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**The Experiences of Survivors and Trauma Counselling Service Providers in northern  
Uganda: Implications for Mental Health Policy and Legislation**

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## **Abstract**

Previous research in northern Uganda found high levels of trauma-related difficulties amongst the conflict-affected population. There is international evidence that psychological therapy can reduce depression, as one of the psychological effects of trauma, but very limited literature regarding the experiences of trauma counselling in Sub-Saharan Africa. The current British Academy and Leverhulme-funded research investigated the experiences of service users and providers of trauma services in Kitgum and Gulu, northern Uganda. It also examined their implications for mental health policy and legislation.

A decision was made to utilise qualitative methodology to highlight the in-depth experiences of participants. The researcher's carried out interviews with 10 women and 10 men survivors attending trauma services in Kitgum and Gulu. The researchers also interviewed 15 key informants in Kitgum, Gulu and Kampala including trauma counselling service providers, ministers, cultural leaders and mental health professionals. The authors report the findings of the research based on thematic analysis of the interviews. Themes included the experiences of survivors, bearing witness and instilling hope, constraints to service provision, stigma and abuse, holistic approach, service providers doing their best, specialist populations, limited understanding, training and skills development, gaps in service provision and mental health policy and legislation.

The interviews resulted in a clear indication that counselling and medication was valued by service users, and that service providers felt the treatments that were provided improved depression, and increased empowerment and engagement in social activities. However, the authors argue that there was a limit to the benefits that could be achieved without using the holistic approach that the survivors requested. Thus, in cases of trauma arising from conflict, there is a clear need for the state to ensure reparation and/or justice for the atrocities witnessed

by and perpetrated against survivors. This might include the provision of compensation, which would help to meet social needs and reduce feelings of shame and anger.

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

## **1. INTRODUCTION AND CONTEXT**

Since 1998, Liebling and colleagues have carried out research with women, men and child survivors of conflict and post-conflict sexual and gender-based violence and torture (e.g. Liebling *et al.* 2012; Liebling-Kalifani *et al.* 2008; 2011; Liebling-Kalifani and Baker, 2010; Liebling and Baker, 2010). Research carried out in northern Uganda recommended a holistic model to meet the needs of women war survivors. The research argued for:

*“A holistic, gender-sensitive public health intervention approach, in order to address the physical and mental health needs of women war-survivors in Uganda. This should include the provision of free treatment services for women, including HIV/AIDS testing and treatment, access to specialist gynaecologists, obstetricians and female counsellors. Female war survivors should be included in all aspects of decision-making in order to increase autonomy and empowerment”*

(Liebling-Kalifani *et al.* 2008: 186).

The towns of Kitgum and Gulu in northern Uganda have been at the very heart of the sustained terror campaign carried out by Alice Lakwena in 1986-1987 and the Lord's Resistance Army under Joseph Kony from 1986 to 2006; a conflict that lasted for 21 years. The rebel group, led by Joseph Kony, caused untold damage to the lives, culture, health, education and livelihoods

of the people of the northern districts. In order to create a slave army, Kony abducted more than 30,000 mostly teenage boys and girls (Blattman and Annan, 2009). Adolescents were deemed to be the most effective and reliable forced recruits due to their pliability. Kony's strategy was, according to those close to him, to abduct mainly young people who could be brainwashed into becoming unquestioning foot-slaves; slaves who would blindly obey his orders to fight, kill, and torture, and to yield their bodies for sexual services (Invisible Children, 2016). The chronic war in this region has led to severe war-triggered trauma as a result of acts of torture, including sexual and gender-based violence (Amnesty International, 2005; Isis-WICCE, 2006). It has been estimated that during the sustained conflict, 2 million people were forced into Internally Displaced People's (IDP) Camps in Kitgum and Gulu, due to the presence of the Lord's Resistance Army (UNHCR, 2012). Those within the camps had limited access to health care, food, water and sanitation (Liebling-Kalifani *et al.* 2008; World Health Organisation, 2007).

The appalling wide-scale depredation and human rights abuses carried out by the LRA included girls being forced to enter into 'marriages' with LRA commanders, as well as acting as soldiers. During their abduction, both girls and boys were forced to commit atrocities, including murders, maiming, setting bombs and landmines, and torture. If they refused to engage in atrocities their lives were threatened along with those of their family members or friends. They were made to carry enormously heavy loads, including military equipment, munitions and food supplies, walking for long periods without food, water or footwear. Frequently those who refused to obey were killed in horrific ways.

Within a context of sexual violations and the enforced breakdown of social and moral values, the spread of HIV/AIDS was rife. Coupled with a breakdown in the health infrastructure as a result of the conflict, northern Uganda has persistently posted the poorest health indices in the country. Compared to the rest of the country, this region has a high HIV prevalence rate of

10.5% (the national average is 6.4%), the lowest rate of contraceptive use at 12% (with a national average of 23%) and a high rate of abortions and unwanted pregnancies (1 in every 5 pregnant women in northern Uganda endures an abortion, and 50% of pregnancies are unwanted (Liebling *et al.* 2008; World Health Organisation, 2007).

One of the investigators proposed a holistic model based on her prior research with survivors of conflict and post-conflict sexual and gender-based violence and torture (Liebling *et al.* 2008). The research argued not only for the need to address both physical and mental health needs, including access to services that achieve long-term improvements in survivors' health, but also for these needs to be met in conjunction with social, economic, legal and political empowerment.

In the context of a long-term conflict, previous research carried out with former abductees in northern Uganda (Liebling and Baker, 2010; Pham *et al.* 2004) found untreated mental health problems to be highly prevalent. Poverty, lack of health and justice services or adequately trained professionals, and a poor transport infrastructure, affected the ability of survivors to access badly needed mental health care (Liebling 2008; Liebling and Baker, 2010; Olak, 2007). Cultural specificity has been greatly neglected, and the cultural issues that might affect service access and experience had not been investigated.

Since the publication of this research, trauma centres have opened in northern Uganda. Following the tragic death of Peter Alderman in the World Trade Centre bombing on 11<sup>th</sup> September 2001, his parents created a foundation to provide trauma treatment centres in his memory (<http://www.petercaldermanfoundation.org/>) in order to address post-conflict trauma. Accordingly, in 2008 the Peter C. Alderman Foundation partnered with the government of Uganda, Makerere Medical School, Butabika National Psychiatric Referral Hospital, the Catholic Church and locally respected non-governmental organisations. Four trauma centres

were set up in northern Uganda, including the Kitgum clinic in June 2009 (opened through a partnership with the Ministry of Health). Pre and post-conflict, there have been a few non-governmental organisations providing services for survivors of traumatic experiences. Despite this, the experiences of service users and survivors of post-conflict atrocities who access trauma services in East Africa, has been largely neglected (McPherson, 2002). There was therefore a pressing need to investigate their experiences and the adequacy of services provided.

The authors' recent research involved interviews with service users and providers of trauma counselling and treatment services in Kitgum and Gulu, northern Uganda. The specific aims 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 policy and legislation.

## **2. METHODOLOGY**

Ethical approval was gained from Coventry University and the Uganda National Council for Science and Technology in June 2013. Thus, the researchers were able to interview thirty-five participants in Kitgum, Gulu and Kampala. Ten women and ten male trauma survivors were individually interviewed with the requirement that they had been attending trauma services for at least a year. Our 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. These bodies identified volunteers who fell into the chosen categories and were willing to participate in the research. The survivors we spoke to 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 were social workers, psychologists, psychiatric clinical officers and nurses (see Table 1). Interviews were also carried out with other specialist mental health professionals, policy makers, and ministry representatives, as well as one Acholi traditional leader.

Interviews were digitally recorded and then transcribed verbatim. Examples of the questions for survivors included:

- What were your experiences of the services you accessed?
- Did the intervention help you to deal with the effects of your experiences? If yes, in what way?

Thematic analysis was used to develop common themes and concepts. The procedures recommended by Braun and Clarke (2006) using six phases to identify and refine themes were followed to carry out analysis of the interview data. The coding was double checked within the research team to ensure validity of the data analysis. To protect participant's identities, pseudonyms were used.

The research team comprised of a Clinical Psychologist and Researcher, with a prior research relationship with the research assistants from KIWEPI. This established relationship was beneficial for the recruitment of the participants. The co-investigator was a Barrister with a Ph.D. in mental health law and human rights. The researchers adopted a reflexive position regarding their thoughts and influences on the research process, and continual reflective practice was utilised within the researcher team. During these processes, the researchers

explored their experiences, views, and biases in order to ensure that these did not unduly influence the analysis of data obtained.

**Table 1: Details of Key Informants Interviewed**

<b>Professional</b>	<b>Organisation</b>	<b>Gender</b>	<b>Location</b>
Social Worker	Non-Government Organisation	Male	Gulu
Psychiatrist	Government	Female	Kampala & n. Uganda
Psychiatrist	Government	Male	Kampala
Programme Director	Non-Government Organisation	Male	Gulu
Social Worker	Non-Government Organisation	Male	Kitgum
Psychologist	Government	Female	Gulu
Medical Professional	Ministry of Health	Female	Kampala
Psychiatric Nurse	Trauma Centre	Female	Northern Uganda
Psychologist	Trauma Centre	Male	Northern Uganda
Psychiatric Nurse	Government	Female	Kitgum
Social Worker	Non-Government Organisation	Male	Kitgum
Policy & Advocacy Officer	Non-Government Organisation	Male	Kampala
Clinical Psychologist	Government	Male	Kampala
Clinical Psychologist	Government	Male	Kampala
Psychiatric Nurse	Government	Female	Kitgum
Acholi Cultural Leader	Government	Male	Kampala

### 3. RESULTS

#### 3.1. Impact of survivors' experiences

Those survivors of abduction and trauma between 1986 and 2001 who were interviewed had suffered horrific conflict-related experiences involving significant violence. Many were forced to commit atrocities or witness the brutal killing of loved ones. The violence experienced included receiving, witnessing or the forced perpetration of mutilation, torture or sexual violence. Some service users had been forced to carry out bomb attacks. Most described common and understandable responses to their traumatic experiences, including severe depression and suicidal feelings. The trauma experienced frequently led to isolation and loneliness, anger, nightmares, flashbacks and low self-esteem, as had also been found a decade before by Musisi (2004). Lucy, a survivor interviewed in Gulu, described how her traumatic memories would return when she was in periods of stress:

*“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.”*

Lucy conveys her trauma not through psychological language, but through the physical experience of feeling unable to eat or drink. Many survivors we spoke to also described experiencing severe pain, which was sometimes considered somatic by the professionals. A relatively common complaint during interview was that many participants were not provided with pain relief medication. Somatisation and the description of psychological pain through physical symptoms are common in non-western cultures (Kirmayer and Young, 1998).

Survivors told us that this appeared to lead to an inadequate response to their physical symptoms.

The research identified the fact that a significant number of the participants had accessed non-medical services prior to accessing trauma services. A number of the interviewees had accessed the support of religious organisations. Prayer and church attendance provided ongoing support in conjunction with mental health services. Others visited traditional healers and consumed the herbs proposed, or engaged in local cultural rituals.

The majority of survivors interviewed in Kitgum and Gulu had a desire for redress. They expressed feelings of anger and of being 'let down' by the insufficiency of support available, the lack of basic and social need provision, and their difficulty in accessing justice. Numerous participants related that the result of internment in IDP camps was a dramatic increase in land disputes, exacerbating traumatic impact. One psychiatric clinical officer interviewed informed us:

*“Suicide rates have increased terribly in Gulu. In 2012 there were 51 suicides, but these are only the ones we know about; the true figures are likely to be very much higher.”*

### **3.2. Bearing witness and instilling hope**

It appeared from analysis of survivors' accounts that those interviewed related to professionals as experts and trusted their judgement, not seeking clarification of the purpose of the treatment provided. This relational approach did not appear significantly to enhance self-esteem or engender insight, but it was clear that the trauma services provided served to restore hope in survivors, and that was extremely valued.

In our participants, the counselling period extended up to a maximum of eleven sessions. Survivors had to travel for long distances to access the service, with poverty restricting regular access. Although a survivor could rarely choose the gender of the counsellor, they voiced universal appreciation of a listening ear and the availability of professional advice. Group counselling tended to be offered after individual counselling. This was often greatly valued since it gave survivors comfort to realise that their experiences had been shared. It also served to decrease isolation, as participants met others who then provided mutual social support. Margaret, a 30-year-old survivor described her response to the services in Gulu thus:

*“I have 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. 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.”*

Regarding the relative value of individual and group counselling, survivors differed in their views. Some found group counselling more helpful than individual sessions due to the commonality of experience; knowing others were suffering more was helpful to them, and a corresponding decrease in isolation led to a gain in confidence. Others preferred individual counselling and found a group less helpful. Angela, a 35-year-old woman from Kitgum, told us:

*“I feel okay opening up to a single person rather than a group because they tried group counselling but I found it very difficult to open up in the group about my experiences. I fear stigma and I may open up and others might come to talk to other people and talk about you so I am worried about confidentiality as well as stigma.”*

Certain survivors preferred individual counselling, and particularly those who experienced hearing voices and those who had difficulties with thinking too much. Their reasons for preferring one-on-one sessions included feeling calmer afterwards, engendering increased resilience, feeling comforted, and more free to trust and confide in one person in relation to their experiences. However, the researchers noted an inconsistency in the meaning of ‘counselling’, and different professionals were utilising different therapeutic approaches. There was also no accreditation of counsellors.

### **3.3. Constraints to service provision**

At the trauma services, survivors accessed both medication and counselling which 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, and related that this was not explained to them. Although most services were free, some survivors referred to clinics having a fragmented supply of medicines, and stated that sometimes they had to purchase drugs themselves, which they could rarely afford. The inevitable consequence for those without sufficient income was relapse and deterioration in their mental health. Interviewees said that staff were unavailable on occasions in Kitgum, and that clinic hours were limited due to a lack of resources and competing demands, particularly the prevalence of ‘nodding

disease' (thought to be a form of epilepsy), which had affected large numbers of children in the District.

Interviewees also described several other problems that affected access to services, including transport difficulties, poverty, stigma, and peer pressure, in addition to a lack of understanding of the value of counselling within the population.

### **3.4. Stigma and abuse**

The majority of survivors reported experiencing stigma and abuse that was directed towards them by community members. This stigma negatively affected their willingness to access services which undermined their healing. The community was said often to reject abductees on their return from captivity, believing that they were in some way implicated in the atrocities committed, despite participation having been under severe duress.

Former abductees felt 'let down' by the government due to the lack of justice and support provided since their return. In some instances, survivors were forced to leave their communities and families due to the rejection and abuse they suffered. The on-going land conflict appeared to cause a re-emergence of traumatic symptoms for several of those we interviewed. This appeared particularly prevalent amongst male survivors.

Interviewees felt medication and counselling in combination with access to income-generating activities helped to combat their preoccupation with traumatic experiences and relieve depression. Some considered that the stigma in communities was particularly directed towards those living with HIV/AIDS or former abductees. This left survivors in either or both categories feeling doubly stigmatised and isolated. Those with children born as a result of rape and forced marriage felt particularly lonely and stigmatised.

### **3.5. Holistic approach**

Survivors voiced a desire for a more holistic approach to their difficulties, including regular provision of medication, a choice of individual and/or group counselling, vocational opportunities and the provision of 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 re-categorised as post-conflict; although there was still reported conflict in the area as a result of land disputes and attacks by the Karamajong. A 36-year-old male survivor interviewed in Gulu said:

*“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 traumatised 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 traumatised and stressed.”*

### **3.6. Service providers ‘doing their best’**

Service providers indicated that they were doing their best to empower local health services and provide group counselling, using techniques including education and problem-solving approaches. Survivors also perceived that counselling services did their best, even though there were some complaints that they were under-resourced. It was felt that services needed to be extended to cover all of the Districts in northern Uganda. In rural areas in particular, it was reported that there was a severe lack of counselling, support and professional expertise, with limited outreach services. There were insufficient numbers of experienced mental health professionals to provide quality and holistic trauma counselling services, and it was felt that

more psychologists and counsellors were needed to capacity-build the village health teams and rural health centres. A Team Leader interviewed at one of the trauma centres explained:

*“...[W]e 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.”*

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 mostly described their services as leading to a reduction in depression, and greater empowerment of survivors as evidenced by their return to engagement in productive activities. However, the challenges already referred to were considered a constant barrier to carrying out their work effectively. Service providers we spoke to demonstrated care for clients and experienced feelings of frustration and disappointment when they felt unable to improve the quality of service provision, survivors’ situations, or their distress.

### **3.7. Specialist populations**

The researchers asked about the provision of counselling in prisons, but it was reported that these services were very limited. Those we spoke to also said that alcohol use was common as a coping-strategy, especially by male adolescents and men. This was thought by interviewees, both survivors and service providers, to have exacerbated the levels of domestic violence and suicide rates in the region. As a result, we were told that former male abductees in particular often ended up in prison as a result of alcohol-related crime. Service providers described anger as a frequent traumatic symptom in former abductees, with alcohol use and domestic

violence also common, being exacerbated by polygamy. A Team Leader we spoke to explained:

*“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 two to three 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.”*

### **3.8. Limited understanding**

It was voiced by some interviewees that there remained country-wide a lack of understanding of the traumatic impact of war in the context of the beliefs, rituals and values of the Acholi people. Those interviewed referred to tensions between different services working together; in part due to a lack of clarity as to which traditional healers could be trusted by communities. A male social worker in a non-government organisation described how people’s attitudes towards counselling affected their engagement in services:

*“In most cases people don’t believe in only talking...Then for the young people it may be peer group influence - ‘Why do you bother to go? For me, I was with you in the same place, but for me I am not experiencing the same things.’ You are wasting time, as they undermine it.”*

### **3.9. Training and skills development**

As indicated, service providers expressed concern that many non-governmental organisations and support services had pulled out of the country since the insurgency had ended. Despite

this, the numbers seeking services had actually increased. Some trauma service providers also related that they had to deal with their own traumatic experiences, with ‘burn out’ and secondary trauma commonly reported. They spoke of a desire for more skill-development, training (including more regular refresher training), support and supervision.

Staff felt that more effective long-term planning was required to carry out their role better, and should include logistics such as vehicles for outreach work, the provision of a transport allowance for those accessing services, and better career development that would enhance professional motivation.

### **3.10. Gaps in service provision**

Research by Nakimuli-Mpungu *et al.* (2013a; p.2) which focused on the overall mental health services provided, rather than trauma counseling, concluded:

*“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.”*

Although our study found survivors and providers valued the services provided, it also revealed a dearth of professional skills and expertise available for the effective delivery of trauma counselling, especially in the rural areas. There is a particular shortage of psychologists and counsellors in northern Uganda to provide support, training, supervision and capacity-building in the rural areas. Those we spoke to said that the most skilled trauma service providers including psychologists and psychiatrists in Uganda tended to be based in the capital, Kampala. Similarly, there are few specialist therapeutic services for trauma

survivors in the rural communities. There is no psychiatrist in Kitgum District, and the psychiatric coverage for Gulu was also insufficient for the population, particularly given the increasing levels of suicide reported.

The medication supply for survivors was sometimes erratic, with insufficient information provided to service users regarding its function. Medication tended to be prescribed by psychiatric clinical officers, who have only received brief community psychiatric training.

One of the psychologists described the gaps in the rural areas as follows:

*“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.”*

The research found that 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 survivor’s experience.

In terms of survivor’s views regarding service gaps, we were told that counselling is provided mainly in towns, with erratic service-use described by service providers. This was often due to transport problems arising from poverty. Many survivors complained about the great difficulties they had accessing services, either attending only when they had sufficient money for transport, or walking for very long distances, sometimes with conflict-related physical

health problems. Some also expressed regret at the limited number of sessions available to each individual.

### **3.11. Mental health policy and legislative shortcomings**

The dearth of public funding and trained professionals available in African countries means that mental health legislation based on colonial western concepts is often meaningless, ignored, or not followed or enforced (Bartlett *et al.*, 2011). However, mental health legislation also has an important symbolic as well as functional role, and can progress a moral imperative for improved mental health systems.

Survivors and service providers tended to place emphasis on the need for education for themselves and/or their children, educating communities regarding the impact of conflict, and tackling stigma. Survivors wanted to be listened to. Numerous interviewees longed for resolution of their land conflicts in order to access their land. Survivors also wished to have more support from local leaders in terms of housing, employment, and assistance with justice and reparation processes as a way of relieving the traumatic impact of their experiences. For example, a 22-year-old man interviewed in Gulu said:

*“I wish the government could come up to support the people, who have come back from captivity, educate us, and take us to a technical school where we could be educated and do some technical work. And after which, we come back and we are given start-up kits to make us begin our lives.”*

Survivors reported their experiences of a lack of support and social justice for the atrocities committed against them. As Lucy, a 58-year-old survivor interviewed in Gulu, explained:

*“We all need shelter and education, and I feel I would have [a] life when I take the medicine and attend for counselling. However, the communities do not listen to people with mental health problems, and they don’t allow us to contribute...even the local leader. If there was a law it should be strengthened so those who abuse us are prosecuted, and the rights of people with mental health problems are protected.”*

Currently there is a mental health policy in draft form; the National Policy for Mental Health, Neurological and Substance Abuse Services (2012), which sets out the main direction the Ministry of Health, will take in these areas for the next ten years. Unfortunately there is no specific policy 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. For that reason, some key informants stated that they deliberately ignored requirements under the legislation. Some of the participants advocated for an improvement in understanding and greater political will to recognise the importance of trauma services and provision in Uganda. Others complained that a lack of resources meant that insufficient advocacy by knowledgeable mental health professionals, service users and providers in the political arena occurred.

### **3.12. The Draft Mental Health Law**

A new mental health Act has been under discussion for numerous years. The Mental Health Bill 2014 was finally published in the Uganda Gazette on 19 December 2014 (Bill No.15) as required under national law prior to Parliamentary passage. The new law does not include

any specific provisions on trauma or stigma. In a country with a recent history of conflict, it was to be hoped that the new mental health law and any new policy would have included a specific focus on the provision of services for the treatment of trauma-related difficulties experienced by persons affected by conflict. It is understood by the researchers that the Bill is in its final form, having gone through a lengthy negotiation process with key stakeholders, and therefore it is unlikely to be altered. Nonetheless, there remains an opportunity for the government to use a new mental health policy to earmark sufficient resources for effective policy and legislation implementation; a hope which many of those interviewed had expressed.

Part III of the Bill is headed ‘protection of the rights of persons with mental illness’. The rights and duties are specified as being in addition to those in Part IV and under “any other law” (section 35(1)). However, the Bill does not set out particular rights in one clear section. Further, clause 35(2) states that in upholding rights and performing duties under Part III, regard must be had to the “best interests” of the patient, which implies that certain rights can be ignored according to the subjective view of a professional.

The authors note that clause 36(1) of the Bill has a loose over-arching right to respect for “the person, human dignity and privacy of a patient”, which is to be welcomed. However, the majority of the Bill refers to patients detained in a hospital or prison, and not to those in the community, and it is assumed that the intention behind including this sub-section was to protect the rights of those patients actually detained. Clause 37 also refers to non-discrimination of “patients’ on the grounds of “mental health illness”. However, clause 37(3) is one of the few sections of the draft law where the mentally ill generally are mentioned. In

the context of employment, it is disappointing that clause 34(4) essentially permits discrimination if that person's illness affects the performance of their duties.

The authors were pleased to note that clause 38 of the Bill is headed 'exploitation and abuse' and creates an offence for such ill-treatment, but it refers exclusively to employees of mental health units providing treatment, and does not include members of the public. However, clause 60 of the draft law sets out the functions of a new body known as 'the Board' which has a duty under sub-clause (g) to "promote and protect the rights of persons with mental illness". Arguably this relates not only to those detained in hospital. Nonetheless, this is a vague statement, and it is unclear precisely how it will do this, particularly for those who are not detained in hospital.

By way of clause 61(2), the Board "may" inquire into a complaint made to it concerning "the failure to uphold the rights of a person with mental illness" or any other matter related to the administration of the Act. Again, presumably this was intended to relate only to those in hospital, but it is not explicit. This clause may, therefore, provide a way for those in the community who are being discriminated against and/or abused to raise a complaint.

In addition, a number of criminal offences related to ill-treatment have been included in the draft Bill. In particular, clause 5(10) makes it an offence to ill-treat a person with mental illness in the community. The penalty is a prison sentence of up to fifteen months and a fine of up to 600,000 Ugandan shillings (currently approximately £120). There is no definition of 'ill-treatment' provided, which is likely to lead to confusion. There would need to be wide-scale advocacy across the country about the meaning and content of the Bill. If it is understood and policed, clause 5(1)) could prove a deterrent to abusers within the community.

However, an offence only takes place if the person in question is subject to a community treatment order, or if the accused who is allegedly ill-treating the person is “a resident of the area” and ‘*knows*’ “that person to be a person with mental illness”. This provides scope to argue a lack of knowledge in order to avoid recrimination. In addition, it is unclear if additional funds are being earmarked by the government to ensure that the legislation is effective – so, for example, funds for the making of complaints, investigation by the police, and the prosecution of those committing offences under the new legislation.

One noteworthy inclusion in the draft legislation is clause 18(3), whereby a voluntary patient has “the right to receive treatment”. Unfortunately this appears to be only when an inpatient. Clause 42(1) of the Bill states that before a voluntary patient is given treatment, a mental health practitioner must inform them of their rights. However, as the Bill does not set out (or describe) rights in one clear section, it is unclear to what this refers. Unfortunately there is no mention of involuntary patients here. Furthermore, the authors note that the following sub-clause states that a psychiatrist may restrict or deny rights when to do so is considered to be in the best interests of the patient. This provision, we suggest, is arbitrary and arguably a breach of a number of Conventions, including the Universal Declaration of Human Rights and the UN Convention on the Rights of Persons with Disabilities (‘CRPD’). As Article 1 of the CRPD makes clear, mental ill-health comes within the Convention, the purpose of which is to promote respect for the dignity of those with disabilities and to protect their human rights. The provision may also fall foul of other Conventions which protect autonomy and self-determination, requiring equality and non-discrimination, including Articles 2, 3 and 19 of the Banjul African Charter on Human and People’s Rights (‘ACHPR’); Articles 1, 2 and 7 of the UN Universal Declaration of Human Rights (‘UDHR’); Article 1 of the International Covenant on Economic, Social and Cultural Rights (‘ICESCR’); and Articles 1 and 2 of the

International Covenant on Civil and Political Rights ('ICCPR'). Furthermore, paragraph 34 of the General Comment by the UN Committee on Economic, Social and Cultural Rights on the right to the highest attainable standard of health under Article 12 obligates states to respect the right to health by refraining from applying coercive medical treatments. Whilst “an exceptional basis” may be found where the treatment of mental illness is concerned, such exceptions are subject to specific and restrictive conditions, respecting best practices and applicable international standards. The Ugandan Bill does not appear to set the bar high enough in this regard.

In the current Bill, there is no right to legal representation for those detained under the legislation, just as there is no mention of legal redress for rights' violations. This absence appears to be a clear violation of a number of international treaty requirements, including Article 13 of the CRPD which provides a right to “effective access to justice”, Articles 6 and 10 of the UDHR under which there is a right of access to the law and to an independent, impartial tribunal in determination of rights, and Article 9 which demands that no detention should be arbitrary. It would be difficult to assess the arbitrariness of a patient's detention without an investigation by an independent court or tribunal. Similar provisions are found within the ICCPR (Article 9), and the ACHPR (Article 7).

It was clear from our interviews that 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 or during a mental health relapse. By way of Article 12(5) of the CRPD, the Ugandan government has a duty to take appropriate and effective measures to ensure the equal right of persons with disabilities

to own or inherit property, and therefore it must investigate such alleged abuses and provide redress. The authors suggest that such powers ought to have been included in the Bill.

Further, effective access to justice post-conflict is required for those with legitimate civil claims for compensation, and the authors strongly recommend that free legal assistance should be provided to enable such redress. This needs greater legislative consideration, and the authors also suggest that the government consider setting up a fair compensation fund. Further, the anti-discrimination provisions for those with psychosocial disabilities contained in the new law appear insufficiently stringent to comply with various international Convention obligations or to give effective protection and equal recognition before the law as demanded by Article 12 of the CRPD. In addition, it is suggested that the range of offences and severity of the penalties may be inadequate to deter those who abuse or exploit those suffering from mental health problems.

It is noteworthy that there is no specific protection in the Bill for vulnerable groups such as former abductees and/or those suffering from trauma. Nothing in the new law will secure a right to treatment outside of the hospital inpatient context. Whilst the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care are non-binding, this ignores Principles 7 and 9 which protect the right to care and treatment in the least restrictive environment if possible in the community.

That said, there is also no right to travel expenses for the receipt of community mental health care which is a major practical block to the receipt of necessary treatment, and so any such right might have proved illusory. It is of note that there has also been no inclusion in the Bill of a right to *appropriate* mental health treatment - including and in particular psychological

help. There is also no duty included in the new law for mental health practitioners to provide the option of alternative treatments - and no patient right to choose between them.

Within the Board's duties, clause 60(i) of the Bill requires it to "promote public awareness on mental health and mental illness". However, there is no duty to educate the populace about human rights, the terms of the new law, or the duties of mental health providers, despite the reported lack of knowledge amongst survivors and key informants regarding the utility of the current legislation. The present research also indicated a wide lack of knowledge regarding the psychological impact of traumatic experiences. The authors recommend the inclusion of a governmental duty to provide mental health education in the school curriculum, including information on the causes and effects of, and treatments for, mental ill-health, including trauma and the diagnosis of post-traumatic stress disorder. In any event, to be effective upon implementation, country-wide education will be essential to ensure that the population knows about and understands the rights enshrined within it, and how to act upon those rights.

#### **4. CONCLUSIONS**

The occurrence of a wide variety of psychological symptoms in conflict populations is widely documented by available research. However, research from different conflict-affected countries consistently demonstrates the value of both physical and psychological support in minimising the effects of war-related traumas (Murthy and Lakshminarayana, 2006). Survivors and service providers in the current study repeatedly blamed land disputes, stigma and harassment by communities, as well as a lack of basic resources, for the continued traumatic impact of their experiences and block to their recovery and resilience. Survivors expressed the desire for a holistic approach to meet their needs, as has been previously recommended by earlier research (Liebling *et al.* 2008). This included regular provision of medication, trauma counselling, vocational opportunities and financial support; especially the

provision of school fees for their children. In terms of the approach to therapy and counselling, our research found survivors greatly valued person-centred approaches that also assisted them to build their own resilience. Those we spoke to also valued the opportunity to participate in group therapy, which has also found to be an effective approach within resource-constrained settings in Africa. However, the importance of choice of individual and/or group counselling approach for survivors was found to be imperative, along with the gender of the therapist. The holistic approach our study recommends also recognises the cultural and social realities of survivors continuing to struggle in their daily lives, and seeks to support and build resilience in individuals within their communities.

Miller and Rasmussen (2010) recommend building a bridge between more clinically focused and psychosocially-oriented approaches for survivors of conflict-related violence. The current authors argue that there is a limit to the progress survivors can make through counselling and medication alone in the absence of meaningful justice for the atrocities they have experienced. Although there has been a peace and development programme for northern Uganda, this does not appear to have given sufficient attention to justice processes for the survivors. This issue has been discussed more fully in the key investigator's previous research (see Liebling and Baker, 2010). Where there is evidence of abuse, a formal acknowledgement that survivors were wronged should be given by the government. In addition, medical treatment could be funded. Schooling for children born from rape and if necessary, the re-settlement of such families to a safe area should also be facilitated.

Our research concludes that survivors perceived a benefit from having a listening ear and someone to confide in, and find this leads to greater reported empowerment and lifting of depression. However, the importance of continued reconciliation processes in order to transform society following conflict is also important here. Indeed, Rimé *et al.* (1992) found

that describing experiences to others can transform its representation so that it takes a less emotive form. Rimé's research argues that this also assists survivors to gain a better sense of coherence, and social support and coping are also invaluable where a person's basic security is undermined.

As found in the current study, shame and stigma the survivors we spoke to experienced, had a profound effect on their lives, and sensitive approaches to dealing with these issues are imperative. As Ahmed and Braithwaite (2006) also argue, social relationships and shame management are central to the processes of restorative justice.

## **5. RECOMMENDATIONS**

The authors hope that the policy recommendations made herein arising from the research will provoke further debate amongst key stakeholders and experts in Uganda, and result in further development and implementation by local organisations (see also SAHMSA, 2003). Further, it is hoped that the Ugandan government will amend the new mental health legislation in light of the deficiencies the authors have highlighted, and successfully implement it.

### **5.1. Provision of mental health specialists and supervision**

Easier access to trauma services for survivors should be facilitated in the towns and rural areas, particularly by extending services to those who are severely depressed, suicidal and/or abuse alcohol. Psychiatrists and mental health specialists could be employed at the District, Regional and rural levels to increase the capacity of trauma counselling services. As a key informant interviewed in the Ministry of Health explained:

*“Of course we need to have more psychologists; but not only psychologists. We need more clinical psychologists because I have seen the kind of psychologists which are general psychologists, and not very many of them are well-grounded in mental health issues. So we need more clinical psychologists, and we need more psychiatric social workers - at least in the general hospitals.”*

There also needs to be support for professional organisations seeking to register and monitor professionals to provide trauma counselling. Regular provision of training, support and supervision, along with logistics to carry out their role, must be ensured to tackle ‘compassion fatigue’.

## **5.2. Increased capacity and knowledge regarding trauma and improved referral mechanisms**

The research found a significant gap in treatment caused by the difficulties inherent in travelling to trauma counselling centres. Thus, the government must ensure that funding available, perhaps initially through external partnerships, to increase outreach to rural communities, train and to increase the capacity of village health professionals at local community health centres. Capacity-building would enable greater provision of person-centred counselling. Local organisations and personnel who survivors approach need to be clear regarding the referral processes for trauma counselling services.

We further recommend a community dialogue approach (Westoby, 2014) to be rolled out in the rural areas involving Acholi cultural leaders, with further research and evaluation carried out on its effectiveness. This would assist to educate communities regarding the impact of traumatic experiences in a culturally meaningful way, alerting them to signs and symptoms

that would trigger a person's referral to appropriate primary care mental health and trauma services.

### **5.3. Community outreach services**

Mental health community outreach provision is required and must continue to be integrated into primary health care services in rural areas for those who cannot afford transport. Mobile clinics and the greater use of group counselling, as also recommended by Nakimuli-Mpungu (2013a; 2013b), would ensure the provision of more regular mental health support and counselling provision to rural areas.

Ideally, as our participants and earlier research supports, there should be a holistic approach to survivors' difficulties, including; regular provision of medication, counselling, vocational opportunities, and financial support, especially the payment of school fees for survivors' children, and the meeting of social needs. Links between District Hospitals and rural health clinics should be strengthened in order to ensure that those with higher mental health needs receive sufficient support. A more integrated and comprehensive approach may have a positive impact on trauma levels for example, by reducing associated rates of alcohol use and suicide, and could assist with resolving land conflict issues and ensuring that survivors' basic needs are met. However, clearly considerably more funding and additional resources would need to be provided by the government for these improvements. In the meantime, one practical way to improve greater access to trauma counselling services would be to expand the use of group counselling. One of the psychiatrists interviewed during the research stated:

*“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.”*

Our research therefore provides further support for 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.”*

The authors argue research is required to evaluate different types of therapeutic approaches; including group and individual therapy for survivors of conflict and post-conflict human rights abuses and the effectiveness of each from the perspective of survivors. In addition, the further development and impact of the use of a holistic model of services would benefit from evaluation, particularly in the rural areas.

#### **5.4. Community training and sensitisation**

Countrywide education and advocacy to reduce stigma, potentially through radio and the local media would help to increase the general level of understanding about vulnerable groups with trauma-related problems, associated substance use difficulties, and the close relationship between physical and mental health difficulties. This is needed in order to reduce the stigma and cycle of relapse experienced by former abductees and those with trauma-related difficulties. As a representative from the Ministry of Health interviewed explained:

*“We would want to see trauma services provided everywhere... [W]e have scaled up mental health services to most of the districts, so we have trauma services there. But one thing that is lacking is, we need massive public education for people to understand psychological trauma. But the kind of resources we need are enormous and they are not available now.”*

An increased sensitivity to women and girl survivors of rape who became pregnant during their abduction is also essential. For these survivors, women professionals are often preferred, but there are insufficient numbers for those accessing services to choose the gender of their counsellor. There has been very little research into gender differences in relation to trauma treatment and responses, and we recommend this as an important subject for further research.

To increase country-wide understanding of the impact of traumatic experiences and the need for service provision, we recommend that education is provided at primary and secondary school level. A psychiatrist interviewed in Kampala stated:

*“They should teach human rights in schools as war prevention. More importantly, we need to teach every healthcare provider to give some kind of counselling. In places where there has been massive trauma, we have hygiene classes or sex education in schools, and they should also do something on trauma and reconciliation; starting with early concepts in primary school and more complex concepts up to University. We need a Ministry of Peace-building and Conflict Resolution. I think that would go a long way.”*

It would be helpful to ensure that the general population understands the impact of traumatic experiences, the importance of reconciliation, the concept of restorative justice, and key

principles in relevant policy and legislation. As Tate (2015) has argued, mental health education and interventions may help to improve the effectiveness of measures designed to mitigate the risk of further violence in post-conflict regions:

*“Untreated mental health issues could seriously affect both capacity and desire to engage in reconciliatory and restorative processes designed to lower tensions. Furthermore, individuals suffering from pathological anger were seen...to struggle to engage positively in their communities for a long time after conflict subsided. There was also a risk of transmission of trauma to the next generation if children were exposed to episodes of explosive rage.”*

Education is therefore best carried out in the context of meaningful justice for victims and redress for survivors of atrocities, whether conflict or post-conflict related. As one of the key informants interviewed stated:

*“There is a weak link; redress, legal material and 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 service 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 people.”*

## **5.5. Shortcomings of and recommendations for national mental health policy**

Flowing from our research, we argue that mental health policy in Uganda should include a specific focus on the provision of services for the treatment of trauma-related difficulties as experienced by persons affected by conflict. Ideally, it should involve survivors and service providers from northern Uganda in its design, and have the backing of the government and politicians; including District and local leaders. Any new policy's efficacy must be systematically evaluated. There is a need to improve ethical practice and methodology, and to agree professional boundaries in trauma counselling. Accreditation bodies for every type of mental health professional are required in order to ensure and maintain high standards and to build capacity. Only those appropriately skilled should carry out interventions in order to ensure healing and avoid re-traumatisation of the survivor, as well as to help protect the professional from secondary trauma. There should be more clarity on what is meant by 'counselling', and more research is needed in the African context to ensure that the focus is on culturally appropriate therapy. For example, Kirmayer (2001) found the clinical presentation of depression and anxiety to be a function not only of patients' ethno-cultural backgrounds, but of the structure of their health care system. Mental health policy must also clearly define the roles of professionals and service providers who deliver services.

In addition, in order to protect against relapse, we recommend that a more robust policy is developed with respect to the procurement of medicines; it is crucial that the government ensures that a consistent supply is readily available throughout the country. As a psychiatrist interviewed in Kampala told us:

*“With respect to mental health policy, that’s where we’re way off. The Mental Health Act was made in 1964; that’s almost 50 years ago... [I]t’s not in keeping with the modern understanding of mental health or human rights. It’s far behind the times. There is no policy with regard to trauma; it’s absent. It’s high time we developed some sort of policy. We have to address the Act and then subdivide it into specific aspects, and [the] mental health consequences of trauma would be one aspect.”*

In this context it is also important to enhance the autonomy of service users by providing them with sufficient information for them to gain insight in order to remain well whenever possible. This aim would be greatly bolstered by specific policy and legislative provisions. With sufficient implementation it would also assist to increase knowledge and understanding within Ugandan communities, including survivors and service providers, which will improve attendance at relevant services.

Policy implementation requires sufficient resource allocation and concomitant continuous country-wide advocacy and education in order effectively to protect survivors’ rights. Such resources, the authors argue, are essential to ensure that anti-discrimination provisions with penalties for those who abuse those suffering from mental health difficulties (if included in the new mental health legislation) are effective.

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