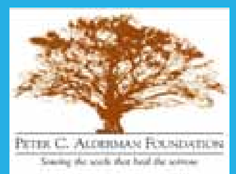
AFRICAN JOURNAL OF TRAUMATIC STRESS

Volume 3 Number 2 June 2014

SGBV

Mutilations, Rape, Burning, Beatings Torture, Poverty Sorrow, Disease



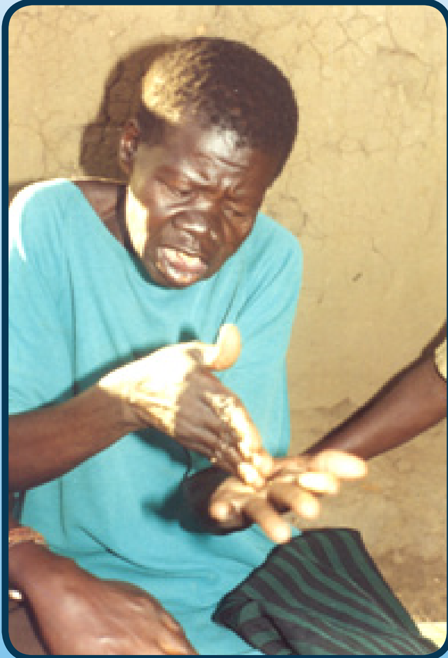
A publication of
Makerere University College of Health Science
In Collaboration with Peter C. Alderman Foundation

Cover Story:

1. *Women traumatised during the Northern Uganda insurgency.*
   Source: *Courtesy of Isis-WICCE, Kampala, Uganda*

PUTTING THE FACE TO THE TRAUMA

Courtesy of Isis-WICCE, Kampala, Uganda



At 51, demonstrating her genital pain.

Depression: Abducted & forcibly married off to a commander

RAPE

Devota was raped by 16 soldiers and died from HIV/AIDS

PEACE WITHOUT JUSTICE IS NOT SUSTAINABLE PEACE

Source: *www.isis.org.ug*

AFRICAN JOURNAL OF TRAUMATIC STRESS

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ABOUT THE AFRICAN JOURNAL OF TRAUMATIC STRESS

The African Journal of Traumatic Stress (AJTS) was established after the long realization of the need for all workers caring for traumatized people in Africa, to communicate to each other, to share experiences, knowledge, skills and to support each other. It was realized that there was a need to document and communicate all this knowledge to a wider audience beyond the African continent for the world to know, appreciate and help the traumatized peoples of Africa in the context of the now globalized increase of torture and organized violence as well as other man-made and natural disasters.

The primary objective of the AJTS is to provide a forum for discussion and presentation of papers to enhance the care and rehabilitation of the traumatized people's of Africa and beyond and ultimately to contribute to prevention efforts to eradicate this evil of torture and organized violence from Africa and the world at large.

The AJTS will publish original papers from wide and far-reaching multi-disciplinary backgrounds, including research papers, field experiences, new innovations in care, reports, commentaries, book reviews and even personal stories. Evidence-based papers will be of paramount importance. Short communications, newsworthy reports, review papers, cross cutting issues as well as picture-stories will all be welcome. The AJTS does not espouse any particularly ideology/philosophical view but believes in the universal respect to human rights for all, in good participatory democratic governance and in the empowerment and protection of vulnerable groups and all peoples from exploitation and oppression and advocates for an end to warfare and all its industry; and for peace, freedom and justice for all the peoples for the world irrespective of race, colour, creed, ethnicity, religion, gender, age or political persuasion.

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ABOUT THE PETER C. ALDERMAN FOUNDATION

The Peter C. Alderman Foundation is a non-profit organization established by Dr. Steven and Mrs. Elizabeth Alderman to help traumatized survivors the world over to heal from the mental health effects of trauma.

The Foundation is named after Peter C. Alderman, the second son of the Aldermans who was killed in the September 11, 2001 terrorist attacks on the World Trade Centre, New York City, USA. He was at the tender age of 25. In memory of their son, the Aldermans, together with friends and relatives, decided to do something positive about their grief, hence the Foundation.

The Foundation's mission statement is "To heal the emotional wounds of victims of terrorism and mass violence by training doctors and establishing trauma treatment centres in post-conflict countries around the globe."

As part of its mission, the Foundation works to alleviate the suffering of war survivors in communities affected by conflict. The Foundation aims to provide holistic mental health care including (but not limited to) physicians, psychiatric clinical officers, psychiatric nurses, counselors and psychiatric social workers in these areas and to equip them with the tools to treat mental disorder using western medical therapies in combination with local healing traditions.

To fulfill this mission; the Foundation provides services in the areas of:

1. Mental health care to war affected persons through supporting "Trauma Treatment Clinics."
2. Psychosocial support to vulnerable peoples like formerly abducted children, former child soldiers, victims of rape, war widows, single mothers and HIV/AIDS patients in the war affected communities.
3. Training health workers in the war affected areas in the management of the mental health effects of war.
4. Awareness raising, sensitization, mobilization and holding training workshops on Management of Trauma.
5. Research in the mental health effects of war trauma on the population.

To achieve these objectives the Foundation works with and within the existing Ministry of Health structures of the host country. In Africa, the Foundation currently supports work in Uganda (three trauma clinics and soon to open a fourth clinic) and Rwanda (one clinic) and is soon to open up a service in Liberia and Kenya.

EDITORIAL

War and Sexual and Gender Based Violence in Africa

The shame facing Africa today and especially Sub-Saharan Africa is the unprecedented high level of Sexual and Gender Based Violence, SGBV, in African wars. Sexual and gender based violence has reached alarming rates in the conflict prone countries in Africa to become a matter of concern for international peace, security and human rights.

Women, for long, have been the battleground for men's wars. Women have been considered war booty for centuries. At other times, they have been used as exchange for peace, pacifying soldiers or even in peace treaties. Outside of Africa, Chinese women were used as sex slaves for Japanese soldiers in WWII. In the Bosnia-Herzegovina war, systematic rape of women was carried out to change the genetic composition of the "enemy". So one has to ask: "What's new about SGBV in war in Africa?"

Over decades, numerous African countries have endured decades of armed conflicts that have had traumatic consequences on the lives of her people. The human dignity and rights of women and girls have been violated due to a systematic 'culture' of rape and other forms of sexual and gender based violence that prevail in the conduct of armed conflict and which continue long after conflict has ended. The commonly shared perception of sexual violence as an inevitable by-product of war has contributed to making these atrocities 'normal' occurrences during war and has resulted in widespread and opportunistic sexual violence in post-conflict contexts with almost total impunity.

In Northern Uganda, women were raped systematically and many had their lips, ears, noses cut off "for aiding the enemy". Young girls were targeted for abduction by the Lord's Resistant Army (LRA) to be used in forced marriages or as sex slaves, in the distorted and absurd intention of "producing pure Acholis for the future" as the boys were taken to be child soldiers. Other women were caught up in survival sex practices which were forced on them such as commercial sex, camp following, soldier comforting, sex in exchange for security, shelter, food or gifts etc. Women became objects for gratifying men's sexual appetites and machismo insecurities. As communities broke down in war, defilement and teenage pregnancies became the order of the day.

In the Rwandan genocide, Tutsi women were raped in an effort to change the genetic composition of the population in the mistaken cultural belief that only the father's genes counted in the offspring. Today in war-torn Central Africa Republic and the Eastern Democratic Republic of Congo, rape continues on a daily basis. Studies suggest that 80% of women in the age bracket of 20-45 years have been raped at one time or another. Children as young as 3 years old and women as old as 80 years have also been raped!! Repeated gang rapes of women to the point of coma have been reported. Public rape, gang rape, forced incest, forced rape, forced witnessing of rape, defilement, genital mutilations and foreign body insertions in women's vaginas have all been done.

The long term consequences of these endemic rapes on the fabric of society are difficult to measure, but already the increasing phenomenon of children born out of rape and rejected by the communities bear with it the seeds of future violence. Mass mental illness such as Rape Trauma Syndrome, Complex Post-traumatic Stress Disorder, suicides and high HIV infection rates are all being reported. This does not bode well for the future of the continent.

The prevention of sexual and gender based violence has become an imperative for the observance of human rights on the continent as elsewhere in the world. However, in view of the historical absence of accountability for sexual violence, it is not surprising that the level of crime has increased as the level of impunity is high everywhere on the continent. What is disturbing is that those involved in the fighting (be them rebels or government forces) all partake in the practice. Why the commanding officers deliberately fail to curtail the practice is very worrying. Indeed some have been known to encourage it only to end up at the International Court of Justice (ICJ) at The Hague. But some Africans are opposed to the ICJ, yet there is no African Court of Justice with real powers to try these crimes against humanity and where impunity will not be tolerated. We cannot, as Africans, just sit by and watch as our daughters, sisters, mothers and grandmothers get raped on a daily basis. Definitive measures must be taken to ensure the elimination of SGBV in African wars as well as ensure a change of mindset that makes both sexual violence and impunity unacceptable and abnormal and a threat to peace and stability. This is our hair in our nostrils which only we can pluck out. UN resolution 1820 (2008) calls for "The cessation of war-related sexual violence against civilians in conflict zones" and UN Resolution 1325 calls for "Women's full participation in politics, the prosecution of people for war crimes against women, and for extra protection of women and girls in times of war". Africa, let's roll on this.

Seggane Musisi
Editor-in-Chief

An Assessment Of The Effects Of Trauma On Victims Of Sexual Violence In South Kivu Province, Democratic Republic Of Congo.

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ABSTRACT

Introduction: *Sexual violence directed to women has become a serious problem in the eastern regions of the Democratic Republic of Congo where there is incessant warfare. All the fighting groups have been implicated in this unfortunate and unchecked abuse of women.*

Objective: *The aim of this study was to document and understand the effects of sexual violence on its victims and their responses to solve them at the individual and community level as seen in South Kivu province, Democratic Republic Of Congo, DRC.*

Methods: *The research used mixed qualitative and quantitative methodologies and adopted a non-systematic sampling strategy. Data from the year 2007 to 2012 was reviewed supplemented with information provided by different NGO managers at various places. Qualitative interviews were conducted which provided in-depth information about trauma consequences to the sexual violence survivors.*

Results: *Our findings revealed that rape of women was a common feature of life in South Kivu province. Both soldiers and civilians raped women and girls daily even on the streets, leaving many badly traumatized and depressed. The consequences of the trauma were of physical, psychological, social and economic nature. Most of the survivors sought help in the "Maison d'écoute" (listening houses) in rural areas where the only assistance they got was from village 'wise women'. NGOs that attempted to take care of the sexual violence survivors lacked human resources and professional skills. No professional efforts, legal recourse or reparations were in place. Victims were forced to live with these deleterious effects for the rest of their lives.*

Conclusion: *There is a serious deficit of carers of the sexually traumatized in South Kivu province, DRC. There was no documentation which left no database and no coordinated care for the sexually traumatized. There is need to train health workers in the care of victims of sexual violence in South Kivu province and the setting up of a service to coordinate these efforts.*

AJTS 2014 3(2): 41-47

INTRODUCTION

Sexual violence is an old phenomenon in the world and it happens in different forms at different periods and places. In peace time it happens to humiliate, debase and hurt the victims while in wartime it has become a war strategy particularly in Africa (Richters, 2001; Hagen, 2010). In the Democratic Republic of Congo (DRC) context, it became an issue that attracted the interest of national and international Non-Governmental Organizations (NGOs) since it became a weapon of war used in the wars of between 1996 through 1998 to now. In addition to the destruction of the state infrastructure that was already critical, the wildly war in DRC has claimed lives of more than four million people and sexual violence was widely used as a 'war weapon' with various consequences including the fast spread of sexually transmitted diseases, HIV/AIDS, gynaecologic complications due to rape, unplanned pregnancies and children born from rape as well as psychological trauma (Kalonda 2008; Zihindula 2011).

In the DRC, sexual violence has been conducted with particular brutality, atrocity and has had long term effects on individual and community levels. It is estimated that 40 women are raped each day in the

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DRC where 3% die and 10-12% contract HIV/AIDS (Rodriguez, 2007); 60% are teenagers and one of three are less than 13 years old (Goblet, 2007). The statistics reported by the media are totally different and misleadingly low from the reality on the ground as many women go into hiding for fear of being labelled by the community members and this becomes very frustrating and traumatizing to them. The trauma and frustration is also due to the fact that sexual violence in most cases occurs in public often forcing one family member to observe when the other is being raped and this is regardless of age or gender (Banza-Nsungu et al., 2011). Due to this continued and ever increasing sexual violence, statistically, the country ranks among the highest regions with gang rape and sexual slavery (Sebit, 2013).

In order to respond to sexual violence and its consequences, Non-Governmental Organizations (NGOs) and health care workers play an important role. On the ground, actions to raise community awareness to break the silence and to reintegrate survivors in their communities are on-going. The above organisations have established small offices called "maison d'ecoute" ("house for listening") in which survivors receive counselling, encouragement, orientation and medical care after being subjected to sexual violence. The aim of this study was to document and understand the effects of trauma on victims of sexual violence and to explore responses built from the ground level and from the health care institution level to solve them.

Psychosocial care at Panzi Hospital

Psychosocial care at Panzi Hospital was framed into a chain of processes starting at the reception. The sexual violence survivor is welcomed by the Assistant of Psycho-social Services (APS) who has had some basic training in psychosocial care, This APS has the first discussion with the survivor after which she opens a file for the patient for reference. She then refers the survivor to the psychologist who then assesses the patient. The patient may then be referred back to the APS for administration of the treatment/counseling. OR, if the problem needs a neuropsychiatrist, the patient is referred on without passing back to the APS.

This psychosocial care is organized at three levels: Primary, Secondary and Tertiary. NGOs consider only the primary or first level that is handled by 'wise women' called : "Assistants of Psycho-Social" Services (APS) who work in a variety of small houses called "maison d'ecoute" or 'houses for listening'. Almost a 100% of these 'wise women' are not schooled and are not professionally trained into psychosocial treatment. Nevertheless, Panzi hospital has organized a process that tries to encompass all the three traditional levels of psychological treatment as follows.

***Primary/First level*:** This was started after the cultural consideration of some women who were seen as being 'wise, mature, confident and respected' in their community. Since the rise of the high rates of sexual violence in 1998, the survivors of sexual violence used to visit these women for advice. NGOs involved in the fight against sexual violence trained them on psychosocial care for victims of sexual violence and started using them as focal points to reach victims of sexual violence. They were offered short courses of training lasting for just 2 months after the completing of which, these 'wise women' qualified to be called: "Assistant of Psycho-Social" Services or APS in short. Most of these 'wise women' had limited levels of education but they knew at least how to read and write. They invite the sexual violence survivor to a confidential place called "Maison d'ecoute" (listening house) where the survivor is guaranteed total confidentiality and is encouraged to give details and the circumstances of the sexual violence tragedy. The wise woman (APS) is expected to provide psychosocial assistance on any disorders or related issues to the survivors. If she cannot assist the survivor then she refers the survivor to either the main Panzi hospital or to the NGOs involved in the fight against sexual violence at the place.

***Secondary/Second level*:** This is usually located at a house built in the rural health zone called "Maison de transit" (transit house) where there is a nurse trained in psychosocial care called "Principal Counselor". This nurse collaborates directly with doctors in the referral hospital. After training she receives a guideline manual with the job description and key focus areas. She also works hand in hand with the psychologist based at Panzi hospital in Bukavu city. If the problem persists, the psychologist at the Panzi hospital transfers the patient to the psychiatrist.

***Tertiary/Third level*:** Here the free referral circuit is broken at this level as mental health is not an integrated program in the health care system in South-Kivu province. Patients have to abandon the free health care they started at the first (primary) and second levels. When they get to the third level they are asked to pay out of their pockets for any further treatment. In the whole province of South Kivu, there is only one private Mental Health Centre called "SOSAM" that has a psychiatric department. However, SOSAM unfortunately charges for services but it is the only center which treats manifest psychiatric disorders.

METHODOLOGY

This research study used a mixed methods approach consisting of both qualitative and quantitative methodologies. A non-systematic sampling strategy was adopted. It used case studies, unstructured interviews and questionnaires to gather data.
Survivors of sexual violence who presented unusual attitude and behaviour were classified as affected by psychological traumas. Data on the psychological trauma were collected from the grassroots level “maison d'ecoute” or “listening houses” situated in the sub-districts of Kitutu, Kamituga and Mwenga zones. There were 4371 survivors of sexual violence using those houses who participated in the study. Also 1243 survivors seeking treatment for psychological traumas at Panzi hospital were included in the study. Data on sexual trauma were collected at the Panzi hospital from 2008 to June 2013 and analysed manually and through SPSS version 20.
The study's ethical clearance was received from both the Evangelic University of Africa and the main referral Hospital of Panzi. Prior to collecting data, informed consent was obtained after reading for the respondents the details of the study, its purpose, benefits and risks. Then the consent form was signed by them. The respondents were informed in advance of their rights to withdraw from the study at any stage and they were assured that their identities would remain anonymous and that information collected will be kept confidentially.

RESULTS

This study identified three kinds of trauma encountered by survivors of sexual violence. These were physical, psychological and socio-economic trauma. To each trauma, the study applied particular methods to gather and analyse the data. The victims' responses were initiated according to the type of trauma effects.

Physical trauma and their responses

Physical traumas were considered as those that touched directly the body and had effects on the parts of the survivors' bodies and required medical attention. Because of physical pains, survivors sought medical assistance from health care centres and from the “Maison d'ecoute” (listening houses). Many others were referred to Panzi hospital, this being the only place where survivors were being taken for care in South Kivu province. Victims of sexual violence seeking medical treatment presented various types of physical trauma including body or genital mutilation, sexual infections, HIV/AIDS, unwanted pregnancy, gynaecological complications, wounds, injuries, and fractures. Figure I shows the survivors of rape with physical injuries.

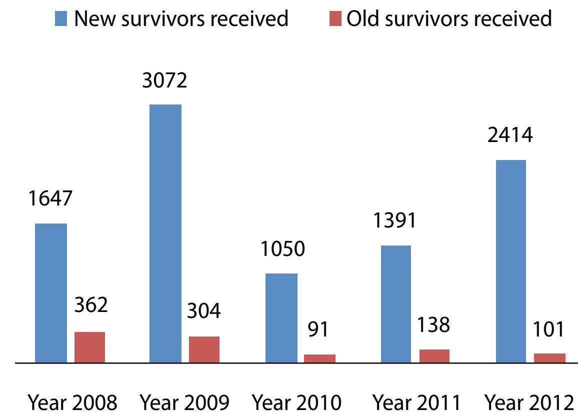


Fig. 1 Survivors of rape with physical trauma

Ten thousand five hundred seventy survivors of rape sexual violence were identified and transferred to Panzi hospital for medical care from 2008 to 2012. Survivors presenting physical trauma were divided into two groups. The first group was made of those survivors who went and received medical treatment for the very first time. The second group was made up of those who, after being treated, went back home in their respective villages but got raped again. However, the perpetrators lived in the same villages or they lived in forests not far from the village. Thus many victims were raped again and again and had to come back many times seeking treatment again and again. They were called ‘old survivors received' (Fig.1). The number of survivors increased following the war of 2008 but the number continued increasing in the 2009 post conflict time. This increase was due to the fact that there was a relative security on road and survivors could travel from their homes to the city of Bukavu in which the Panzi hospital is located. The number of survivors decreased in 2010 when the peace agreement between rebel and government was signed and safety increased in rural areas.
In addition to the raped survivors with physical trauma, many other victims of sexual violence who were not raped but presented gynecologic problems were also considered for the study.

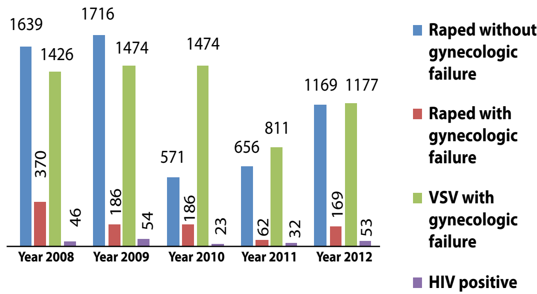


Fig. 2 Victims of sexual violence with pysical trauma

Survivors from rape without gynecological problems represented 44%. Those with gynecological problems were 7% and survivors from other forms of sexual violence other than rape were 49% (Fig 2). From 2008 to 2012, there were 349 (3%) pregnancies due to sexual violence and 3166 (24%) surgeries done to save survivors.

The data was later analyzed through grouping of the participants by age groups. These groupings allowed us to identify at which level each age group was affected and also the most affected age group. Figure 3 below summarizes these age groupings.

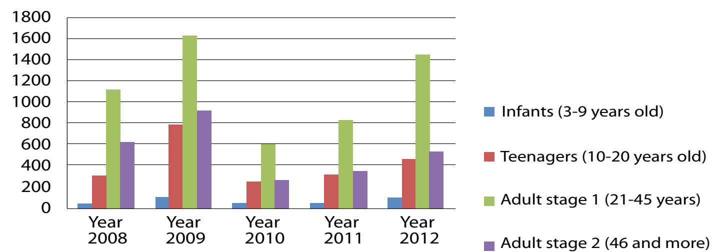


Fig. 3 Age of survivors with physical trauma

i) Figure 3 above shows that survivors of sexual violence were divided into 4 groups :Infants aged 3-9 years, 334 (3%),

ii) Teenagers aged 10-20 years, 2076 (20%),

iii) Young adults aged 21-45 years old 5578 (52%)

iv) Older adults aged from 46 years and above, 2677 (25%).

Psychological trauma and their responses

Many victims of sexual violence suffered various physical and psychological traumata. Some were wounded, some killed and others witnessed relatives being killed or were forced to assist in the killing of others. Figure 4 below shows the various reported traumata by the survivors.

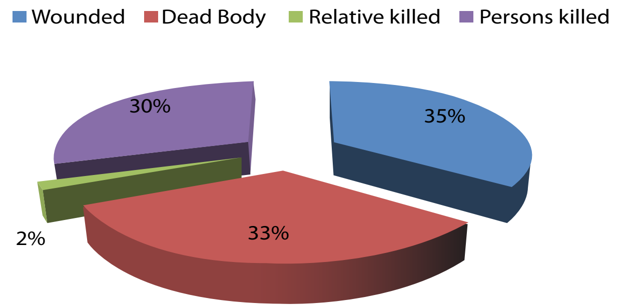


Fig. 4 Sources link to trauma

The above figure 4 represents figures linked to sexual trauma. It shows that among the victims of sexual violence as seen at Panzi hospital between April 2011- March 2013, 62% had been wounded, 59% had seen a dead body and 56% had been forced to assist in the killing of a member of their family/relative (6%) or neighbor (50%). They all came for psychological care because of psychological problems (98%), psychiatric disorder (1%) or after being rejected by their family and/or community (1%). Rape as a war weapon was the most violent and humiliating of offences. It was aimed to negatively affect the rape survivors, their entire family and the community at large. The methods used to abuse the survivors (injuries, death sights, or forced killing of people, public rape or forced incest resulted in grievous psychological harm to the survivors of the different types of trauma.

Results from the rural territories

Results from the three rural territories of Kamituga, Kitutu and Mwenga, revealed that 4371 persons had been identified as victims of sexual violence. Around 10% of them refused psychological treatment leaving ninety percent who accepted psychological treatment and these consisted of 10% men and 90% women. They received different care services for their psychological treatment with some receiving two or more types of treatments. About 90% received active listening and counseling, 10% body therapy

exercises, 54% were visited at their homes, 22% got family mediation and lastly, 5% received group therapy.

Types of survivors and distribution based on gender (Figure 5)

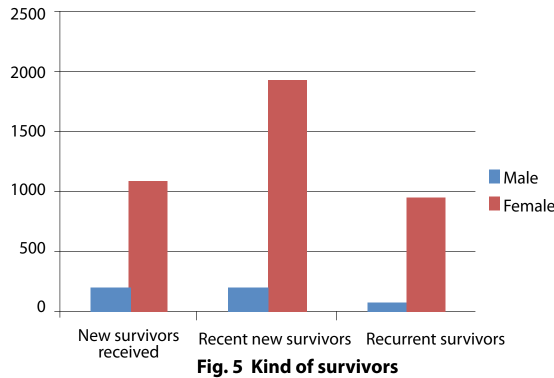
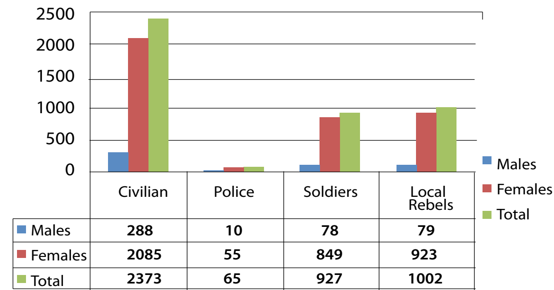


Fig. 5 Kind of survivors

As shown in Figure 5 above ther weree more women than men who received treatment. The reasons for this are culturally based. In the qualitative responses it was revealed that it is not culturally allowed for a man to break the silence when he survives sexual violence. This culture made it hard for men to come forward and report their sexual assault, hence keeping the numbers of their reported cases very low compared to those of the women. Overall, sexual violence onto men represented 12% and women 88% of the reported cases in South Kivu province.

Table 5 above also shows the different types of survivors being grouped as: new, recent and recurring survivors. New survivors were those who had come for the first time for their psychosocial visit in the program but were not newly raped survivors. Recent new survivors were those who had come for the first time in the program and they had been recently raped. Recurrent survivors were those who had been raped and received assistance at some point in the past and had been discharged from the hospital but once back in their respective villages, they were raped again hence returning for further treatment. There was thus a difference between these three kinds of women survivors who received psychosocial treatment. For example, when there was more insecurity (armed conflict/fighting) there were more and increased numbers of new recent survivors.

It remained, however, a challenge for both and community and the state to identify and punish the perpetrators of these actions of sexual violence. In most cases rapists were believed to be coming from the rebel army but findings from this study revealed differently. Table 6 below summarizes the different types of perpetrators of the sexual violence in the South Kivu province.



	Civilian	Police	Soldiers	Local Rebels
Males	288	10	78	79
Females	2085	55	849	923
Total	2373	65	927	1002

Fig.6 Perpetrator of sexual violence

As shown in Figure 6 above, 54% of the rapists were civilians The second group of rape perpetrators was made up of soldiers, 21%. Local rebels made up 23% and the last group of perpetrators were the police force who made up 2% of the rapists. Many women were raped by more than one group and were raped many times over. Thus 92% of the women reported rape by civilians and soldiers and 85% by police. The big numbers of rape by civilians was because of the campaign of demobilisation of soldiers particularly the child soldiers who then became civilians but continued their practices of raping women and other crimes including theft and robbery. Indeed many women, community leaders and NGOs reported that those child soldiers who had been demobilised and reintegrated in the community found it hard to adjust to civilian life and continued their renegade lifestyle and thus became part of the rapist groups. These were also hard to identify because the country has not had any census hence lacking the statistics for this particular population group.

Socio-economic trauma and their responses

Socio-economical trauma was defined as the relationship between the society and the resultant livelihood of the survivors of sexual violence. In most cases, the isolation of the survivors from the community affected their economic survival and often led to severe poverty. Attempts were made to encourage for the creation and implementation of formal jobs for these women survivors of sexual violence. During the sensitization campaign, people both survivors and non survivors of sexual violence were asked to create associations for micro-credit loans in their villages with each association to have at least 25 members. They

would meet on a regular basis as agreed upon by the group members and purchase shares with each person being allowed to buy maximum of 5 shares. Besides the shares, at each meeting, members were encouraged to bring something for sale to the social cashier (caisse de solidarite).

In Kitutu, Mwenga and Shabuda where the research on socio-economic trauma was conducted, two types of socio-economic trauma emerged with one being cultural and the other war caused. The cultural one was that women in the DRC were less economically empowered and did not have financial decision making powers. The war-related one was that women were less considered in financial matters. These two factors, as discussed below, were aligned and increased the social and economic trauma for the women survivors of sexual violence.

Culturally based factors

Culturally in patrilineal DRC society in matters of inheritance of property and land, a woman does not count because she is expected to get married and join the family of the husband which she is supposed to become part of for the rest of her life. In cases where all the siblings are female and the father dies, then the family chooses a male member from the extended family to inherit the property and land.
Although women do and are expected to cultivate the fields, grow the crops and do the harvesting, once the farm produce reaches home, the man/husband has the total power over it and he is the one to decide on how to use the products or its sales. At harvest time, the woman invites other women in the area in the principle called "woman solidarity" to assist her do the harvesting and transportation of the farm product back home. Because of the continuous rainfall all year, there are six agricultural growing periods and the woman is expected to be in the fields all the time. The woman also prepares food for the family but she eats her portion of the food in the kitchen with all the girl children and the boy children under 15 years of age. The rest of the food is served outside the kitchen in the "Baraza" or "meeting/seating room where her sons aged above 15 years join the fathers to eat the food. Sometimes women organize themselves to eat together around the fireplace/hearth where they may also discuss their own problems.

War-based factors

As a result of war in the eastern DRC province of Kivu, from 1996 to date, many people have moved from the rural areas to big towns seeking peace and security. Consequently, women have not been able to cultivate their fields. During the period of insecurity many women could not access their fields which were often located at further distances from their houses. Those who tried to go to the distant fields were the most victims of sexual violence. Once raped, a woman was rejected by her husband and family and the society to some extent, Even the church rejected these women survivors of sexual violence. They thus became totally isolated and this increased their socio-economic trauma. Upto 10% of women treated at Panzi hospital for rape, upon their return visits for treatments, they reported being refused to return to their villages. They then stayed in the city of Bukavu without any employment.

DISCUSSION

Our study revealed serious problems of sexual violence in South Kivu province of the Democratic Republic of Congo but with a huge deficit of services taking care of the sexually traumatized, the vast majority of whom were women. There was no documentation , no database and no coordinated care on the sexually traumatized. The majority of the organizations that attempted to take care of the sexually traumatized people did not have the necessary skills or competencies to handle the cases. This was particularly so in the rural areas where most of the violence took place.

The authors of this paper concur with Stevens (2001) who argues that the victim cannot be blamed for the actions of their offenders. In many cases survivors of sexual violence were abandoned by their partners and others were even denied re-integration into their communities following the sexual violence they endured. The fact of these denials negatively pervaded almost every aspect of the survivors' lives. As Kay et al (2005) observed, all of the physical, social, and psychological sequelae of sexual assault resulted in considerable disruption of the victim's entire life, including relationships, daily activities and their emotional feelings. Johnson et al (2010) explained further that many survivors of sexual violence were deprived of their human rights, became victimized and traumatized in indescribable ways which affected them psychologically, socially and physically. Frazier et al (2005) conducted a study looking at the coping strategies of sexual assault survivors and their findings were similar to our findings and those of the above-mentioned authors. Sexual violence survivors lacked coping strategies and they found it hard to be reintegrated in their communities and yet had no psychosocial specialized health practitioners to provide them assistance on a regular basis.

In addition, existing literature reveals that survivors of sexual violence have many other issues of concern which are of immediate, pragmatic, and realistic nature reflecting the physical, social, and emotional impacts of the sexual assault. Our study had similar findings. Most of these concerns were health issues such as getting access to hospitals for care of acquired pregnancies, venereal diseases, even HIV/AIDS as well as the nature and seriousness of the sustained physical trauma. Survivors also had concerns of whom and how to tell about their sexual assault fearing how others would react, retaliation by their assailants, the implications of reporting and for their future safety. They also had concerns regarding finances, the effects of the emotional trauma, and the immediate situational needs (Stevens 2000; Frazier et al 2005; Johnson et al 2010). All the above concerns resulted in increased trauma for the survivors due to the disruption of their lives. For some, life became unbearable which led to some committing suicide or opting to hide and not seek medical attention resulting in increased ill health and premature deaths. Yet others went into permanent exile in neighboring countries or abroad if given the chance.

CONCLUSIONS AND RECOMMENDATIONS

There is a dire need to address the problem of sexual violence in South Kivu province, DRC. This will ultimately improve the physical, psychological and economical health of the sexually traumatised survivors who are mostly women and young girls. The health sector needs to ensure that measures are put in place to tackle this problem of sexual violence before it gets worse as it affects entire communities of women and hence the society at large. Psychologists, psychiatrics, psychiatric clinical officers, psychiatric nurses and social workers should be sent in each health zone in the province to assist and train the 'wise women' leading the "maison d'écoute" .

A service to coordinate the interventions for the effects of sexual trauma should be set up by the government to treat cases of sexual trauma. The study findings suggest that there is a need for a variety of responses to address the problem of sexual trauma as presented by the survivors. First response is a need to sensitize the community on the problems of sexual violence in their war torn community. Second is the need to recognise and accept the survivors of sexual violence as innocent victims who need help for an illness they did not bring onto themselves. They are victims and cannot be blamed for the actions of their offenders. It is also not the fault of the community or the husband and his family who must be supported to be willing to allow the integration of the survivor back to their home and community. The third needed response for awareness is the sensitization of the community on the rights of women as human beings. There a need to join hands with respondents from the NGOs in assisting to raise awareness of the concept of human rights with a focus on women and children. Many community members did not seem to be aware of the concept of universal human rights for all. Finally there is a need for the integration of mental health care in general health training and that of all healthcare providers calling for mental health to be integrated in the national health system plan of the country.

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The Experience Of Chronic Sorrow Among War Victims With Traumatic Facial Disfigurement In Northern Uganda.

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Abstract

Introduction: *In post war Uganda, many people suffered physical injuries including facial disfigurement with the intention to uglify the individual for permanent outcasting and instill fear in the community. Such facial disfigurements and the ugly appearance enter into interpersonal exchanges and forces the negotiating of new rules of social engagement. This loss and grief often led to psychological distress and chronic sorrow.*

Aim: *This study explored chronic sorrow among those who were traumatized and facially disfigured during the war.*

Methods: *Twenty two facially disfigured individuals were studied using the Burke/Eakes Chronic Sorrow Assessment Tool after collecting their socio-demographic data. The tool has 10 items with "Yes or No" questions investigating feelings of loss experience: self-image disparity before and after the disfigurement, chronic sorrow, grief, trigger factors and coping strategies. Data was analyzed using SPSS version 11 and EPI-info version 2002.*

Results: *The respondents were mostly women (81.8%), aged 20-40 years (68.2%), of primary school or no education (77.3%) and 36.4% were divorced/separated. They experienced persistent Chronic Sorrow with negative self image and pathological grief. The trigger factors were thinking about and caring for their disfigured faces (86.4%), meeting others (72.7%), lost opportunities (81.8%) and anniversary dates (72.2%). The commonest coping strategy was prayer. They experienced some helpfulness from friends, family and health workers, but who did not use professionally proven interventions.*

Conclusion: *War-related traumatic facial disfigurement in Uganda led to chronic sorrow beyond understandable sadness, hence progressing to pathological grief with negative impacts on the functioning of affected individuals. The most common coping strategies were prayer, attending church/mosque and getting help and support from family, friends and health workers. Government needs to fund training for health workers for effective interventions for individuals with facial disfigurements, whether in war or peace including acid or epileptic burns. There is need for international efforts to curb the traumatisation of women as weapons of war.*

Keywords: *Chronic sorrow, trauma, facial disfigurement, grief.*

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Background

For more than 20 years, Uganda experienced political insurgence and rebel activities with mainly the Lord's Resistance Army (LRA) fighting government forces (Ovuga et al., 2008). Uganda is thus described as a post conflict country (Durick, 2013). This war was mainly in the northern and part of the eastern region of the country. During the war, massacres of civilians were perpetrated and hundreds of thousands of people were displaced from their homes. Abduction by the Lord's Resistance Army was very common; and the ages ranged from school going to adults who were forced to commit atrocities (Ovuga et al 2008). Various acts of atrocities resulted into physical disfigurement among the victims. This involved cutting off lips, noses, ears, poking out eyes and setting huts ablaze where

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victims escaped with numerous burns. These acts were often associated with other humiliating acts such as public rape, nakedification, flogging, forced incest etc to instill fear in communities and prevent them from resisting rebel activity and be submissive to them (Musisi and Kinyanda, 2001 & 2002). They often left victims with psychiatric disorders such as depression, post-traumatic stress disorder and general psychological dysfunction.

Studies, worldwide, have consistently described the problems that people with facial disfigurement encounter for example, discrimination and loss of self-esteem (Herskind,Christensen, Juel & Fogh- Anderson 1993,Turner, Thomas, Dowell, Rumsey &Sandy, 1997, Walters, 1997, Millard & Richman, 2001, Rumsey & Harcourt, 2004). The predominant difficulties lie within the area of social interactions with people and being subjected to unwanted intrusions such as staring or comments (McGrouther, 1997). McGrouther (1997) described facial disfigurement as "the last bastion of discrimination in the United Kingdom" with the root of the person's distress lying in the pressure in modern cosmopolitan society to conform to an idealized appearance. Image and beauty are marketing tools portraying particular 'supermodels' as the desired 'look,' diminishing the value of individuals who deviate from that. (McGrouther, 1997, Patridge, 1994). Consequently the concern with appearance devalues and marginalizes those who do not fit into the perceived ideal. Those with visible disfigurements, are therefore further down the ladder of beauty, and hence challenged.

The facially disfigured victims of war experience psychological disorders and physical problems including the most commonly recognized psychological disorder of torture is posttraumatic stress disorder (Tomb, 1994). The person's response to this traumatic event usually involves intense fear, helplessness or horror. The impact of physical and psychological disorders in facially disfigured individuals may result into chronic sorrow. Chronic sorrow is defined as periodic recurrence of permanent, pervasive sadness or other grief related feelings associated with ongoing disparity resulting from a loss experience (Eakes, 2004). Disfigured war victims experience a permanent loss of self image because they can never regain it or their former selves including their self-esteem. The middle range theory of chronic sorrow developed by Eakes, Burke and Hainsworth (1998) offers a framework to explain how individuals may respond to both ongoing and single loss events. It also provides an alternative way of viewing the experience of grief as the losses experienced cause disparity when people compare their reality to the desired ideal (Eakes, Burke, & Hainsworth, 1998; Roos, 2002). Chronic sorrow is considered a normal response to the ongoing negative disparity and usually the people who experience it use internal and external coping strategies throughout the experience (Eakes et al., 1998). However, if maladaptive strategies are used, the disparity created by the loss will continue to intensify and may progress to a pathological grief state such as depression or complicated grief (Eakes et al., 1998; Gordon, 2009). It is also possible that the chronic sorrow may trigger the onset of other psychiatric disorders such as substance abuse, post-traumatic stress disorder etc. There is very limited literature reporting on the experiences of chronic sorrow among war victims especially those with facial disfigurement. When the face is abnormally disfigured and ugly in appearance, it enters into interpersonal exchanges and forces negotiating new rules of social engagement. Such experiences trigger event leading to the experience of chronic sorrow. Therefore it is important to identify the existence of chronic sorrow among the facially disfigured so that they are helped in developing effective coping strategies in order to ensure good quality of life for them. This study explored chronic sorrow among those who were traumatized and facially disfigured during the war.

METHODS

Study design, setting and sample.

This study employed a cross-sectional descriptive design using quantitative methods. It was conducted in Lira and Gulu districts in Northern Uganda which were among those districts most affected by the LRA war. The participants were assessed in their communities in their local Luo language.

The respondents were individuals with acquired facial disfigurement due to war-instigated trauma in the war. Non-probability purposive sampling was used employing a snowball sampling strategy, where the already interviewed individuals referred other potential participants. A sample size of 22 individuals participated in the study as these were the only accessible participants. This sample size was small because at the time of data collection, the Internally Displaced Peoples (IDP) camps had been disbanded and the potential respondents had left and could not be reached.

Study Instruments.

We used two study instruments. The first was a sociodemographic questionnaire prepared by the first author. It collected demographic data including sex, age, ethnicity (tribe), marital status, educational level and religion. The second instrument was the Burke/ Eakes Chronic Sorrow Assessment Tool. This is a 10

item tool with “Yes or No” questions that investigates feelings at the time of a loss experience. It measures the presence of self-image disparity (before & after the disfigurement), chronic sorrow, grief related feelings, trigger factors and internal and external coping mechanisms. The instrument was piloted and adapted for use in the studied community. The participants were recruited through contacts from trauma rehabilitation centers in Lira and Gulu. The first author approached each respondent by a home visit with the help of the local village chief. The data was cleaned, coded and entered into the computer and analyzed using Statistical Package for Social Sciences (SPSS) version 11 and EPI-info version 2002.

Ethical Considerations

The research was approved by the Faculty of Medicine, Department of Nursing Makerere University and subsequently by the Uganda National Council Of Science and Technology (UNCST). Letters of permission were then obtained from the respective district authorities to carry out research in their districts. Participation was voluntary. Confidentiality was assured and observed and informed consent was obtained after explaining to the participant about the study, its benefits and risks. Written permission to use the Burke/Eakes Chronic Sorrow Assessment Tool was obtained from Georgene Eakes, one of the theorists and author of the tool.The study was then explained to the participant including risks and benefits. Voluntary informed consent was then obtained. The questionnaires were then filled out in confidence. No monetary incentives were given to the participants.

RESULTS.

These results will be presented as (i) Socio-demographic characteristics of the respondents, (ii) Disparity of self image and life circumstances before and after the disfigurement, (iii) Feelings of grief and chronic sorrow, (iv) Trigger factors and (v) Coping strategies.

Socio-demographic Characteristics of Respondents

There were 22 respondents in this study of whom the vast majority, 81.8% were women and those in the age bracket of 20-40 years were 68.2%. Table I below summarizes the demographic characteristics. Nine (40.9%) of the participants were married, 36.4% were divorced/separated and up to 87.3% only had primary school education or below and they were peasants by occupation. The majority of the participants were Christians making up to 68.2%.

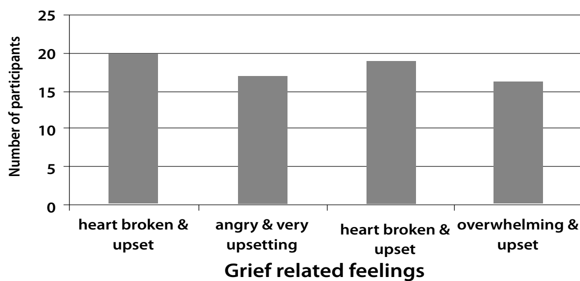
Table I: Social Demographic Characteristics (N=22).

Variable	Frequency	Percentage (%)
Sex		
Male	04	18.2
Female	18	81.8
Age in years		
Less than 20	02	09.1
20-30	10	45.5
31-40	05	22.7
41-50	03	13.6
51 and above	02	09.1
Marital Status		
Married	09	40.9
Single	03	13.6
Widowed	02	09.1
Divorced/Separated	08	36.4
Education Level Attained		
No formal education	08	36.4
Primary level	09	40.9
Secondary level	03	13.6
Certificate level	02	09.1
Religion		
Protestant	08	36.4
Catholic	07	31.8
Moslem	02	09.1
Others	05	22.7

Self Image Disparity And Chronic Sorrow.

Twenty one (95.5%) of the respondents stated that the loss they experienced had created a negative impact in their lives. All the respondents 22(100%) indicated that they experienced unpleasant changes in their lives including poor self image, poor self esteem and low self confidence and all of which they attributed to the facial disfigurement they had suffered. However they all, 22(100%), described this experience as intermittent i.e. on and off depending on the circumstances. Eighteen (81.8%) of the respondents believed that the effect of facial disfigurement would impact on their life forever

Grief related feelings associated with facial disfigurement.



When respondents were asked about grief related feelings, 20(90.9%) agreed that they were heartbroken and upset with 17(77.2%) stating that they experienced anger and found it very upsetting. Nineteen (86.4%) agreed that they experienced sadness and also found this very upsetting. Fifteen (68.2%) experienced anxiety which too was very upsetting to them. Overall, 16(72.7%) stated that they were overwhelmed and upset by these persistent negative emotions in their lives which they had not had before the disfigurement.

Trigger Factors.

Significant triggers of sorrow were identified by the study participants. These included: 19 (86.4%) who pointed to the realization of new responsibilities in looking after their disfigured faces and having to think about their disfigured (uglified) looks all the time; 17(77.3%) on meeting someone else in the same situation; ,16(72.7%) on comparing lost life potentials and opportunities; and 18(81.8%) when experiencing the anniversary of when the facial disfigurement occurred.

Coping Strategies/ Mechanisms.

The most useful internal coping strategies identified by participants were: praying 16(72.7%), talking with others in similar situations 16(72.7%), and going to church, mosque or shrine 14(63.6%).

Table II below summarizes the external coping strategies as stated by health professionals, relatives and friends.

Table II: The External Coping Strategies.

Relatives and friends Strategy/ Response	Trauma due to war, N=22 n (%)	Health Professionals Strategy/Response	Trauma due to war, N=22 n (%)
Listens to me		**Listens to me**	
Never tried	4 (18.2%)	Never tried	3 (13.6%)
Tried but not helpful	3 (13.6%)	Tried but not helpful	4 (18.2%)
Tried, somewhat helpful	5 (22.7%)	Tried, somewhat helpful	1 (4.5%)
Tried & very helpful	10 (45.5%)	Tried & very helpful	14 (63.6)
Recognize my feelings		**Have a positive out look**	
Never tried	2 (9.1%)	Never tried	4 (18.3%)
Have tried but not helpful	6 (27.3%)	Have tried but not helpful	3 (13.6%)
Tried& somewhat helpful	3 (13.6%)	Tried &somewhat helpful	3 (13.6%)
Tried & very helpful	11 (50.0%)	Tried & very helpful	12 (54.5%)
Answers me honestly		**Accepts my feelings**	
Never tried	4 (18.2%)	Never tried	0 (0%)
Tried but not helpful	3 (13.6%)	Tried but not helpful	4 (18.2%)
Tried &somewhat helpful	5 (22.7%)	Tried &somewhat helpful	5 (22.7%)
Ttried & very helpful	10 (45.5%)	Tried & very helpful	13 (59.1%)
Allows me to ask questions		**Provides emotional support**	
Never tried	3 (13.6%)	Never tried	2 (9.1%)
Tried but not helpful	5 (22.7%)	Tried but not helpful	2 (9.1%)
Tried& somewhat helpful	1 (4.5%)	Tried &somewhat helpful	4 (18.2%)
Tried & very helpful	13 (59.1%)	Tried & very helpful	14 (63.6%)
Takes time with me		**Offering a helping hand**	
Never tried	2 (9.1%)	Never tried	1 (4.5%)
Tried but not helpful	4 (18.2%)	Tried but not helpful	0 (0%)
Tried &somewhat helpful	2 (9.1%)	Tried &somewhat helpful	10 (45.5%)
Tried & very helpful	14 (63.6%)	Tried & very helpful	11 (50.0%)
Provides good care of me		**Acknowledge my situation/ loss**	
Never tried	2 (9.1%)	Never tried	4 (18.2%)
Tried but not helpful	1 (4.5%)	Tried but not helpful	4 (18.2%)
Tried &somewhat helpful	7 (31.8%)	Tried &somewhat helpful	2 (9.1%)
Tried & very helpful	12 (54.5%)	Tried & very helpful	12 (54.5%)

As is shown in Table II above, what the facially disfigured respondents found most helpful to them from friends and family was being listened to (45.5%), their feelings being recognized (50%), being given honest answers (45.5%), being allowed to ask questions (59.1%), taking time with them (63.6%) and 54.5% felt that family and friends tried to provided them with good care. As for the involvement of Health workers, 63.6% of the respondents stated that Health workers listened to them, with 54.5% agreeing that health workers had a positive outlook/attitude to them. Thirteen (59.1%) of the respondents felt health workers accepted their feelings and 63.6% felt health workers gave them support. Finally 50% felt that health workers offered help or acknowledged their loss 54.5%.

Rising above facial disfigurement

Source: *Daily Monitor Newspaper, March 19, 2012*

DISCUSSION:

Our sample of 22 was composed of 88.2% women and most (68.2%) were in the reproductive age bracket of 20-40 years. It has often been argued that women are the battleground for men's wars. Clearly our sample showed that the majority of the facially disfigured were women. It was the armed men who perpetrated the facial disfigurement on the women. This traumatisation of women by the armed men was being used as a weapon of war. It made them ugly, outcasts in their communities and abandoned by their husbands. Musisi and Kinyanda (2001) have argued that the disfiguring and uglification of women in war is probably to deter them from supporting their warring husbands and to instill fear in the communities. Many of the affected women were divorced/separated again showing that these poor and uneducated women were the intended victims of war to intimidate the community into submission to the demands of the fighters. Over 87.3% had only attained primary school or below education level. The study indicated that these facially disfigured women experienced considerable chronic sorrow. This is not surprising as these women had experienced a significant loss of self image and self-esteem. The facial disfigurement was not reversible. Such feelings have also been documented among individuals with various chronic conditions including diabetes, HIV, cancer, multiple sclerosis or Parkinson's disease (Eakes 1993, Hainsworth 1995, Lindgren 1996, Ross 2002).

The experienced chronic sorrow could be viewed as a normal response to the facial disfigurement and the subsequent ongoing self image disparity compared to the life before and the void created by the significant loss. However, it is important to note that the grief-related feelings that were experienced by the respondents were very intense and could not be ignored or trivialised. Their lives had significantly negatively changed, sometimes with total loss of hope for a better future. This is similar to what Eakes et al (1998) observed, that the normalization of the chronic sorrow as understandable sadness in no way diminished the validity of the intensity of the feelings they experienced. Therefore, means that it is of great importance for the facially disfigured to be helped to deal with their intense feelings so that they could come to terms with their loss and learn to deal with the daily challenges that trigger their ongoing sorrow. To address the trigger factors and especially to deal with societies reactions and future hopes are important components of facial disfigurement. Therefore, besides helping with reconstructing their faces, the psychological component of the disfigurement should always be emphasized. . The emotional feelings of our respondents clearly described the characteristics of chronic sorrow as stated by Eakes et al, (1998).

Praying or attending church/mosque activities was the most commonly practiced coping strategy used by the respondents as they had no idea what else to do. Their situation was irreversible and yet very visible in their community. Family, friends and health workers tried to help the facially disfigured. However they did not use specific professionally proved interventions, for example engaging in stress-relieving practices (such as exercise or journaling), psychotherapeutic interventions in grief therapy such as self-awareness, acceptance, or strategized techniques to seek out social interaction with others who share similar feelings as these have been found to be effective internal coping strategies (Gordon, 2009). Indeed 16(72.7%) of our facially disfigured respondents found talking with others in similar situations very helpful.

Our results also indicated that friends and relatives helped the facially disfigured cope better than the health workers. This could be to due to overwhelming number of patients that health professionals are responsible to care for, for example the nurse: patient ratio at Mulago hospital is 1:20 during the day and 1:50 at night (Hospital records, 2001). It would thus be difficult for health professionals to find time to provide emotional and other support for all of their patients with this high nurse: patient ratio. Facially disfigured individuals require more and intense emotional support than ordinary patients.

Limitations

The study population was very small. Therefore the results cannot be generalized to the whole country. A bigger study that involves traumatic facial disfigurement or such loss is highly recommended. Such a study could also involve other types of acquired facial disfigurements such as from facial burns in those with uncontrolled epileptic fits or acid burns.

Conclusions

This study found that individuals with traumatic facial disfigurement in Uganda experience chronic sorrow. Although this phenomenon may be viewed as a normal response of understandable sadness to the ongoing loss it is important to note that it negatively impacts on the day today functioning of the affected individuals. Their most commonly used coping mechanism were prayer, attending church/mosque and getting help and support from family and friends. However, these were not always effective with fears that the chronic sorrow could progress to pathological grief or other psychiatric disorders. The health workers, themselves, did not employ professionally proven coping or psychotherapeutic strategies, different from what families and friends were using. This was most likely due to lack of skills/training in these techniques. It is therefore important that Government, through the Ministry of Health, funds training for specific courses

for effective internal and external coping strategies to be applied in those with facial disfigurements, which don't only happen in war but also in peaceful civilian populations as is commonly seen in (facial) acid and other burns. Lastly, efforts should be taken, internationally, to prohibit the use of traumatic injuries to women as weapons of war including facial disfigurements, pregnancy slicing and rape.

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Improvements To National Health Policy: Mental Health, Mental Health Bill, Legislation And Justice

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ABSTRACT
Previous research in Northern Uganda has found high levels of post-traumatic stress-related difficulties amongst the population. There is international evidence that psychological therapy can reduce depression, but very limited research regarding the effectiveness of therapies for trauma-related difficulties in Sub-Saharan Africa. The current research investigates the experiences of service users and providers of specialist trauma services recently opened in Kitgum and Gulu, Northern Uganda. It also examines their implications for mental health policy and legislation.
A qualitative methodology was utilised whereby in-depth interviews were carried out with 10 women and 10 men survivors attending trauma services in Kitgum and Gulu. The researchers also spoke to 15 key informants in Kitgum, Gulu and Kampala. The data was analysed using Interpretative Phenomenological Analysis, to highlight the meaning behind the experiences of the participants.
The research found that counselling and medication was valued by service users; and service providers felt these treatments improved depression and increased empowerment resulting in a return to engagement in social activities. However, there was a limit to the benefit that could be achieved without meaningful justice for the atrocities witnessed by and perpetrated against survivors, and the provision of compensation, which would help to meet social needs.

Key words: *Counselling, Experiences, Trauma, Uganda, Mental Health Policy, Legislation.*
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INTRODUCTION

This research investigated the experiences of service users and providers of trauma counselling and treatment services in Kitgum and Gulu districts, Northern Uganda and examined the implications for mental health policy and legislation. Specific objectives of the study were to: (1) assess service provision and the experiences of those accessing specialist trauma services; (2) examine gaps in current service provision; and (3) evaluate the implications for mental health, educational policies and legislation.

Previous research with former abductees in Northern Uganda (Liebling & Baker, 2010; Pham et al., 2004) found untreated mental health problems were prevalent. Poverty, lack of health and justice services and transport, as well as an absence of adequately trained professionals, affected the ability of survivors to access badly needed mental health care (Liebling & Baker, 2010; Olak, 2007). Earlier research recommended the provision of holistic services, including trauma counselling (Liebling-Kalifani et al. 2008). Since this time, trauma centres have been opened in Northern Uganda. Despite this, there is limited research investigating the experiences of service users and survivors of post-conflict violence and torture who access trauma services, or the experiences of service providers within East Africa and therefore this subject has been largely neglected (McPherson, 2002). There was therefore a pressing need to investigate experiences of treatment efficacy, gaps in service provision and implications for mental health policy and legislation.

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METHODOLOGY

The research carried out was innovative and distinctive in five ways:

1. It evaluated the experiences of post-conflict survivors of traumatic events, often including war, torture and sexual violence that accessed specialist trauma services in Northern Uganda;
2. It explored the lived experiences of survivors and service providers;

3. It provided a greater understanding of the experiences of specialist trauma services;
4. It evaluated gaps in service provision; and
5. It provided important data that could help shape future mental health and education policy, as well as legislation.

In June 2013, the researchers interviewed thirty-five participants in Kitgum, Gulu and Kampala districts which included individual interviews with ten women and men survivors who had been attending trauma services for at least a year. The Ugandan co-investigators from Kitgum Women's Peace Initiative, KIWEPI, liaised with the Trauma centres and TPO Uganda, a non-government organisation working closely with the Ministry of Health, who identified volunteer survivors that participated in the research. The interviews were carried out in Kitgum and Gulu towns. The interviewed survivors were between twenty-one and fifty-eight years of age. In addition, fifteen interviews were carried out with key informants including; professionals working at the Trauma centres. These included social workers, psychologists, psychiatric clinical officers and nurses. Interviews were also carried out with other specialist mental health professionals, policy makers, and Ministry of Health representatives as well as Acholi traditional leaders some of whom were interviewed in Kampala. Some examples of the questions for survivors included:

- What were your experiences of attending trauma services?
- What were the responses of services you accessed?

Interviews were digitally recorded and then transcribed verbatim and interpretative phenomenological analysis (IPA) was used to develop concepts (Smith et al. 2009). To protect participant's identities, pseudonyms were used.

RESULTS

Provision And Experiences Of Trauma Services

Provision of Services

We found various Non-Governmental Organisations, NGOs involved in providing trauma services to the surviving victims of trauma in Northern Uganda. These mainly were:

The Peter C Alderman Foundation (PCAF). Following the tragic death of Peter Alderman in the World Trade Centre bombing on 11th September 2001, his parents decided to create trauma treatment centres in his memory (http://www.petercaldermanfoundation.org/). The first Peter C. Alderman Foundation (PCAF) trauma treatment clinic opened in Siem Reap, Cambodia in March 2005. In Uganda, in 2008, the organisation partnered with the Government of Uganda, Makerere Medical School, Butabika National Psychiatric Referral Hospital, the Catholic Church and locally respected non-governmental organisations. Trauma centres were opened in Tororo, Soroti, Gulu and Kitgum in Northern Uganda. The Kitgum clinic opened through a partnership with the Ministry of Health, Uganda in June 2009.

TPO Uganda. TPO Uganda. is a Non-Governmental Organisation that provides mental health services in conjunction with the Ministry of Health, particularly for women and children, in addition to some short-term counselling. TPO Uganda.also receives external funding from organisations including UNFPA, USAID and CORDAID.

Other Non-Governmental Organisations, NGOs. There are also a few other non-governmental organisations providing services for survivors of traumatic experiences but unfortunately many organisations have left the region as it has been re-categorised as a non-emergency setting e.g. World Vision. Religious organisations e.g. Faith-Based Organisations and Traditional Healers, also provided services.

The Uganda Ministry of Health also provides services through established mental health services in the Government-run hospitals and Health Centres. However, these are often poorly staffed, poorly funded and lack medicines and equipment. The services where we carried out the interviews were staffed by a small number of social workers, psychiatric clinical officers, psychiatrists, psychologists and nurses. Psychologists tended, in the main, to be employed by non-governmental organisations rather than at Government hospitals.

Survivors' experiences and coping

Many of the survivors we spoke to gave horrendous stories of the trauma they had experienced. A 58-year old woman survivor who was interviewed in Kitgum Town had this to say:

> *"I was taken to captivity and I was separated from my husband who was in another group and he kept insisting on escaping and the rebels caught him and an assembly was called. He was brought over to the other group and killed. They started cutting him and my child was close to his father so he screamed seriously and this made me cry and the rebels summoned me and they killed the child in front of me and I was beaten. I was tortured and beaten and they left me unconscious thinking I had died. I regained*

consciousness and the rebels came and found me and then left me there saying 'let her suffer the consequences."

(A 58-year-old woman survivor interviewed in Kitgum)

Survivors of traumatic experiences who attended services and who were interviewed had often suffered torture including bomb attacks, burns and sexual violence, as well as other horrific conflict-related experiences during abduction by Alice Lakwena in 1986-1987 and the Lord's Resistance Army led by Joseph Kony. Many had been forced to commit and witness atrocities, which included the brutal killing of loved ones. Most related normal responses to traumatic experiences including severe depression and suicidal feelings, which led to isolation and loneliness, anger, nightmares, flashbacks and low self-esteem. Lucy, a survivor interviewed in Gulu explained how she was affected:

"I found my husband in the coffin. I collapsed. It brought back all the problems I encountered in captivity, and when I came back and buried my husband, that was the beginning of the sickness. I never felt, good, I had been sick. I could stay for one or two days without drinking water, without eating, and I did not feel even hungry or thirsty."

Many of the people we spoke to described experiencing severe pain, which was sometimes considered somatic by the professionals to whom we spoke to and therefore many participants did not receive pain relief medication. Several of our interviewees had accessed the support of religious organisations, visited traditional healers and taken herbs or engaged in local cultural rituals, prior to accessing trauma services. Prayer and attending church was used for ongoing support in conjunction with mental health services. Most had a desire for redress and expressed 'anger and feelings of being let down' by the lack of sufficient support available and difficulty in accessing justice, in addition to a lack of provision for their basic and social needs. Participants related that since returning from Internally Displaced Person's (IDP) camps, land disputes had dramatically increased, exacerbating trauma and suicide rates, particularly in Gulu amongst men. A Psychiatric Clinical Officer whom we interviewed explained:

"Suicide rates have increased terribly in Gulu. In 2012 there were 51 suicides but these were only the ones we knew about. The true figures are likely to be very much higher."

Survivors' Experiences Of Services

Survivors were generally grateful for the services and the chance to have access to someone who would listen to their problems. A woman survivor whom we interviewed in Gulu had this to say:

"I have been accorded good hospitality from here; I have been getting proper services. As for my case now, they are saying that I should be able to leave these [trauma] services because they can see that I am recovering, and I'm a bit better. In case I over-take the drugs it may cause me some problems. The health centre here has been a great help to people, and the number of patients are overwhelming...I'm grateful as I'm getting a lot of services. I've even managed, as a result of the counselling, to test myself [for HIV] several times, and I've found myself not positive, I'm negative."

(Margaret, a 30-year-old survivor interviewed in Gulu)

At the services where the interviews took place, survivor's accessed medication and counselling that varied in length and quality. Antidepressants, sleeping tablets and anti-psychotic medication were frequently prescribed for trauma-related difficulties and insomnia. Our interviewees lacked knowledge and understanding about the purpose of the medication given. However, it was clear that the provided trauma services served to restore hope in survivors, which was extremely valued. Counselling extended up to a maximum of eleven sessions. Survivors had to travel for long distances to access the service. This was often too costly for the survivors and poverty thus restricted regular access. Although a survivor could rarely choose the gender of the counsellor, they voiced universal appreciation of a listening ear and the giving of professional advice. Group counselling tended to be offered after individual counselling, which survivors valued since it helped them realise that their experiences were shared. It also served to decrease isolation, as participants met others who then provided social support. Although survivors were generally grateful for the services and access to someone who would listen to their problems, they felt provision needed to be available over a longer period of time.

Often survivors had to travel for long distances to access the service and poverty restricted regular access because the cost of regular transportation was preclusive. Although most services were free, some survivors referred to clinics having a fragmented supply of medicines and stated that sometimes they

had to purchase medication themselves, which they could rarely afford. This could lead to relapses and deterioration in their mental health. On occasion in Kitgum, staff were unavailable and the clinic hours would be limited due to a lack of resources and competing demands, particularly due to the prevalence of 'nodding disease', which had affected large numbers of children in the District.

In rural areas in particular, it was reported that there was a severe lack of counselling, support and professional expertise, with limited outreach. Stigma and abuse towards some survivors in the community negatively affected access to services and undermined healing. Despite the fact that abductions by the Lord's Resistance Army caused severe trauma, the community often rejected abductees on their return, considering that they were in some way implicated in the atrocities committed, even where participation was under severe duress. In some instances, survivors left their communities and families, due to the rejection and abuse they suffered. This was a double jeopardy.

Survivors expressed the desire for a more holistic approach to their difficulties, including regular provision of medication, counselling, vocational opportunities and financial support; especially school fees for their children. They expressed concerns that most of the organisations that had provided services during the conflict had left as the region was viewed as being post-conflict, although there was still conflict in the area as a result of land disputes and attacks by the Karamajong. A 36-year-old male survivor interviewed in Gulu told us:

> *"The hand {which has been broken} is from the land conflict as people from my home are conflicting with me over land and so they beat me recently and my arm got broken. These are my major problems and this is why I am here. I was very traumatized and I could not do anything. I could go and stand on the road and cars could come and knock me...I was actually having mental problems as I was so traumatized and stressed."*

Survivors and service providers related the increase of land disputes which appeared to cause a re-emergence of earlier traumatic effects that made it more difficult for those affected to cope.

Alcohol use became common as a way of coping with traumatic experiences, especially by men and male adolescents. It was thought by the local population and the service providers to have exacerbated the levels of domestic violence and suicide rates, which were especially high in Gulu. Survivors felt medication and counselling in combination with access to income-generating activities helped to combat preoccupation with traumatic experiences and relieve depression. Some felt that the stigma in communities was particularly directed towards those living with HIV/AIDS and former abductees. Many of these survivors felt very 'let down' by the Government due to the perceived lack of justice and the absence of support provided since their return from captivity. Their unfulfilled basic needs limited the progress that could be made through counselling and medication alone.

Service Providers' Experiences Of Services

Many service providers expressed dissatisfaction with the low levels of service provision. They wanted to do more but were limited by a number of factors. A team leader who was interviewed said:

> *"The facilities we have here is that for us we don't carry out holistic services. We have drugs for them; we have information and we have techniques. We carry out therapy with them and we have the ability to link them maybe to other organisations that have other activities. So those are the facilities we have."*
>
> *(Team Leader interviewed at a Trauma Centre in Northern Uganda)*

It was felt that there was still a lack of country-wide understanding of the traumatic impact of war including how this was understood in context of the beliefs, rituals and values of the Acholi people. Service provider's described anger as a frequent traumatic effect with alcohol use and domestic violence in the community also common, being exacerbated by polygamy. A Team Leader interviewed told us:

> *"Men have developed that kind of dependency… like not wanting to work in the villages and we have this polygamous marriage and a man decides to bring 2 -3 women and whenever they are together this causes conflicts within the family and through this process there is this sexual behaviour and there is risky sexual behaviour then the woman also becomes a bit aggressive and problems start setting in and domestic violence starts."*

The researchers asked about the provision of counselling in prisons but it was reported that these services were very limited. Providers indicated that they were doing their best to empower local

health services and provide group counselling, which included education and problem-solving approaches, but there was a strong view expressed that services needed to be extended to cover all of the Districts in Northern Uganda. There were insufficient numbers of experienced mental health professionals to provide quality trauma counselling services, and it was felt that more psychologists, particularly clinical psychologists, were needed to build the capacity of the village health teams and rural health centres to meet the mental health needs of trauma survivors. Those service providers we spoke to felt they were doing their best to rebuild trust amongst survivors, but were failing to meet service demand. Many spoke about the increasing rates of suicide in the region, particularly amongst young men in Gulu. They demonstrated care for clients but experienced feelings of frustration and disappointment when unable to improve survivors' situations and distress.

Service providers expressed concern that many non-governmental organisations and support services had pulled out of the country since the insurgency had ended. Yet in fact the numbers of people seeking services had actually increased whereas the numbers of providers had decreased. Some also related dealing with their own traumatic experiences, and as a result, 'burn out' and secondary trauma was commonly reported. They spoke of a desire for more skills development, training (including more regular refresher training), support and supervision. They also described several problems that affected access to available services, including transport difficulties, poverty, stigma, and peer pressure, in addition to a lack of understanding of the value of counselling within the population. Staff felt that more effective long-term planning was required to more effectively carry out their roles, and should include logistics such as vehicles for outreach and the provision of a transport allowance for those accessing services, as well as better career development that would enhance professional motivation. One of the psychologists we interviewed explained:

> *"There is the need for support in other areas of career advancement as it is very important. I wish to continue to advance. I need a break and advance my career. To have support for this would be really good as I have a big family and it would help with this. I would like the opportunity to do the Masters in Clinical Psychology and for this to be funded because Makerere University is a long way from here."*

On the whole the service providers felt rewarded by positive responses to their individual and group interventions, which included cognitive-behavioural therapy, person-centred approaches, interpersonal therapy and medication. They described their services as leading to a reduction in depression, greater empowerment of survivors and their return to engagement in productive activities.

Gaps In Service Provision

Although our study found that survivors and providers valued the provided services, it also revealed a dearth of professional skills and expertise available for the effective delivery of trauma counselling; in particular, clinical psychologists and psychiatrists, especially in the rural areas. Research by Nakimuli-Mpungu et al. (2013a; p.2), which focussed on the overall provided mental health services rather than trauma counselling, and concluded that:

> *"The ongoing prospective evaluation of the Peter C. Alderman Foundation [PCAF] programme participants offers valuable information on the potential benefits of treating depression, post-traumatic stress disorder, and other mental, neurological and substance use disorders in post-conflict low- and middle-income countries."*

However, those we spoke to said the most skilled trauma service providers including psychologists and psychiatrists in Uganda are mainly based in Kampala. There is a particular shortage of clinical psychologists in Northern Uganda to provide support, training, supervision and capacity building in the rural areas, as well as specialist therapeutic services for trauma survivors. The medication supply for survivors with trauma-related problems is sometimes erratic with insufficient information given to service users regarding its function. There is no psychiatrist in Kitgum District, and the psychiatric coverage for Gulu is also insufficient for the population, particularly given the increasing levels of suicide reported. Counselling is provided mainly in towns with a limited number of sessions available to each individual. There is erratic service use due to transport problems arising from poverty. One of the psychologists described the gaps in the rural areas thus:

> *"The trauma service feels like a drop in the ocean and a lot needs to be done in the rural communities. People are living in denial in the communities and there is a real need to go to the rural areas and knock on doors. We are restricted as a service because of our funding restrictions. There is a lot of work to be done including more training {and} more outreach*

work so people in the communities can be more aware of the purpose and the benefits of mental health services for the benefit of the whole community and our future generation."

Unmet basic needs such as inadequate shelter, arising from lack of employment opportunities and poverty, affects the progress clients can make in response to the services provided. Levels of stigma in communities towards former abductees, rape survivors with children and those living with HIV/AIDS are very high and exacerbate the trauma difficulties.

Implications For Mental Health Policy And Legislation

Currently, in Uganda, there is a mental health policy in draft form; the National Policy for Mental Health, Neurological and Substance Abuse Services (April 2011). This draft policy sets out the main direction the Ministry of Health aims to take in these areas for the next ten years. Unfortunately there is no specific policy statement in it for those with trauma-related difficulties. The current mental health legislation, the Mental Health Treatment Act, 1964, has not been properly implemented because of a lack of infrastructure, making adherence impracticable. This demonstrates insufficient advocacy by and lack of influence of knowledgeable mental health professionals, service users and providers in the political arena. Some of those we spoke to advocate for an improvement in understanding and political will to recognise the importance of trauma services and provision of care in Uganda.

In a country with a recent history of conflict, it is to be hoped that the new mental health policy and law will include a specific focus on the provision of services for the treatment of trauma-related difficulties as experienced by persons affected by conflict and disaster. The new Mental Health Bill is currently in draft form. To be effective, there must be sufficient resources ear-marked for policy and legislation implementation.

There is a need to observe ethical practices and professional standards. The researchers noted an inconsistency in the meaning of 'counselling', and there was no accreditation of counsellors. There is a need to improve training, ethical practice, methodology, and professional boundaries and standards in trauma counselling. Accreditation bodies for every type/ cadre of mental health professional are required in order to ensure and maintain high standards and build capacity.

In order to protect against patient relapses, we recommend that a more robust policy is developed with respect to the procurement of psychotropic medicines to ensure a consistent supply is readily available throughout the country. It is also important in this context to enhance the autonomy of service users by providing them with sufficient information for them to remain well whenever possible. This aim would be greatly bolstered by specific policy and legislative provisions.

It is suggested that the new law include a Governmental duty to include mental health education in school curricula; about the causes and effects of, and treatments for, mental health, including trauma and the recognition of traumatic stress consequences. When the new law is implemented, country-wide sensitisation will be essential to ensure that the populace knows and understands the rights enshrined within it, and how to act upon such rights. Effective access to justice is required for those with legitimate civil claims for compensation arising out of the conflict or the criminal acts of others post-conflict, perhaps via a newly-created Government fair compensation fund. Where theft of land and other property has occurred during the course of a person's mental ill-health, or during conflict, free legal assistance should be provided to enable redress. Furthermore, the authors recommend that stringent anti-discrimination provisions are included in the new law, incorporating penalties for those who abuse or exploit those suffering from mental health problems.

CONCLUSION AND RECOMMENDATIONS

The authors argue that there is a limit to the progress survivors can make through counselling and medication alone in the absence of support services and justice for the atrocities they have experienced. Survivors expressed the desire for a more holistic approach to their difficulties, including regular provision of medication, counselling, vocational opportunities and financial support; especially school fees for their children. The authors give their guidance based on our findings for further debate and development by local organisations and experts in Uganda.

The following policy recommendations arising from the research are therefore made for post conflict communities:

1. **Provision of mental health specialists:** Access to co-ordinated trauma services and therapy for survivors should be increased in the rural areas and in the towns, particularly by extending services to those who are severely depressed and

may be suicidal, and to those who abuse alcohol. Funding should be obtained through the government and externally for the provision of more clinical psychologists, social workers and certified counsellors (as also recommended by the Ministry of Health). Mental health specialists should be employed at the District, Regional and rural levels to increase the capacity of trauma counselling services. We note that many such personnel are currently not employed. It was felt by some we spoke to that services could be guided by a more in-depth understanding and knowledge of the beliefs held by Acholi people. We recommend a community dialogue approach is rolled out in the rural areas to include the involvement of Acholi cultural leaders, with further research and evaluation carried out on its' effectiveness. One of the key informants in a non-government organisation in Northern Uganda told us:

> *"If you are there the [community] will respond positively because we will not work alone - we involve the elders, the local leaders, the religious leaders even the political leaders so they [the community] respond so positively. It takes time to appreciate and start to welcome them."*

Increased capacity and knowledge regarding trauma difficulties, treatment and adequate referral mechanisms: The Government should make funding available, perhaps initially through external partnerships, to increase outreach to the communities and to train and increase the capacity of village health professionals and staff at local community health centres. This would greatly assist in improving the assessment of the health needs of local community members with trauma-related difficulties. The capacity building would enable the provision of person-centred counselling. There is also the need for sensitisation and education of the local population so that they are made fully aware of referral processes and procedures, which need to be more effectively implemented.

2. **Community outreach services:** Community outreach mental health provision is urgently required and should continue to be integrated into the primary health care services in rural areas for those who cannot afford transport costs. Mobile clinics and the use of group counselling would ensure the provision of more regular mental health and counselling provision to the rural areas. The Ministry of Health should be facilitated by the Government and external funders to carry out further evaluation, research and monitoring in relation to mental health provision. There should be a focus upon building a holistic approach to access to services and the meeting of social needs, as well as strengthening links between District Hospitals and rural health clinics. We suggest that this process should be carried out within a dialogue of western trained health personnel with religious leaders, traditional leaders, clan chiefs and traditional healers, and which would require recognition and appreciation of local beliefs and customs. An inclusionary approach may have a positive impact on trauma levels (including associated rates of alcohol use and suicide) and could assist with resolving land conflict issues and with the meeting of basic needs for trauma survivors.

One of the psychiatrists interviewed for the research told us:

> *"Group counselling is effective, and it's preferred, especially for the community. Right now we have a research project relating to group family therapy for Northern Uganda trauma victims, especially targeting where children have been involved, and we help the whole family. We need a bit more research to know which best approach to use."*

Accordingly, the authors suggest that further research and evaluation focuses on the provision of group counselling in combination with a holistic model of services in the rural areas. We support the recommendation of Nakimuli-Mpungu et al. (2013b) which stated:

> *"The group counselling intervention offered in the PCAF clinics may have considerable mental health benefits over time. There is a need for more research to structure, standardize and test the efficacy of this intervention using a randomized controlled trial."*

3. **Community training and sensitisation programmes:** Countrywide sensitisation through radio and local media, particularly targeting families of survivors, will increase knowledge and understanding of vulnerable groups with trauma-related problems, associated substance use difficulties, and the close relationship between physical and mental health difficulties. This is sorely needed in order to reduce both stigma and relapse experienced by former abductees and those with trauma-related difficulties, including those also living with HIV/AIDS, survivors of domestic violence, and those who fell pregnant from rape. One of the psychologists we interviewed told us:

"There needs to be better community awareness and education as it helps a lot in understanding and support. There needs to be more community outreach work and mobilisation through use of the radio. There is limited knowledge of mental health problems and if knowledge is increased within communities, then stigma towards clients and regarding this could reduce."

Increased sensitivity to women and girl survivors of rape who became pregnant is also required, with easier access to a choice of women professionals and counsellors. The stigma associated with these situations make it very difficult for many men and women to come forward for assistance. This must be broken down. We recommend further research into gendered approaches in relation to trauma treatment and responses.

4. **Education and training:** Education about the causes and effects of, and treatments for trauma should be provided at primary and secondary school level. This will ensure that the population understands the impact of traumatic experiences, the importance of reconciliation, and all relevant policy and legislation which protects vulnerable people in the community who have mental health problems. However, this can only be carried out in the context of meaningful justice for the survivors of atrocities, whether conflict or post-conflict-related. One of the interviewed key informants stated:

   "There is a weak link – redress, legal material and moral [obligations]. That's the weakest point. We used to have a law reform project which was a pro bono service for victims of trauma. I think they ran into funding problems. So right now there is almost no pro bono services for victims of trauma, and I've not heard of any truth and reconciliation commission in this country trying to address the moral injustice to the people."

5. **Improve professional structures for service providers:** There needs to be support for professional organisations seeking to register to provide trauma care, and a consistency of services and monitoring of all professionals providing trauma counselling. Regular and adequate provision of support and supervision structures must be ensured to tackle 'compassion fatigue' and 'burn out', and to ensure optimal confidential counselling for survivors accessing services.

6. **Improvements to national health policy:** Mental health, Mental health bill, Legislation and Justice: Mental health policy should also include a specific focus on the provision of services for the treatment of trauma-related difficulties as experienced by persons affected by conflict and disaster. It should involve survivors and service providers from Northern Uganda in its design with the backing of the Government, politicians and District and local leaders for greatest effect. Its efficacy must be systematically evaluated. Policy implementation requires sufficient resource allocation and concomitant continuous population sensitisation in order to effectively protect survivors' rights. This requires the inclusion of anti-discrimination provisions with penalties for those who abuse those suffering from mental health difficulties, and adverse consequences in law for those who violate the legislation. Such legislation should also clearly define the roles of professionals and service providers who deliver services, including trauma counselling services. Survivors would benefit from greater recognition and compensation for their suffering, as well as legal assistance to obtain redress relating to the restoration of land and property stolen from them during the conflict period. Those who have sustained grievous traumatic abuse e.g. rape victims, gun shots, landmine injuries or severed parts of their bodies need special consideration calling for justice and reparations. All this needs greater legislative consideration.

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Two Case Reports

Attempted Suicide In Pregnancy In Post-Conflict Northern Uganda

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Abstract

Gender differences in suicidal behavior in terms of precipitants and methods used have been reported worldwide. Female suicidality compared to males is under-researched particularly in Sub-Saharan Africa. Among the known precipitants of suicide, pregnancy is the least studied. Pregnancy is a period usually seen with optimism and it is expected that a new born infant should bring about change in suicide ideation. However, this is not always the case. This paper presents two cases of suicide attempt in pregnancy in post-conflict Northern Uganda. The factors that contributed to the suicide attempts in these two pregnant women are examined and discussed.

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INTRODUCTION

Female suicidality is under-researched compared to males particularly in Sub-Saharan Africa (Beautris, 2006, Lestar 2008). Compared to men it is widely reported that women commit fewer successful suicides but make more frequent attempts (Mendez, Bustos et al, 2013). There are known gender differences in suicidal behavior in terms of the reasons leading to the suicide, thus calling for gendered suicide prevention strategies. (Canetto, 2008).

Risk factors of suicide in low and middle income countries are predominantly external stressors. In low income countries, women suicide is often precipitated by interpersonal conflicts between spouses and family members (Canetto 2008, Ndosi, 2009). Fatal self-poisoning by women is often immersed in worry and painful suffering resulting from extreme tensions that have built up within inter-personal relationships or families (Ndosi 2009, Kizza et al, 2012). Female suicidal behavior is often disregarded because of women's lower rates of successful suicides compared to males (Beautris, 2006, Canetto, 2009).

Suicide among women in Africa is reported to be on the increase (Dolan, 2009, Mael, 2009. However, there has been paucity of research data into women suicidality over the last decade (Ndosi, 2009). In Uganda, there is increasing incidences of suicidal behavior especially in the war ravaged Northern (Kinyanda et al, 2009; Ovuga et al, 2008; Kizza et al, 2012). Northern Uganda is a region which suffered more than two decades of civil war between the government of Uganda and the Lord's Resistance Army (LRA) rebels (Harlachen Okot et al, 2006). This period was characterized by horrifying, ruthless and dehumanizing acts, a condition that gave birth to Internally Displaced Persons (IDPs) camps in an effort by the Government forces to isolate the rebels (Roberts, Ocaka et al, 2008). These camps were densely populated and in dreadfully precarious conditions.

People mainly depended upon humanitarian aid for food for survival because arable land was inaccessible. Life was hence associated with lack of freedom of movement, poor living conditions, fear of contracting HIV/AIDS through sexual assaults and other inhuman behavior (Harlacher et al, 2006, Liebling-Kalifani et al, 2008, Kizza et al, 2012). This situation led to desperation, depression, severe alcoholism and hopelessness which in turn was associated with increased rates of suicidal behavior in the population. (Dolan, 2009; Kinyanda et al, 2009). The conflict led to a breakdown of cultural values and morals with people living in a permanent state of trauma and depression (El-Bushara and Sahl, 2005, Ovuga, Oyok and Moro, 2008). There were limited opportunities for income generating activities, especially for men.

Consequently, women assumed a greater number of responsibilities in the camp. The long lasting conflict changed the psychosocial relations dramatically and considerably changed the traditional balance of power relationship between men and women (Olaa, 2001, El-Bushara and Sahl, 2005, Dolan, 2009). These imbalances have inadvertently spilled over to the post-conflict Northern Uganda, resulting in much distress to the populace, especially women who have adapted desperate measures to cope, sometimes with frustrating failure. Two cases of women who attempted suicide during pregnancy in this post-conflict erea are hereby presented to illustrate this human dilemma.

CASE 1: A.S.

Problems Identified: A.S. is a 30-year old Langi woman who lives in Kitgum. She was born and raised in Apac district in Northern Uganda. Both of her parents died in unclear circumstances during the war while she was still very young. She then lived with relatives in the IDP camps till adolescence when she could fend for herself. She did not attend much school. She worked as a market vendor who was carrying her second pregnancy at six months of gestation. She was a single mother but was unclear on who was responsible for her pregnancy as she had had multiple relationships for economic survival. Her older child was a 13year old son who lives with his father, a driver who had defiled her at age 16 but with whom A.S. had long separated. A.S. presented with her index history of suicide attempt by attempting to drown herself in a river.

Related History: It all begun when A.S. found herself heavily financially indebted, having borrowed from a number of sources including from the "cash box" (a Women Vendors' Association Saving Scheme) and from many colleagues at the market. When the different parties begun to demand payment, A.S. felt highly pressured. She also had an additional stress from looking after 6 dependants who are her late sister's children, and whose school fees was due. Being single and with no one to turn to, A.S. engaged in multiple sex relationships for survival. She became pregnant but could not be sure who the father of the child was. A.S had also been recently diagnosed as HIV- positive and had started Antiretroviral Therapy, ART, two weeks prior to suicide attempt when she had gone for the first antenatal visit. A.S. felt alone as her financial problems worsened. As she pondered these problems on her way to fetch water, she, on impulse, decided to kill herself. She ran to the river near her home and at the non-barricaded bridge she jumped into the river.

Hospital Course And Treatment: A.S. was rescued from the river by good Samaritans who took her to the medical ward of Kitgum General Hospital, where she lay unconscious for two days. She was resuscitated there and referred for counseling. On coming around, A.S.'s attitude towards the suicide attempt was that it was the only solution to deal with the nagging people and for her financial helplessness. She felt that suicide was a good way to exert her revenge to those who kept demanding her to pay back the money she had borrowed. She gave no history of prior mental illness, no history of alcohol or drug abuse and no history of abduction during the insurgency but was displaced from her home because of conflict. She admitted to early sexual relations with men for economic support. Her Mental Status Examination was clinically unremarkable for gross psychopathology except for a preoccupation with her poor financial situation. She was not suicidal at the time of assessment and was easily persuaded to accept alternative ways to solve her problems.

Case 2: A.J.

Problems Identified: A.J was a 27year old Acholi lady who lived in Kitgum, where she was born and raised. Her father had died during the war but the mother was alive and they lived together. She was unemployed. She was carrying her second pregnancy at nine months of pregnancy and very much near term when she attempted suicide again. A.J..was a single mother and the father of her current pregnancy was only a porter in the market who gave her no financial support. Indeed she had decided to leave him and therefore had no current boyfriend. Her first born was an eight year old boy who had been living with his father, but who had died of natural causes and with whom A.J. had been separated. A.J.'s level of education was secondary school. She presented with her 3rd suicidal attempt, all in the current pregnancy. She was also HIV-positive and on Antiretroviral drugs (ARVs). A.J. presented having attempted suicide by taking an overdose of her ARVs. She reported that she did this because she was experiencing excessive chest and back pains, and also had had distressing dreams of her abductions and dead relatives whom she claimed to hear crying all the time. She was also being accused by her late husband's relatives of "infecting" them with epilepsy.

Related History: A.J.'s index suicide attempt had been when she was 6 months pregnant, and a second attempt at 8 months. The present attempt had occurred one week prior to consultation and very much near

term. On the first and second suicide attempt, she had overdosed on a few tablets of her ARVs, was counseled by her mother and never taken to hospital. However, the third attempt had been quite serious as she emptied all bottles of her medications, collapsed on the floor and was rushed to Kitgum hospital by her mother in a semiconscious state.

A.J. had been on treatment for Post Traumatic Stress Disorder (PTSD), depression and epilepsy at the time of this suicide attempt. She was HIV positive and had been on Antiretroviral Therapy, (ART), for ten months. She gave a history of abduction by LRA rebels in 2003 at which time she witnessed her brother get killed. She also witnessed the torture and killing of fellow abductees. She escaped two days after abduction during a cross fire between rebels and Government forces. Her family was displaced and she lost all her belongings and property to the LRA. She had 3 adopted children, these being her late brothers' children. She also gave a history of past domestic violence from her first husband but whose family believed that she might infect them with her seizures. A.J. did not abuse drugs or alcohol.

Hospital Course and Treatment: Her Mental Status Examination on admission revealed a young lady with a persistently sad and tearful mood. She experienced "weird sensations, visions of dead people and loud cries of the abducted". She believed that she was experiencing all these problems because of bewitchment from relatives of her first husband who accused her of having "infected" them with epilepsy. She denied ongoing suicidal wishes and saying that "suicide was wrong and sinful but the pain is too much". She agreed to receive help "to reduce the pain". Her cognition was intact and she agreed to have help.

She was found to be overdue by the obstetric team who subsequently delivered her of a healthy baby boy by Caesarian section. Psychiatrically, she was treated for psychotic depression, PTSD and epilepsy with antidepressants, antipsychotics, anticonvulsants and counseling (psychotherapy). She continued on with her ARVs and her baby was put on the PMTCT regimen. She improved and was discharged with advice to continue her treatment at her local Health Centre

DISCUSSION

Suicide And Suicidal Behaviour

Suicidal behavior is common in post–conflict communities in Northern Uganda (Kinyanda et al, 2009; Ovuga et al, 2009; Kizza et al, 2012). Indeed suicide is commonly reported in all post-conflict communities, worldwide. Northern Uganda is waking up from a 20+ year insurgency that saw millions displaced and thousands lose their lives and property. Kitgum, a Northern Uganda district, was at the heart of the war. Today the town still seems ghostly. Just as Kizza et al (2012) observed in their study, the women of Northern Uganda seem to have been going through unpleasant and intolerable conditions which make them feel like "they cannot bear it anymore". The traumatic experiences observed in the women of Northern Uganda are all attributable to the prolonged war, and this could have made women more vulnerable to suicide (Musisi et al 2001). These factors and experiences leading to suicide were very well illustrated in these two case-reports and they include:

- Overwhelming family demands as seen in both cases. Both were looking after a number of orphaned and helpless dependants.
- Financial difficulties were seen in both but worse in the case of A.S, which seemed to be the driving motivator for her suicidal behavior especially when debt payments were demanded.
- Low social support. Both cases were single, pregnant mothers with no supporting partners.
- Physical health problems in both cases two women were both HIV positive and on ARVs.
- Pregnancy. Unplanned pregnancy is common in conflict/post-conflict communities. This puts excessive burden on the women socially, economically, health-wise and emotionally.
- Psychotrauma. The trauma of war continues on the women even after the war is over. This is because of their nature as women for their productive and reproductive expectations. Sexual and gender based violence increase even after the guns go silent.
- Culture and Roles: Patriarchy continues even in war times, yet it is this very culture which dis-empowers women and makes them victims of sexual indiscretions, exploitation and abuse. Women often resort to sex for survival in conflict/post-conflict society with all the deleterious consequences which lead to suicide as was illustrated by these two cases.

Socio-economic factors

The above cases were both dealing with overwhelming family demands as seen in the number of dependents under their care, financial difficulties as seen with case 1 who was heavily indebted and low social support structures for both. Findings from other African studies (Ndosi et al, 1997) have identified low social and family support to be associated with low self esteem and a sense of hopelessness and acute emotional pain, which are among risk factors which enhance suicidal behavior. Being single is a risk factor for suicide. Ndosi et al (1997), reported that the top three triggers for attempted suicide included social conflicts, financial problems and chronic mental illness (Ndosi et al, 1997)

Clinical factors

Both of these cases had HIV/AIDS and were on ART for less than a year. HIV, in itself, is associated with social and psychological difficulties including depression and the two conditions ofen co-exist with a prevalence of over 30% (Musisi et al, 2013; Nakimuli-Mpungu et al, 2011). This could have contributed to a sense of hopelessness in the two women that may have led to suicidal behavior. The association between chronic medical conditions and suicidality has long been documented. The incidence of suicide attempts is highest among individuals suffering from mental and physical illnesses (Buck, 1982, Alleck and Allgullander, 1990). Studies also show that people living with HIV/AIDS with scanty means of living and poor social support attempted suicide frequently (Ndosi et al, 1997)

Pregnancy

Pregnancy and a promise of newborn baby would ordinarily be viewed with excitement and optimism. However, sometimes, pregnancy can be a major stressor. In these two cases, it appears that their overwhelming personal stressful situations coupled with pregnancy-related stress contribute to their suicidal behavior.

The relationship between pregnancy and suicidal behavior is generally well documented especially where there are relationship problems as in threats of spousal estrangements including separation, divorce or lack of support from the would be fathers (Tsoi and Kok, 1982). In these two cases presented, both women had been separated from the men responsible for the pregnancies and A.J. even had a history of domestic violence. Also unplanned pregnancies lead to acute stress reactions, with loss of self esteem, anxiety, feelings of guilt, hostility and hopelessness, and these often culminate into suicide attempts (Tsoi and Kok, 1982). All these factors were operative in these two cases. What is unclear is how the gestation of six months is associated with suicide. Both women first attempted suicide at 6 months of gestation. Could this be a coincidence or are there factors during pregnancy around 6 months of gestation which particularly play a role in suicide behavior?

Psychotrauma

These two presented cases both had experienced traumatic effects of the war and the vulnerabilities that followed. These included chronic mental illnesses of war i.e. Post Traumatic Stress Disorder (PTSD), Traumatic Depression, Epilepsy etc and war-related poor socio-economic circumstances. These post-conflict vulnerabilities were a major direct factor in the women's decision to attempt to commit suicide. This is comparable to what was found in Kizza's et al (2012) study in which the decision for women to end their lives seemed to be a combination of factors and experiences both in the recent past and the distant past prior to the suicidal behavior (Kizza et al, 2012). Studies from Tanzania reported that neuropsychiatric disorders were significantly associated with suicide attempts with the worst offending disorders being acute psychosis, major depression, alcohol and substance abuse and epilepsy (Ndosi, 1997). The woman in case 2, suffered from PTSD, Depression and Epilepsy which caused her "unbearable (psychological) pain" or angish.

Intentions

Some people attempt suicide to solicit for help and social sympathy during acute social problems (show value). These could be deemed as "attention seeking" behaviors. Yet others actually do have real death wishes and they attempt suicide with the intention to die. A.S. did a "revenge" suicide attempt to punish the people who were harassing her for money they had lent her. This could fit in the category of "help seeking" suicide attempts. However, the method used was quite daring and she was not remorseful at all in the aftermath, which means that she also had a death wish. A.J. sought suicide to relieve her of the pain she was experiencing. This was her third attempt and it was a serious attempt leading to her collapse to semi-consciousness. It is therefore very possible that had a serious death wish.

Other factors

Age: Both cases were young women between 20 and 30 years of age. Studies from Europe and North America found suicide attempters to be between this

particular age group (Beautris A.L, 2006; Canetto S.S, 2008 & 2009).

Methods: In a study by Ndosi in Tanzania, the most common methods used by suicide attempters were medication-overdoses (68.7%), poisons (22%) and hanging (2.7%) (Ndosi, 1997). The women in these two cases used drowning and medication overdose.

CONCLUSION.

Suicide is difficult to predict even in high risk groups. Suicide attempts are known to be at least twice as common in women as men. In pregnancy, suicide attempts are reported to be found embedded within socio-economic deprivation, recent interpersonal conflicts, ill health, mood altering effects of pregnancy and the complexities of psychological trauma in post-conflict situations. These two cases illustrated all these points. The methods used by these two women included drowning and drug overdoses. In both of these cases, the suicide attempts expressed a cry for help with real intentions to die (death wish).

Both of these cases call for a need for closer surveillance of suicide in pregnancy in post-conflict communities. This should be done both at home and at the ante-natal care visits. This would facilitate timely referral to mental health services. Further studies on suicide attempts in pregnancy and the interplay with war trauma are needed to determine the extent of this psychological suffering so that appropriate interventions can be sought.

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Traumatic Experiences And Poor Mental Health Among University Students In Uganda

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Abstract

Background: *University students' experiences of traumatic events may present with psychological, social or even physical sequelea such as substance use, suicide attempts, sexually transmitted diseases, depression, examination malpractices and lack of motivation to study; thus jeopardizing their academic studies. There is a dearth of studies addressing Ugandan university students' traumatic experiences.*

Aim: *The purpose of this study was to explore the association between university students' traumatic experiences and the resultant emotional, academic, and antisocial behavioral problems.*

Methods: *We employed a cross-sectional descriptive study design using the University Students Evaluation of Psychosocial Problems scale (USEPP) to investigate the students' traumatic experiences and any emotional, academic and antisocial behavioral problems. We randomly recruited 1101 university students from five purposively selected Ugandan universities representing the variety of Ugandan university students in terms of ethnicity (tribe), religions affiliation, gender, social class and courses of study. The association between the students' traumatic experiences and their socio-demographic and study program characteristics and the USEPP sub-scales scores of emotional, academic and antisocial behavior symptoms was assessed.*

Results: *We found a 48.9% prevalence of Traumatic Experiences amongst the Ugandan university students with an overall prevalence of psychosocial problems (USEPP caseness prevalence rate) of 36.5% comprising of Emotional problems, 34.5%; Academic problems, 37.8%; and Antisocial behavior problems, 21.4%. The significantly associated factors were age (≥30 years , $X^2 = 34.32$, $p \leq 0.001$) and marital status ($X^2 = 14.37 p \leq 0.001$)*

Conclusion: *This study found a high prevalence of traumatic experiences amongst the Uganda university students and this translated into their developing emotional, academic and antisocial behavior problems especially in older married students. These findings call for a need for effective screening for psychosocial problems among university students in Uganda preferably at the beginning of each academic year as part of their annual medical check-ups and for seting up multidisciplinary mental health services at university campuses to effect early detection and interventions.*

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INTRODUCTION

Mental health problems among students and university students in particular have been widely reported in recent literature (Harper & Peterson, 2005; Hunt, & Eisenberg, 2010; Md Yasin, & Dzulkifli, 2009; Storrie, Ahern, & Tuckett, 2010). Indeed, their increased prevalence has been the subject of concern for the students themselves (Stone et al, 2003). This has resulted in the recommendation of the setting up of Mental Health Counseling Centers on university campuses worldwide (Stone, & Archer, 1990). Among the many

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reported causes underlying this increase in mental health problems have been changing cross-cultural issues, family dysfunction, low frustration tolerance, increasing use of drugs and alcohol, poor interpersonal relationships, increased academic demands/ work load, living conditions, "enriched lives" with cell phones, computers, classes, jobs and financial strains (Kiztrow, 2003). Of note, however, have also been reports of increased traumatic experiences on university campuses. These have included, physical assaults, robberies including break and enter, student riots, domestic violence, sexual assaults such as rape including date rape, sexual harassment from teachers and fellow students, sex for marks, as well as muggings and students themselves engaging in war-fare or being affected by wars as has been witnessed in Uganda (Gred, 1992; Gold, 1992; Betancourt, Speelman, Onyango, & Bolton, 2009). Other reported causes have been refugee experience, culture shock, racial/tribal prejudice, sexism, acculturation as well as poor physical health and mental illness before entry to university (Ghandour, Kogan, Blumberg, &. Perry, 2010). In addition, studies in Africa have noted high levels of poverty, social injustices, social disruptions including internal and external migration and the unprecedented population explosion (Lambo 1981). Omokhodion & Gureje (2003) in a Nigerian study identified lack of money, fear of examinations, family and relationship problems and cultism. In East Africa, Atwoli et al (2011) noted high rates of substance abuse and related deleterious effects like quarrels, fights, damage to property and unprotected sex. Earlier studies by Prince (1960) reported on the Brain Fag syndrome as the academic study stress found among African students due to the anxiety of too much expectations from them as a result of study success and hence exam anxiety.

Regarding traumatic experiences in general, studies in Western countries suggest that 50-80% of young people (including university students) experience traumatic experiences but which could be prevented (Falitti 2009, Sharfstein 2006, Vrana & Lauterbach 1994). These studies showed that life threatening illness or death among close relatives were the most common traumatic experiences followed by accidents, natural disasters, physical violence and sexual assault (Read, Onimette, White, Colder & Farrow 2011). In Africa, only few studies have examined the relationship between traumatic experiences and the development of psychopathology among students. Studies in South Africa found prevalence rates of 70-90% of experiencing trauma leading to psychopathology among adolescent students (Md Yasin & Dzulhifli 2009, Fairbal 2008). The most commonly reported disorders are Post-Traumatic Stress Disorder and Depression (Seedat, Nyamai, Njenga, Vythilingum & Stein, 2004). Ndetei, Ongech-Owor, Khasakhala, Mutiso &Odhiambo, 2007) reported similar findings in Kenyan students. In Uganda, studies of traumatised adolescents in war-torn areas have found significant association of trauma and development of Post-traumatic Stress Disorder (PTSD), Depression, Substance Abuse and other anxiety disorders (Okello, Onen & Musisi). Recent studies have suggested a relationship between trauma and Nodding syndrome as well as PTSD, Depression and other epilepsies (Musisi, Nakimuli-Mpungu, Akena, Bangirana, & Kinyanda, 2013.). Despite all these studies and the reported increased incidence and prevalence of traumatic experiences among students in Africa, only a few studies have attempted to investigate the relationship between the experience of trauma and development of psychopathology among university students in Uganda.

OBJECTIVES

This study aimed to investigate the relationship between university students' traumatic experiences and the development of mental health problems (psychopathology) with a view to prevention and treatment of the latter. In particular, the study sought to investigate the prevalence of traumatic experiences, emotional and behavioral problems among university students in Uganda. Finally the association between these traumatic experiences to students' academic performance and antisocial behavior on campus will be investigated. It was hoped that such a study could yield very important information as mental health problems in college students have been reported to negatively impact on academic performance leading to poor marks, exam failures and student drop outs as well as to leading to adulthood mental ill-health. Early intervention, therefore, would be of essence.

METHODS

Study site, Design, Sample and Participants

This study was part of a larger study leading to the award of a PhD degree. It took place at five purposively selected university campuses representing the broad-spectrum of the variety of students attending university in Uganda in terms of ethnicity (tribe), religions affiliation, gender social class and courses of study. Both genders were equally represented. The Universities were:-

Makerere University: A public secular university.
Nkumba University: A private secular university.

Mukono University: A private Protestant (COU) university.
Nkozi University: A private Catholic university.
Mbale University: A private Muslim university.

Each of these universities was registered by the Uganda National Council of Higher Education (NCHE), had a University Charter and had a Mental Health Service.

We used a cross-sectional descriptive study design using quantitative methods. The sample size was determined based on the Yamane (1967) simplified formula for calculating sample size for descriptive proportions. A prevalence of 50% (p = 0.5) for traumatic problems was assumed as no such previous studies had been carried out in Ugandan university campuses. The Uganda students population in the all universities was 92543 and the calculated sample size was 1101 assuming a 95% CI. The actual numbers of students recruited per university was proportionate to each university student body population in the ratio of numbers as follows: Makerere : Mukono : Nkumba : Mbale : Nkozi of 634 : 164 : 124 : 112 : 67 to give a total of 1101 students.

The participating university students were randomly recruited. Permission to carry out the study was obtained after scientific and ethical approval from Nkumba University Internal Review Board for research studies then the Uganda National Council of Science and Technology and finally permission from each of the participating universities administrative authorities. Written informed consent was obtained from each recruited participating student after explaining the study, the purpose, risks and benefits. No incentives were given to the participants.

Study Variables and Instruments:
The variables of study included; (a) Socio-demographic, study program and health characteristics; (b) students' traumatic experiences (c) students emotional and antisocial behavioral problems and (d) students academic problems.

Instruments: A standardized questionnaire was prepared by the first author which included (i) socio-demographic characteristics of gender, age, religious affiliation, nationality and marital status; (ii) students' study program characteristics which included the university residence location, program of study, year of study, education sponsorship and who paid the tuition; (iii) the student-related burden variables including chronic medical conditions, previous mental health problems and the students' subjective perception of their overall health.

The students' trauma experiences were assessed using the University Students Evaluation of Psychosocial Problems Scale (USEPP) (Nsereko, Musisi, et Holtzman, 2014). The USEPP is a 17-item multidimensional culturally sensitive scale specifically designed to assess psychosocial problems of university students. It has four subscales namely: Emotional Problems, Academic Problems, and Traumatic Experiences and Antisocial behavioral problems.

For purposes of this paper, only the subscale of Traumatic Experiences will be considered in the analysis of their relationship to the students' psychopathology. The USEPP is a self-administered scale. Each of its 17-items is scored from 0 to 3; thus giving a maximum score of 51. The cut off point for caseness is ≥18 for psychosocial problems. The USEPP has a sensitivity of 99.1%, a specificity of 98.3% and internal consistence of 0.81. The Traumatic Experiences subscale has 4 items, each scored 0 to 3, thus a maximum of 12 points and the cut off point for caseness for significant Traumatic experiences is ≥5.

The three other USEPP subscales of Emotional Problems, Antisocial behavioral problems and Academic Problems, were used to measure the students' emotional, behavioral and academic problems respectively. The overall prevalence of Psychosocial problems was compared to the prevalence rate of Ugandan university students' psychopathology found in an earlier study using the Hopkins Symptom Check List, HSCL-10 (Nsereko, Musisi, Nakigudde & Ssekiwu, 2014). Data collection took place in one week. The study was advertised in all the five universities by posters and student campus newspapers. Students were approached in their classrooms at the end of study hours. The study was explained to them including its purpose and the voluntariness of participation, risks and benefits as well as the random nature of selecting participants. Those who agreed to participate were given numbers and those who were randomly selected using the table of random numbers were recruited for the study and given the 2 self-administered questionnaires. Those who were not selected were asked to accept the outcome and leave the lecture halls. Participants were asked to fill out the questionnaire individually, privately, and confidentially, not to share information and to leave no identifiers. Each participant voluntarily signed the informed consent form. Anonymity was protected. The questionnaires were then inspected for completeness. Of the 1101 recruited students, 976 (88.6%) correctly completed and returned the surveys and these were the ones included in the analysis.

Univariate descriptive statistics (frequencies) were carried out to estimate the percentages of the various variables of socio-demographic characteristics, study program characteristics and student burden characteristics. The prevalence of psychosocial problems as depicted by USEPP was calculated and compared to the prevalence of Ugandan University students' psychopathological problems status as measured by the HSCL-10 from an earlier study (Nsereko, Musisi, Nakigudde & Ssekiwu, 2014). For purposes of this paper, multivariate analyses were only conducted to examine the relationship between the independent variables and the outcome variable of traumatic experiences as the chosen psychosocial problem. At each stage of analysis, a p-level of ≤0.05 was considered significant.

It should be noted that the HSCL-10 was not administered to our sample of student participants in this study. The compared prevalence rate of Ugandan university students' psychopathology was from an earlier study (Nsereko, Musisi, Nakigudde & Ssekiwu, 2014).

RESULTS

Out of 1101 sampled students, 976 (88.6%) completed the questionnaires and returned them. These were the ones included in the analysis. Table I below shows the socio-demographic characteristics of the 976 participating students. The majority of the students were aged 18-24 years (73.2%), single (87.7%) Ugandans (93.8%). They were 51.6% females and 48.4% males giving a male: female ratio of 1:1.1 and they were mostly of Christian religious affiliation (76.2%) with 22.2% being Moslems and 1.6% being of other religious affiliations or none.

Table I: Socio-Demographic Characteristics Of The Participants

Variable	Number (N = 976)	Percentage (%)
Gender:		
Male	472	48.4
Female	504	51.6
Age:		
18 – 24	714	73.2
25 – 29	208	21.3
30 – 34	34	3.5
35 – 39	16	1.6
≥ 40	4	0.4
Religion:		
Moslem	217	22.2
Protestant (CoU)	272	27.9
Born Again	190	19.5
Catholic	281	28.8
Other	16	1.6
Marital Status:		
Single	856	87.7
Married	94	9.6
Other	26	2.7
Nationality:		
Ugandan	916	93.8
Other	60	6.2

In terms of their study program characteristics and reported health status, the majority lived in off-campus student accommodation i.e. hostels (57.9%) with only 30.5% living in on-campus hostels and the rest (4.7%) elsewhere. The student participants were either in their second or third year of university (83.1%) and in day study programs (95.1%). Over half of them (51.9%) were in professional courses but excluding Human Medicine, Veterinary Medicine and Agriculture. Table II below shows their study program characteristics and reported health status.

Table II: Students Study Program Characteristics And Reported Health Status

Variable	Number (N = 976)	Percentage %
Residence in Study time:		
On Campus hostel	298	30.5
Off Campus hostel	565	57.9
Other	113	11.7
Program of Study:	928	
Full time Day or Evening	48	95.1
Part time and Weekend		4.9
Year of Study:		
1st	137	14
2nd	412	42.2
3rd	399	40.9
4th & 5th	28	2.9
Course of Study:		
Professional Course	486	49.8
Non-professional Course	490	50.2
Tuition affordability:		
No difficulty	311	31.9
Some difficulty	495	50.7
Huge difficulty	170	17.4
Medical Status:		
Chronic Medical Condition	144	14.8
Diagnosed Mental illness	64	6.6
Perceived Health Status:		
Good	675	68.5
Fair	266	27.3
Poor	35	3.6

Over half (50.7%) of the students found some difficulty with paying tuition and 17.4% found huge difficulty with some totally unable to pay it pushing them to borrow or work part-time. Only 31.9% had no difficulty with paying tuition. In terms of their health, 21.4% had ongoing health conditions with 14.8% having chronic medical problems or diagnosed mental illness (6.6%) and 3.6% perceived their health as poor.

Psychosocial Problems

These were measured by using the USEPP Scale with a caseness cut off point of ≥18. The overall prevalence of psychosocial problems was 36.5%. The mean USEPP total score was 15.6 (SD = 9.07). On the individual subscales, the Traumatic Experience Subscale had the highest scores. Table III below shows these results.

Table III: Frequence Of Caseness On USEPP Scale And Its Subscales

Scale	Number (N = 976)	Percentage %
Overall Psychosocial Problems (USEPP Score ≥ 18)	357	36.5
Subscale Caseness:		
Emotional Problems	337	34.5
Antisocial Behavior Problems	209	21.4
Traumatic Experiences	478	48.9
Academic Problems	369	37.8

*Some students scored positive caseness on more than one subscale.

As can be seen in Table III, almost half of the students (48.9%) scored positive for caseness on the Traumatic Experiences Subscale followed by the Academic problems subscale (37.8%) and the Emotional problems subscale (34.5%) with Antisocial problems subscale being the least at 21.4%

The overall prevalence rate of the university students' psychosocial problems as measured by the USEPP was 36.5%. This was comparable to the prevalence of psychopathology among Ugandan university students from an earlier study using the Hopkins Symptom Check List – 10 (HSCL-10) with a cutoff point of 22 for caseness to screen for anxiety, depression or both (Nsereko, Musisi, Nakigudde & Ssekiwu, 2014). In that study, using the HSCL-10 at a cutoff score of 22 for caseness, 341 (34.8%) were found positive for psychological distress indicating that these students manifested mental health problems of anxiety and or depression. The Mean HSCL-10 score was 25.4 (SD = 3.25).

We then assessed our sample of university students for the association between psychosocial problems (Traumatic experiences, emotional problems, academic problems and antisocial behavior problems) and sociodemographic characteristics. Table IV below shows the findings.

Table IV: Association Of Psychosocial Problems With Gender, Age, Religious Affiliation, Nationality And Marital Status Among The Respondents (N = 976)

Associated Factor	Students without Psychosocial Problems (n = 620)	Students with Psychosocial Problems (n = 356)	Chi- Square	p-value
Gender:				
Male	302 (48.7%)	170 (47.8%)	0.7734	0.7740
Female	318 (51.3%)	186 (52.2%)		
Age (years):				
18-29	601(96.2%)	321(90.2%)		
30-40	19(3.1%)	35(9.9%)	32.34	0.001*
Religious Affiliation:				
Moslem	130 (21%)	87 (24.4%)		
Church of Uganda	180 (29%)	92 (25.8%)		
Catholic	170 (27.4%)	111(31.2%)		
Born Again	128 (20.6%)	62 (17.4%)	9.792	0.400
Other	12 (1.9%)	4 (1.1%)		
Nationality:				
Ugandan	587 (94.7%)	329 (92.4%)	0.1569	0.1632
Other	33 (5.3%)	27 (7.6%)		
Marital Status:				
Single	561 (90.5%)	295 (82.9%)		
Married	43 (6.9%)	51 (14.3%)	14.37	0.001*
Other	16 (2.6%)	10 (2.8%)		

Note: *Significant at $p \leq 0.05$ level

There was a significant association of experienced psychosocial problems to age ($X^2 = 34.32$, p= 0.001) and marital status ($X^2= 14.37$, p= 0.001). Being older than 30 years and being married were both more likely to be associated with psychosocial problems. However, there was no significant association of nationality, religion, or gender to development of psychosocial problems. It should be recalled that the most common psychosocial problems were traumatic experiences which occurred in nearly half of our respondent university students as is shown in Table III above.

DISCUSSION

This paper aimed to present the findings of the study of the relationship between University students' psychosocial problem of traumatic experiences and the manifest mental ill-health problems of emotional and behavioral problems as well as academic problems and their associations among university students on Ugandan University campuses. Five purposively selected universities were chosen as the site of the study to represent the broad-spectrum of students attending university in Uganda in terms of their ethnicity (tribe), religious affiliation, social class, gender, tuition affordability and courses of study.

Our findings indeed reflected the general socio-demographic distribution of students attending University in Uganda. They were mostly of Ugandan nationality, aged 18-24 years, with a male: female ratio of almost 1:1. Most were single and belonged to the two main religious divisions in the country: Christianity and Islam. During study time, they lived in student hostels either on or off campus. They were equally divided in terms of taking professional or non-professional courses and were engaged mostly in full day or evening courses with

just a few (22.5%) taking part-time or weekend courses. So our sample was very representative of the general university student population in Uganda.

The prevalence rate of psychosocial problems as measured by the USEPP scale was found to be 36.5% . This prevalence rate was similar to that of the manifest psychological distress/mental ill-health as measured by the HSCL-10 which was 34.8% from an earlier study (Nsereko, Musisi, Nakigudde & Ssekiwu, 2014). Furthermore, these findings are similar to others in the literature who report similar prevalence rates (Stallman, 2008; Hunt & Eisenberg, 2010; Sherina, Med, Rampal, & Kaneson, 2004). The USEPP scale was specifically designed to be culturally and contextually sensitive to screen for psychosocial problems among Ugandan university students (Nsereko, Musisi & Holtzman, 2014). Its four subscales (Traumatic Experience, Emotional Problems, Academic Problems and Antisocial Behavior Problems) group together the common university campus problems that Ugandan students face. Thus under the Traumatic experience subscale, the detailed and specific experienced traumata of our student participants were found to be grouped under the subscale items of (i) the psychotraumatic experiences of economic stress (poverty with insecure tuition affordability or little money for personal use/survival), (ii) the pyschotraumatic experiences of family problems (illness, death, family relationship problems), (iii) the traumatic experiences of adjusting to university campus life (hostels, dates, independence and sexual abuse – harassment, sexual coercion/trickery and even rapes or attempted rapes including date rapes, sex for marks etc).

The Traumatic Experiences Subscale had the highest subscale score with a caseness prevalence of 48.9% or almost half of the students. It thus contributed the most to the USEPP cases of psychosocial problems which were at a prevalence of 36.5% in total. The Emotional Experiences Subscale had a caseness prevalence score of 34.5% and here the subscale items were feeling emotionally stressed and in low mood, poor sleep, poor concentration/memory, irrational fears/phobias and death wishes. These symptom groupings suggest depression and anxiety symptoms (DSM V, 2013). It is therefore likely that these similar symptoms contributed significantly to the HSCL-10 scores which found a prevalence rate of 34.8% of psychological distress. However, the second highest subscale caseness prevalence rate was on the Academic Problems Subscale at 37.8%. All this suggests that Traumatic Experiences led to emotional problems which then negatively impacted on academic performance. The specific item groupings of the Academic Subscale of the USEPP are: inability to concentrate on studies, poor/inadequate study skills for university courses and low academic grades. Lastly, the Autisocial behavior subscale caseness prevalence rate was 21.4% and the specific antisocial subscale items were: being involved in shameful behaviors, gambling/sports betting, sexual indiscretions, drug and alcohol abuse and academic malpractices/cheating in exams or when required to write papers/dissertations.

In terms of the associated factors to the manifest problems, the only significant were older age and being married. However it is important to note that although the other factors were not statistically significantly associated, they still occurred in big percentages as reflected in the USEPP subscale scores. The likely explanation here is that these findings simply reflect those factors of high vulnerability to being affected by the Traumatic Experiences or may be socially drifting to that group because of circumstances

An example is:

"A poor orphaned university girl who can't afford university fees and has to live off-campus in a low class hostel and then engages in age-disparate sex with a sugar daddy to raise funds and puts herself at risk of contracting HIV/AIDS or getting pregnant or being sexually mistreated. She then feels guilty and feels she has to pray to God for redemption and thus joins a Born Again church. On top of this, she may feel the peer pressure to keep up with the seemingly "enriched" lives of her colleagues with their cell phones, expensive clothes, TVs, music systems and even cars".

Such a student will likely have high Traumatic Experience subscale scores and high Emotional Problems subscale scores as well as a manifest psychopathological state of depression. Engaging in age-disparate sex for financial/material gain (for fees and support) will be her antisocial behavior.

LIMITATIONS

This study used dimensional scales (USEPP and for comparison HSCL-10) for screening for the respective problems with cutoff points for caseness. No attempt was made to have categorical psychiatric diagnoses of mental disorder e.g. as depicted in DSM V (APA, 2013). Thus no specific interventions could be

recommended. Secondly, the five selected universities were purposely chosen as part of a wider PhD study to represent Ugandan University students. However, except for one, they are all located in the Central Region of Uganda and may not reflect the students reality on other university campuses e.g. in the post-conflict areas of the country. Moreover, certain professional students such as Medicine, Veterinary Sciences and Agriculture were not included in the sample. This may reflect a bias in the recruited participating students. Lastly, the USEPP instrument is new and has not been tested across the country. Because of those sighted limitations, one has to be cautious in generalizing these findings to the whole country. Nevertheless, the study calls for further studies in the causes, manifestations and associations of mental health problems of university students in Uganda and Africa in general, a traumatized continent in transition with many changes that affect people's lives daily, university students inclusive.

CONCLUSIONS AND RECOMMENDATIONS

Traumatic Experiences were found at a high rate among Ugandan University students with these experiences involving almost half of the student population (48.9%). These gave rise to Emotional Problems and Academic Problems in more than a third of the students. Antisocial behavior occurred in almost a quarter of the students. The manifest psychosocial problems (USEPP caseness prevalence rate) were found at an overall prevalence of 36.5%. This rate was very comparable to an earlier study of the manifest psychological distress prevalence of 34.8% as measured by the HSCL-10 (Nsereko, Musisi, Nakigudde & Ssekiwu, 2014). That the USEPP score findings were very similar to the HSCL-10, makes the USEPP a very useful scale for use in screening for psychosocial problems on Ugandan University Campuses as an indication of potential students' psychopathology. The USEPP is culturally and contextually specific to Ugandan settings (Nsereko, Musisi & Holtzman, 2014). These findings call for effective screening for psychosocial problems among university students in Uganda at the beginning of each academic year as part of their annual medical check-ups via set up mental health services at university campuses. This way, problems can be detected early and interventions implemented to prevent them from developing into full blown psychopathologies which will certainly interfere with the students' academic performance and eventual outcome in life. In all this, traumatic experiences were evidently the big problem affecting University students' wellbeing in Uganda.

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