LOOKING TO THE FUTURE WITH THE BURDENS OF THE PAST:

Exploring the Systems of Mental Health Treatment for War-Affected Youth in Northern Uganda

by

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ABSTRACT

Conflict-related trauma is linked intrinsically to mental health. This reality remains ever-present in Northern Uganda, as war-affected youth continue to suffer from the lingering effects of the LRA insurgency. With struggling health infrastructure, little capacity exists to address the magnitude of this issue. In place of hospitalized treatment, many local NGOs provide a variety of mental health services. These programs range from PTSD counselling to art-based therapies. This thesis asks, how do these services help war-affected populations and how can the system be strengthened? Based on the qualitative findings from grassroots practitioners, additional funding and attention is needed to combat challenges of coordination, apathy, participation, and gaps between policy and practice. Societal issues impacting scale, stigma, and poverty must be addressed. For a working holistic model of psychological care, infrastructure, capacity and finances must be strengthened and concentrated to heal the wounds of trauma which left from decades of conflict.

LIST OF ABBREVIATIONS USED

ARLPI – Acholi Religious Leaders Peace Initiative

CAMH – Child & Adolescent Mental Health

CCVS – Centre for Children in Vulnerable Situations

DDR – Disarmament, Demobilisation & Reintegration

DRC – Democratic Republic of Congo

EST – Ecological Systems Theory

FCS – Former Child Soldier

HPH – Hope & Peace for Humanity Uganda

JRP – Justice & Reconciliation Project

ICC – International Criminal Court

IDP – Internally Displaced Person(s)

IMF – International Monetary Fund

LRA – Lord's Resistance Army

MH – Mental Health, "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." (WHO, 2014)

NET – Narrative Exposure Therapy

NGO – Non-Governmental Organisation

OHCHR – Office of the United Nations High Commissioner on Human Rights

PTSD – Post-Traumatic Stress Disorder

RLP – Refugee Law Project

TF-CBT – Trauma-Focused Cognitive Behavioural Therapy

UPDF – United Patriotic Defense Front

VSLA – Village Savings & Loan Association

WAY – War-Affected Youth

WAYA – War-Affected Youth Association

WHO – World Health Organisation

WPDI – Whitaker Peace & Development Initiative

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Foremost, this work has been informed by amazing academics and research partners across the globe that continue to advocate for the needs of war-affected youth. At the core of this thesis is the acknowledgement that, although the guns have been silenced, there is so much important work to be done to address the lingering trauma of conflict. Children find themselves at the apex of war, with little ability to control the chaos that surrounds them. This is just one case study, but the abhorrent atrocities within these pages are found across the globe. I am left in constant awe of the important work done by the practitioners I spoke to for this study. The endless dedication will continue to inspire my academic and professional interests, and I am deeply thankful for their contributions to mental health advocacy, treatment and much more. These individuals have stepped up, and I am so proud to have the opportunity to amplify their work and message. Innocent lives are forever changed by violence, and, as a global collective, we must shift the attitude of indifference and inaction which plagues these vulnerable people. This is not just about righting the wrongs of the past to help the next conflict, this is about advocating for those who we have left behind.

CHAPTER 1: INTRODUCTION

During my time in Uganda, I had the opportunity to speak with a variety of organisations that work with the mental health concerns of war-affected individuals. One group I visited faced with a unique issue: a patient was selected for a prescribed therapy to process their recent psychological diagnosis, but the patient was unable to attend the remote therapy sessions. As poverty is widespread, the inability to attend was attributed to the financial implications of missing work, traveling to and from the site, and arranging for child-care. However, the advocate for this patient said the concern was that the patient had a bullet in their leg that had to be removed. The bullet caused pain that kept the individual from walking, and it exacerbated their psychological state. The patient might have had it removed by a partner group, but it had to be verified that it was from the war. If the bullet was from before 2002 (16 years prior to this conversation) or after 2006, the staff were limited in what could be done (personal communications, 30 August 2018). In this, and many cases, there are barriers to accessing mental health support.

The Lord's Resistance Army (LRA) insurgency (1989-2006) impacted millions of civilians with unimaginable atrocities, and widespread brutality committed by both rebel and government factions (Mugisha, et al., 2015). From displacement to physical and sexual violence, trauma remains ever-present in the lives of these Northern Ugandans (Kelly et al., 2016). Although this war concluded nearly fifteen years ago, it can never be forgotten. The government has shifted to progressive civic development that rebukes the lingering impacts of conflict. Efforts to transform Gulu, the regional hub of the northern districts, into a 21st century city are apparent with new sidewalks and buildings (personal

communications, 27 September 2018b). This development is intended to reclaim the narrative surrounding this land. Finally, the north of Uganda might not be synonymous with the LRA. Yet, progress can never be so simple as infrastructure alone. These changes fail to address the root of developmental stagnation in the region. Northern Uganda has too often been left to its own self-determination - without the necessary support and resources from the capital (Cheney, 2007). While conflict ended in 2006, the scars of this violence are imbedded in the northern region. As the popular sentiment suggests, the gun has been silenced, but the war rages on in the minds of the people (personal communications, 4 September 2018b).

Recognizing trauma associated with conflict is part and parcel of understanding the circumstances of modernity in Northern Uganda. Over time, international and local groups have delivered rehabilitative services. But the scope of these programs does not match the magnitude of this widespread problem (Murray et al., 2015). While mental health injuries are not always physical, they are no less life threatening than chronic illnesses (Briere & Scott, 2015). Left untreated, psychological distress can upend the lives of those struggling. This is especially true in the socio-economic context of Uganda. How can the scope of this issue be addressed? This thesis responds to this question in using evidence-based research that can lead to better advocacy for mental health support.

Practical Problem

Ugandans have very limited access to mental health care. Significantly, there is only one mental health referral hospital, located in the capital, for the entire population (Cooper et al., 2010). Kigozi et al. (2010a) found a noticeable concentration of mental health services in urban centres. Countrywide, only 0.8% of doctors and 4% of nurses

had psychiatric training (ibid). Disarmament, Demobilization and Reintegration (DDR), often promoted in post-conflict settings, may focus on combatants exclusively, thus marginalizing those with other experiences (Pauletto & Patel, 2010; Muldoon et al., 2014). Stigma for those associated with armed groups is often exacerbated by stigma related to cultural understandings of mental health (Veale & Stavrou, 2007; Neuner et al., 2012). Poverty, gender inequality, and sexual violence can also exacerbate mental health issues amongst war-affected youth (Kohrt et al., 2010; Tonheim et al., 2014).

Without the ability to offer comprehensive services, Northern Uganda remains trapped in a cycle of trauma originating from a long history of conflict. This overwhelmed system is further strained by refugees fleeing violence in the eastern Congo and South Sudan (Harvard Humanitarian Initiative, n.d.). In response, a community of mental health non-government organisations (NGOs) encourage the development of mental health treatment through active service delivery with holistic strategies for care (Cooper et al., 2010). Given the high burden of disorders, concerns related to access, funding and scope remain (personal communications, various 2018). As a result, questions must be asked about the state of mental health in Northern Uganda, in order to better understand its future service capabilities for a population much in need of support.

Research Questions

Through the practical context of conflict-related mental health available to war-affected youth, I answer a series of questions related to the experiences of practitioners delivering treatment, as they are the best advocates for their patients and well-versed in the realities of operating mental health programs in the Northern Ugandan context.

This thesis asks, based on the lack of psychosocial services available in Northern Uganda, what treatment options are in place from local mental health NGOs to address the trauma experiences of war-affected youth? How are elements, including but not limited to, demographics, the efficacy of treatment, cultural understanding and stigma considered in their work? From the perspectives of grassroots mental health practitioners and NGO staff, what are the most important considerations for providing effective mental health treatment? To compliment this, what limitations prevent them from delivering care? How can solutions be put in place to address these concerns?

Through these questions, with their relevant sub-queries, this thesis provides a basis of knowledge on the experiences of practitioners working to provide mental health treatment for war-affected youth. This series of questions aims to provide a thorough analysis of relevant grassroots psychosocial programming in Northern Uganda. To address these questions, I use narrative-driven qualitative methods - in semi-structured interviews and naturalistic observation - to appreciate the opinion-based perspectives of mental health practitioners on the state of services in Northern Uganda.

Research Problem

Through an exploration of the limitations involving mental health service delivery, opportunity exists to better understand how effective care can be distributed. However, a startling lack of information is available on how services are accessed in a system that lacks formal infrastructure for psychological treatment. With vulnerable populations relying on the local NGO sector, not enough academic research is dedicated to accessing the perspectives of individuals addressing the psychosocial needs of war-affected youth. Studies by Ndyanabangi et al. (2004) and Kigozi et al. (2010a) point to

the status of mental health treatment in Uganda more broadly, but it is the practical activities of local partners that truly empower war-affected communities for treatment. Only Vindevogel et al. (2012) provides an overview of both informal and formal support. While that study acknowledges the importance of comprehensive support for war-affected youth, it emphasizes quantitative participation through a methodological survey. This aligns with the methodological limitations seen in psychological studies as presented in Chapter 2 and 4 of this thesis. As such, a shift towards qualitative methods can allow practitioners a greater voice in demonstrating the realities of the current system.

Based on a series of interviews and observation conducted throughout Northern Uganda, I collected qualitative data to address the scale, quality and accessibility of mental health services, in helping to fill this knowledge gap. I chose to gather the perspectives of local practitioners from various community-based mental health NGOs throughout Northern Uganda. I conducted 24 semi-structured interviews and 4 naturalistic observation activities with a total of 10 organisations. All groups had mandates directly related to psychosocial support or adjacent programming which considers mental health, creating a representative sample of the grassroots structures of care available for war-affected youth for this study. Based on this testimony, I reflect to the research questions and highlight the perspectives of practitioners in the field. These perspectives factor into Bronfenbrenner's ecological systems theory (1979), which aims to understand childhood development through the holistic societal lens of different actors.

Thesis Statement

This thesis argues that current health services are unable to provide quality care for war-affected youth in Uganda, who continue to struggle with mental health disorders.

This is apparent in the immense burden of trauma stemming from the events of the LRA insurgency, and the lacking state-run health infrastructure within the region. Local NGOs work to provide robust, holistic psychosocial services, but are unable to match the scope of this concern due to resource limitations, a decentralized support network, and competition for funding. Taken together, it is clear that the lacking mental health services are not widely valued or prioritized within the country's current state of development.

Background & Context

Defining the term "war-affected youth" provides important boundaries for this study, while recognizing the connection between mental health and conflict is essential to identify the experiences of this cohort in the modern context. Furthermore, Northern Uganda has a long history of armed conflict and violence. As a result, it is necessary to examine the historical precedence for civil strife in Uganda, and the complexities that led to the LRA insurgency. The locations of war-affected communities demonstrate a bias to the northern region of the country (see Figures 1 to 3 in Appendix A). With these structures, there is an opportunity to understand the context that led to the current status of conflict-related mental health treatment.

Operationalizing: War-Affected Youth

With greater inclusivity applied to "former child soldiers" in contemporary literature, the term "war-affected youth" requires a succinct operationalization to define the confines of this study. The former is often applied as shorthand for the *Paris Principles* (2007) definition of "a child associated with an armed group", defined the as:

> "… any person below 18 years of age … who has been recruited by an armed … group in any capacity, including but not limited to children, boys and girls,

> used as fighters, cooks, porters, messengers, spies or for sexual purposes[,] … not only … a child who … has taken a direct part in hostilities." (p. 7).

A "child" is understood as "every human being below the age of 18 years, unless under the law applicable to the child, majority is attained earlier" (OHCHR, 1989). Based on this understanding, the international legal parameters for child protection within conflict are set. This enables a pertinent discussion surrounding the rights of the child and who might be considered war-affected for this study. Amone-P'Olak et al. (2014) provides a definition for "war-affected youth" with inclusion criteria for their study in Northern Uganda, which focuses on those abducted by rebel groups that were within a set age range at the time of the study. The age range is important, as the category of "youth" is defined by the African Union's *African Youth Charter* (2006) as "every person between the ages of 15 and 35 years" (pg. 3). This was echoed by this study's participants who noted that, within the cultural context of Uganda, the age range of "youth" fits with the aforementioned definition (personal communications, 16 August 2018).

Furthermore, the term "war-affected youth" also links with participation in armed groups, as many of the organisations participating in this study work with formerly abducted persons. In this way, the term casts a wider net to consider impacts outside of the "soldier" archetype (Mouthaan, 2015), similar to the definition and guidelines for children associated with armed groups put forward by the Paris Principles (2007), the Vancouver Principles (2019) and child welfare adopted with the OHCHR's *Convention of the Rights of the Child* (1989). For the purpose of this study, the term war-affected youth includes those persons who were exposed to conflict as youth, without abduction. These experiences have psychological impact (Lokuge et al., 2013), but the greater war exposure is linked with increased psychological impairment (Miller & Rasmussen, 2010).

Many of the "most-in-need" patients in Northern Uganda will fall into the category of "former child soldier" or Amone-P'Olak et al. (2014)'s "war-affected youth".

This narrows in on an important consideration. Do those persons impacted by the LRA insurgency as children (under 18) have greater psychological burdens due to their stages in development, coping abilities, and access of rehabilitation or support? The Machel study for UNICEF demonstrated impacts of war on children and highlighted the importance of protection in war zones and the immense burden that young people impacted by conflict face – even after conflict has ended (UNICEF, 2009). To highlight the impact of the LRA, UNICEF reported, while revisiting Machel's work in 2009, that one third of all children in the northern districts of Kitgum and Pader were abducted for at least one day (ibid). As some time has passed since the formal end of conflict in 2006, these Ugandan children have grown into the youth age bracket but may not have properly alleviated the psychological trauma related to past conflict experience.

For this study, the operationalization of "war-affected youth" is designed to remain inclusive of those currently between the ages of 15 and 35 (as culturally appropriate) that had trauma-generating war exposure (ranging from displacement to abduction and abuse) as children (0-18) that require psychological support based on the screening standards of the partners in the field (personal communications, various 2018).

Mental Health & Conflict

For war-affected youth, an undeniable connection links war experience and psychological need. Across countries, adolescents who experienced extreme conflict suffer from long-term mental health struggles stemming from traumatic events

(Betancourt & Khan, 2008; Amone-P'Olak et al., 2014a; Briere & Scott, 2015). War exposure, which includes witnessing extreme violence, experiencing sexual or physical abuse, suffering forced displacement, and seeing the death of family members, has been associated with worse psychological status on scales rating anxiety- and depressive-related disorders (Miller & Rasmussen, 2010; Betancourt et al., 2010a; Liebling et al., 2016). For young people at formative stages during war exposure, such detrimental impacts can last into adult-life (Boothby et al., 2006, Olema et al., 2014). By impacting the neurological and psychological development in this way, the presentation of PTSD, depression, general anxiety and fear, and other issues can become common place – even after violence has ceased (Betancourt et al., 2010b; Schauer & Elbert, 2010). In this way, it is important to recognize how such disorders become increasingly difficult to address with prolonged exposure and trauma.

When considering that many of modern conflicts occur in countries lacking infrastructure to address the nature of these illnesses, experiences of war can be exacerbated by the post-war environment (Miller & Rasmussen, 2010; Amone-P'Olak et al., 2014a). During conflict, the decimation of a nation embroiled in heinous conflict creates little opportunity to address the mental impacts of war. Entire communities are fragmented, leaving people unable to visit hospitals with the intent of accessing mental health treatment. Furthermore, foreign aid for health may not prioritize psychological needs within health care (Bird et al., 2011; Patel, 2014; Kleinman et al., 2016). This leaves psychological care to be deferred until conflict ceases. This does not begin to address the systematic burden of widespread poverty and social disruption in the post-war space. Poverty and insecurity exacerbate mental health detriments associated with trauma

(Miller & Rasmussen, 2010; Annan et al., 2013). War-affected youth need income for treatment, but opportunities are limited by lack of education and debilitating symptoms.

PTSD, and other anxiety-related disorders, can cause detrimental physical and mental symptoms, including headaches, stomach pain, sleep disorders, depression, anxiety, increased aggression, extreme pessimism, intolerance to frustration, struggles with concentration and somatisation, and lethargy (Schauer & Elbert, 2010; Haer & Bohmelt, 2015; Schultz & Weisaeth, 2015). Furthermore, persons with these disorders may suffer from flashbacks, avoidance, fear, intense psychological distress, distrust, constant worrying, sadness, loss of interest and pleasure, hopelessness, body pain, impulsiveness and delinquent behaviour (Bastien, 2010; Lokuge et al., 2013). Individuals with these disorders require holistic therapy that includes counselling, medication and livelihood support (Bastien, 2010; Ertl & Neuner, 2014), which is difficult to procure with the limited resources found in Northern Uganda. Such disorders are common in this cohort, particularly among those traumatised as children (O'Callaghan et al., 2014).

Based on this information, Uganda presents an important case study for understanding mental trauma associated with conflict – particularly as it involves civilian populations. Yet these testimonies, which connect mental health and trauma, do not explicitly identify why Uganda continues to overlook mental health. Instead, it is necessary to review the history of conflict that has devastated the population over the past five decades. Although fighting is over, a historical account of violence provides looks to how such atrocities have instigated mental health degradation among the Acholi people.

A History of Violence: Elizabeth II to Museveni

Historically, looking to the post-independence period provides a starting point for Uganda's modern state of violence. This is not to discount the legacy of colonial atrocities prior to 1962, but rather a method of tracing what many would agree is the genesis of regional disparity of the country. Following the British departure, the colonial authority instituted Northern Ugandan Milton Obote as prime minister (Finnstrom, 2008). Without delving too deep into the controversy surrounding his leadership, it is safe to say that he was not universally celebrated. His tenure oversaw the collapse of the multi-party coalition government that had led to his leadership. Following an armed struggle, Obote dissolved the traditional kingdoms of Uganda. By 1969, he assumed the post of president. These callous displays of power left Obote with few friends in Kampala, Uganda's capital, and in 1971, General Idi Amin seized power in a military coup (Branch, 2011).

The years that followed were some of the darkest times in Uganda's modern history. Amin ruled the country with an iron fist and showed little reserve when it came to brutal tactics of suppression and violence. Over the eight years of his dictatorship, Amin became notorious for mass killing and established a state fueled by fear (Branch, 2011). Amin's genocidal activities were widespread, and targeted ethnic groups from both the North and South of the country. His blatant disregard for human rights was infamous but obscures the loss of life during this period. This culture of violence has scarred Uganda and contributed to the conflicts that followed (Finnstrom, 2008). Significantly, Amin, like Obote before him, was born in the North.

Amin's downfall is often linked to his erratic and eccentric behaviour. This is often manifested in popular media as comical, despite the horrid history of violence

associated with him. Regardless, Amin's leadership ended in 1979 when he attempted to annex part of Northern Tanzania. Not only was this attempt catastrophically unsuccessful, it led to another period of political instability resulting from the installation of Obote as president once again in 1980 (ibid). The election of Obote was contested and instigated the Ugandan Bush War. This five-year conflict featured country-wide chaos, guerrilla warfare and widespread human rights abuse. This included the murder and rape of civilians, the recruitment of child soldiers, and the use of landmines in civilian areas. Obote was removed from power in 1985 by General Tito Okello, but Okello was deposed less than one year later by the current president, Yoweri Museveni (Cheney, 2007). Okello, like those before him is northern. Museveni is not. By the late 1980s, Uganda emerged with a new power structure that would favour the South. Although Museveni is from the Ankole ethnic region of Southern Uganda, he embodied a shift in leadership to represent the interest of Central Uganda's largest ethnic group, the Buganda, following the power loss suffered by the discrediting of the monarchy (Branch, 2011).

The issue is that Uganda is not a simple dichotomy. There is great complexity beyond the traditional categories of "North or South", "Buganda or Acholi", "Amin or Museveni". Many in the north felt alienation from the new leadership and the growing southern resentment towards ethnic groups in the north (Branch, 2011). The political loss was significant in that it led to the installation of Museveni, who also participated in widespread violence and war crimes committed in northern areas (ibid).

Continuing Chaos: Kony & The Lord's Resistance Army

The civilian population of Northern Uganda were targeted during the reign of Amin and the Bush War, and tensions increased over what would come when Museveni

took power in 1986. These feelings of insecurity developed into armed conflict against the Ugandan People's Defense Force (UPDF) occupying the north. The LRA insurgency, led by Joseph Kony, led to skirmishes between the LRA and the UPDF, which eventually escalated to a violent insurgency (Finnstrom, 2008). During this time, for most, support from the LRA was more of a passive acceptance given the previous violence towards the Acholi people from the Central region (personal communications, 5 October 2018).

With the government severely underestimating the LRA's fighting power, the insurgency grew as Kony's group began enacting violence throughout the northern region (Veale et al., 2007). As the violence between the two factions grew, more civilians were impacted, renewing the upheaval of the Amin and Bush War eras (Branch, 2011). Negotiations were ongoing between the LRA and national military, but the little progress was made and the LRA continued to expand across Northern Uganda into other non-Acholi areas. In 1994, Museveni demanded the LRA surrender, catalyzing support for the LRA from the Sudanese government (Conciliation Resources, n.d.). The increased military capacity caused widespread devastation to the civilian populations with increased disregard for human life or traditional ethnic boundaries.

This period saw the recruitment and use of child soldiers, rape, mass murder, destruction of infrastructure, and other brutal acts by the LRA (Finnstrom, 2008). In response to this violence, the UPDF forcibly moved ethnic Acholi into internally displaced person (IDP) camps. These camps were frequently attacked and unable to adapt to the needs of this massive population (Dolan, 2009). Fear defined this period for Northern Uganda. Fear of abduction, leading to tens of thousands of children fleeing their homes each night to hide in urban centers. Fear of displacement, due to anxiety from

combatants setting fire to camps and villages. Fear of sickness, from unsanitary conditions, rampant disease outbreaks and rumours of HIV-positive soldiers instructed to rape civilians (ibid). Fear of torture, fear of losing loved ones, fear of sexual slavery. Fear of the heinous destruction that characterized the region (ibid). Ultimately, fear dictated the human experience for the decades of this conflict. The LRA targeted the Acholi through their violence, and government forces targeted the Acholi as collaborators of the LRA. The people of Northern Uganda were in a "no win" situation, with both armed groups showing blatant disregard for their rights. Between 60 000 to 100 000 children were abducted and more than 2 million civilians were displaced as a result of the LRA insurgency (Auletta-Young et al., 2015).

In 2001, the relationship between Sudan and the LRA shifted. This is attributed to Sudan's fear of the United States intervening with civil war (Finnstrom, 2008). As a result of the LRA's lessened military strength, Museveni's UPDF doubled down on the attacks against Kony despite a relative calm having been established in the late 1990s. As the LRA retreated into the Acholi subregion, they committed violent atrocities at a massive scale, including attacks on camps and abductions of women and children across the war-affected districts (Finnstrom, 2008). Violence repeatedly interrupted peace talks, with both the LRA and UPDF seemingly uninterested in bilateral negotiations (Harvard Humanitarian Initiative, n.d.). The LRA moved into the eastern provinces of the Democratic Republic of Congo (DRC), adding to the suffering from its regional conflict for decades prior. In 2006, the LRA and Ugandan government finally entered into lasting resolve during the Juba Peace agreements (Peace Insight, n.d.). The LRA continued to operate in other nations with a similar disregard for human life (Okiror, 2017).

Outline of Thesis

This historical account of violence represents a 35-year period of unending violence in Northern Uganda, accumulating with an offensive campaign by a Northern rebel group and the national military which decimated the Acholi population of Uganda. These instances of violence have scarred generations of Ugandans. By exploring the impact of war-related trauma on mental health, the harsh realities for so many people in Uganda can be unearthed. Over the following chapters, I demonstrate the status of mental health treatment in Northern Uganda and I look to how this system may be influenced by socioecological factors - for better or for worse. It remains the ultimate goal to magnify the narratives and experiences of mental health practitioners in the field. Both the research questions and context found within this introductory chapter provide a guide for understanding the mental health treatment in the region.

Chapter 2 deals exclusively with a review of academic literature in the field of mental health systems and psychological treatments for war-affected populations. These two topics connects through an investigation of Uganda's mental health system and the broader literature of war-affected populations.

In Chapter 3, I explore the theoretical framework that guides this study. Ecological System's Theory (seen in Figure 4 of Appendix A), as briefly alluded to in this chapter, is a framework aims to highlight the interconnected systemic elements of society as they impact adolescent mental health (Atilola, 2017).

Chapter 4 reviews, and justifies, the methods of this study. The semi-structured interviews and naturalistic observation conducted as part of this study work to highlight the narrative experiences of practitioners in the field.

Chapter 5 and 6 provides the data presentation and analysis sections, respectively, of this thesis. Chapter 5 provides details drawn from the responses of those in the field, Chapter 6 takes themes from this data set and applies them to the systemic levels of ecological systems theory explored in Chapter 3. As a result, Chapter 5 highlights the experiences and general responses to the research questions posed in this chapter, while Chapter 6 digs deeper into the source of limitations reported by the participants of this study. This is analogous to the traditional parameters of "Results" and "Discussion".

Finally, Chapter 7 offers conclusions from this research and makes recommendations for future program implementation in the north of the country and in other post-conflict environments.

CHAPTER 2: LITERATURE REVIEW

The best way to conceptualize the connections between mental health and war-affected youth is through an in-depth literature review to cover two primary topics; a health system review of mental health in Uganda and; presenting relevant psychological studies regarding war-affected populations. In this chapter, I will review these topics – each with their own concessions given the status of mental health treatment in Uganda.

Health Systems

For this section, I will explore how the defining principles of global health aid to recognize psychological distress and how Uganda's health system incorporates mental health. Beyond this, it is necessary to explore how mental health is perceived by impacted communities and government structures, and how cultural interpretations influence care.

Perspectives on Child & Adolescent Mental Health in Global Health

Global health aid grew from $5.6 billion (USD) in 1990 to $21.8 billion in 2007, corresponding with a focus on HIV, tuberculosis, malaria and maternal health, as dictated by the Millennium Development Goals (Eaton et al., 2011). Despite this, mental health funding has not grown, feeding a vicious cycle of little attention leading to a desperate lack of services (Bird et al., 2011). Exacerbated by poverty, unequal distribution of services, and conflict-associated trauma, it is estimated that 11.5 million Ugandans suffer from mental illness, with less than half seeking treatment (Murray et al., 2015). With such a representation of mental health ailments, more must be done to address this crisis.

Although diagnosis and rehabilitation of mental disorders is increasingly prioritized in North America, the global budget for mental health treatment remains deeply inadequate for addressing the needs of vulnerable populations in the Global South (Eaton et al., 2011). This unfortunate fact reflects the prioritization of communicable diseases within global health policy and aid (Packard, 2016), which fails to address that roughly 13% of the entire disease burden in our world is related to neuropsychiatric conditions (Bird et al., 2011). In fact, roughly three-quarters of the entire global mental health burden is found in the resource-poor settings of the Global South (Mendenhall et al., 2014). This is due to the interactions between poverty, cultural understanding, access to quality care, and other social conditions (ibid). Considering this failure, the global community remains unwilling to commit resources to address this burden (Allen et al., 2014). This is seen through lackluster policy, the huge impacts of cultural understanding on stigmatization, and the place of mental health within global health – all of which represent barriers that prevent patients from seeking, and receiving, treatment.

Over the past twenty years, a shift to update independence era mental health policy in Sub-Saharan Africa has emerged (Petersen et al., 2017). As stated by Shen & Snowden (2014): “Mental health policies are not, in and of themselves, necessarily ‘good’; the true measure of national health governance lies in the configuration and performance of mental health systems.” (p. 17). Shifting to a greater prioritization of mental health within health care can offer progress, but these trends fall flat without capital to translate policy into practice (Patel, 2014; Faydi et al., 2011). Policy shifts are the macro-level are the ultimate responsibility of both the Ugandan health care structures.

As these policies continue to ignore the systemic challenges, these government reinforce structural violence of vulnerable communities suffering from mental health detriments.

With respect to the perceived triviality of mental health within global health, there is another dimension of consideration for this study, Child & Adolescent Mental Health (CAMH). Whether or not considering war-affected populations, CAMH is an area for concern regarding mental health as it presents unique concerns. The impact of conflict of the developing brain cannot be underestimated. CAMH has lagged in terms of independent capacity building around the globe (Appleton & Hammond-Rowley, 2000). Being that mental health and developmental disorders represent a relevant burden of childhood disease around the globe, it is important that the international community respond to the needs of this group (Patel et al., 2013). In Sierra Leone, Yoder et al. (2016) point to relevant capacity building to address the failing CAMH system. The authors note that child soldier rehabilitation did not translate into long-term social welfare for CAMH – particularly given the lingering strain of conflict on their health care system.

These are the realities when considering adolescent mental health. The specialty does not receive enough attention on a global scale, particularly given the population burden, and this is *within* a system that fails to receive attention in terms of health issues. Specific mandates often driven global health to illness-focused projects. This fails to translate into health systems that provide universal and long-lasting support – which is required for robust mental health support. Immunization is in Sub-Saharan Africa, and efforts in maternal health have yielded (albeit incomplete) strides decreased mortality. Such support has not been widely implemented with mental health.

True Disparity: Uganda's Mental Health System

In Uganda, economic aid does not favour mental health (Ndyanabangi et al., 2004). Instead, it is fixated on the eradication of communicable diseases. Among populations impacted by the civil war, some 54% displayed symptoms of post-traumatic stress disorder, while 67% displayed depression (Ford, 2008). Despite achieving relative peace over a decade ago, these disorders do not disappear in the way that other physical ailments of conflict do, preserving life-long impacts for survivors. Whereas treatment for HIV and malaria is often structured with medication, mental health requires additional considerations, such as therapy and rehabilitation. As disabled persons face experiences in poverty more intensely than the general populations, particularly as they are often unable to access economic empowerment (Lwanga-Ntale, 2003), there is a definitive need to address the impact of mental health in Uganda and other countries.

For the estimated 11.5 million people who suffer from mental illness in Uganda, there is only one dedicated mental health facility: the Butabika National Referral Hospital (Murray et al., 2015). With only 500 beds (1.83 beds per 100 thousand Ugandan citizens), the facility provides relevant services to the urban population of Kampala (Kigozi et al., 2010a). However, some 85% of the total mental health budget is directed towards Butabika (Murray et al., 2015), despite of the fact that 88% of Ugandans live in rural areas and would be thus ineligible for treatment at this urban centre (Kigozi et al., 2010a). Only the remaining 15% of the annual budget (which is approximately $2.5 million (USD)) is allocated for community mental health outreach, which fails to address the magnitude of this issue as it relates to rural populations (Raja et al., 2010). The Ministry of Health attempts to address this imbedded centralization, but with little

practical progress (Kigozi, 2007). For example, a mandate to train nurses in mental health support failed to adjust their workloads to allow time and resources for treating these disorders (personal communications, 30 August 2018). Beyond Butabika, Uganda has 28 outpatient clinics (none of which specialize in CAMH), 382 psychiatric beds in community-based units, and one day treatment centre (Kigozi et al., 2010a). Of these services, 62% of all available beds are located in or near Kampala, with few other clinics offering comprehensive services in areas with dire need (Kigozi et al., 2010a).

One of the main reasons for the constrains on mental health treatment in Uganda lies with the fact that services are dangerously underfunded. With only 1% of Uganda's health expenditure devoted to mental health (Kigozi et al., 2010a), psychological treatment is deeply restricted. This is despite mental disorders representing 13% of the disease burden in our world (Bird et al., 2011). Advocates of psychological care in Uganda point to recent addendums to their health care policy, which promise to decentralize care and diversify access to mental health (Petersen et al., 2011). Uganda's 1964 Health Act provided a very limited guide for mental health treatment. In 2000, these outdated principles were amended with prospective policy updates (Kizogi et al., 2010a). Accumulating with a submission in 2005, legislators worked to present a draft policy to implement education and advocacy of mental health (ibid) in accordance with an African Development Bank loan to boost the profile of mental health (Bird et al., 2011). Despite the increased budget for psychological care (ibid), it did not present a significant change, as mandates do not reflect the shifts needed in this sector (Omar et al., 2010).

More work is needed to address the status of mental health among war-affected youth in Uganda. Even with the strategies to expand care, the current infrastructure of

Northern Uganda does not, and can not, support integration of specialized CAMH treatments, let alone the sub-population of war-affected youth. In place of this, an exploration is required as to how the informal sector attempts to fill the gaps left by the formal system. This inquiry is the basis of this study.

Perceptions of Mental Health in Uganda

Stigmatization represents, perhaps, the most significant barrier to receiving equitable mental health treatment within the African context (Verelst et al., 2014; Omar et al., 2010). This manifests in a variety of ways, but it informs the basis of psychological care in Uganda. In worsening many mental disorders, stigma presents a huge barrier to developing rehabilitation and progressive methods for addressing symptoms (Quinn & Knifton, 2014). Even in the Global North, with bountiful progress towards destigmatizing mental health, public perception of long-term hospitalization is often viewed in terms previous centuries' imaginaries of asylums and psychotic breaks (Verhaeghe et al., 2007). Stigma is found at every level of society, and there must be efforts to stop these exploitive practices (Flisher et al., 2007). Without action, stigma emboldens within the harmful relationship between poverty and mental health. This prevents access to social services or formative normative relationships (Ssebunnya et al., 2009). As a result, excessive, and oppressive, stigma generates economic vulnerability. This creates high levels of stress that worsen anxiety, depression and trauma (Ssewamala et al., 2009).

Stigma is often tied to cultural understandings of mental disorders. Ugandan culture involves spirituality, which can include witchcraft, possession, evil spirits and sin generating symptoms (Quinn & Knifton, 2014). The cultural importance of spirituality and religion has come to define mental health, as religious beliefs can generate stigma by

tying the mental health struggles of family and community members to demons that require exorcism and cleansing as opposed to trauma-related symptoms that require counselling (Liebling et al., 2016). Within this cultural understanding, person with mental disorders can be viewed as dangerous, incapable, and unpredictable (Quinn & Knifton, 2014). For vulnerable groups, this can result in corporal punishment, poor access to services, social disenfranchisement, and other abhorrent treatment (Verelst et al., 2014).

When communities view mental health through the supernatural, the potential for positive treatment and policy shifts is jeopardized (Omar et al., 2010). Although social stigma stemming from cultural understanding presents a problematic misrepresentation of symptoms, it is perhaps equally harmful to negate the cultural experiences of Ugandans by rejecting non-western conceptualizations of mental health. This conflict, in and of itself, presents a set of practical questions that are outside of the scope of this research. Nonetheless, it remains an important consideration regarding this complex topic. Cultural understanding may offer an opportunity for treatment, but the stigma generated from this conceptualization of mental health creates barriers to the access and efficacy of treatment.

On the surface, Ugandan institutional stigma means that people with mental illness cannot vote, inherit property and lack the basics for survival (such as food, shelter and clothing) (Quinn & Knifton, 2014). However, beneath this obvious discrimination, legislative work on mental health has stalled in Uganda partially due to such perceptions of mental health. Policy implementors fail to recognize the influence of stigma on their work, which creates a cycle of dangerous practice that disregards mental health as ritualistic (ibid). Among media partners, mental health is not seen as a large issue and thus does not command the necessary level of attention (Kigozi et al., 2010b). As such,

there is a severe lack of public engagement with mental disorders which inevitably fails to disrupt the harmful social understanding that generate stigma. Beyond this, negative media portrayals of mental disorders cause further disturbance to social cohesion (Quinn & Knifton, 2014). Additionally, there are reports of Ugandan activists losing their jobs for association with mental health advocacy, people suffering from disorders being shunned by colleagues, and even a Ugandan member of parliament being refused a cabinet position after being exposed for utilizing a psychiatrist (ibid). The lack of funds and attention given to mental health is exacerbated by its associated stigma.

Psychological Studies

In order to achieve support for war-affected populations, many mental health practitioners defer to the expertise of the academic community. With the diverse background of psychological studies dedicated to acknowledging, and addressing, the trauma of former child soldiers and war-affected youth, a wealth of information regarding the psychological needs of these groups exists. Many of these studies are based within countries that have a destructive history of conflict, and each provides information about how the global community should respond to the needs of this population. By examining this literature, an opportunity arises to build understanding on different tactics of support.

Post-Traumatic Stress Disorder & Psychological Treatment Literature

Chapter 1 discussed the common symptoms surrounding PTSD associated with armed conflict. These debilitating symptoms remain pervasive within the lives of war-affected youth (Lokuge et al., 2013; Schultz & Weisaeth, 2015). However, mental health professionals have methods to address PTSD. In the Global North, recommended

treatment consists of a combination of prescription medications alongside dedicated therapy (Haagen et al., 2015; Bastien, 2010). In the Global South, socioeconomic and political instabilities often result in a lack of medical infrastructure such as skilled professionals and necessary pharmaceuticals. In lieu of the treatments familiar to the Global North, researchers and NGOs turn to innovative techniques to address symptoms.

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is one such technique. TF-CBT is designed to enable patients to reinterpret complicated emotions and feelings that are associated with a traumatic event. In teaching coping strategies for dealing with stress and working through the presented issues, therapists can create an educational approach that is effective for adolescents suffering from mental disorders (Cary & Curtis-McMillen, 2012; Ahmadi et al., 2012; McPherson, 2012). Narrative Exposure Therapy (NET) is a sub-set of TF-CBT which can be applied to the context of war-affected youth. Through the implementation of psychoeducation and trauma-related narrative development, patients can process reactions to traumatic events and limit anxiety-related symptoms associated with PTSD (McPherson, 2012; Robjant & Fazel, 2010; Ertl et al., 2011). Ertl et al. (2011) analyzed changes in PTSD severity over a period of one year following NET in Northern Uganda. Significantly, this study demonstrates that NET could be implemented successfully by community members who did not have a background in mental health. Those who received NET had the practice administered by locally trained workers, with support from the research team. Patients saw a reduction in PTSD symptom severity compared to a control group.

Outside of Uganda, health researchers sought to alleviate PTSD through means of TF-CBT. In the eastern provinces of neighboring DRC, McMullen et al. (2013)

demonstrated the validity of group-based TF-CBT among former child soldiers. These individuals experienced a dramatic drop in rating of PTSD symptom severity via the culturally adapted visual prompts. Furthermore, implementing the therapy in a group setting creates a safe space for discussion of traumatic events and created bonding among former child soldiers through collective participation. The work of O'Callaghan et al. (2014) demonstrated the effectiveness of community members participating in therapy with war-affected youth and their families, through the use of mobile cinemas and life-skill training. For this group in the DRC, patients remained in fear of increased violence or abduction but found symptom reduction through the application of TF-CBT.

Psychosocial therapy outside of TF-CBT offers excellent opportunities for significant progress among war-affected youth. In Rwanda, collective trauma therapy has proven effective for both community reconciliation and reducing health care costs (Jansen et al., 2015). Ertl & Neuner (2014) point to the importance of school-based programs for reducing trauma-related distress and resilience based on several studies on war-affected populations. Acknowledging the importance of social ecology was a relevant tool for Kohrt et al. (2010), who saw psychosocial improvements among reintegration of former child soldiers in Nepal. Perhaps most significant, Betancourt et al. (2013)'s academic *tour de force* provides a review of numerous academic studies which successful implement psychosocial programming among former child soldiers around the globe – thus pointing us in a direction of improving PTSD symptoms of war-affected youth on a global scale based on the excellent work of the academic community and their dedication to mental health literature.

These psychological studies focus on PTSD symptom reduction, but each provide an important note on how successful mental health programs may be put in place in low-resource settings. Each of the aforementioned studies were completed in regions with very limited options for psychological hospitalisation, and instead relied on local partners and academic expertise. By treating PTSD, these academics were able to show significant improvement in the daily lives of these war-affected youth. This represents only one avenue for successful programming, as psychosocial support and education is also incredibly valuable to these populations (Pauletto & Patel, 2010). With this knowledge, I look to success stories of Northern Uganda and understand the experiences of those local stakeholders in delivering care. Some may have utilized similar practices as seen in these studies, while others may have different innovative practices. To appreciate this work, it is important to have this basis of knowledge on PTSD symptom reduction.

Considerations for Mental Health in the Ugandan Case Study

Mental health presents a unique set of parameters within the context of the Global South. Although many attitudes that influence Ugandan mental health aid are directed from Global North actors, there are relevant considerations in cultural manifestations of psychiatric disorders, the nature of mental health within a post-conflict setting, and the opportunities for long-term care. These aspects are congruent with other post-conflict case studies in Sub-Saharan Africa, which link tradition, trauma and treatment. Together, such elements define experiences of patients and practitioners alike.

Psychological disorders often present symptoms that are misconceived in popular understanding. In many settings, local knowledge precedes neuroscientific explanations of trauma-related disorders. This can cause conflict in understanding and processing

mental illness, including aforementioned cases of stigmatization (Quinn & Knifton, 2014). One junction between culture and mental illness is spirit possession. Being that psychological inference is a relatively new field, the historical precedent for understanding different physical representations of symptoms through somatic complaints and psychotic symptoms associated with war-related trauma. This relationship provides an opportunity for reflection, as many of these explanations contribute an avenue for healing and recovery. Neuner et al. (2012) note that, in Uganda, spirit possession is a relevant concern for mental health practitioners dealing with war-affected youth and former child soldiers. The authors identify that patients who identify with spirit possession can have exacerbated symptom presentation and have the potential to alleviate trauma with traditional ceremony. These results are corroborated by research which identifies spirit possession as an important cultural framework for trauma-related mental health detriments (Hecker et al., 2016; Schultz & Weisaeth, 2015).

These spiritualized activities align with traditional concepts of coping within the Acholi culture of Northern Uganda. Healing and cleansing rituals add an important key for tackling trauma and symptoms. Rituals for returning home from conflict – including *Nyono tonggweno* (stepping on the egg) and *Moyo tipu* (cleansing the spirit) – offer relief for war-affected youth in the north of the country. For *Lwoko pik wang*, or washing away the tears, the community comes together to cleanse the tears that were shed (for having thought the returnee had died) by washing the face of the returnee with blessed water and pouring the remainder on the entrance to their home, where they will enter and exit (Harlacher et al., 2006). Although foreign to the "western" outlook, these traditional

ceremonies allow the Acholi population to conceptualize the mental distress seen in former abductees of the LRA insurgency through their own culture.

These ceremonies exist within the boundaries between science and tradition. Whereas some embrace these practices for their cultural value, others would dismiss these tactics due to their lack of clinical applicability (Neuner et al., 2012). Many in the academic community support the importance of cultural sensitivity within mental health treatment for war-affected youth due to the opportunity to engage the community and offer cultural healing (Hecker et al., 2016). These activities may not offer the same recorded reductions in PTSD symptom severity as others – although alleviated of spirit possession has been shown to have a significant impact (ibid) – but they offer benefits to war-affected populations. Despite this, implementation is not formalized in Uganda.

War experience can be extremely varied for traumatised youth. Whereas all experiences in war may generate deeply impactful trauma on an individual's mental health, instances of abduction, sexual violence, mental and physical abuse, forced combat, torture and drug use can increase symptom severity and frequency (Amone-P'Olak et al., 2014a). Mugisha et al. (2015) notes how a greater number of traumatic events (representing physical, psychological and sexual trauma) can lead to higher PTSD severity rating in war-affected populations. Vindevogel et al. (2011) provides further information regarding the scope of abuse among former abductees of the LRA, noting how different experiences within conflict led to varying needs during post-conflict rehabilitation. Harnisch & Pfeiffer (2018) comment on the importance of trauma experience within war as a measure of developing appetitive aggression in a post-conflict setting, showing that aggression acted as a protecting factor against PTSD while equated

to the subject's relative experiences during conflict. Outside Uganda, there is continuity with these findings: Hermenau et al. (2013) observed that former child soldiers who spent time within armed groups in the eastern DRC showed a greater presentation of aggression and trauma-related suffering. Significantly, the authors link this aggression to re-enlistment, military promotion and greater perpetrated violence (p. 7).

Post-conflict experience impacts survivors of the insurgency. Among war-affected youth and child soldiers, experiences within a post-war environment offer important considerations for treatment. Beyond the continued insecurity and political instability associated with armed conflict, even in the absence of armed fighting, instances of poverty, family disconnection, physical and mental abuse at the hands of community members and/or civil enforcement, and other daily stressors have been seen to impact on the psychological welfare of war-affected youth (Newnham et al., 2015).

This is seen in both combatants and victims of sexual violence in Northern Uganda (Amone-P'Olak et al., 2014b; Amone-P'Olak et al., 2016). Being that many war-affected youths will suffer from psychological distress in a post-war environment, McMullen et al. (2012) notes the importance of local development and community support for those impacted the most by conflict. In this way, the authors suggest that by addressing long-term factors of support, war-affected youth will have better outcomes for processing traumatic events and managing continued therapy in the low-income setting of Northern Uganda. Similarly, Pauletto & Patel (2010) examine the limitations of demobilization, disarmament & reintegration (DDR) strategies in the Congo, finding that generalized programs were ineffective due to lacking community involvement and culturally awareness. Banholzer & Haer (2014) interviewed child soldiers in Uganda and

looked to perceived attachment to armed groups as a deciding factor for successful reintegration. The authors suggest having been integrated into a violent system of warfare, the subjects required support to rehabilitate their responses to daily stressors in a caring environment rather than adopting aggressive tactics (ibid). This is to say that economic and educational support was necessary to move forward.

These different experiences within wartime or post-conflict periods underscore the importance of examining which strategies for reintegration and trauma healing work best. Miller & Rasmussen (2010) point to the need for a collaborative and integrative approach to mental health treatment for war-affected persons, which builds on trauma-focused therapy for addressing war-experience and psychosocial support for post-conflict insecurity. Conclusively, it is important for successful strategies of mental health support to tackle both conflict and post-conflict experiences. Given the financial limitations for NGOs in Uganda, notably with staff and funding, a single organisation may not have the resources to address both considerations. This leaves trauma exposure and symptom exacerbation as separate entities, without continuity of support for vulnerable groups.

Long-term support is an important factor as it allows for sustainable programs to thrive, meaning that relapse or untreated persons can continue to be aided with mental health support long after conflict (Betancourt, 2008). Boothby et al. (2006) provide formative knowledge on the crucial topic of longitudinal impacts with their examination of life outcome of former child soldiers in Mozambique. This study demonstrates that war-related trauma creates lifelong psychological impacts if undertreated. Considering generational impact, the potential for war-affected persons to pass on trauma through child maltreatment in a post-conflict setting is another relevant concern, meaning it is

necessary to address war-affected trauma in order to prevent a cycle of violence (Olema et al., 2014). Haer & Bohmelt (2015) provide the euphuism of child soldiers as "time bombs", given reoccurrence of aggression and psychological distress if mental health related to conflict is left untreated. Ultimately, these studies tie together the notion that mental health must be considered in terms of longitudinal progress, rather than through short-term solutions that might be delivered in the immediate aftermath of conflict.

Longitudinal studies of mental health treatment are underrepresented in conflict psychology literature, particularly due to the required funding and logistical commitments from research teams. Nonetheless, Betancourt et al. (2013) provides an endorsement of long-term support in their review of psychological studies involving former child soldiers – with specific emphasis on the importance of longitudinal studies to track the impact of education, employment and other factors that influence the experiences of war-affected youth after treatment. This comes back to the importance of building a strong support network, in which those suffering from mental disorders like PTSD can continuously and reflexively engage with health practitioners and the community. Coping mechanisms are strengthened and discussing trauma is normalized. In this way, triggering events and daily stressors may not threaten positive progress made in counselling (Newnham et al., 2015). The feasibility of long-term treatment in a post-conflict environment remains a concern, but without additional longitudinal studies, reflecting upon true cost of disengaging patients following therapy remains a challenge.

Conclusion

The literature discussed here provides important context for this thesis – whether it be related to Ugandan health care or the psychological wellbeing of vulnerable groups.

By understanding not only the efficacy of the Ugandan health system, but also the impact of war on youth through psychological studies, I am able to look to the work of grassroots organisations for inference into what services are available given the current limitations. Moreover, the conversations regarding patient support and successful practice help identify room for improvements within the current system. The testimonies of this insightful group have not previous been explored with explicit emphasis to address the status of mental health for war-affected youth.

To address this gap, it is necessary to review the experiences of those who work within the context of conflict-related mental health, particularly given their ability to speak to the limitations, best practices and general impressions of war-affected youth in Northern Uganda. It is with this recognition that it is necessary to approach the topic of conflict-related mental health in Sub-Saharan Africa with a holistic approach: one that encompasses both the realities on the ground and the broader impacts of nation and international governance. Notably, Ecological Systems Theory (EST) provides the foundation for such an exploration by highlighting the holistic nature of this testimony.

CHAPTER 3: THEORETICAL FRAMEWORK

Given the depth of literature dedicated to psychosocial wellbeing of war-affected youth, it is impractical to focus on one level of society in isolation – the system is impacted by an interconnected network. Through examining conflict-related mental health in Northern Uganda, the opportunity to recognize how systemic societal influences (such as family, government or international aid) come together to form, conceal, and alleviate trauma. Rather than fixating on a specific element like schooling or health policy, the strength of this global mindset is to recognize the interconnected nature of different elements as they impact services. In utilizing a framework with this distinctly widened (and systematic) lens, it is possible to appreciate how different components of local, national and international society allow this system of mental health support to continue to exist at a substandard level.

With this conceptualization in mind, the natural fit for the theoretical framework of this study is ecological systems theory. This theory, often based within psychological literature on childhood development, encourages the consideration of different structural levels of influence on a growing child (Paat, 2013). Although the cohort of war-affected youth in this study may be beyond the childhood development stages that ecological systems theory is practically applied to, the perspectives related to framing the differential impacts of society – particularly as it becomes compounded – provides a relevant baseline for exploring the status of mental health treatment as it impacts war-affected youth (Atilola, 2017; Diab et al., 2018). Through this chapter, I explain this theory and justify its application to the case study of mental health services in Northern

Uganda. By framing this thesis within the theoretical framework of ecological systems theory, I hope to illuminate the ways in which mental health cannot be properly addressed without acknowledging the complex network of societal influences on CAMH.

Ecological Systems Theory

Ecological systems theory (see Figure 4 of Appendix A) was developed by Urie Bronfenbrenner, to explore the interconnected nature of childhood development. This theory interweaves psychological models of development and social bonding, particularly as they apply to cultural setting and support. Through strategic amendments, various academic literatures apply Bronfenbrenner's complex network of childhood development to a variety of disciplines (Neal & Neal, 2013). As a result, the field of social ecology examines the influence of society on psychological wellbeing as a progression of the broader discipline of "systems thinking". For this thesis, the psychosocial juncture seen in Bronfenbrenner's work provides a foundation for understanding mental health among adolescents. This applies to trauma experiences as a young person in conflict settings and post-war rehabilitation work (Diab et al., 2018).

Bronfenbrenner's Concept

From Bronbenbrenner's perspective, adolescent development is influenced by the social networks around the child, with divided levels at different societal levels. At its core, ecological systems theory presents the "microsystem" as the most intimate level of development influence, including parents and family members (Paat, 2013). This proceeds to further levels such as the "mesosystem" – the connections between elements of the microsystem, such as interactions between family and the community. Next is the

"exosystem" - the influence of the indirect environment, such as the parental work environment (Diab et al., 2018). The "macrosystem" looks to dominant cultural values that influence the child. Finally, the "chronosystem" is the influence of time as the systems below change and adapt in their influence on the child (Bronfenbrenner, 1979).

Each of these interactions presents a complex stage of developmental influence on the adolescent. Each provides pivotal and ever-changing control over childhood development and the experience of a young person. For each child, these systems will act and react differently, providing a unique experience for the young person. Higher-level continuities factor in the importance of community and societal values, which provide continuity of experience for those within then same neighborhood, country or culture (Neal & Neal, 2013; Diab et al., 2018). Bronfenbrenner's ecological model of childhood is an important derivative of ecological systems theory. This complex model of social organisation emphasizes the role of relationships and social systems that impact childhood (Betancourt & Khan, 2008).

Further Application: Child & Adolescent Mental Health in Africa

Rather than focusing on Bronfenbrenner's original concept, it is better to shift focus to adaptations from authors who highlight the cultural and societal specifications seen among adolescent mental health support within sub-Saharan Africa (See Figure 4). In such a case of alteration, Atilola (2017) provides recent insight into adapting Bronfenbrenner's childhood model for child and adolescent mental health in Sub-Saharan Africa. By specifying the broad concepts of Bronfebrenner's model to the status of child and adolescent mental health in Sub-Saharan Africa, Atilola (2017) champions the convergence at the forefront of this study: the psychological status of young people

within the instability of low-income nations. Figure 4 presents these concepts, as specifically designed by Atilola (2017) using ecological systems theory. The authors preform this application as a means to advocate for the prioritization of early childhood intervention and expanded mental health policy for those in low-resource settings. While it is not my aim to focus on childhood development, this theory provides a relevant framework for encouraging child and adolescent health intervention within the contexts of poverty-stricken nations like Uganda. Atilola begins by presenting the traditional level of ecological systems theory: the micro-, meso-, exo-, macro- and chrono-systems.

For Bronfenbrenner's model, the microsystem is analogous to aspects that are directly involved in a child's development (family, peers). This influence of family and school is similar to the base theory. Within the "African" context, unequal access to education and the extreme cultural importance of the family unit provide some important shifts (Atilola, 2017). Each of these elements has the most direct influence on a young person, even within the stereotypical "communal" aspects of childhood. These elements may vary in duration or amount for different Sub-Saharan countries, but Atilola (2017) maintains that these elements provide the foundation in a distinct experience in child & adolescent mental health, and childhood social development.

Following this, Atilola (2017) offers an important alteration to the ecological model, with the mesosystem as a continuum to the microsystem. Here, the author identifies the mesosystem as the active relationship between the separate entities of the microsystem (family and neighborhood interacting to represent utilization of community services at the mesosystem level). This is more reflective of the application of ecological systems theory seen in the work of other authors which look at vulnerable populations

(Diab et al., 2018), compared to Bronfenbrenner's original formulation (1979). Rather than focusing on the mesosystem as a separated level of structural influence, the elements here are not autonomous but rather representative of the interactions. By emphasizing the mesosystem as a continuum of interactions in the microsystem, the author postulates that mental health in Sub-Saharan African can be viewed not through individual elements, but the ability of these elements to come together. In this way, Atilola (2017) points to opportunities to intervene in early childhood care and to improve psychological resilience among children in low-resource settings that may not have the security and structures of support seen in the application of ecological systems theory in the Global North. At this level, Atilola (2017) encourages policy which empowers low-income families with social protection as a means to encourage positive emotional and behavioural growth of children. Notably, the social protection schemes proposed in this work would focus on those impacted by disease, ethnic discrimination, malnutrition and stunting, lack of maternal care, and other risk factors related to poverty in low-income nations (ibid).

The next levels are the exosystem (larger social context that has bearing on child development) and the macrosystem (systems at a national or global level). Both were modified to emphasize CAMH. Atilola maintains the base components but shifts the focus to reflect the unique experiences of the African context, including sociocultural representations and knowledge of mental health, and the role of child protections laws. While both elements may be important in any deviation to ecological systems theory, the realities of developing countries in Sub-Saharan Africa require the acknowledgement of differing perspectives on legal systems and national governance. The global sphere of the macrosystem has a unique emphasis on the child and adolescent as it relates to the global

aid sector in low resource settings (Coetzee et al., 2015). In Atilola (2017)'s packaging of ecological systems theory for Africa, these two elements represent the opportunity to enact policy and legislation to combat negative impacts on childhood mental health. This highlights many of the concerns related to the mesosystem, but in the exosystem and macrosystem there is a vehicle for shifting the legislative and political attitudes that current jeopardize childhood development in low-income settings.

Finally, the chronosystem represents time-bound variations over the course of child development. Here, Atilola (2017) does not deviate from the traditional scope of ecological systems theory. This is due to the chronosystem being the most abstract level, meaning that it's components can be maintained across varied context. Nonetheless, the cultural role of growing up and/or age groupings can be uniquely applied to the Sub-Saharan context. The demographic diversity of these experiences across the continent is less continuous compared to other layers that examine experiences of poverty, conflict or other generalized realities of developing nations.

The suggestions made with Atilola (2017) renew focus on child and adolescent mental health look to provide a holistic model of care. Rather than focusing psychological treatment among adolescent groups on the individual, the author positions that – particularly given the poverty found in Sub-Saharan Africa – policy and practice for adopting mental health must be inclusive of empowerment for the family and community as well. While focusing on the child provides resilience and coping mechanisms, these individuals remain tied to the societal elements at higher levels that must be addressed. If a holistic model is not adopted, Atilola (2017) suggests childhood

mental health will continue to struggle in its African application, which fails to recognize the detrimental impacts of poverty, disease, resource-limitations and child protection.

Application to the Ugandan Case Study

Ecological systems theory provides an important framework for understanding the model of holistic mental health care in Uganda. Instead of focusing on a specific element of a patient's trauma, ecological systems theory acknowledges the interconnected nature of environment and livelihood as it impacts childhood mental health (Atilola, 2017). With this application, it is important to perceive a wide net of support generated from different areas. This includes community organisations, formal support structures and the home, all which work together to challenge trauma-related symptoms (Diab et al., 2018). This lens encourages the encounter of work from different groups dedicated to supporting war-affected youth and offers a comprehensive vision of how the challenges of trauma might be addressed. Three levels of ecological systems theory provide emphasis to the case study of war-affected youth in Uganda: the mesosystem, exosystem and macrosystem.

The mesosystem of ecological systems theory represents the interactions between family, schooling, health services, local government and other local aspects that have a direct impact on the life of a young person (Bronfenbrenner, 1979). Each of these elements is found within the microsystem autonomously, whereas the mesosystem represents the interconnected nature between these local institutions in the means that they impact the individual (Atilola, 2017). The mesosystem is as a continuum of the microsystem and takes priority by encompassing both the individual elements and their interactions (ibid). In this way, the mesosystem is the starting point and definitively local.

Within the Ugandan context, this provides a lens that encourages mental health detriments to be viewed in terms of multiple combining factors, rather than isolated to trauma. If trauma is isolated, therapy alone can be accepted as transformative and finite treatment – but in practice this remains to be seen. Instead, it is necessary to incorporate social models of mental health that highlight the importance of stigma, poverty and much more in diagnosis and treatment. This moves beyond the abstract to ground ecological systems theory within the everyday lives of war-affected youth in Uganda, in which ongoing violence is not a major concern. Instead, the debilitation of mental health is tied to unresolved trauma, daily stressors and the inability to access care. Whether considering family, schooling or community, these aspects have a direct connection to individual and interact to have a deep influence on the them (Coetzee et al., 2013). With community cemented into Acholi culture and the post-conflict space, each interaction dictates how a young person can comprehend trauma, receive treatment and grapple with the ongoing injustices of poverty and inequality.

Determining what can truly be considered local for a heterogenous group like those classified as "war-affected youth" is particularly difficult. Ecological systems theory excels in the ability to connect the individual to increasingly abstracted levels of society. As such, the mesosystem's local nature can be encapsulated within this case study by examining the Acholi subregion. Although expansive, this region faced the brunt of atrocity and violence during the LRA insurgency and remains home to many of Uganda's vulnerable and traumatised.

The exosystem is the level of this framework that is concerned with societal links as they impact the individual. Here, features like industry, media, and politics are

determining features in how mental health is considered. The exosystem interacts with the mesosystem and the macrosystem, creating a mid-point between the local interactions of daily life and the cultural attitudes that dominate our global sphere. Traditionally, the exosystem ties together things that impact a family member can in turn impact a child – like stress at work causing a parent to target stress towards the child (Neal & Neal, 2013).

For the context of this case study, these national attitudes towards the conflict, regional inequality, mental health and budgeting create barriers to providing efficacy among psychological programming in Northern Uganda. Both Bronfenbrenner (1979) and Atilola (2017) implicate the exosystem as the ground for shifting welfare services and protection of vulnerable groups. This means that the exosystem of the Ugandan case study implicates the national strategies (or lack thereof) for addressing the lingering trauma surrounding the conflict (ie: mental health among war-affected groups). It is at this level that Atilola (2017) suggest the policy can be enacted to shift the interactions of the mesosystem that threaten to deteriorate childhood mental health, and as an extension of this I would suggest it is the area of analysis for challenging government policies towards the youth cohort as well.

Whereas the exosystem can represent the national consciousness of Uganda, the macrosystem must take the next step to examine the broader societal themes that influence mental health policy and practice in the nation (Atilola, 2017). These themes are ubiquitous within the local context of Uganda, but the origins of these concerns as related to mental health are tied to the global junction between conflict and psychological care. In this sense, the macrosystem represents the traditional understanding as related to cultural boundaries (Neal & Neal, 2013), but also that these attitudes are fundamentally

influenced by leading global health donors. Other authors reflect on the macrosystem in similar ways, particularly as the influence on global inequality impacts health service delivery (Coetzee et al., 2015) and immigrant values upon entering a cross-cultural setting of a host country (Paat, 2013). In this way, war-affected youth in Northern Uganda are impacted by dominant global attitudes towards mental health.

Contrary to this, stigma and cultural representations might be attached to mental health within the macrosystem. Instead, I propose that the macrosystem connects the previous levels of systems theory to dominant global attitudes surrounding the prioritization of communicable disease over mental health, how aid is received in a post-conflict space, and the way in which war-affected youth are abandoned in favour of a war-peace binary that ignores the ongoing transition periods. In this way, Northern Uganda presents a unique set of parameters for understanding how global attitudes towards war-affected populations play out in the long-term. Notably, the abandonment of mental health practices following rehabilitation (if it ever occurs) is enforced by lack of capacity building by donors for the mental health sector yet implementing strategies within internationally mandated combatant recovery such as DDR. From the perspective of mental health, the cultural attitudes of the traditional macrosystem can influence the systems of care, but it is also important to leverage development and dependency.

Focusing on these three elements provides the necessary theoretical analysis to appreciate adolescent mental health and the ongoing struggles of traumatised populations. The microsystem does present unique considerations, but Atilola (2017)'s assertion that the mesosystem acts as a continuum of these values and thus encompasses the latter absolves consideration of this level. Beyond this, the chronosystem offers unique time-

bound challenges in delivering treatment for the Ugandan context. However, it is these longitudinal matters can be covered within the other levels of analysis being that time has already passed since conflict. In fact, time acts as a habituate traumatic experiences and lessen mental health detriments. Ironically, acknowledging that time has passed, and mental health should not be a problem seems to be the current government strategy for addressing mental health, and as a result analysis at this level would offer little novel contributions or policy implications for Northern Uganda.

Conclusion

The structures found in both Bronfenbrenner (1979)'s ecological systems theory and Atilola (2017)'s child and adolescent mental health focus can be applied to the plight of war-affected youth in Northern Uganda. No longer is it appropriate to consider the limitations of service providers through a singular lens: although different elements may have weight in each scenario, providing a full picture of how mental health can be influenced is relevant for future policy (Diab et al., 2018). This is a holistic model of mental health, and results in appreciating the need for holistic models of treatment advocated for within the broader literature of Chapter 2 (Annan et al., 2013; Liebling et al., 2016).With an appreciation of this multi-sector framework, it is possible to appreciate the complex web of influence on the relatively specific case study of war-affected youth in Northern Uganda.

CHAPTER 4: METHODS

Through this section, I provide an outline of the methods used in this study. Using qualitative methods, I proceeded with data collection to answer my central research question: what mental health services are available to war-affected youth? With the semi-structured interviews and observation focused on mental health practitioners in Northern Uganda, a variety of important data was collected. This chapter explains the methods used, with an overview of the stakeholders who participated in the study.

Participants

Recruitment of organisations was based on email contact, which utilized an approved recruitment script for initial contact. These contact details were collected from organisation's web sites. Only one organisation, Caritas, was included as a result of referral in Uganda and participated in the signatory procedure for consent and research partnership. Table 1 (seen on page 46) depicts the participation of each organisation, including the methods they participated in and how many individuals took part in the study. Important locations are found on the provided reference map, Figure 3 of Appendix A. Participants represented 10 different community organisation that operate in Northern Uganda, with an additional interview being conducted with an academic contact from Gulu University. Recruitment of organisations was based on email contact, which utilized an approved recruitment script for initial contact. Each participant was assigned a pseudonym to ensure anonymity within this study, as listed in Table 2.

Table 1 List of participating organisations with partnership details.

Name of Organisation	Abbreviation	Primary Operations	Participated in Interviews?	How Many?	Participated in Observation?	Description of Observation
Acholi Religious Leaders Peace Initiative	ARLPI	Traditional Acholi-land	Yes	1	No	[redacted]
Caritas Uganda	Caritas	Throughout Uganda	Yes	1	No	
Centre for Children in Vulnerable Situations	CCVS	Lira District, Acholi & Lango Subregion	Yes	5	No	
Hope & Peace for Humanity	HPH	Gulu, Nwoya & Amuru District	Yes	3	No	
Justice & Reconciliation Project	JRP	Gulu District	Yes	1	No	
Refugee Law Project	RLP	Throughout Uganda	Yes	1	Yes	Visit to National Memory & Peace Documentation Centre in Kitgum
THRIVE Gulu	THRIVE	Gulu & Amuru District	Yes	3	Yes	Daytrip with Organisation Staff for Site Check-Up, Mobile Mental Health Clinic
Vivo International	Vivo	Gulu & Nwoya District	Yes	2	Yes	Staff Meeting of Counsellors/Admin
War-Affected Youth Association	WAYA	Gulu District	Yes	2	Yes	Observation of Various Dance Practices for Trad. Ceremony
Whittaker Peace & Development Initiative	WPDI	Throughout Uganda	Yes	3	No	[redacted]
Independent Academic	Academic	Kampala, Gulu	Yes	1	[redacted]	

Table 2 List of interviews.

Date	Pseudonym	Location	Citation Note
16 August 2018	Luka	Gulu	[redacted]
17 August 2018	Cleo	Gulu	
23 August 2018	John	Gulu	Session 1 (cited as a)
23 August 2018	Simon	Lacor	Session 2 (cited as b)
27 August 2018	Abby	Gulu	[redacted]
4 September 2018	Jeanie	Lira	Session 1 (cited as a)
4 September 2018	Mark	Lira	Session 2 (cited as b)
4 September 2018	Dave	Lira	Session 3 (cited as c)
4 September 2018	Benton	Lira	Session 4 (cited as d)
14 September 2018	Elizabeth	Kampala	Session 1 (cited as a)
14 September 2018	Carol	Kampala	Session 2 (cited as b)
18 September 2018	Doug	Kiryandongo	Session 1 (cited as a)
18 September 2018	Susan	Kiryandongo	Session 2 (cited as b)
21 September 2018	Robert	Gulu	[redacted]
24 September 2018	Greg	Gulu	
25 September 2018	Anna	Barabili	
26 September 2018	Ray	Gulu	Session 1 (cited as a)
26 September 2018	Michael	Gulu	Session 2 (cited as b)
27 September 2018	Samantha	Gulu	Session 1 (cited as a)
27 September 2018	Donald	Laliya	Session 2 (cited as b)
28 September 2018	Kerry	Barabili	[redacted]
4 October 2018	Neela	Gulu	
7 October 2018	Archie	Gulu	
8 October 2018	Deb	Gulu	

As stated, qualitative methods encourage an opportunity for narrative reflection that is often disregarded in the dominant literature. Simply put, I do not have the necessary training or experience in trauma counselling to encourage war-affected youth to revisit the trauma of their past to reflect upon their experiences within a treatment regimen. Key to successful mental health projects is developing a trust-based relationship between traumatised persons and counsellors, and the short-term nature of my field research and lack of experience would jeopardize care. Linguistic barriers may have come up as well in, but with the avoidance of interviewing or observing patients, this was not a concern. This served as the exclusion criteria for this study, which was seen in

naturalistic observation. The NGOs required longer time commitments for observation than I was able to provide, and as a result was selectively avoided.

It was with this acknowledgement that I turned my attention towards the individuals who manage this informal treatment. While the patients would provide some important insight into the feasibility of this treatment, it is the stakeholders and practitioners of mental health who are best suited to address the structural concerns of delivering treatment. Individuals that facilitate mental health work can reflect on their experiences in the field, delivering their unique treatment, and look to the larger societal concerns that impact access and availability of treatment in an important way. Moreover, there is simply not enough literature dedicated to understanding the perspectives of those delivering care within this sector, with most major contributions focusing on the patients.

The selection criteria of this study used convenience sampling (Sedgwick, 2013), in which organisations that responded with interest to recruitment were selected. Each organisation was initially identified with purposive sampling, as the participation criteria for this study focused on practitioners who have actively participated in mental health support and post-conflict rehabilitation of war-affected youth. The participating NGOs are not a wholly representative sample of mental health programs, but rather were willing to contribute to this study through interviews and observation (Table 1). The interviewees from these NGOs were staff, partner therapists, local health workers, and administration. Interview screening was from the recommendations of NGO partners.

Qualitative Methods

Qualitative methods, such as interviews and observation, have a narrative focus

the world (Gerring, 2017). These methods allow for focus on personal details that might be overlooked through quantitative studies (Brockington & Sullivan, 2003). Whereas quantitative methods tend to focus on providing encompassing reasoning, qualitative methods embrace narrative-driven data collection that works for mental health systems research (Vinci et al., 2017). With conversations of emotional weight, these methods provide added context for the researcher, participants and reader (Ashton, 2014).

Within studies regarding mental health, there is a gravitation towards quantitative research methods (Ward et al., 2010). This results in very few studies on war-affected youth that tackle narratives surrounding population of the mesosystem. As a result, advancing the literature must come through a study that looks to recommendations for addressing mental health in the testimony of practitioners. This method focuses on promoting the testimony from individuals as they reflect upon their own experiences (Luchins, 2012). Efforts to identify areas of strength, as well as generating comments on how mental health is perceived, provides an excellent opportunity to engage with a diverse group of participants (McIntosh & Morse, 2015).

Semi-structured interviews allow for a strong basis of understanding the complex realities of delivering health care in a low-resource setting, while also ensuring that the voices of participants can shine through (Gerring, 2017). The semi-structured nature is useful as it alleviates formal interview boundaries, encouraging conversations to develop naturally and thus allowing discussion of sensitive topics like those related to trauma and conflict (Ashton, 2014). In this study, every participant completed an interview. They were guided through common themes that aligned with the research questions, while also being encouraged to reflect on their personal and professional experience.

By assessing relevant concerns of each interviewee, the content of the interview adapted as the conversation unfolded. While some questions were posed to every participant, others were adapted to the role of the individual in their organisation. The interviews were broken up into questions related to three themes: Basic Information, Program-Specific Implementation & Opinion-Based Questions.

For "Basic Information", I aimed to develop an understanding of how each organisation contributed to the needs of war-affected youth. Within this section, I identified the specific role of each interviewee at their organisation and how this translated into a stakeholder role for mental health treatment. In alignment with the diversity of responses, individuals with different roles at the organisation were able to speak to various aspects of the organisation's programs. Interviews began with a request for each interviewee to describe the services of their NGO and how they related to mental health, followed with questions that related to the daily responsibilities of each person, and the differences between their chosen services and to others in Northern Uganda.

With questions related to "Program-Specific Implementation", there were different responses from interviewees of each organisation, which lead to varied questions between interviews. These questions fixated on how organisations respond to the needs of the communities they serve, particularly through participation and service-delivery. Interviewees were able to speak about the reception of their communities and speak about their perceived best practices for mental health treatment.

Finally, I ended every interview with opinion-based questions about the services each organisation delivers and the broader theme of trauma-related mental health treatment. I requested that these questions be more thematic – to address how mental

health is seen in Northern Uganda. In practice, this shifted the conversation from interviewees commenting on their own organisation to become more critical of what else could be done to achieve success at a higher level. As most interviewees represented smaller NGOs, this allowed for some critical reflection on how larger service distributors may not align with the needs of the impacted population or result in long-term support.

I completed 24 audio recorded interviews with stakeholders and employees from 10 different organisation. At most, I interviewed 5 individuals from one organisation and just one from others. Interviews were completed over the three-month field research period between July and October of 2018. Interviews occurred at facilities operated by the NGOs (in private areas where employees could speak freely) or in public spaces.

Second to interviewing was observation. This method allowed me to witness the daily experiences of trauma counselling and mental health services that are available for the population (Luchins, 2012). In practice, observation was carried out in a variety of ways. While semi-structured interviews were limited to a general design, the naturalistic observation was a collaborative design with each organisation.

Initially, I had aimed to complete an observation period with each organisation, but the unfortunate yet realistic limitations of these groups prevented this. As I chose to focus on grassroots partners, most staff were occupied with daily activities and felt that observation might interfere with their work. With no interest in this study interrupting the importance of their work, I chose to forgo observation in several cases. Similarly, it was not possible to conduct observation with some organisations as they operated programs that required greater commitment from the researcher. Since a survey of different organisations was the aim, it would have been unethical to temporarily enter the lives of

traumatised patients by observing therapy sessions without the experience to contribute in a constructive way.

Instead, each organisation had the opportunity to contribute naturalistic observation in a variety of different ways. This included observation of dance training, office meetings, site visits and other non-therapeutic activities. This observation allowed for note collection and general impressions to be collected for data analysis, but mostly served as an opportunity to confirm some of the techniques and comments from interviews with the opportunity for clarification and greater depth of understanding. Some activities were planned beforehand, while others were drawn from the interviews.

With these two methods, I was able to collect a variety of data that caters to the research questions of this study. Interviews allowed for a second-hand account of daily activities, while the observation presented some first-hand note taking regarding on their activities. Together, these methods worked together to generate an encompassing portrait of the services delivered by each organisation. These two methods came together to develop complex understandings of how each organisation was able to contribute to the needs of war-affected youths without infringing upon the work they complete.

Ethical Considerations

This autonomous study was undertaken in association with Dalhousie University's Queen Elizabeth Scholar (QES) program via Makerere University in Kampala. Dalhousie University provided research ethics accreditation (REB File #2018-4495) prior to the onset of field work in Northern Uganda.

Participants of this study were formally associated with local mental health groups, who had offered provisional support for this study, and took part with the consent of the organisation. Prior to beginning interviews, participants provided free, and informed consent, to participate in the study, including the caveat that should they need to remove themselves from the study they would have from the interview date up until September 15th, 2018. No participants chose to withdraw themselves, and all collected interviews and observation were confirmed with written and discussed consent.

Every interview was recorded, with notes generated from audio records to consolidate further analysis. All interviewees were ensured confidentiality in correspondence with relevant privacy concerns – such as the use of pseudonyms and removal of identifying information. Each participant will be guaranteed an opportunity to revoke statements from interviews, based on the individual's recall ability, but regardless each participant will not be identified as the organisation title and name of participant will be obscured in the final thesis and through transcriptions. The only identifying information tying participants to this study was voice recordings, which were kept until December 2018, in accordance with the agreements set in place for consent and research ethics documents. Collected data, including interviews transcriptions with only redacted identifying information, has been stored with encrypted and password protected storage electronic storage, only accessible by the lead researcher. No breaches in confidentiality were identified and participants remain under pseudonym as part of this study. As a result, the presented quotations and data of this study provides no identifying information or even relays which organisation anonymized participants represented. Interviews and observations focused on the psychosocial and health outcomes of very vulnerable

populations. Although these topics are difficult to discuss, they also represent the normative livelihoods of these individuals, as this is their chosen practice. Beyond this, the ability of each organisation to provide psychosocial support allotted professional medical experience for dealing with discussions of extreme trauma.

In accordance with these ethical considerations, Dalhousie University's Social Sciences & Humanities Research Ethics Board processed a review of this study between May and July of 2018, with final approval dated on July 9th, 2018. This approval was based on the review of the application, in response to the Tri-Council Policy Statement on *Ethical Conduct for Research Involving Humans.* This approval covered a research period, from July 17th to October 15th, 2018, prior to expiration on July 9th, 2019. Documents for recruitment, consent and withdrawal were approved by the Ethics Board in accordance with said application and delivered in the field during the study period

CHAPTER 5: RESULTS

This section explores the results of the qualitative methods described in Chapter 4. These 24 interviews, conducted with 10 organisations, provide an opportunity to better understand the past, present, and future of mental health treatment associated with trauma in Northern Uganda. This is particularly relevant as these implications apply to mental health prioritization and the complex regional divides of post-insurgency Uganda. This chapter focuses on direct testimony, rather than stepping into analysis found in Chapter 6.

To begin, I explore an overview of the organisations that participated in this study, which are listed in Table 1 (found on page 46). These details will focus on the activities of the organisations as they align with mental health treatment and support, as well as the location of activities and demographics of the program participants. Following this overview, this chapter explores participant responses applied to the study's themes, including community support, cultural understanding and the long-term nature of mental health treatment. These key themes defined the conversations had with participants and inform the analysis that follows. As I did not conduct observations with every organisation, the themes from this data set will be applied in Chapter 6.

Organisations

The organisations which participated in this study provide a variety of different strategies for addressing mental health. Participating organisations included the Acholi Religious Leaders Peace Initiative (ARLPI), Caritas Uganda, the Centre for Children in Vulnerable Situations (CCVS), Hope & Peace for Humanity (HPH), Justice &

Reconciliation Project (JRP), Refugee Law Project (RLP), THRIVE Gulu, Vivo International, the War-Affected Youth Association (WAYA) and the Whitaker Peace & Development Initiative (WPDI). Each organisation is based or has operations throughout Northern Uganda targeting war-affected populations, which often fall into the youth category. This ranges from religious-based counselling, trauma-focused therapy (including NET), economic empowerment (education & employment training, VSLA models), sensitization and cultural-based therapies. These different strategies respond to the diverse needs of war-affected populations, and each unique activity come together to highlight the importance of mental health. Key information regarding the activities, focus and demographics of the participating organisations can be found in Table 3 (page 58).

For groups such as CCVS and Vivo, psychosocial therapies come to the forefront of their programming (personal communications, 27 August 2018; 4 September 2018a), while others such as THRIVE and HPH have diversified programming to engage livelihood support for general mental health (personal communications, 23 August 2018a; 4 October 2018). Many organisations access popular beliefs for greater engagement and impact. For example, ARLPI and Caritas take a religious approach that engages with the importance of faith in the lives of many Northern Ugandans (personal communications, 23 August 2018b; 28 September 2018). A representative of ARLPI commented: “Religion plays a big role in people’s lives, and people normally take it seriously, so … [that is why] we use that approach.” (personal communications, 28 September 2018)). Similarly, WAYA utilizes traditional Acholi knowledge and customs in their programming. Following the insurgency, the organisation’s founders became stakeholders in mental health through the Acholi ceremonies that were pervasive before

the disruption of conflict. For this organisation, "… counselling is not about [clinical] support, but] is more creative activities that help change the mind." (personal communications, 16 August 2018). JRP and RLP both access avenues of justice and advocacy for vulnerable populations, including the use of group support models for refugees and former IDPs (personal communications, 14 September 2018a; 25 September 2018), while WPDI includes technology education in their approach (personal communications, 17 September 2018). These strategies cast a wide net, as each of the participating groups has adopted unique perspectives regarding mental health as a means to deliver the best available care to war-affected populations.

Collectively, these groups all maintain a dedication to addressing mental health. While services and strategies may differ between the various organisations, there is great continuity through the successful treatment found in these psychosocial programs targeting war-affected youth. Participants reported positive responses to their programs and found that open strategies for recruitment enabled war-affected youth to seek much-needed support (personal communications, 14 September 2018b). Each organisation provides a fundamental component of the network of support available for war-affected youth in Northern Uganda. Each of the NGOs share the common thread of building on the work of post-war rehabilitation to engage local populations striving for progressive trauma-healing strategies. As many of these groups work in tandem with one another, the different perspectives blend together in referral networks.

For these groups, their goal is rehabilitative in nature. "[T]o [patients], human beings become a source of danger. Their trust is broken. So, we need to re-establish that."

Table 3 Summary list of partner organisation key details.

Acronym	Location	Target Group	Areas of Concern
ARLPI	Acholi Region	Open (further details unspecified)	Religious emphasis. Peacebuilding activities for land conflict & DV. Sensitization for SGBV.
Caritas	Gulu District, Acholi Region	Women & Children, Interest in targeting Men	Livelihood & Development, Relief & Rehab, Social Services, Agricultural Support, Counselling
CCVS	Lango & Acholi Region (Amuru, Kole)	Women (18-35) with ~30% Adults (to 65). School Programs (10-17). Prisoners.	Sensitization. Counselling at drop-in clinic and in Villages/Schools. Coordination with Health Centres. Radio Programs.
HPH	Acholi Region (Gulu, Amuru, Nwoya)	~70% Women (15-25), Vulnerable Children, School Programs (7-14).	HIV advocacy. Education & Economic Empowerment. Human Rights & Child Protection. Holistic dialogue surrounding mental health related to DV, poverty, HIV, conflict.
J&RP	Gulu District	Women, Former Abductees (18-40). Younger participants with parents (~15).	Advocacy (Justice & Reconciliation). Storytelling, arts/crafts, group-based trauma dialogue. Spiritual methods. Support for SGBV/Family conflict.
RLP	Throughout Uganda (Based in Kampala)	Refugees (Burundi, Rwanda, Somalia, South Sudan, DRC). Ugandan Population.	Trauma support. HR/SGBV advocacy. Legal Support. Education. VSLA programs (empowerment).
THRIVE	Acholi Region (Gulu, Layibi, Odek)	Returnees/IDP camp. ~80% Women (15-45 – emphasis on 16-25). Schooling (<18)	VSLA programs. Sensitization for MH, SGBV. Group therapy, psychoeducation with Village/School. Mobile MH clinic. Radio programs. Drop-in therapy.
Vivo	Acholi Region (Nwoya, Gulu)	Former Abductees (12-80, average 32 & age of abduction 11).	NET (TF-CBT) for PTSD – Formal counselling in Villages. Prison counselling. Referral support.
WAYA	Acholi Region (Gulu, Agago, Pader, Amuru)	War-affected youth (12-35), Mainly women.	Cultural methods of healing (Dance, art, ceremony). Non-clinical counselling. Economic & education support.
WPDI	Gulu, Refugee Settlements.	Open (18-35). ~45% women. Refugees.	Peacebuilding. Community outreach. Technology & business training. Sport. HR & Conflict. Counselling & psychoeducation.

(personal communications, 14 September 2018a). Each of the practitioners which participated in this study dedicate their time to servicing the needs of war-affected youth. The core identity of these organisations addresses the economic, social and psychological impairment that comes as a result of trauma. These differing perspectives ensure that war-affected youth are able to access a multitude of services. Yet undertaking this mission is far from this simplistic. The very real limitations in providing mental health care to traumatised populations dictate the experiences of these groups, meaning that barriers exist around every corner that challenge the work being done.

Reflections from the Field: Themes in Delivering Mental Health Treatment

Clearly, there is a wealth of personnel willing to bridge the gap of mental health treatment left by the insufficient system found in the health care sector. The grassroots nature of these organisations requires that they operate within the confines of small budgets, and thus relatively small operations. These organisations are able to reach the population of war-affected youth, but the needs of this cohort supersedes their financial and resource limitations. Each participating organisation provides an essential part of addressing trauma, but the work cannot fall solely on the shoulders of these groups.

The Efficacy of Formal Treatment

Is enough being done to address mental health among war-affected youth in Northern Uganda? It comes as no surprise that out of the 24 people interviewed for this study, and the numerous others that contributed knowledge off-the-record, the answer to this question was a resounding "No". Elizabeth reflects that:

> "… [T]he services are inadequate. … Mental health is not very developed in Uganda. There are not enough mental health workers, there are very few. …

> We have [very few] hospitals where you can receive psychiatric services … [and we] do not have very many counsellors or properly trained social workers. … [These things] affect access." (personal communications, 14 September 2018a).

Acknowledging this lapse encourages the exploration of the services implemented by the local NGOs in the field. Many practitioners provide programs that address mental health, but these partners are restricted by limitations in funding, logistics and the insufficient formal health sector. Instead, the perspective of these practitioners encourages thinking beyond the traditional scope of program implementation towards knowing who receives services, how the community can be involved.

Demographics

In terms of demographic representation, most organisations focus on youth (aged 15-35) impacted by conflict. This burden may have been direct or indirect but has seen increased trauma as a result. This strategic choice is reflected in selection criteria for this study. On younger children, Susan suggested that they are difficult to treat due to specific needs and strategies that are not widely available within Uganda, but that efforts can be made to alleviate trauma through creative therapies (personal communications, 18 September 2018b). Most groups use an open recruitment strategy, meaning there is an opportunity to reflect upon why certain groups are more disproportionately represented.

Many organisations felt that women and school aged children were more likely to participate in mental health treatment. Several reasons exist for this, including that women (as both mothers of child patients and traumatised individuals themselves) have responsibilities over family concerns. Furthermore, domestic and sexual violence (whether war-related or not) impacts women and children disproportionately. Many

activities see men absent, particularly as "…culturally, men do not come out openly to talk about [psychological] challenges that they have – and so it leaves women and children … to access services because man feels, 'Oh this will show to the people that I am defeated.'" (personal communications, 23 August 2018b). This "… situation of wounded masculinity", as detailed by Simon (personal communications, 23 August 2018b), leads to an increased rate of suicide among the male population.

The age range can be attributed to the Rome Statute, which provides funding for victims impacted by the conflict after Uganda's ratification in 2002 (ICC, n.d.) This statue allowed the International Criminal Court to have jurisdiction over war crimes committed in the country – including the abduction and abuse of young people during the insurgency. This means NGOs can seek reparative funding for survivors of the conflict via "The Trust Fund for Victims", including potential beneficiaries impacted as children after 1st July 2002 (Dutton & Aolain, 2019), who fall into the cohort of war-affected youth rather than older individuals who may have been victims of trauma prior to 2002. Carol acknowledges the ethical dilemma regarding recipient criteria, but also the reality of this factor: "In practice, … there is no place to refer a person [impacted prior to 2002] to receive same services … but donors have set rules and we [have] to navigate within the set rules." (personal communications, 14 September 2018b).

Urban vs. Rural Divide

Organisations look to both rural and urban populations in different manners. For example, THRIVE hosts a drop-in centre just outside Gulu town, but also provides remote counselling in villages and sub-counties throughout the Acholi subregion (personal communications, 7 October 2018). However, for THRIVE, "… the number of

people met from the community is greater than that seen from the centre." (personal communications, 4 October 2018). The rural emphasis is a response to the unequal distribution of medical support for rural areas compared to those in urban hospitals. Cleo notes that "… people in town may have better access to services." (personal communications, 17 August 2018) as many NGOs and any hospital access are located in the urban setting. On the contrary, the urban setting of many operations is necessary for coordination with the state and the availability of personnel.

Another major factor for rural war-affected youth is poverty. As many rural villages suffer from limited opportunities for financial gain, poverty is a major concern. Looking to the perspective of the rural poor, one interviewee commented "… at the end of the day, somebody says if I can't afford dinner, how can I afford to access services – even if its free of charge because [of money] need[ed for] public transport." (personal communications, 17 August 2018). Benton spoke to the impacts of poverty on care:

> "… [They] would think, 'instead of me going [for treatment] to spend an hour to [speak to] somebody, … I would rather go look for money' … [that leaves] people struggling [financially] to survive with very much [*sic*] psychological burdens inside of them." (personal communications, 4 September 2018d).

In this way, the urban vs. rural divide becomes intensified, with the rural population suffering from poverty and unable to access services due to the costs associated with traveling to the urban settings in which treatment is more widely available.

The lack of psychological services available within village settings has a unique impact on returnees and former IDPs. Luka reflected on the participants of mental health programs often being initially based within the urban setting following the conflict, often related to people moving into urban areas (including Gulu) to escape fighting

concentrated in urban areas. Over time, this concentrated population began returning to villages following the end of violence, meaning that there was a diffusion of war-affected youth across the northern region (personal communications, 16 August 2018). John acknowledges "… rural communities are the apex of conflict … [and as] people began moving back, … they have limited access to … services." (personal communications, 23 August 2018a), meaning organisations must reach out to restricted settings.

Formal services are diversified in this way, meaning that local NGOs will seek out specific villages (often coordinated by local authorities) to provide services. This creates an inherent conflict in the local organisations being based within urban settings but moving to rural areas for their work. This includes having many resources (counsellors, buildings, logistics) coordinated in urban settings but needing to travel some distance to provide their care. This has a cost, but the organisations which participated in this study maintained that those impacted by extreme poverty in rural settings are often the most in-need populations for treatment. Instead, it is important to acknowledge that rural areas have a demand for psychological support due to the limitations of their local health infrastructure, which results in some participants of this study catering specific services to rural populations.

Culture & Tradition

Cultural understanding of mental health provides a junction between clinical organisations and partners that use arts-based approaches to incorporate Acholi culture and tradition. Many organisations feel that it is necessary to use contextually appropriate services to mental health in Uganda. For example, Chapter 2 demonstrated spirit possession as a potential route of understanding symptoms of PTSD among traumatised

populations in the DRC, which can inform best practices for mental health treatment through traditional understanding (Hecker et al., 2016). Westernized methods can be amended for cultural understanding and community ownership of health projects.

For organisations working in the field, mental health is often operationalized as a mix between traditional and clinical knowledge. This presents a contrast between the structures of the mesosystem, exosystem and macrosystem. Ugandan spirituality challenges the western perspectives implemented within the broader healthcare strategy, which creates a clash of values in the macrosystem. These seemingly incompatible perspectives come together in their unique understanding of how the community perceives mental health disorders and the proven psychological methods for addressing trauma. WAYA uses play, drama and music as a cost-effective strategy for shifting the mindset of war-affected persons, in which Acholi culture takes the forefront (personal communications, 16 August 2018). The group accesses practices used by Acholi society prior to the conflict and re-examines traditional rituals as methods for alleviating trauma.

This is not dissimilar to rituals preformed by village leaders, but WAYA makes explicit emphasis to include psychoeducation and discussions of trauma that prescribe to the necessary standard of mental health, and advocate for clinical intervention where available (ibid). Harlacher et al. (2006) note that, for Caritas, those seeking treatment for psychological distress will request a dual approach of prayer combined with medication and counselling, or that rituals were considered when other avenues had failed to yield the necessary symptom reduction. These authors, like the participants of this study, call "… for open-mindedness and inclusiveness when considering different ways to help and

heal troubled and suffering people." (p. 123), which addresses the cultural basis of healing, the role of "western" treatment in ensuring symptom reduction.

That being said, some organisations diverge from "traditional" methods, such as cleansing rituals, as they felt their mandates were to offer the strongest proven standards of care. Samantha notes that her organisation has a different approach. "… Clients have learned that even after preforming rituals, the spirit will still haunt them, so they realize maybe our counselling helps because we do a lot of talking." (personal communications, 27 September 2018a). In this way, many practitioners focus on treatment that can be applied across cultural contexts.

Instead, these strategies challenge the notion that certain standards should be sacrificed – particularly if they would never be forsaken if Uganda was in a stronger economic situation. Should formal mental health treatment become widely available, it would follow a westernized model. Abby suggests: "… if there was a new antibiotic, … why should Africa not get that? In that sense, [treatment] should be the same … if there is a proven evidence-based mental health approach." (personal communications, 27 August 2018). There are decades of history regarding the positive implementation of therapy around the world, meaning that these strategies should not be sacrificed. This divergence encourages a dialogue surrounding both the standard of treatment and the value of traditional beliefs (personal communications, 27 August 2018; 27 September 2018a).

Approaching Stigma

Every organisation highlighted the importance of tackling stigma as foundation of their activities. The toll of stigma on war-affected youth is explored in the literature, with

this prejudice being attributed to greater stress, receiving poor treatment from others, increased poverty, limited access to services and other factors which inevitably result in increased symptom presentation (Betancourt et al., 2010a; Quinn & Knifton, 2014; Betancourt et al., 2016). Mark notes that patients may "… see a reduction in level of stress … but when the person goes back to the community, the levels raises high because the triggers – the ones causing this pain – are in the community with the person." (personal communications, 4 September 2018b). Ray suggested that "… people do not see returnees in good hands … so they generalize the situation to everyone … who lived with the rebels." (personal communications, 26 September 2018a). Stigma manifests from both being mentally distressed and from being part of conflict. This means dialogue and sensitization are a key method for addressing the severity and scope of this issue.

Many organisations focus on sensitization and psychoeducation within their program framework and implementation. Susan commented that sensitization drew large turnouts and generated transformative discussions about trauma-related healing from community stakeholders (personal communications, 18 September 2018b). It is important to consider how alienating traumatised individuals may increase stigma, so sensitization of the entire community is necessary for successful programming.

Mark's organisation promotes a "systemic approach" for addressing sensitization, which "… involve the community like siblings, family … so that these people can support client …" (personal communications, 4 September 2018b). Such an approach mandates that psychoeducation and sensitization of mental health is not exclusively focused on the patient, but rather inclusive of the entire community. This encourages community members to approach mental health within their own lives, but also to

understand how disruptions to psychological wellbeing can occur related to war-experience and trauma. Confrontation may arise from differing perspectives on mental health, particularly related to cultural understanding, but sensitization aims to provide information that reduces misinformation regarding trauma-related distress. In this way, the community becomes aware of mental health, preventing unequal knowledge.

Archie supports the use of radio for sensitization, as it expands the audience of sensitization. Media reaches a broader audience, but sensitization must remain based in psychoeducation and stigma reduction for this strategy to be effective:

> "Call in radio is extremely successful … great opportunity for reaching wider audience, particularly that of men: … Topics that are sensitize to men for whatever reason, alcoholism… people don't want to stay and listen to that … - [they view it] as too invasive. But in talking over radio, … the audience … is men, so we get a lot of calls from men after they have the opportunity to listen and … learn." (personal communications, 7 October 2018).

By accessing groups that would not traditionally be open to sensitization with media, knowledge regarding the lingering impacts of the conflict become widespread and operationalized in the community. This strategy broadly expands the audience of sensitization and psychoeducation for greater impact, but this must be done in a strategic way. There is legitimate concern that using media may become problematic should the organisation focus on listing symptoms that may generate further stigmatizing of traumatised people or create a quasi-witch hunt for those presenting symptoms.

Community Involvement & Response

Every organisation reported positive responses to their programs, as expected. While some noted initial difficulties of recruitment, this was associated with concerns of sensitization as opposed to acceptance. Community members were unwilling to

participate in activities as they viewed mental health in a negative way, often seeing war-affected persons as troublemakers or disruptive, or even just holding resentment for their participation in conflict. However, with efforts of sensitization and psychoeducation, including targeting community leaders, the organisations noted that participation increased, and stigma could be decreased (personal communications, 18 September 2018a). Practitioners commented that participants had expectations for material goods – particularly given the history of dependency on NGOs during the insurgency:

> "[Some organisations] think by giving something, it is enough. But … in Northern Uganda, there are a lot of things we were given - especially during the period of war - but … at the end the person just goes and sells [it]." (personal communications, 4 September 2018c).

This dependency on material goods has not translated into longitudinal mental health symptom reduction or proper channels for adjusting the efficacy and accessibility of care. The consideration is that, whether directly involved in programs or just supportive, the success of these programs depends on community partners to become stakeholders within their own success. As Deb states:

> "We do not sleep in those villages, we do not go those markets, we do not go to those schools, so our focus is to strengthen … community structures to be able to identify [and] respond … to [the] needs [of war-affected youth]. Where we go to work, we always start … by training a layer of community actors … who act as first line responders in their community." (personal communications, 8 October 2018).

This requires participatory programs that include leaders within the community – such as cultural figures who may not view mental health with the same lens as the organisation.

Notably, both HPH and WPDI use community leadership (including religious and opinion leaders, local legislators and politicians, etc.) as facilitators of their programs, in both mentorship roles and as community health advocates (personal communications, 17

August 2018; 26 September 2018a). These strategic partners in the community have developed coordination and fostered influence in their communities and can be important actors in encouraging acceptance of mental health and treatment. In this way, community leaders play a key role in encouraging discussions of mental health and the implementation of collaborative treatment programs (personal communications, 26 September 2018a). This offers an essential bridge to ensure community acceptance of projects for sustainability (personal communications, 27 August 2018; 4 September 2018b). Within Uganda, the most successful programs implemented by these partners include community ownership and leadership dialogue, which provides an important point of reference for creating a network of support and potentially defeating NGO reliance for other post-conflict zones. This can be understood with a quote from Luka:

> "If you come to [community] addressing a problem, they will accept because you said it, but this does not address the very problem and *how* you should address it. … When [organisations] understand that culture plays a very big role in addressing issues of the Acholi, they started involving the leaders of Acholi … Most paramount is that they must understand their culture." (personal communication, 16 August 2018).

These concepts highlight the holistic nature of mental health care that many practitioners champion – one that looks to the future while recognizing the trauma of the past.

The next step is to expand community ownership over mental health projects, which remains the long-term goal of many organisations. This transitions counselling and support to be deliver by trained community stakeholders and allows the organisation to focus on new communities with limited oversight (personal communications, 8 October 2018). However, this shift currently remains an unexplored priority for the future with these organisations, as at the time of this research, the organisations were still the chief

operators of programs for the immediate future. This effort to involve the community provides foresight to the future of mental health treatment in Northern Uganda, but at this time it remains just in the proposal stage and requires additional investment.

Collaboration

For all organisations, collaboration was an essential part of their success. With local government, many organisations referenced the importance of "memorandums of understanding" as an important bridge for ensuring their services could reach communities in need (personal communications, 14 September 2018b; 7 October 2018). This comes with administrative oversight and support, but rarely with financial or logistical components due to the restricted budgets of these local entities: "On the district level, … trying to have a two-way relationship, … we put in all the effort, … it is not like a dialogue." (personal communications, 14 September 2018b). Instead, organisations look to one another as key partners for service delivery. By working together, either directly or through referral networks, training, capacity building, or working groups, many organisations build positive relationships with one another to ensure that overlap and competition will not get in the way of patients (personal communications, 17 August 2018). For Carol, these collaborations are the foundation of successful programs:

> "Collaboration is one of the most important things within our organisation because we are really small, we only have 8 counsellors … we reach a couple of hundred people a year but still it is not enough given the needs are much more higher [*sic*] … so you have to work together. … Like 1 out of 4 people, in their lifetime, is dealing with mental health issues – so like almost in every family - … we need to work together to put mental health into the [government] agenda and not to fragment our efforts and resources …" (personal communications, 14 September 2018b).

These relationships require work and equal exchange, so naturally difficulties emerge. A common consideration was that organisations offer different standards of care: “What others are doing… they give advice. We provide counselling” (personal communications, 4 September 2018a). Nonetheless, each group spoke to the importance of building connections and their hopes for collaboration moving forward.

This potential collaboration speaks to the multitude of different approaches taken by these organisations. In some ways, this allows for participants to promote the idea of intersectional care, as “ individuals [with] … mental health challenges do not just live in a mental health bubble, … [and] require services that [are] multi-disciplinary …” (personal communications, 7 October 2018). With organisations often speaking to different core themes of mental health, this collaboration encourages groups to provide the best services they can deliver and rely on one-another to fill in the gaps. This is complex in practice, as will be explored in Chapter 6, but it nonetheless addresses the treatment gap of these smaller organisations in their (justified) focus on specific strategies for holistic mental health support for war-affected populations. Together, these unique perspectives could come together as a broader holistic model.

Providing Long-Term Support

Another important finding concerned the long-term nature of mental health support. Many psychological services are offered in the short-term, with either an immediate end date or the intention to alleviate responsibility in a low number of sessions. Many organisations reflected on the need for long-term care moving forward: “… treating persons … is not something that is … a one-time thing. It is a long-term kind of treatment. This … comes with different diagnosis … [or] with multiple disorders …

[that] can keep changing [over] time." (personal communications, 26 September 2018a). The best way to ensure this practice is with capacity building that encourages the community to become stakeholders in the success of the project.

Post-conflict development strategies do not address mental health with emergency aid sufficiently (personal communications, 14 September 2018b), and practitioners report that spending has moved to the military and agriculture (personal communications, 26 September, 2018a). As a result, maintaining, or prioritizing, focus on mental health becomes even more challenging in the long-term. Funding is not available for projects over multiple years or decades, and mental health is viewed as a post-conflict issue in a way that does not address the longitudinal impacts of war (Betancourt et al., 2010b). From the perspective of the organisations, a shifting focus of development programming away from war-related and health-related issues emerges (personal communications, 14 September 2018b). This is reflected in the limited government expenditure on mental health, which is a major concern for practitioners.

This requires a shift in how mental health is approached to champion the long-term nature of disorders in a way that community groups can champion. Strategies for implementing long-term projects are being developed, such as those enabling community members as leaders, counsellors and partners – including the prospective strategies mentioned previously relating to community ownership over projects. In practice, this is difficult as autonomous long-term operation cannot be guaranteed by organisations that rely on inconsistent funding. Nonetheless, this remains a commitment of many organisations, including THRIVE who train lay counsellors in the field to provide ongoing support to members of their VSLA groups after their staff has shifted their focus

to other communities (personal communications, 4 October 2018). This represents only one method for long-term sustainability of mental health projects.

Capacity building within Uganda to support the needs of war-affected youth in the long-term is necessary by advocating education in psychology, counselling and social work. Cleo said, "when the war ended, [many organisations] finished, so what happens to the programs that have been implemented? If they do not empower the community, we can't have the long-term impact" (personal communications, 17 August 2018). Instead, awareness and greater continuity of care is required. As Deb suggests, "if communities understand mental health signs and symptoms as well as [they] understand malaria, … we would be better." (personal communications, 8 October 2018).

By providing supportive environments for war-affected youth to access care, there exists an opportunity to advocate for future stakeholders of mental health. In one such situation, a participant commented about their trauma rehabilitation:

> "Trauma takes a long time to heal. I, for one, when I was in secondary … were abducted and spent 7 months in captivity. The pain that we went through, was so painful. … When I was at the University – every time, I would always remember the abduction and friends who I knew that never came back. … I felt that there was a calling for me, … I knew I was one of them and was helped, so I know I could move onto this. … [I] felt if people changed me, I can positively changed [*sic*] someone and that's what drew me. I do what I can to help trauma, and my abduction became a pillar for what I am today." (personal communications, 23 August 2018a).

Addressing the Shortfalls of Treatment

Creating change in the understanding and implementation of mental health is constantly on the minds of practitioners in the field. While the burden of disease remains overwhelming, these innovators look to different strategies for disseminating care. Participants noted that, from both the public and larger government structures, mental

health is not taken seriously or given the prioritization it deserves. Anna suggests that the responsibility falls with both NGOs and the government:

> "There should be focus on mental health first. In Uganda, most the health-related services… mental health you rarely hear about … If the focus can also be on mental health - but targeting the root cause would be really important[.] … NGOs are doing very little on such because they don't have their own interest – when [donors] give you money you have to use it based on how they want … Sometimes we want to do much [*sic*] on mental health, but the donor also have their own interest [and] if you don't go with their interest you cannot get money." (personal communications, 25 September 2018).

These are the restrictions of NGOs operating at the local level – they are beholden to the guidelines set by donors in a way that the national government is not. This results in a lack of services and awareness, increasing the need from vulnerable populations and stretching the limited resources that grassroots organisations have to address trauma.

There are various strategies suggested by the participants to encourage government spending and allow for partnership between the NGO sector and government budgets. Impact assessments ensure that mental health can become quantifiable will allow Uganda to shift the concept of mental health to recognize how everyone is impacted. Greater research and education on the topic can only help to serve vulnerable groups and service providers (personal communications, 14 September 2018b). By streamlining mental health into primary care, participants commented on the opportunity to create referral networks and developing greater prioritization of mental health with the government:

> "[The government must] understand the magnitude of the problem. Because for us, we cannot address it for long. … They are obliged to do that work but they are not. … If we do not bring them on board, we cannot sustain that intervention. … We can do community awareness, [but] the government has the role of increasing the budget and … training. … For us, we are complimenting. … How will you refer if, when you refer and they reach there, there is no service?" (personal communications, 26 September 2018a).

Ultimately, budget increases from the highest level encourage district allocations for mental health to be addressed, and collaboration between government offices and local groups currently addressing the issue can facilitate a meaningful and immediate shift. Change can be advocated at the local level but shifting the status of mental health among war-affected youth requires broader changes at multiple societal levels.

The Price of Practice: Implementing Change with Grassroots Services

There are a variety of key details to take-away from the data presented in this section. Participants note that formal treatment does not address the scope of care, in part due to the problematic emphasis of services in urban areas leading to the need for rural areas to receive the treatment provided by local groups. Within this service delivery, collaboration is key to ensuring success – both with other organisations for support networks and involving the community as stakeholders for sustainability of projects. Sustainability is necessary as the long-term nature of mental health is not adequately considered by stakeholders and researchers alike. That said, NGOs take efforts to change this with lay counsellors, community members who are trained by the organisation with the purpose of providing care in the long-term. The success of treatment provided by local groups is perceived to rely on their ability to address the junction between cultural and clinical values, as the best practices can be extracted by considering both realms. In approaching mental health through a culturally appropriate lens, treatment can be encouraged with sensitization and ensuring support from the entire population.

The organisations that participated in this study have important ideas to address the shortfalls of psychological treatment for war-affected youth. Many of the considerations found in this chapter are actively being addressed in the work of these

organisations, but the limitations of operating small-scale programs are still apparent in their work. The comments of these organisations provide the foundation, but in order to champion these ideals it is important to analyze the limitations of this system in a broader sense. This leads into the next chapter, which takes aim at the three thematic barriers to implementing a truly holistic model of health care in a meaningful way. By challenging these ideas, mental health could become a priority for global health and avenues to properly addressing the magnitude of trauma in Northern Uganda might be implemented.

CHAPTER 6: DISCUSSION

Through the presented data, there is an opportunity to reflect upon the experiences of war-affected youth. These realities have shaped the operations of the practitioners, and with that the comments from this study present a clear picture of struggling psychological support in the region. The results can be used to spark a dialogue about the shortfalls of mental health – particularly the situations of NGOs that support vulnerable groups in lieu of formal support. Yet, it is necessary to analyze the themes as they apply to broader perspectives on mental health, inequality, and much more.

In this chapter, I utilize EST (Atilola, 2017) to tease out the themes of fractured mental health support and expose the three distinct levels of analysis that can help to elucidate the Ugandan case study. Based on these three levels of EST, there is an opportunity to incorporate abstract analysis to reflect of profound experiences of both the war-affected youth and the mental health practitioners that endure in the region. Within this chapter, the structural levels of EST provide a relevant foundation for the exploration of the mental health system in Northern Uganda. These elements are derived and supported by the conversations found in Chapter 5, as at the core this study is an amplification of the testimony from specialists in the field as they work to alleviate trauma. Particularly with the interconnected nature of this framework, the experiences of trauma among youth encourage a dialogue of how the three systemic levels come together to represent the deficiencies of the current health system – and how these limitations are systematically, and consciously, enforced.

State of Mind: The Mesosystem & Trauma in the Acholi Subregion

As described in Chapter 3, Atilola (2017)'s adaptations to EST present the mesosystem as the interactions of different parts of the microsystem. This includes family, schooling, health services and the local government, which come together to have a profound direct impact on the life of a child. Based on the specifications made for sub-Saharan Africa, these interactions provide an account of how the local sphere begins to interact and define the experiences of adolescent mental health. These immediate factors have profound influence on the everyday life of a young person (Paat, 2013). In this section, I explore three concepts: stigma, poverty, and collaboration, all which are found in the local sphere of the mesosystem – as they relate to the themes of treatment.

Conquering Stigma

Stigma represents one of the largest barriers to producing effective mental health treatment. There are multiple dimensions to stigma – it can be related to trauma events such as violence or rape, judgement of those associated with armed groups and/or those associated with symptoms of mental illness, and related to seeking mental health support (personal communications, 27 August 2018; 4 September 2018b). Stigma can originate from one's self, neighbours, societal pressure, family members, colleagues, and through health services or even community leadership (Quinn & Knifton, 2014). As an example, Anna presented a hypothetical yet familiar instance of community stigma:

> "… a community member saw that, when you were 8, you were forced to kill your brother – and the whole community saw [but] everybody knows that child was forced [to do it] and [they were] a child and, still, they blame the child." (personal communications, 27 August 2018).

Stigma is innately emotional, and does not always following a logical rationale, meaning that it is difficult to address. As a result, stigma is a major concern for those disseminating mental health services to war-affected populations and requires constant attention to truly ensure efficacy of treatment and the acceptance of mental health.

Strategies for addressing stigma in the long-term were implemented by NGO partners with great success. One participant suggests that stigma is unavoidable given the conflict, but it can be addressed in collaborative approaches with the community (personal communications, 4 September 2018b). This includes sensitization training at the onset of programs, in which participants are encouraged to learn about the psychological impacts of war and identify the nature of conflict-related disorders. The community is encouraged to discuss mental health, and counsellors are available to address misunderstandings and provide additional information (ibid). Implementing community dialogue that targets the sources of stigma which make symptom presentation worse and alleviate ongoing stress is a key practice (Verelst et al., 2014). Neela acknowledges the role of stigma reduction in encouraging community participation in and acceptance of mental health (personal communications, 4 October 2018). The nature of stigma requires that breaking down the best methods for alleviating it in the long-term. It is not enough to learn about symptoms, there must be efforts to normalize trauma.

Programming dedicated to sensitization and addressing stigma must come hand-in-hand with ongoing community participation and ownership. HPH and RLP both work actively to promote community sensitization at the onset of mental health projects to address societal bias that would prevent traumatised individuals from accessing treatment (personal communications, 23 August 2018a; 14 September 2018a). These NGOs bring

together traumatised persons and community members to discuss grief, guilt and general trauma, as a means to show that individuals are not alone in their suffering. This also encourages participants in need to access the services provided by the NGOs (ibid). This is an innovative method to truly normalize mental health concerns in Northern Uganda and properly advocate for those that have or are currently seeking treatment.

For Caritas, the "social support groups" that the organisation utilizes are not implemented by them, but rather are "… groups that are there in the community already … [as the organisation is] aware that [this] is how the Acholi people do things: they act based on … their own [existing] groupings." (personal communications, 23 August 2018b). In this way, stigma can be tackled using existing community networks by providing sensitization and support to the entire community rather than isolating war-affected groups. The ownership over projects is based in the community, and the ongoing success is a result of their participation. As such, specific sensitization surrounding stigma can be meaningful to communities that have been impacted by trauma.

Individuals who have suffered will be more likely to come forward to discuss their experiences and access available services. Culturally appropriate methods of spiritual cleansing, such as traditional Acholi cleansing rituals (Harlacher et al., 2006), may be an appropriate tool to encourage community and self acceptance of those suffering from mental illness (Scultz & Weisaeth, 2015). WAYA utilizes cultural activities through dance, and observation of these activities demonstrated the community coming together to support one-another through tradition and shared experiences (personal communications, 15 August 2018). The dances bring the community together for a joint activity, often in which specific arguments or stigma can be addressed. Luka

suggests that this communal activity puts aside class, war-experience, education and more, as the dance is something that everyone can (and, on an ethnic basis, often already do) engage with (ibid). NGOs encourage participants to address conflict in this safe space, meaning support and forgiveness can take the centre stage as a result of their art.

This promotes a fundamental shift in how the individual can operate within the societal structures of the Acholi subregion. Therein presents the underlying concern: addressing stigma is fundamentally an issue of attitudinal change. It is inherently local in nature, and the response must be as well. Stigma is generated as the community views mental health in a negative way. Michael acknowledges that "[w]hen [the community] looks at mental health, they think of someone who has already gone 'mad'." (personal communications, 26 September 2018b). Instead, mental health must be seen as a normative part of the human experience, and trauma that threatens the positive can be addressed with support. Eliminating stigma must start with embracing conversations about processing emotion, mental health, conflict, and an overall understanding that individuals with difficult traumatic experiences require acceptance and support (ibid). To reduce stigma, a societal attitude shift must be addressed within the mesosystem and the local sphere. The organisations in this study aim to accelerate this process by encouraging the community to discuss, understand and become sensitized to the mental health concerns of war-affected youth. To truly progress, there must be efforts to incorporate the entire population – not just those accessing treatment.

Poverty & Access as Oppression: The Ultimate Barrier?

Poverty is another major concern in addressing mental health in Northern Uganda. Cleo and Benton both spoke of how many people are simply unavailable to access

services due to distance or time constraints (personal communications, 17 August 2018; 4 September 2018d). Moreover, health services underserve the population as they do not have the necessary funding or support available for the region (Murray et al., 2015).

The reason that poverty must be intrinsically tied to the mesosystem is based on the responses from participants. Many of the organisations that participated within this study utilize a holistic model of care that incorporates both mental health counselling and livelihood support, such as HPH and THRIVE that offer economic support through school fees and VSLA programs respectively (personal communications, 23 August 2018a; 7 October 2018). WPDI invests in job training, recreation, and information-technology education (personal communications, 18 September 2018a). These strategies target the convergence (present at the mesosystem) of trauma and daily life that can either uplift or silence war-affected youth.

That being said, Abby commented that providing livelihood support would not be possible given the demands of her organisation's therapy interventions and limited resources – she felt that it was difficult to know if symptom reduction could be maintained while living in extreme poverty, but felt it was the duty of her organisation to implement their practices to the best of their ability rather than overexerting themselves by expanding programming (personal communications, 27 August 2018). This is related to a quality vs. quality conversation within mental health: is it better to treat as many people as possible with lesser support or to treat fewer people to the standard that is required for long-term success? Based on the interviews, reducing poverty requires embracing a holistic model of care. That requires investment in programming that moves

beyond the traditional parameters of psychological counselling to embrace other elements of the individual's life such as education and employment (Annan et al., 2013).

This can be best achieved through two methods: partnership between organisations that specialize in mental health and those that specialize in livelihood support or expanding programming of organisations that alleviate trauma to encourage a holistic view. These strategies implement local solutions and programming that alleviate poverty in their own means. This also encourages small organisations to seek funding that is outside of the scope of traditional mental health grants, such as funding available for poverty reduction projects associated with the Sustainable Development Goals (personal communications, 14 September 2018b). With this, relative poverty can be addressed by, and for, the people of Northern Uganda's microsystem and shift the way that economic interactions are determining factors in the local scope of the mesosystem. Being that poverty is a major concern in Uganda, with over one third of the population living in extreme poverty (under $1.90 USD/day) and high vulnerability to "fall back" into poverty (World Bank, 2016), there must be efforts to address impacts such as mental health that may further ensure poverty among vulnerable groups. By addressing this relative (and absolute) poverty within the mandates of growing partnership or expanded livelihood support, there is an opportunity to create small-scale shifts that will in turn generate widespread success for the individuals and community members that are invested within the mental health system of the Acholi subregion.

On Collaboration

Collaboration represents another important take-away from the research presented in Chapter 5. This can be difficult to properly implement and foster, particularly as there

are no formalized referral networks in place for local organisations to work together. There is a lack of awareness regarding what other organisations provide in terms of mental health support, and this inconsistency leads to some war-affected populations being left with incomplete support. In one such case, Cleo reflected that in a previous job she visited a community which her organisation bypassed for mental health treatment as they were being supported by a larger NGO, in which she found participants wanted counselling that wasn't provided (personal communications, 17 August 2018). fostering true collaboration requires an exchange that must be balanced: As Deb suggests, "For [some] NGO workers, they want to be competitive, they want to feel superior, so that is why many times you will find [they] are trying to run their program single-handedly." (personal communications, 8 October 2018).

That being said, many organisations commented on the importance of collaboration in some capacity, and others were extremely open to engaging in inter-organisational partnership with immediate effect (personal communications, 14 September 2018a; 7 October 2018). Carol saw this as a chance to strengthen the network of support for war-affected youth as well as boosting their own abilities to provide services (personal communications 14 September 2018b). The data collected in this study continued positive perspectives on collaboration that were dominant throughout my interviews. In an observation with THRIVE, I saw an ongoing collaboration between their organisation, the local community and regional health authorities to ensure that medications were available to more remote locations with their mobile mental health clinic (personal communications, 5 October 2018). This collaboration is an excellent demonstration of coordination, ongoing dialogue, and support that encouraged

community members to come together for very specific goal (in this case, medications for rapidly assessed psychological conditions) within the limitations of the NGO and their formal sector partners. Some of the medications were psychotropic drugs that are not used in Canada due to difficult side effects. But this collaboration improves the lives of these rural communities that were previously without any access (ibid).

In order to achieve proper and lasting collaboration, oversight is needed. In the case of THRIVE, the organisation took charge of fostering the relationships that led to the success of the mobile mental health clinic (personal communications, 7 October 2018). This is not feasible for every organisation, and oversight of larger networks cannot be charged to partners that should be operating on a level playing field. In this sense, there must be a structural body to advocate for the NGO, the communities they serve, and the local government which supports their activities. As the national government falls short in providing health care needs, local authorities have encouraged organisations to help certain communities in need: "We went to the district leadership … and they directed us to go to [a sub-county] … saying that [it] is the most affected …" (personal communications, 5 October 2018). That being said, there is still work to be done to allow this leadership to translate this support into fostering collaboration on a larger scale backed with funding (personal communications, 16 August 2018).

The local government structures must assume responsibility and take charge of allocating time, space, and support for collaboration among their NGO partners. This investment will lead to a strong opportunity for widening the network of support for both organisations *and* war-affected youth. In response to active participation from different groups, the partners from both communities and local organisations can utilize the

connections of the mesosystem to strengthen the legacy of mental health support. These actions require oversight to cement their contributions and to allow for resources to be shared. Competition was not a major concern among the participants of this study (personal communications, 4 September 2018a; 25 September 2018), so naturally this togetherness can become the greatest link in providing support for war-affected persons. Local government oversight is not to dictate how NGOs can operate, but rather to expand the existing relationship between these two communities to provide a proper multi-sector approach that encourages NGOs to work together and to offer diversity of treatment.

Where should this funding come from? Should the Ugandan government be involved? What will be the ultimate outcome of collaboration? These are the questions that push collaboration beyond the local scope. This encourages analysis from the exosystem: if the local authorities are responsible for oversight, there must be a support response from the national government in the form of budget allocation and more.

State of the Union: The Exosystem & The Ugandan National Consciousness

The exosystem represents societal aspects such as the media, politics and general industries as they impact the developing adolescent (Bronfenbrenner, 1979). When examining the experiences of child and adolescent mental health, many of these elements are factors in trauma-generating experiences that might be seen within war-affected youth. Moreover, these influences are defined on the national level by focusing on the ways in which mental health is defined by the decisions made by government bodies.

Participants of this study commented on the need for greater involvement in mental health from the national level (personal communications, 7 October 2018).

Simply put, the era of disinterest in mental health has prolonged the psychological burdens of war-affected youth in the country. The participants drew the conclusion that treatment is stagnant due to the structures of national care (personal communications, 17 August 2018; 14 September 2018b). This is not the responsibility of the Ministry of Health's mental health unit, but rather their bureaucratic positioning within the Ministry. The lens of the exosystem exposes the lack of support for such initiatives.

North-South Divergence

From the historical division of post-colonial Uganda, it is clear that there is a divergence between the Northern & Central regions in Uganda (Mamdani, 2015). More broadly, it is possible to group together the Central, East and Western regions of the country to represent the antithesis of the North as a collective "South". The Central region of Uganda has remained relatively prosperous and peaceful due to the wealth and centralization in Kampala (ibid). Meanwhile, the East and West regions have their own developmental barriers but did not host as much of the violence during the LRA insurgency as the North. This is not to say that the insurgency did not impact the entire nation, in fact large parts of the Eastern region (particularly the Teso subregion) also saw extreme tragedy and ongoing violence during the insurgency period (Harvard Humanitarian Initiative, n.d.). Rather, this categorization looks to the reverberations of this era that can be felt more strongly in the North as opposed to the collective South.

Based on this categorization of North & South, there is a clear dichotomy in place. Violence and trauma are centralized in the North (ibid), while psychological support is clustered in the Central region (Kigozi et al., 2010a). Displacement has left a huge impact on post-conflict way of life (Bolton et al., 2007), while the rest of Uganda

has surged forward towards economic development and international partnership (Bwambale, 2018). Deepening inequality between the central government and the citizens of the North created little progress for mental health.

Whether purposeful or subconscious, the central government has left the North to fend for themselves, as echoed by comments from the participants: "… [officials] said leave the North to the NGOs" (personal communications, 14 September 2018b). As many hypothesize, this is due to the lingering resentment towards the North for the failed leaders of the past and the insurgency that followed. For Deb, the divide between North and South is apparent: "I am Acholi. When I went to University during the war, colleagues from other regions would … say, 'This is Kony'." (personal communications, 8 October 2018). While the contrast may be less divisive than in other nations, the divide is carved into the nation.

Following the Money: Uganda's Health Budget

There are other, less political, factors that influence mental health. Uganda does not seem to have the finances to spend on mental health (Kigozi et al., 2010), so little opportunity exists to address the needs of the North. It is not malicious, it is a consequence of operating an underfunded health system in the Global South. This argument falls short in the centralization of mental health care: The health budget expenses are fixated on the Butabika Referral Hospital, which provides excellent care but is inaccessible to most of the nation (Murray et al., 2015).

There are multiple means to address this. The overall health budget could be dramatically increased to mirror the successful health strategies of other post-conflict

nations, such as the excellent community-based health programs of Rwanda (Palazuelos et al., 2018). However, this requires shifting funds away from other areas, which does not seem to be the current administrations priority. Instead, mental health might see an increase from its current expenditure within the health budget to 5% or 10%, where the additional funding would not be taken away from Butabika. Jeanie spoke to this:

> "What needs to change? The attitude of the government. If that could change, it can help change the attitude of the people. … They have to put a budget line for mental health. If you go to, for example, the mental health [unit] that we have [nearby], it is serving 8 districts and they don't have a psychiatrist. … They have clinical officers [and] psychiatric nurses … [and] the people from the ministry do come to give support but… it's not enough." (personal communications, 6 September 2018a).

This might also allow for budgeting to look beyond psychotropic therapy and expand counselling, which practitioners in this study advocate for (personal communications, 26 September 2018b). As communicable diseases remain prioritized within global health, this shift would also be met with opposition. It is important to note that, while other low-income nations spend a similar percentage of their health budgets on psychological programs (WHO, 2017), they may not have the burden of trauma seen in Uganda. If these shifts are improbable, perhaps it comes down to decentralizing mental health care and shifting funding towards areas with higher populations of vulnerable people.

Any of these three proposals would help to alleviate the limitations of delivering mental health support to the people of Northern Uganda. With emphasis for programming to target war-affected youth, many of the organisations which participated in this study would be empowered to continue or expand their work. Perhaps the government could even directly fund organisations that are currently addressing these concerns, rather than leaving their financial sourcing from the international community ("We have an NGO

license, but that is more of an administrative formality, so there is no specific support from the government [at that level]." (personal communications, 27 August 2018)).

The financial limitations of developing nations are complicated, but perhaps the ongoing investment from the international community in Uganda should be paired to a caveat to also invest in the people of the country. During my time in Gulu, international contractors partnered with the local workforce to build sidewalks and pave roads – an initiative brought about to turn the former town and IDP settlement into a proper municipality (personal communications, September 2018). If infrastructure partnerships are available, why are so few international projects available to transform mental health in Uganda? The issue that stands in a way is an apathy towards mental health and a refusal to revisit the trauma of the insurgency.

Fostering Dialogue… Or Lack Thereof?

The LRA insurgency created an immeasurable impact on the people of Northern Uganda. The sheer number of people that fled their homes and were forced into squalled conditions multiplied the causalities attributed to the conflict (Auletta-Young et al., 2015). Although the north now looks to the future, there is no discounting the legacy of trauma in this region. The Acholi were caught in the crossfires of these two factions, with the LRA decimating Acholiland with complete disregard for human life and the UPDF assigning blame for the uprising, only to respond with their own brutality (IRIN, 2011).

However, little effort has gone into revisiting and reconciling the trauma of the past through ongoing dialogue – whether formal or casual. There is an understandable unwillingness for some war-affected individuals to discuss the intense experiences of

conflict, but the uneven sharing of blame or reconciliation results in a glaring omission that stagnates progress in reducing stigma. Where many people are free to discuss the pain suffered at the hands of the LRA, one interviewee acknowledged that those who suffered at the hands of government forces were less likely to come forward. From their perspective, this would alienate potential patients and ostracize neighbors who associate them with rebel groups despite no previous connection (personal communications, 27 August 2018). Those that do come forward are unable to seek justice for the crimes committed during this period if the perpetrators remain associated with the current administration. This is not to say that President Museveni is unwilling to condemn acts of the UPDF during this time, but rather that no comparable consequence for these actions tantamount to the ongoing ICC trials of LRA warlords (ICC, n.d.).

Arguably, these conversations need not focus on justice. The practice of openly discussing the conflict revisits a dark period in Uganda, instead of bringing the wounds of the war to the light for proper healing (Alipanga et al., 2016). One-sided discussions that fail to highlight the impact of government forces do not offer proper reconciliation, and even discussions surrounding the LRA are not formalized or encouraged, and as a result, reconciliation has never really been brought to Northern Uganda on a large scale (ibid). While the 2007 Peace Agreement promoted reconciliation through ethnic practice (UNSC, 2007), this policy failed to develop into practice. Some organisations are tasked with fostering a dialogue – particularly with sensitization (personal communications, 18 August 2018a) – but this cannot be isolated to the north.

> "[Reconciliation] would need to be happening on many different levels. If you think about what happened in Germany after the Second World War, you had things brought forcibly from the government into the curriculum of the

> schools. … In Rwanda, … [with] community courts where people could talk about specific stories. … Or like … Israel[‘s] … *Yad Vashem* - trying to honour the heroes, despite all the atrocities, … so it is many different levels. [In Uganda,] they sometimes have monuments for the massacres … but it needs to be much much [*sic*] more[.] … If you want to talk about it, you have to talk about every side. [But] ‘the winners write history’, of course that is done here.” (personal communications, 27 August 2018).

The entirety of Uganda was involved in the conflict, even if not through violence like in the north (personal communications, 16 August 2018). To move forward as a collective nation, there must be more conversations on the impact of the insurgency.

Reconciliation is not often utilized in a post-war space in the way that it should. Moreover, it is not my place as a researcher to suggest that the government of Uganda denigrate anyone involved in the conflict. Instead, the central government must respond to the need for reconciliation with a legitimate and workable strategy to discuss the trauma of the past in a neutral and open space: “I don’t think [reconciliation is] possible [if] only private actors do this.” (personal communications, 27 August 2018). Whether this leads to transitional justice is another concern, but the act of opening this dialogue will encourage those suffering from trauma to understand they are not alone, and they deserve support. Reconciliation may encourage sensitization and expand mental health services, so it is a necessary step to achieving balance in Uganda. How can reconciliation properly occur? In the sensitization from NGOs that alleviate stigma provide a model.

The reality is that this is almost guaranteed to never happen in Uganda. Years have passed since the end of conflict and little was done in the immediate aftermath to address this (Alipanga et al., 2016). It is not too late, but these conversations would open wounds that have political implications for Uganda. As a result, conversations will not be encouraged, should it result in a power shift that is unfavourable for those that have the

greatest opportunity to implement it (personal communications, 27 August 2018). This means that this – and other injustices – must be addressed outside of the exosystem.

State of Emergency: The Macrosystem & Mental Health on a Global Scale

The macrosystem represents the broader societal influences present within EST (Atilola, 2017). As mentioned in Chapter 3, these aspects concern both cultural boundaries and the influence of international aid on Uganda. This may be a departure from the traditional understandings, but the impacts of global inequality as it relates to health services are an important consideration (Coetzee et al., 2015). This means the macrosystem is not exclusively attached to Ugandan values, and places greater emphasis on how those values are informed by donor-recipient relationships.

In this way, the macrosystem and exosystem are distinct, yet interconnected. The financial limitations seen in the exosystem of Uganda's national budget are reinforced by the dominant aid trends of the macrosystem, but the latter cannot be addressed at the level of the exosystem as Uganda has little bargaining power compared to donor countries. Examining these dominant global attitudes, particularly as they influence the previous layers of EST, can encourage further discussions.

International Aid & Response

International funding for global health fails to prioritize mental health as a major concern – particularly in post-conflict scenarios which require long-term support. As discussed in Chapter 2, the growth of health funding over time has not seen comparable increases in mental health spending (Bird et al., 2011). This contrasts with the fact that roughly three quarters of the entire global health burden is found in resource-poor

settings (Mendenhall et al., 2014). Mental health is not a priority among the donor community, and this has monumental impacts on Uganda's post-conflict rehabilitation.

By failing to prioritize mental health, particularly among vulnerable populations, the international community consciously chooses to disregard the psychological burden of Uganda. As a result, the government is free to maintain their apathy towards mental health, meaning that those on the ground are left to struggle to meet the needs of their communities. The development community fails to recognize that the problem is not solved, and that dependency generated from Global North funding contrasts with the needs of the state (Kohrt et al., 2010; Allen et al., 2014; Anderson, 2018).

Should the political forces that influence global health funding continue to disregard the importance of mental health, there is very little capacity for Uganda to autonomously shift priorities. This is particularly true when Uganda seemingly has no interest in doing so and requires pressure or outside funding to support these budgetary shifts. On the mental health expenditures: "… most of that is from [the] African Development Bank." (personal communications, 14 September 2018a). That requires action from on a global scale, which means actively responding to these needs with the finances required, rather than failing to meet the scope of the problem. As Archie states:

> "Because there are international agencies that have a mandate towards post-conflict recovery … the burden also falls on them. But … I understand they are under major constraints; they don't have enough money. So, something like … less than 30% of the requested budget to help South Sudanese [refugees] … [was] given. When … [only] 30% of the money that is identified as needed is given, … that is significant … The United States had been … the largest contributor to the UN and have just removed [major funding] … The burden for a lot of these things falls with the international community. Globally we should be acting as one, in an ideal way, but that doesn't happen." (personal communications, 7 September 2018).

If the necessary budgets put in place cannot even be met, there is little opportunity for mental health (or other forms of development) to see drastic shifts that properly address the sustainability and efficacy of care. With the focus is placed on service delivery and patients, which are important aspects but not encompassing of the general attitudes that dictate funding and aid. Once again, like the national budgeting of the exosystem, this comes back to the theme of dependency that undercuts any potential solutions.

Short-Term Solutions for Long-Term Problems

As discussed in Chapter 5, mental health is fundamentally a long-term concern. It is insufficient to temporarily alleviate symptoms of mental health in a post-conflict setting such as that of Northern Uganda. There are far too many daily stressors that impact anxiety- and depressive-related disorders, including but not limited to poverty, family dynamics, access to education and stigma (Annan et al., 2013). Long-term support, for years or decades, with trained physicians is the best strategy. For low-income nations that lack health infrastructure, ensuring ongoing support for local partners that commit to multi-session programming is another key area of success (Omar et al., 2010).

This not happening in Northern Uganda, and many other post-conflict zones. While many smaller organisations are advocates for these tenets, they lack the financial security and workforce to implement this with a necessary scale. International organisations that operate in post-conflict settings have a tendency to implement programs in the short-term (even only for a few months) and then transitioning into a supporting role for grassroots partners. Cleo suggests “most [NGOs] come and go, … so if after 3 years, someone takes off, everything stops. … [We must] build the capacity of the community, so if funding stops, they are able to continue such an intervention.”

(personal communications, 17 August 2018). While financial support is important for the work of local groups, the withdrawal of medical and trained staff often leaves many without support. Many larger organisations do not have the bottom-up perspectives to ensure proper catering to the needs of war-affected youth, instead processing youth through DDR programs that lack long-term foresight (Pauletto & Patel, 2010). This contrasts the reality of war. For many conflicts, there is no distinct endpoint, the transition is complicated to process the trauma of ongoing violence.

The perception that mental health should be considered only in the short-term is defiant of the academic literature that points to the lasting traumatic impact of war experience on young people (Amone-P'Olak et al., 2014a; Yoder et al., 2016). In Canada, the relevance of PTSD among returning service personnel is acknowledged, although there are failures to this population as well. Yet somehow, when it comes to youth in the developing world, funding for mental health solutions are limited to the short-term. Cleo reflects on this reality and the necessary response from those that can enact change:

> "When I started 10 years ago, there were so many partners – so many vehicles and [we] don't even know where the offices are… But when the war ended, they all finished, so what happens to the programs that have been implemented? If they left everything, it stops at that. If they do not empower the community, we can't have the long-term impact" (personal communications, 27 August 2018).

Satisfaction Not Guaranteed: Maintenance of a Broken System

These two themes of the macrosystem come together under a singular reality: the system of mental health support in Uganda is broken, and there is no chance to fix it without a shift in how mental health is considered on a global scale. Looking to the mesosystem to solve this problem leads to the reality that those in the north does not have

the political bargaining power to address the lack of funding, attention and commitment to the system of mental health support (IRIN, 2011; personal communications, various 2018). Grassroots NGOs do excellent work to address mental health that fails to reach the necessary scope. But through the exosystem, the national government's refusal to consider budgetary increases or proper reconciliation limits the work of these local partners. This leaves the international community, at the level of the macrosystem, to dictate meaningful change within the global health landscape.

Unfortunately, there is no effort to advocate for this change. Why? Paraphrasing one participant: I've never heard anyone talk about mental health in regular life. I've never had any issues talking about HIV in the community, but for mental health it's not the same emphasis (personal communications, 26 September 2018). If mental health is to be considered with the relative importance as other health issues, there must be a shift in the way it is addressed. Rather than addressing the needs of this war-torn nation, the international community prefers maintaining the broken and insufficient models of care that aim to diagnose, doctor, and detach en masse. This is done instead of focusing on the patient, building a trust-based relationship with them, and adapting treatment to their unique needs and circumstances. Such models do not actively improve the health support in the developing world but provide dependent care that rarely translates into long-term infrastructure. In Uganda, this leads to patients falling through the cracks, if they even make it to accessing treatment, due to a prioritization on disease rather than person (personal communications, 4 September 2018d). This model put in place is not holistic, and it does not consider the influence of the macrosystem on the ability to provide care. In this sense mental health is doomed to fail. The inaction of the international

community, despite widespread press and academic attention to this topic, is a glaring condemnation of how the Global North views post-conflict rehabilitation.

The response to the Ugandan situation, particularly while maintaining the scope of this research as a case study, need not be dramatic. No doubt a revolutionary shift in the way that health is viewed would benefit mental health, but revolution is (sadly) not a feasible recommendation within this thesis. Instead, it is necessary to challenge the operation of mental health with the broader perspectives of the macrosystem. A holistic view of mental health is humanist in nature and requires us to tackle it with poignance and precision. “Individuals with mental health challenges … [should] not just live in a mental health bubble. … [They] are multidimensional and require services that are … holistic.” (personal communications, 7 September 2018). For Uganda, this means immediate and wholesome investment – not just with capital but with encouragement and political backing. Participants of this study advocate for these shifts on the ground, but it is the broader systemic influences of the global community that prevent this concept from latching on. The maintenance of this broken system comes as a result of the disinterest in mental health among large development actors. The response must be to increase advocacy for this issue in higher level conversations regarding aid expenditure.

Shifting the broken system requires addressing the circular nature of the model of care. It seems that only a global response could properly shift the mental health landscape of this specific case study, using the holistic structures that are considered and addressed at the local level. The mesosystem provides the model, in which holistic care has been adopted and developed. The exosystem provides the method, as budget increases and national governance can improve rehabilitative practice in the case study. The

macrosystem can provide the means, with wholesale investment in the holistic and comprehensive mental health support needed by traumatised persons. Limitations are seen at each level, but progress is being made in local communities. It is the macrosystem that requires dramatic shifts to properly dictate the care for war-affected youth.

Conclusion

These three levels of EST encourage exploration of mental health beyond the initial scope of the interviews presented in Chapter 5. In the analysis of the systems of mental health support for war-affected youth, participants outline a circular vision. The connections of the mesosystem give a local context for our understanding of mental health, and moreover give perspectives on what plagues local partners. For the exosystem, the broader consciousness of Uganda highlights the larger systemic problems that go beyond the Acholi subregion to stunt mental health at the national level. This requires wholesale change to incorporate the holistic models of care, but it is the macrosystem and the global domain which dictates what becomes a health priority.

CHAPTER 7: CONCLUSION

Confronting mental health in Northern Uganda is a difficult process. The evidence suggests that treatment options should be increased, but the realities of the field complicate achieving this goal. War-affected youth continue to struggle with psychological disorders related to trauma during LRA insurgency, and this cohort requires continued support. Being that mental health services, particularly formal services, are insufficient, there has been a response from grassroots practitioners to deliver care. The participants of this study, who operate local psychosocial programming, note that a systematic change to navigate the injustices of treatment in the region is greatly needed. In terms of the insurgency, it is important to reflect on the massive impact of conflict, particularly as two factions struggled back and forth for over a decade, leaving incalculable psychosocial impacts. A participant categorized this with an African proverb: When two elephants fight, it is the grass that suffers (personal communications, 23 August 2018a). As two powerful forces clash, the innocent bystander is most harmed.

The application of this proverb is profound. Northern Uganda suffered immeasurable violence from an inherently political struggle between two factions. Years later, this is apparent through the psychological impacts of war. Yet, this proverb goes beyond the insurgency. It applies to the contradictions of the post-war space. While institutions, like the Ugandan government and international donors, govern mental health treatment, it is those most in need who continue to suffer. Without support, local practitioners at the grassroots level are left to pick up the pieces. This is an ongoing injustice, one in which two great beasts circumvent the needs of the people.

The research questions posed in this thesis focus on the status of mental health in Uganda, what treatment options are delivered to war-affected youth by local partners? What factors are considered with these strategies? What are the barriers exist for these organisations in providing care? What needs to change? Each question, and the responses gathered from testimony in the field, looks to shift the way mental health is perceived and responded to. These questions address how mental health support operates in the region – leaving the vulnerable of Northern Uganda plagued by the trauma of past tragedies. It is with this sentiment that the final comments of this thesis should be directed towards recommending strategies to address this problem. While war-affected youth in Northern Uganda are continually disregarded, it seems that only the grassroots practitioners are willing to advocate for their needs. This must be done with tact and inclusivity, and the work of those on the ground presents an important structure for our consideration.

Realities of the Field

Through the research conducted in Northern Uganda, it is clear that there are extreme barriers to providing treatment with efficacy and proper scope. By using EST, as amended by Atilola (2017), a structured picture of how these limitations govern treatment options are seen. To briefly reiterate, the mesosystem's local scope of personal connections defining mental health struggles allow for the impacts of poverty, stigma, and collaboration to be examined. Similarly, the exosystem's national scope interrupts how regional differences, the health budget and a lack of dialogue share influence on higher structures care. To compliment this, reflecting on global aid patterns, the short-term nature of mental health programs and, ultimately, the maintenance of a broken psychosocial care system, outline how the global community of the macrosystem can be

implicated in this specific case study. Together, these three levels of analysis pair with the conversations seen in Chapter 5: practitioners interviewed for this study discussed the importance of addressing culturally relevant programs, providing long-term support, extreme financial limitations and failed policy, and even providing solutions to addressing these systemic problems. Such responses highlight the core themes of this thesis as they relate to my thesis statement: War-affected youth in Uganda continue to suffer from mental trauma because health services are insufficient, and this must be addressed with the capacity of local NGOs that provide holistic care. This leads to the stark conclusion that not enough has been done to address the needs of war-affected youth. These results provide a baseline for understanding how treatment can be addressed in Northern Uganda, often honing back to the need for holistic and inclusive models of care, which embrace mental health as a priority in the post-conflict space.

Revisiting the Academic Sphere

With these themes put forward to address mental health through the perspectives of grassroots practitioners, it is necessary to acknowledge how the current situation emerges. It remains meaningful to discuss the future, but without exploring the creation of this broken system, there is little opportunity to properly reflect on what can be done. From the standpoint of this thesis, Chapter 2 reflects on the work of academics and policy analysis in the field of mental health and conflict. Taking aim at the Ugandan case study, the work of Amone-P'Olak et al. (2014) and Vindevogel et al. (2011) highlight the importance relative war experience conflated to relative of symptom presentation. Similarly, Neuner et al. (2012) and Harlacher et al. (2006) point to the role of cultural understanding within treatment. Other studies by McMullen et al. (2013) and Ertl et al.

(2011) provide the baseline for understanding the connection between conflict and mental health, while Murray et al. (2015) denotes the state of mental health expenditure in the nation. When pairing this literature review with the contextual background of Uganda from Chapter 1, which comments on the historical precedence of violence (from the colonial era to the insurgency), the imbedded nature of mental health and trauma, and the realities of seeking treatment in modern Uganda, there are clear barriers in place that prevent the necessary treatment in the region.

Moving Forward

The topics presented within this thesis lead to a crossroad. Acknowledging the realities of the field and the complex conflict in Northern Uganda presents a bleak picture. With little infrastructure and, arguably, political willingness to address mental health in the region, it falls on local partners to respond. In doing do, the grassroots nature of these groups leads to stretching budgets and over-working personnel beyond their limit or fixating on a specific problem while failing to meet the needs of their people. This is not a true paradox, but it is a quandary that highlights the limitations of working in Northern Uganda.

Mental health creates a contradiction between need and response, in which the most powerful actors subjugate true justice in favour of turning a blind eye. Yet somehow, the participants of this study cling to a positive outlook. Even within the frustrations of their work, practitioners of mental health advocate for their patients with introspective research and innovative programs. Although complications remain, important work continues in lieu of the formal treatment via hospitalisation or outreach clinics that might be preferred on a global scale. This positivity requires adjusting the

conclusions of this research in a strategic way. As the purpose of this thesis is to identify the plight of those impacted by conflict-related mental health concerns in Northern Uganda, the natural end point is to advocate for grassroots practitioners with recommendations that provide constructive building blocks for amending the system.

Recommendations

As shown throughout this thesis, addressing mental health is a complicated issue that merges the local, national, and global sphere of development influence. It is not enough to analyze the systematic issues, but rather to develop strategies to combat the shortfalls of the system. While some of these recommendations may require widespread attitude shifts and changes, it is my hope that these suggestions present a concrete change from NGOs and the community. This is not to say that the responsibility falls solely with these partners, in fact previous comments have argued quite the opposite. Instead, by targeting these recommendations to partners, a greater opportunity to expand the scope of programs to address the magnitude of mental health detriments emerges.

1. <u>Mandate inclusive programs that embrace local tradition & community networks.</u>

Practitioners of mental health have embraced programs that cater to a wide variety of impacted populations. At the onset of this project, one research question posed how different elements – including cultural understanding – impact the work of grassroots organisations. This recommendation responds to the impact of stigma and community ownership over projects, which was a concern from practitioners in the field time and time again, participants of this study reflected on the importance of participatory mental health, a model which incorporates community values. As a result of this strategy, the

organisations that participated in this study worked with the mandate to include community members in various means – as counsellors, coordinators, and in sensitization (personal communications, 27 August 2018; 4 September 2018b; 4 October 2018). By adopting this inclusive strategy, these partners were able to access the community – but this comes with an important caveat: the community must also have an active voice in shaping programs. Groups like WAYA encouraged the use of traditional methods for addressing mental health (personal communications, 16 August 2018), while THRIVE empowered community members through ownership of mental health (personal communications, 4 October 2018). Such strategies encourage community advocacy and provide a succinct model for adopting local structures and tradition within treatment.

Even while this study focused on youth, mental health programs may best succeed in eliminating stigma if specific groups are not isolated. Most youth in Northern Uganda had experienced the conflict, while the next generation feels the impact that through their family and community members (personal communications, 16 August 2018). It is necessary to rely on mental health programs that go beyond the traditional scope of care. This includes ensuring that programs are widely available to entire communities, with greater focus for patients demonstrating the need for personalized support. In partnership, embracing "traditional" methods of coping are an important facet for strengthening mental health (Harlacher et al., 2006). This is not to dismiss western methods, but rather to incorporate culture to utilize local spirituality in tandem with structured interventions. The final component is to embrace community networks of support, including looking to community members to take part as health care workers, partners and facilitators. This recommendation depends on collaboration at higher systemic levels. Certainly,

collaboration is best implemented using local beneficiaries, but they also require political and structural support from regional and national authorities. Specifically, it is up to national bodies to support training modules for village workers and to ensure they have capacities to work or volunteer. Meanwhile, international partners can partner with national agencies for increased funding for the expansion of such programs.

2. Embrace collaboration among grassroots organisations to prioritize young people.

Going into this project, I assumed collaboration would be difficult given competition for funding among NGOs, but the respondents commented that it was a fundamental part of their success (personal communications, 14 September 2018a; 7 October 2018). From this perspective, collaboration directly addresses the limitations of service deliver in Northern Uganda, by encouraging resource sharing and building networks for patient support and advocacy (personal communications, 14 September 2018b). Work still needs to be done to strengthen these connections. Participants often spoke of the limitations in collaboration, despite ample interest in developing these networks (ibid). The purpose of collaboration must remain to prioritize patients.

This recommendation emphasizes collaboration support for "young people centred" programs, particularly the underserved population of war-affected youth in the north of the country. This thesis focuses on the youth cohort of Northern Uganda, in order to highlight the lingering impacts of war experience on children. As stated in Chapter 1, the children of the insurgency have grown into youth but still require psychological support. UNICEF reports that children in many African conflicts remain in desperate need of assistance. For example, in the Chad Basin over a thousand schools were closed due to unrest, South Sudan and the eastern DRC experienced widespread

violence against children, and Boko Haram continues to target Nigeria's youngest citizens (UNICEF, 2018). These tragic events echo the violence of the LRA. In implementing collaboration, NGOs must make explicit efforts to cater to the unique needs of war-affected youth, by recognizing their unique positionality. While each of the organizations in this study have an explicit focus on youth, accountability for child protection and the specific dynamics of youth-focused rehabilitation must remain a priority in the expanding network.

It is the responsibility of each NGO to ensure that there is greater support for other groups to maximize partnership. Competition for funding is part of this sector, but mental health networks require a variety of different service providers to work together for the benefit of patients. With the testaments provided from grassroots collaborators of this study, this can be achieved through greater capacity building. As stated in Chapter 6, this might be best placed with increasing the role of local government administration (with backing at the national level) to allow for a neutral body to act as a safeguard for the needs of the people while also maintaining balance between different field partners as programs expand and develop. Collaboration is not improbable in this context - it is the key to tackling mental health. This means collaboration must be expanded and formalized at the local, national and international level (personal communications, 5 October 2018).

3. <u>Foster a nation-wide dialogue surrounding the atrocities of the Insurgency.</u>

The true failure of post-war Uganda lies within the lack of dialogue surrounding trauma. As there was little effort for true reconciliation or post-war rehabilitation on a psychological level, the impact of war on mental health still remains elusive in popular discourse. Respondents made a clear call for more openness surrounding the conflict

from practitioners in both Chapter 5 and 6 (personal communications, 27 August 2018; 25 September 2018). Without formal discussions surrounding the insurgency period, interviewees commented that stigma continues to impact those associated with the conflict, and the uneven blame for atrocities ultimately prevents those harmed by the UPDF to seek justice (ibid). While this suggestion remains grounded at the national level to promote reconciliation, it is at the community level where the benefit will be the greatest. In this way, reconciliation occurs at multiple scales to incorporate national strategies for implementing these conversations, while addressing the needs for open discussion in the local setting. Local leaders can lead this strategy, working in tandem with NGOs to provide quality mental health education. However, successful reconciliation requires the government to actively participate in discussions of trauma.

Instead of focusing on striving forward through development, it is absolutely necessary to revisit the atrocities of the past to properly understand their impact. The impact of the LRA defined the deeply traumatic insurgency period, but so long as there is an unequal distribution of blame, and an unwillingness to revisit this dark period, mental health will continue to take a back seat. By taking ownership over the violence of the insurgency and providing neutral ground to discuss the conflict, there is a great opportunity to expand dialogue surrounding its impacts. This can be wholly beneficial for the nation, as it need not focus on reparations or blame, but rather encouraging people to come forward to seek therapy without stigma or community judgement forcing victims to struggle in silence. Reconciliation provides a definitive strategy to diminish shame and stigma surrounding the lingering psychological wounds of war. As an attempt to amplify the importance of this practice, this recommendation is relevant – despite the potential

political limitations – to encourage discussions surrounding the legacy of trauma and the impact of conflict (from all sides) even decades later (Alipanga et al., 2016).

4. Increase national health budget as a means to improve mental health funding.

By providing greater financial allotment for mental health within the Uganda's health system budget, it will not lead to a reduction in services at the centralized hospitals of Kampala, but it will expand services to other areas. Northern districts must be prioritized within this expansion, including enabling the grassroots network of support to thrive and expand by providing ongoing and substantial funding from the government directly to these groups. This funding increase will create an opportunity to expand services to rural communities and sub-standard health centres. Much of this is put forward in progressive policy from the Ministry of Health's Mental Health unit – but the gap between policy and practice must be closed with the greatest urgency. Perhaps the easiest way to increase the mental health budget without divesting from other health needs is to increase the health budget expenditure in the overall national budget. Uganda lags behind other African nations in overall health expenditure (with just 11%) meaning opportunity exists to increase the health budget to mirror regional leaders, such as Rwanda which has stabilized spending at over 20% of their budget (World Bank, 2014).

While Uganda's health spending is comparable to developed nations, the context of Uganda as a poor, post-conflict nation must be considered in its government expenditure. This is a response to the need of wholesale investment to empower local systems of mental health care, as demonstrated in Chapter 6. Here, the budget increase is tangible and progressive, to match the clear needs as demonstrated from practitioners in the field. However, Uganda does not autonomously have a surplus of finances to dedicate

to such a project. Any prospective change would require dramatic shifts in fiscal commitments from the government, meaning an external body (such as the African Development Bank or Global North donors) would have to provide monetary support. In this way, budget increases rely on external factors for financial support, the national system for strategic implementation, and community participation for ensuring care at the community level. Every organisation spoke of the limitations put forward by insufficient formal care and their own budgets – as it to be expected for the NGO sector in a low-resource setting (personal communications, 14 September 2018b; 26 September 2018a). That being said, the work being done in the field, in spite of these limitations, highlights the opportunity for expanding services to properly address the magnitude of the problem.

Budget increases could be directed in two ways. Firstly, the Ministry of Health's Mental Health Unit requires additional support for their projects, particularly in their plan to incorporate mental health training into village nursing. Alongside this is the need for counsellors to be free of other responsibilities in order to provide care. Second to this, deeper partnership with NGO is currently widespread, but additional support is needed to match the scope of necessary mental health support in the region. None of the organisations I spoke with receive financial support from the government (personal communications, various 2018), and in changing this, there is an opportunity to bolster their work. These groups are willing to expand programs, but there must be money put in place to encourage local organisations to continue this important work.

5. <u>Re-shape conversations about trauma to prioritize people over disorder.</u>

This final recommendation is perhaps the most grand and complicated to achieve. While each of the first four recommendations provides a pillar for restructuring mental

health treatment, changing the way that mental health operates in Uganda is the ultimate goal. Discussions with practitioners in the field often hovered around this notion, as their experiences in delivering mental health remain ultimately dictated by the limitations of treatment seen in Chapter 5 (personal communications, 21 September 2018; 24 September 2018). Notably, for these partners, trauma is often discussed in terms of psychological disorders as it provides parameters for treatment – a tangible element that can be fixed. That being said, participants highlighted the higher-level focus of mental health programs to be holistic in nature – ultimately speaking to the need to focus on the client in an encompassing fashion (personal communications, 4 October 2018). After all, the work of these groups is to change the lives of war-affected youth in a holistic manner. For Uganda, this transformation should manifest in greater mental health education and advocacy from the national level to local communities. This might include sensitization campaigns to reduce stigma, but it also requires shifting school curriculum and hosting village town-hall discussions to actively address the existing stigma.

For too long, across the globe, mental health is considered in terms of disorder and disease. Mental health is only discussed in the context of a problem, rather than with each person having their own experience. In the best of times, our mental capacity for emotion and cognitive processing defines our mental health as positive. However, when it comes to treating mental health, these discussions revert to diagnostic conversations. By encouraging Ugandans to recognize that mental health impacts every individual regardless of trauma, there is a powerful opportunity to redefine how war-related mental health treatment operates. This goal cannot be completed with immediate action, but rather a gradual attitude change that embraces universal mental health.

Translating into Practice

None of these recommendations exist in isolation. While I have chosen to focus the results of this thesis within the specific levels of Ecological Systems Theory, each of aforementioned solutions requires cross-cutting implementation that implicates every level of society. For a budget increase, support from the international community is vital. Implementing collaboration requires logistical support beyond local means. Any neutral discussions of reconciliation should meet global standards, while also catering to the unique needs of the community they are implemented in. Most notably, a shift in understanding mental health means embracing a holistic brand of care and credence with the local, national and international scope. Each of these suggestions moves beyond the traditional barriers of the mesosystem, exosystem, and macrosystem. Instead, these recommendations must be grounded in a crosscutting and synthesized manner that explores the implications at each systemic level. This is not to abandon the framework of this study, but to provide a concrete translation of these recommendations into practice. As each of these recommendations cuts across multiple sectors, the way forward is to conceptualize these changes within the scope of NGO capabilities. While implementing these shifts does not rely solely on the informal sector of mental health treatment in Uganda, local groups have the advocacy, passion and capacity to enact these changes.

Final Thoughts

Through these recommendations, there is greater opportunity to offer a reflective and systematic plan for addressing the needs of war-affected youth in Uganda. Although time has passed since the end of formal conflict in 2006, the unseen wounds of mental health problems continue to fester in untreated populations. With the large burden of

those impacted by the insurgency in the North, there must be concrete strategies put in place to address psychosocial care and long-term rehabilitative support in the region. These proposals differ in scope, with each of the first four recommendations providing a corner stone to address the fifth. Without building up the structural support for both practitioners in the field and young people who have been traumatised by conflict, opportunity lacks for the northern districts to embrace a brighter future for Uganda.

However, these lessons need not be isolated to the Ugandan case study. These experiences encourage reflection of other conflict areas and how the best practices of mental health care that might be implemented in this case study could be passed onto war-affected populations in neighboring nations. It is important to explore the realities of post-conflict trauma rehabilitation in a setting such as Uganda to pass on the successes and shortfalls to other emerging conflicts. Based on these findings, there is more work to be done, but that does not prevent the lessons of hindsight given the system of care in Northern Uganda in the years following the insurgency. Uganda hosts the Africa's largest population of refugees at 1.3 million people – many coming from conflicts in the eastern DRC and South Sudan (UNHCR, n.d.). Every post-conflict scenario has unique circumstances for war-affected youth, but the Ugandan case study provides a baseline for expanding care and mental health services for war-affected populations around the globe.

War offers no respite for the young and vulnerable. It is with this in mind that the lessons forged in the tragedy of Northern Uganda's intense conflict give vulnerable groups a bargaining chip for the future they deserve. War is not often authored by teenagers, but this is the demographic group that feels a reverberating impact – often for their entire lives due to untreated mental trauma. The conflict in Uganda has passed, but

the road to recovery is not over. Addressing this must come as from both within the nation and in spreading awareness of what can be done to address the psychological impacts of war. It requires the global community to respond to the needs of fledging generations; To right the wrongs of past mistake and embrace the bright lights working during the darkest times. Across Northern Uganda, there are mental health practitioners working tirelessly to address help war-affected youth. These advocates do what they can, despite the limited resources in the nation. Such individuals strive for change. It becomes a global responsibility to champion these leaders and embrace their work. The guns have been silenced, now it is time to end the war in the minds of the people.

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APPENDIX A: Document Figures

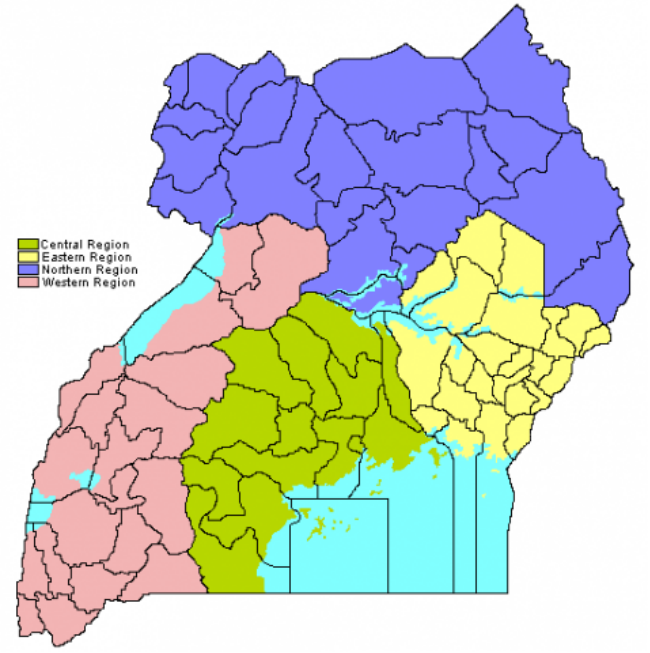

Figure 1. Map of Regions in Uganda. Retrieved from Government of Uganda (2006).

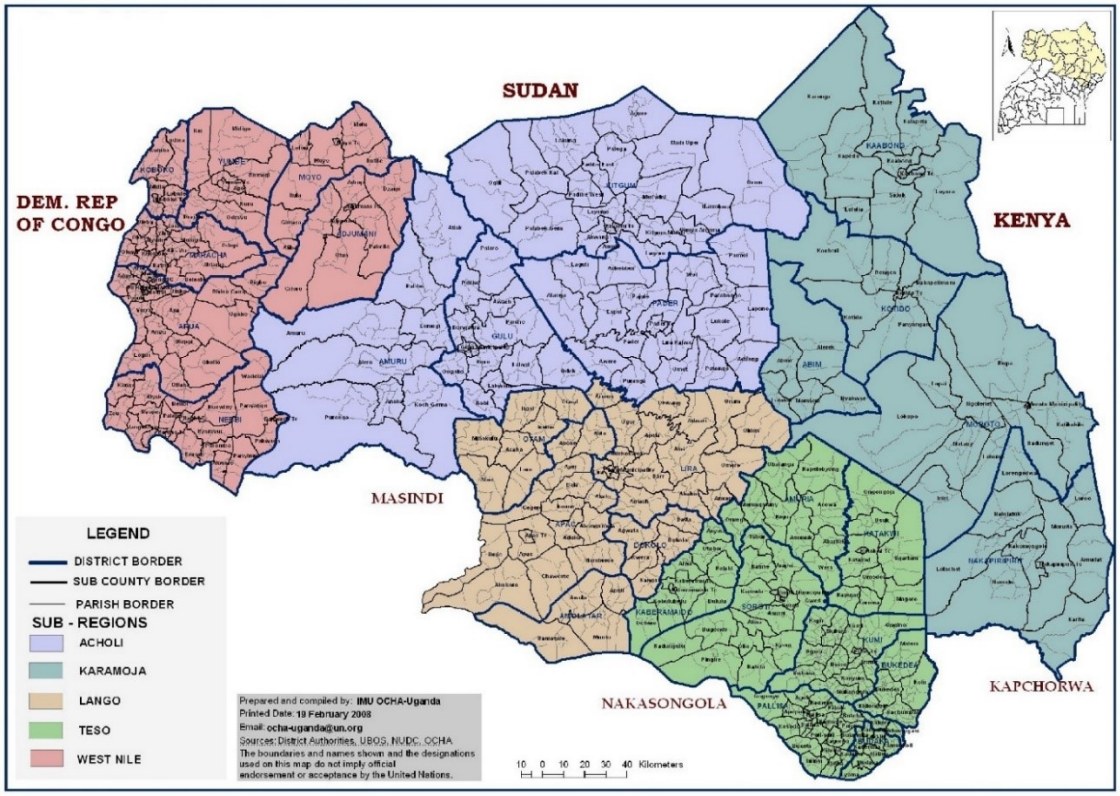

Figure 2. Map of Northern Uganda with Ethnic Subregion. Retrieved from UN Office for the Coordination of Humanitarian Affairs (UN-OCHA) via ReliefWeb (2008).

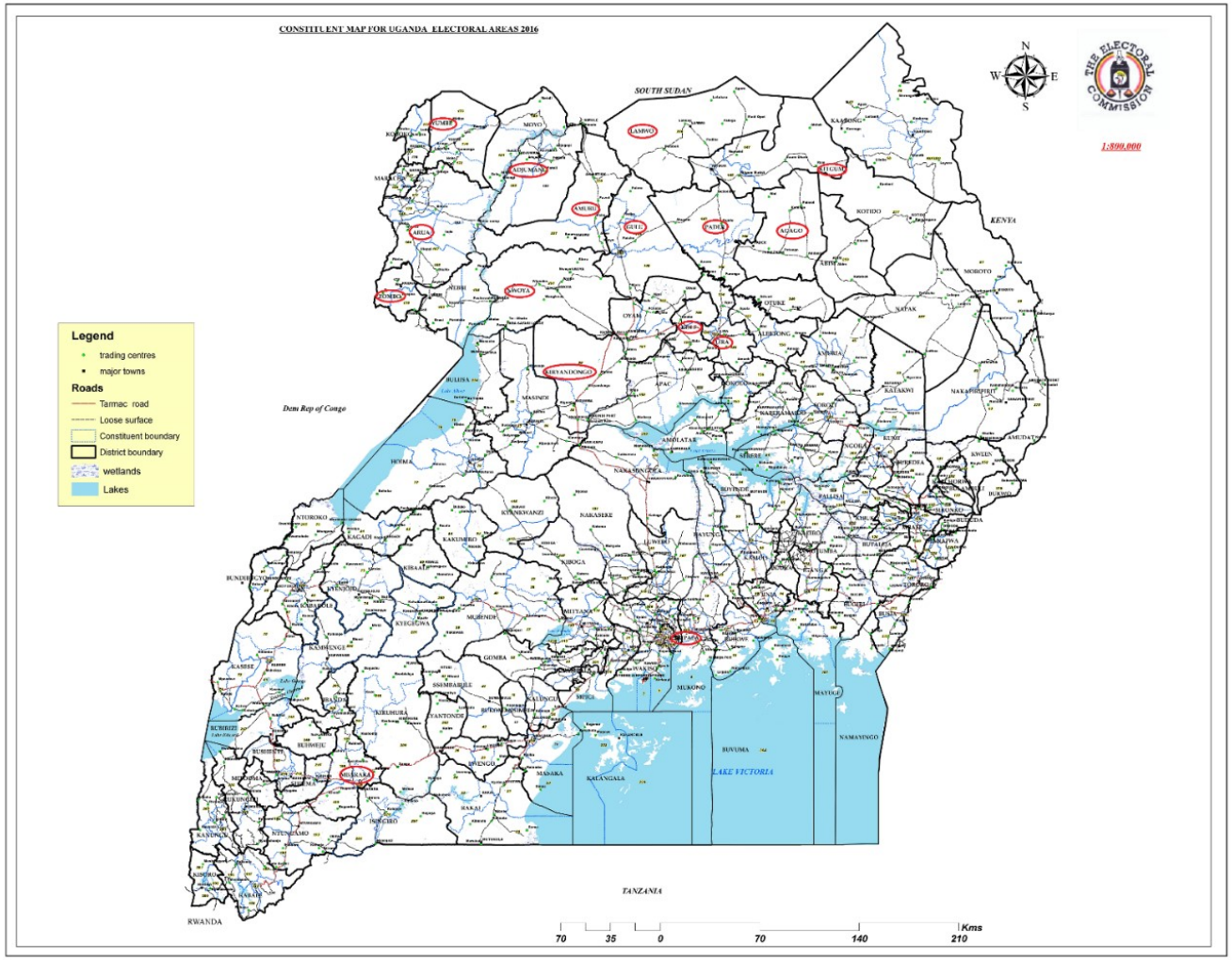

Figure 3. Districts of Uganda with highlighted districts referenced in thesis. Adapted from "Constituent Map for Uganda Electoral Areas 2016", By Ugandan Electoral Commission (2016)

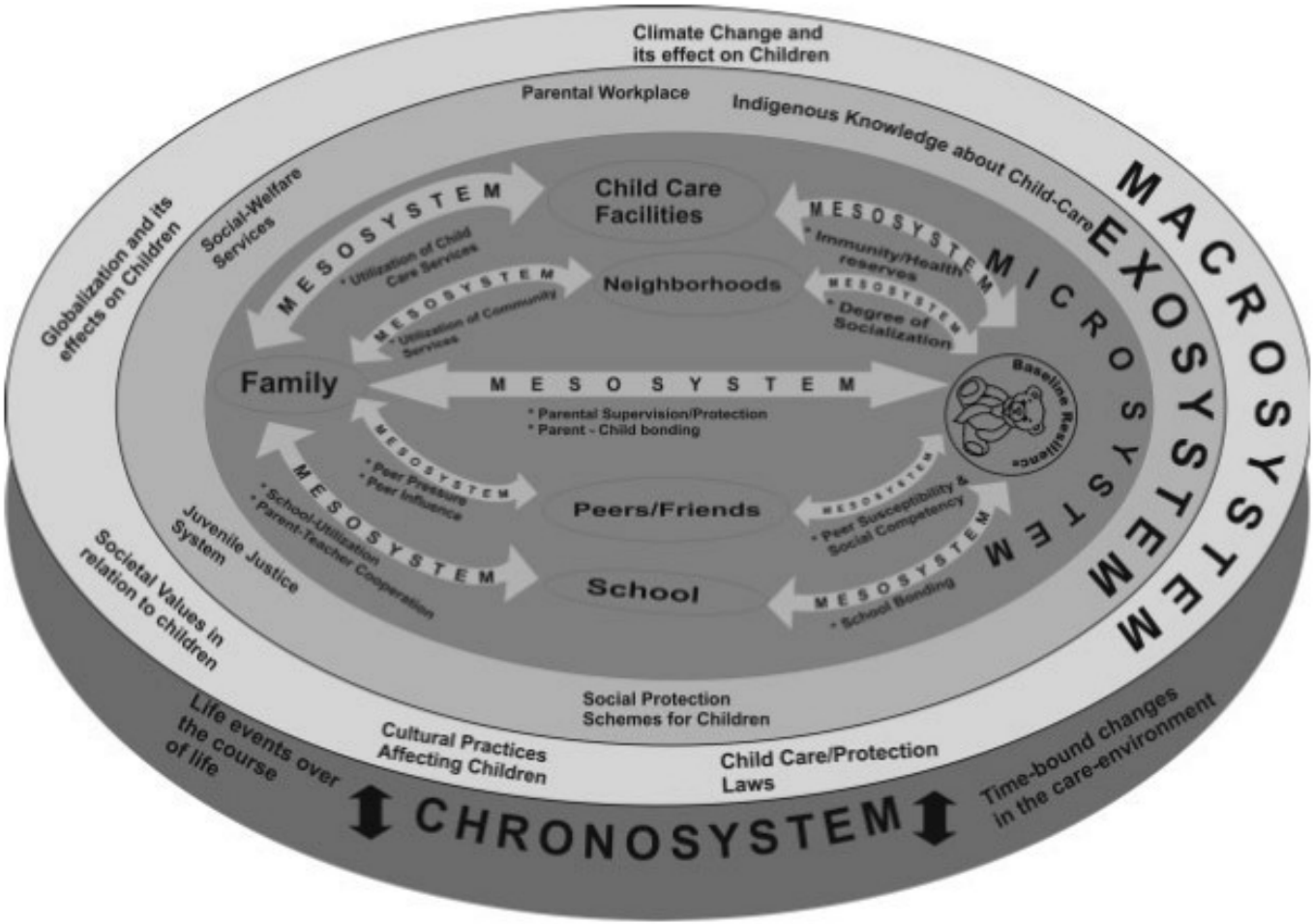

Figure 4. "Ecological care environment for children from mental health perspectives. Adapted from Bronfenbrenner (1979)." Retrieved from Child mental-health policy development in sub-Saharan Africa: broadening the perspectives using Bronfenbrenner's ecological model, By Atilola (2017)