems. Most key services expected by the sample population of Kitgum and Pader Districts are rehabilitation services, of which, on average, 35.3% (respectively 50.0% in Kitgum District and 20.7% in Pader District) mentioned livelihood support, 34.7% (respectively 21.3% in Kitgum District and 48.0% in Pader District) mentioned counselling, 10.0% (respectively 7.3% in Kitgum District and 12.7% in Pader District) mentioned psychotropic medication, 6.7% (respectively 11.3% in Kitgum District and 6.3% in Pader District) mentioned sensitization, 5.3% (respectively 2.0% in Kitgum District and 8.7% in Pader District) mentioned family mediation, 4.3% (respectively 5.3% in Kitgum District and 3.3% in Pader District) mentioned strengthening religious norms, 3.0% (respectively 2.7% in Kitgum and 3.3% in Pader District) mentioned home visits and 0.7% (respectively 0.0% in Kitgum District and 1.3% in Pader District) said they needed trainings on basic MHPSS. During an interview with key informant respondent at Kitgum District headquarters, the male District leader noted that

> *"some rehabilitation programs were implemented in northern Uganda to aid victims in their recovery, but there still appears to be a huge gap in how to handle victims suffering from psychological conditions. This is because many of these programs*

*focused heavily on physical rehabilitation, involving medical treatment for health complications and injuries inflicted upon victims"*

*Chart 13: MHPSS services expected by respondents*




The above analysis confirmed that most respondents pointed towards three key areas that should be strongly supported by CCVS-Uganda not forgetting all the other interventions mentioned. The three most highly rated interventions included psychological counselling at an average of 34.7%, psychotropic medication at an average of 10.0% and livelihood support at an average of 35.3%. Most community members preferred to have livelihood support integrated with counselling services as you can see livelihood and counselling services are the most highly rated on the chart above. In addition, one female participant in the FGD in Pader District stated that

*"On completion of counselling, we also need livelihoods services like VSLA, goat rearing, and provision of assorted farm materials among other things that will support families to pay fees and support quality medication for our children".*

# 4. CONCLUSION AND RECOMMENDATIONS

## 4.1 Conclusion

CCVS-Uganda is providing psychological rehabilitation services in the Districts of Lira, Oyam and Alebtong, supporting war-affected individuals, families and communities. Because of the significant outcomes from the implementation of MHPSS services through research, practice and dissemination of knowledge from the findings of and practice, CCVS-Uganda's intention to expand its operation to Kitgum and/or Pader Districts will promote and improve people's psychological wellbeing in the communities where mental health services are needed the most although its impact may not be felt immediately. However, CCVS-Uganda will work with relevant categories of stakeholders and partnerships to identify clients, make referrals and provide basic counselling upon thorough trainings on PSS to the stakeholders.

While the war in Northern Uganda caused and indirectly continues to inflict more psychological problems to community members, domestic violence and drug abuse were also mentioned as common causes.

## 4.2 Recommendations

Similar findings were evident in a survey that was executed in Lira and Oyam District in 2017. CCVS-Uganda will continue to offer counselling and guidance services to the new project areas of operation with special emphasis to war victims and families with domestic violence.

According to the assessment, both group and individual counselling programmes are found to very effective. Clients in groups find solace in each other and are able to benefit from coping mechanisms of other group members which may not be the case for clients who are in individual therapy. However, it is also important to note that some clients prefer to work one-on-one depending on their needs and preferences, and group dynamics may not be a fit for them.

CCVS-Uganda with lessons learned from the practice of mental health in Lira areas will y continue with flexibility to closely collaborate with local leaders, health workers, youth leaders and cultural leaders among others in its systemic approach of work.

With evidence of analysis data presented categorically between men and women, gender mainstreaming will be a component of CCVS-Uganda gender analysis and programming.

Train the stakeholders on PSS and referral systems and conduct massive sensitisations and psychoeducation to expand the community's knowledge on MHPSS.

CCVS-Uganda will ensure its partnerships with other psychosocial/psychological implementing partners are strengthened in and out of the field.

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## APPENDIXES

### A. Survey

| | | | | |
|---|---|---|---|---|
| | Questionnaire No: | ____________________ | | |
| SECTION 1: GENERAL INFORMATION | | | | |
| 1.1 | District | Kitgum | 1 | \|___\| |
| | | Pader | 2 | |
| 1.2 | Sub-County *(Only the sub-counties in a selected district should be seen in the tablet)* | Acholi-bur | 1 | \|___\| |
| | | Angura | 2 | |
| | | Pajule | 3 | |
| | | Mucwini | 4 | |
| | | Orom | 5 | |
| | | Lagoro | 6 | |
| 1.3 | Parish *(The command selects parishes according to the respective Sub Counties and district)* | Listed in the tablet; they are many | | \|___\| |
| 1.4 | Village | | | \|___\| |
| 1.5 | Interview date *(auto date and time)* | _/_ /20_ | | \|___\| |
| 1.6 | Enumerator *(Select one/enumerators' name only)* | Elsy | 1 | \|___\| |
| | | Stephen | 2 | |
| | | John | 3 | |
| | | Bosco | 4 | |
| | | Stanley | 5 | |
| | | Justine | 6 | |
| 1.7 | Supervisor | Pius | 1 | \|___\| |
| | | Faith | 2 | |
| SECTION 2: INFORMATION ABOUT THE RESPONDENT | | | | |
| 2.1 | Respondents code | | | |
| 2.2 | Sex *(MUST enter)* | Male | 1 | \|___\| |
| | | Female | 2 | |
| 2.3 | Age bracket *(MUST enter)* | 18-24 years | 1 | \|___\| |
| | | 25-34 years | 2 | |
| | | 25-49 years | 3 | |
| | | 50 years and above | 4 | |
| 2.4 | Employment Status | Civil Servant | 1 | \|___\| |
| | | Student | 2 | |
| | | Opinion leader | 3 | |
| | | Farmer | 4 | |
| | | Religious leader | 5 | |
| | | NGO staff | 6 | |
| | | VHT | 7 | |
| | | Farmer | 8 | |
| | | Other (Specify) | 99 | |
| 2.5 | Religion | Catholic | 1 | \|___\| |
| | | Anglican | 2 | |
| | | Muslim | 3 | |

| | | | | |
|---|---|---|---|---|
| | | Pentecostal | 4 | |
| | | SDA | 5 | |
| | | Other (Specify) | 99 | |
| 2.6 | Marital Status | Married | 1 | \|___\| |
| | | Single | 2 | |
| | | Separated | 3 | |
| | | Widowed | 4 | |
| | | Divorced | 5 | |
| 2.7 | Highest level of Education | Primary | 1 | \|___\| |
| | | "O" level | 2 | |
| | | "A" level | 3 | |
| | | College/Tertiary/University | 4 | |
| | | None | 5 | |
| **SECTION 3: DEFINING MENTAL HEALTH (SUPPORT)** | | | | |
| 3.1 | How would you define mental health problems? | | | |
| **SECTION 4: CAUSES OF MENTAL HEALTH PROBLEMS** | | | | |
| 4.1 | What do you think people consider the main causes of mental health problems in this community? | | | |
| 4.2 | Out of the causes mentioned, which ONE do you believe is the MOST IMPORTANT? | | | |
| 4.3 | Which kind of mental health problems do you think are common in your community? | | | |
| **SECTION 5: KNOWLEDGE, ATTITUDES, PERCEPTION AND BELIEFS ABOUT MENTAL HEALTH** | | | | |
| 5.1 | Do you have people with mental health problems in your community? | Yes | 1 | \|___\| |
| | | No | 2 | |
| | | I don't know | 3 | |
| 5.2 | How would you assess the general state of the mental illnesses in this community? | Extremely severe | 1 | \|___\| |
| | | Very severe | 2 | |
| | | Moderately severe | 3 | |
| | | Mildly severe | 4 | |
| | | Not at all | 5 | |
| 5.3 | How can you see someone in your community is not mentally well? | | | |
| 5.4 | What kind of issues do people with mental health problems have? | | | |
| 5.5 | How do you compare your house hold's mental health challenges during the past 12 months (from November 2018)? *(Skip 6.3.1 is the respondent selects option 4(never existed)* | Increased | 1 | \|___\| |
| | | Same as previous year | 2 | |
| | | Decreased | 3 | |
| | | Never existed | 4 | |

| | | | | |
|---|---|---|---|---|
| **SECTION 6: MENTAL HEALTH RESOURCES & SUPPORT** | | | | |
| 6.1 | Which type of support could help people with mental health problems? | | | |
| 6.2 | Where do persons with mental health problems go for support?<br>*(Text)* | | | |
| 6.3 | What are your sources of support for mental health within your community?<br><br>*(Be sure of the options the respondent is & making. Please check all that apply-do not read the options)*<br>*(Multiple response)* | Friends | 1 | \|___\| |
| | | Father | 2 | |
| | | In-laws | 3 | |
| | | Counsellors | 4 | |
| | | Religious institutions | 5 | |
| | | Radio program, "Healing Our Wounds" | 6 | |
| | | Elders | 7 | |
| | | None | 8 | |
| | | Other (Specify) | 99 | |
| 6.3.1 | What was the MOST important source of mental health support for your household during the previous 12 months?<br>*(Text)* | Choose from the options above | | \|___\| |
| 6.4 | Do you think there is enough support for persons with mental health problems in your community? | Strongly agree | 1 | |
| | | Agree | 2 | \|___\| |
| | | Undecided | 3 | |
| | | Disagree | 4 | |
| | | Strongly disagree | 5 | |
| 6.5 | Client referral of persons for mental health services are a common practice in this community | Strongly agree | 1 | \|___\| |
| | | Agree | 2 | |
| | | Undecided | 3 | |
| | | Disagree | 4 | |
| | | Strongly disagree | 5 | |
| **SECTION 7: ASSESSING MENTAL HEALTH AND PSYCHOLOGICAL NEEDS OF THE RESPONDENT** | | | | |
| 7.1 | About how often in the last two weeks did you feel so afraid that nothing could calm you down? | All of the time | 1 | \|___\| |
| | | Most of the time | 2 | |
| | | Some of the time | 3 | |
| | | A little of the time | 4 | |
| | | None of the time | 5 | |
| | | Don't know | 6 | |
| | | Refused | 7 | |
| 7.2 | About how often during the past two weeks did you feel so angry that you felt out of control? | All of the time | 1 | \|___\| |
| | | Most of the time | 2 | |
| | | Some of the time | 3 | |
| | | A little of the time | 4 | |
| | | None of the time | 5 | |
| | | Don't know | 6 | |
| | | Refused | 7 | |

| | | | | |
|---|---|---|---|---|
| 7.3 | During the last two weeks, about how often did you feel so uninterested in things that you used to like, that you did not want to do anything at all? | All of the time | 1 | \|___\| |
| | | Most of the time | 2 | |
| | | Some of the time | 3 | |
| | | A little of the time | 4 | |
| | | None of the time | 5 | |
| | | Don't know | 6 | |
| | | Refused | 7 | |
| 7.4 | In the last two weeks, have you done anything, started to do anything, or prepared to do anything to end your life? | All of the time | 1 | \|___\| |
| | | Most of the time | 2 | |
| | | Some of the time | 3 | |
| | | A little of the time | 4 | |
| | | None of the time | 5 | |
| | | Don't know | 6 | |
| | | Refused | 7 | |
| 7.5 | You may have experienced one or more events that have been intensely upsetting you, such as the LRA war. During the last two weeks, about how often did you feel so severely upset about the war or another event in your life, that you tried to avoid places, people, conversations or activities that reminded you of the event? | All of the time | 1 | \|__\| |
| | | Most of the time | 2 | |
| | | Some of the time | 3 | |
| | | A little of the time | 4 | |
| | | None of the time | 5 | |
| | | Don't know | 6 | |
| | | Refused | 7 | |
| 7.6 | The next question is about feelings of fear, anger, fatigue, disinterest, hopelessness or upset that may have affected you during the last two weeks. During the last two weeks, how often were you unable to carry out essential activities for daily living because of those feelings? | All of the time | 1 | \|__\| |
| | | Most of the time | 2 | |
| | | Some of the time | 3 | |
| | | A little of the time | 4 | |
| | | None of the time | 5 | |
| | | Don't know | 6 | |
| | | Refused | 7 | |
| 7.7 | Could you have had an experience with the past LRA war? *(If Yes, Go to 7.7.1otherwise skip)* *[The respondent narrates to the interviewer their experience]* | Yes | 1 | \|___\| |
| | | No | 2 | |
| 7.7.1 | Please specify its year of occurrence *(MM/YR)* *(The respondent can use events calendar if they do not remember well)* | | | MM/YR |
| **SECTION 8: RECOMMENDATIONS TOWARDS FUTURE PROJECT PROGRAMMING** | | | | |
| 8.1 | Do you see a need for CCVS-Uganda to provide mental health services within your area or location? *(Can be school, Health Centre, Community etc...)* | Not at all | 1 | \|___\| |
| | | Somewhat | 2 | |
| | | Quite | 3 | |
| | | Very much | 4 | |

| | | | | |
|---|---|---|---|---|
| 8.2 | Where possible do you think CCVS-Uganda services are needed the most in this area?<br>*(Multiple response)* | Prison | 1 | \|___\| |
| | | School | 2 | |
| | | Community | 3 | |
| | | Health Centre | 4 | |
| | | Working places/Offices | 5 | |
| | | Other (Specify) | 99 | |
| 8.3 | Who do you think can benefit most from the services of CVS-Uganda?<br>*(Multiple response)* | Children | 1 | \|___\| |
| | | Women | 2 | |
| | | Elders | 3 | |
| | | PWDs | 4 | |
| | | Working population | 5 | |
| | | Ex-combatants | 6 | |
| | | Other (Specify) | 99 | |
| 8.4 | What kind of services do you think people from this community who are experiencing mental health problems need? | | | |
| 8.5 | In your opinion, who are the categories of relevant stakeholders that you think CCVS-Uganda can work with in providing its mental health services?<br>*(Feel free to mention all that is relevant)* | | | |

## B. Focus group discussion (FDG) guide

1. *Defining mental health:*
    a. According to this community, what is your understanding of the word, mental health, what sort of things come to your mind about the word? How would you define mental health?

2. *Causes of mental health problems:*
    a. If people are faced with mental health problems, in your own opinion, what do you think is causing most of the mental health problems in this community/school/health centre?
    b. Do you think the past LRA insurgency impacted on the mental health and social life of the people in this community?
    c. To what extent do you think people in this community/school/health centre are faced with mental health problems that needs attention from the mental health care providers?
    d. What kind of mental health problems do you think are common in your community and which target group is affected the most? Why?

3. *MHPSS interventions:*
    a. What would you consider mental health interventions?
    b. How do you think people experiencing mental health problems in this community are currently being supported? Who are the ones specifically providing support? How easy has it been to deal with or/manage the challenges experienced while offering the support?
    c. To what extent can CCVS-Uganda be of relevance in providing mental health support services within your community? How about other relevant stakeholders?

4. *Concluding question:* Of all the things we've discussed today, what would you say are the most important issue(s) you would like improved as far as addressing psychological need is concerned in this community?

## C. Key informant interview (KII) guide

1. *Defining mental health:*
   a. What is your understanding of people's awareness, knowledge and attitudes as well as perception on mental health in this community?
   b. In your own opinion, what is the nature and quality of information related to mental health concerns provided to the affected population during and after emergencies from the past LRA insurgency?
   c. How culturally and locally sensitive are or could the mental health materials (i.e., counselling/therapeutic interventions and techniques) be provided to this community are/be?

2. *Causes of mental health problems:*
   a. If people are faced with mental health problems, in your own opinion, what do you think is causing most of the mental health problems in this community/school/health centre?
   b. Do you think the past LRA insurgency impacted on the mental health and social life of the people in this community?
   c. To what extent do you think people in this community/school/health centre are faced with mental health problems that needs attention from the mental health care providers?
   d. What kind of mental health problems do you think are common in your community and which target group is affected the most? Why?

3. *MHPSS interventions:*
   a. Which mental health interventions are being promoted by the current providers of mental health services in your District to enhance the recovery of people with mental illnesses in the communities and how they can be scaled up?
   b. What capacity exists in the community at large to address mental health support, including specialized care for people with mental disorders?
   c. To what extent have mental health support concepts been mainstreamed into government plans, policies and frameworks at national and state level??
   d. To what extent can CCVS-Uganda be of relevance in providing psychological support services within your community? How about other relevant stakeholders?
      i. What are the community mechanisms/networks with grassroot presence who could be a potential partner for CCVS-Uganda?

4. *Concluding question:* Of all the things we've discussed today, what would you say are the most important issue(s) you would like improved as far as addressing psychological need is concerned in this community?

## About Centre for Children in Vulnerable Situations (CCVS)-Uganda

Centre for Children in Vulnerable Situations (CCVS) was initiated in 2008 after the closure of the Rachele Rehabilitation Centre for former child soldiers in Northern Uganda. Following a request of the Belgian Ministry of Foreign Affairs, an interuniversity cooperation between Ghent University, Vrije Universiteit Brussel and the University of Leuven (BE) was started to conduct research on support for and wellbeing of formerly abducted children and war-affected children and their families in general.

This interuniversity cooperation, the Centre for Children in Vulnerable Situations (CCVS), aims at enhancing the psychosocial wellbeing of children and youth living in vulnerable situations in Southern countries. CCVS has elaborated activities in eight countries: Bolivia, Uganda, DRCongo, Colombia, Palestine, Uruguay, South Africa and India.

Its activities are built around three central axes which are closely related:

1. *Research* studying the psychosocial wellbeing of persons living in vulnerable situations in the South. These studies are practice-oriented, which means that the research questions are relevant for practitioners, and that the study results are disseminated as widely as possible. Studies are conducted in collaboration with local universities and researchers.
2. *Support* for children and youth in vulnerable situations in the South: in particular, two counselling centres have been established, one in Eastern DRCongo (Bunia) and one in Northern Uganda (Lira), where local staff is involved in a range of diverse activities, all aiming at supporting the psychological health of war-affected persons and their contexts; and
3. *Dissemination of practices and knowledge*, via, amongst others, the organizations of local workshops, publications, website and international conferences and fora.

Since January 2011, CCVS-Uganda, one of CCVS's psychological support centres, has been playing an active role in promoting the psychological health of children, youth and adults living in post-war Northern Uganda and, more specifically, in Alebtong, Lira and Oyam District.

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