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Research Report

Cost-Benefit Analysis of Cash Transfer Programs and Post Trauma Services for Economic Empowerment of Women in Uganda (EWP-U)

TILBURG UNIVERSITY

MBARARA UNIVERSITY OF SCIENCE AND TECHNOLOGY

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Research report

Tilburg University

A Cost-Benefit Analysis of Cash-Transfer Programs and Post-Trauma Services for Economic Empowerment of Women in North Uganda

Research Report (EWP-U)

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Netherlands Organisation for Scientific Research
WOTRO Science for Global Development

KNOWLEDGE PLATFORM ON INCLUSIVE DEVELOPMENT POLICIES

Colofon

Tilburg, 30 April, 2018

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We have made every effort to truthfully report the findings of the research. If there is any error or comment on the content of this report, we are grateful if you bring this immediately to our attention.

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Table of Contents

List of Tables

List of Figures

List of Acronyms

ALREP	Agricultural Livelihood Recovery Programme
ANOVA	Analysis of Variance
APAI	Acholi Psychosocial Assessment Instrument
CAP	Community Action Program
CDD	Community Driven Development
CIR	Community Infrastructure Rehabilitation
CPTSD-RI	Child Posttraumatic Stress Disorder Reaction Index
DFID	Department for International Development
DSM	Diagnostic and statistical manual of mental disorders
EMDR	Eye Movement Desensitization Reordering
EOC	Equal Opportunities Commission
ESP	Expanding Social Protection
EWP-U	Empowerment of Women in Uganda
FAO	Food and Agriculture Organization
FOBA	Force Obote Back Group
HISP	Household Income Support program
HAP	Humanitarian Assistance Programs
GZU	Great Zimbabwe University
ICC	International Criminal Court
IDP	Internally displaced person
IMF	International Monetary Fund
IEC	Impact of Events Scale
IES-R	Impact of Events Scale – Revised
Isis-WICCE	Isis-Women's International Cross Cultural Exchange
KALIP	Karamoja Livelihood Improvement Programme

KIWEPI	Kitgum Women Peace Initiative
LRA	Lord Resistance Army
MAAIF	Ministry of Agriculture Animal Industry and Fisheries
MFPED	Ministry of Finance, Planning and Economic Development
MGLSD	Ministry of Gender, Labour and Social Development
MUST	Mbarara University of Science and Technology
NAADS	National Agricultural Advisory Services
NDP I	First National Development Plan
NET	Narrative Exposure Therapy
NRA	The National Resistance Army
NRM	National Resistance Movement
NUDEIL	Northern Uganda Development of Enhanced Local Governance, Infrastructure and Livelihoods
NUSAF	Northern Uganda Social Action Fund
NUREP	Northern Uganda Recovery Programme
OVC	Orphans and Vulnerable Children
PCAF	Peter C. Alderman Foundation
PEAP	Poverty Eradication Action Plan
PGM	Production and Marketing Grant
PRDP	Peace, Recovery and Development Plan
PRRO	Protracted Relief and Recovery Operations
PTS	Post-traumatic stress
PTSD	Post Traumatic Stress Disorder
PTSS	Post Traumatic Stress Syndrome
PWP	Public Works Program
RALNUC	Restoration of Agricultural Livelihoods in Northern Uganda
SAGE	Social Assistance Grant for Empowerment

SCG	Senior Citizens Grant
SDIP	Social Development Investment Plan
SER	Social and Economic Resilience
SHLCPTS - program	Self Help Low Cost Post Traumatic Stress Program
SLF	Sustainable Livelihood Framework
SUD	Subjective units of distress
TEWPA	Teso Women Peace Activists
UN	United Nations
UNPRAP	United Nations Peace building and Recovery Programme
UN SCW	United Nations 61st Commission on the Status of Women
UPDF	Uganda People's Defense Force
UPE	Universal Primary Education
USE	Universal Secondary Education
VFG	Vulnerable Family Grants
WFP	World Food Program
WHO	World Health Organization
WOPI-U	Women Peace Initiative – Uganda

Acknowledgements

We are first of all grateful to NWO-WOTRO for awarding us this research, which gave us the possibility to research a question of importance for the stakeholders in government and service providing organizations.

We express our sincere thanks to the women's organization, the women's groups and all the women who participated in this research. Our special thanks go to the partner organizations Kitgum Women Peace Initiative (KIWEPI), Teso Women Peace Activists (TEWPA) and Women Peace Initiative – Uganda (WOPI-U) in Northern Uganda.

We are grateful for the support received from the district chairpersons and district and sub county officers in Lira, Kitgum, Katakwi and Amuria, who allowed us to carry out the research and for all the support received in the process. We are also grateful for all those in the districts who helped in implementing the trauma services.

Our thanks also go to the Government of Uganda, specifically the President's Office, the Prime Minister's Office and the Ministry of Gender, Labour and Social Development and Expanding Social Protection Secretariat for their support in carrying out this research and for their interest in the results throughout the investigation. We specifically thank the Head of Social Protection, Mr. Kasaija Stephen and the Senior Program Officer, Ms. Jane Namuddu. We thank the Ministry of Health, especially, Dr. Mugisha.

We were especially honored that the Prime Minister accepted an invitation to attend the dissemination of the results to all the participants during a commemoration held in Borlonyo on February 21st, 2017 on the occasion of the commemoration of the massacre by the Lord's Resistance Army (LRA) in Lira in 2004 when 300 villagers were killed. We very much thank the Members of Parliament and Government, especially the Minister of State for Internal Affairs.

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We are also thankful to the Equal Opportunities Commission (EOC), Ms. Sylvia Muwebwa Ntambi. The EOC took a keen interest in the results and hosted several meetings allowing us to disseminate the results of this study.

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We gratefully acknowledge the contribution of Isis-Wicce to our project and its partners, the Kitgum Women Peace Initiative (KIWEPI)- Kitgum, the Women Peace Initiative-Uganda (WOPI-U) -Lira and the Teso Women Peace Activists (TEWPA)-Soroti. We also thank the community leaders and senior citizens, Ms. Amuge Hellen – Orungo Sub county, Ms. Rashida Odongo – WOPI-U, Ms. Anna Akura – Amida Sub county, Ms. Gladys Cangura – KIWEPI, Ms. Kongai Winnie – Usuk Sub county, and Ms. Jane Ekume – TEWPA.

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We thank all those who provided support during the research from the leadership and staff of Tilburg University, Mbarara University of Science and Technology (MUST) and Makerere University. We especially thank Prof. Dr. Pamela K. Mbabazi (Former DVC MUST), Viola Nyakota, Edward Musoke, Agnes Attalla, Brenda Amullo, Achen Dorcus Achen, Irene Kabale (MUST), Ruth Ochieng, Prof. Eugene Kinyanda, Juliet Were and Suzan Nkinzi from Isis-WICCE and advisers Zecarias Gerrima (Africa Monitors) and Jolanda Asmeredjo (Ph.D. candidate at Tilburg University). Selan Kidane and Zaminah Malole were registered as Ph.D. candidates in Tilburg University based on research carried out for the research presented here and they

have both extensively contributed to the research respectively on trauma and on social protection policy

We extend sincere thanks to the esteemed members of the Steering Committee, Prof. Dr. Josephine Ahikire of Makerere University and Hellen Kezie-Nwoha from Isis Wicce.

Finally, we would like to acknowledge the contributions of advisers who assisted us during this research, specifically Jaap Kool, psychiatrist – with specific knowledge of the research area and context.

We sincerely hope that this research will contribute to better understanding of the relevance of assisting trauma services as a cost-beneficial measure to improve the positive effects of social protection program.

Prof. Dr. Mirjam van Reisen (Principal Investigator)

Dr. Primrose Nakazibwe (Research Coordinator)

Dr. Mia Stokmans (Methodology and analysis)

Dr. Bertha Vallejo (Research Coordinator and Valorization)

Selam Kidane (Ph.D. Researcher)

Zaminah Malole (Ph.D. Researcher)

Purpose of this Report and Origin of Content

This study was carried out from June 2015 to December 2017 under the guidance of the Steering Committee, composed of Prof. Dr. Mirjam van Reisen (Tilburg University), Prof. Akihire (Makere University), Dr. Viola Nyakota (Mbarara University) and Helen Kezie-Nwoha, Isis-WICCE. The Steering Committee composition was a tribute to the importance attached to this research to the experiences of practitioner's organizations and the desirability of the practical implementation of the knowledge from this research for their work.

This research report is compiled to provide a first overview of the research results of the Cost-Benefit analysis of Cash Transfer Programmes and Post Trauma Services for Economic Empowerment of Women in Uganda (EWP-U) program.

The report is compiled under the overall responsibility of Prof. Dr. Mirjam van Reisen, Tilburg University, as the principal investigator of the study. An interdisciplinary team, with background in ethnography, quantitative research, social science, social protection and psychology, worked on this research.

The team from Mbarara University provided the data in relation to the implementation of the research, study sites, sampling and contextual developments during the study.

Dr. Primrose Nakazibwe, Mbarara, was responsible for the implementation of the research on the ground and led a team of senior and junior researchers and support staff during this time. Dr. Primrose Nakazibwe is the author of the Social-Economic Resilience Scale (SER) developed for the purpose of this research. The SER appeared to be a very sensitive scale and was later used in subsequent research carried out in Ethiopia. She has contributed to the theoretical positioning of this research. Dr. Primrose Nakazibwe is the (co-)author of chapters 4, 5, 6, 7, 8 and 9 of this report.

Edward Musoke, Mbarara University, assisted in the data preparation. Prof. Dr. Pamela Mbabazi, who was deputy Vice-Chancellor during the start of the project advised in its early stages.

Dr. Mia Stokmans, was responsible for the assessment of the scales, the design and statistical analysis and interpretation of the findings of the report. She also contributed to

the overall theoretical explanatory framework for the research. Dr. Mia Stokmans is the (co-) author of the chapters 4, 12, 13, 14, 15, 16, 17 and 18 of this report.

Dr. Bertha Vallejo, Tilburg University, provided coordination support for this research and we are grateful for her dedication to help bring this work to completion. She and her team contributed to the documentation of the research process, which is set out in this report, and to the related reports on valorization and the dissemination of research findings, as well as financial reporting.

Julia Were, Isis-WICCE contributed sections on the work of Isis WICCE to this report.

Kristina Melicherova, Tilburg University, is a Ph.D. student who assisted with a few sections of the report, specifically 4.11.2 and 4.13.1.

Selam Kidane, Tilburg University, is a Ph.D. candidate registered at Tilburg University and is responsible for the sections in this report on trauma, collective trauma and the design of an intervention to address post-traumatic stress (PTS) in post-conflict low resource areas. The intervention is called Self Help Low Cost Post Traumatic Stress program (SHLCPTS). It is inspired by the Eye Movement Desensitization and Reprocessing (EMDR) psycho-therapy. Measurements of PTS were carried out with the Impact of Events Scale – Revised version (IoS - R). Her contributions to this research will be part of the dissertation that she will defend as part of her Ph.D. research. She is the (co-)author of chapter 7, 8, 10 and 11. She reserves the right to republish her contributions for academic purposes and for her dissertation to defend her Ph.D.

Zaminah Malole, Tilburg University, is a Ph.D. candidate registered at Tilburg University and is responsible for the sections in this report on social protection policy in Northern Uganda. Her contributions to this research will be part of the dissertation that she will defend as part of her Ph.D. research. She is the (co-)author of chapters 6 and 9. She reserves the right to republish her contributions for academic purposes and for her dissertation to defend her Ph.D.

There are three analyses that are still planned for further analysis of the data. These are: (i) a systematic coding labeling analysis of the 70 interviews carried out for this research; (ii) a

more detailed analysis of the convergence of values reported in the SER and (iii) a statistical analysis of the long-term effect of the SHLCPRS-program on the IoS and the SER.

This report has benefited from peer-review by Prof. Dr. Munyaradzi Mawere from Great Zimbabwe University (GZU) and has received a light editing touch by copyeditor Susan Sellars-Shrestha. Any mistakes, however, are the responsibility of the principal investigator and you are kindly requested to bring any errors to our attention for further consideration.

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April 15, 2018

1. Executive Summary: The Cost-Benefit of Including Trauma-Support in Social Protection Programs

This study investigates the effect of existing government-initiated social protection programs (cash and in-kind) and trauma counselling in Northern Uganda on economic development in Northern Uganda. It also examines the effect of a counselling program developed for this study, the Self Help Low Cost Post Traumatic Stress program (SHLCPTS). The study was carried out using a post-test only design, which encompassed two time-points of measurement, referred to as Wave I and Wave 2. Both qualitative (focus group discussions and interviews) and quantitative (survey) data were collected for the study. The research question was formulated as: *Does support to relief trauma positively affect the relationship between social protection and social economic resilience?*

Whilst originally the aim was to look at the effect of cash-transfer programs, this was broadened to include in-kind transfer programs in order to allow for a large enough sample of respondents. The main variable was identified as the existence of a social protection support program – i.e., support provided for the benefit of increased social-economic resilience. The social protection programs included in this research were provided by the Government of Uganda, in collaboration with local authorities.

The variable trauma was hypothesized as mediating the effect of social protection programs on social-economic resilience, explained by the depressing effect of trauma on the processing of information. The hypothesis was formulated with specific relevance for highly traumatized populations.

This research was carried out among women in Northern Uganda, as studies have indicated that the trauma among these women is very high and that they have less capability than men to improve their situation due to disempowerment, which is heightened by the trauma and its gender-sensitive nature (gender-based violence as a source of trauma is highly prevalent in Northern Uganda). In this research, the highly-validated Revised Impact of Events Scale (IES-R) was used to measure the prevalence of trauma and confirmed the high level of trauma among the women studied. Focus groups held in four districts confirmed the deep trauma and sense of abandonment of these women. They expressed a high degree of helplessness and disempowerment. Even for the researchers, the women's stories were

harrowing and came across as very alive and present in their current situation, despite the long time that had passed since these events happened. The mental processing of the traumatic events was not complete – or had not even begun. As a result, the participants reported feeling that the fear instilled in them by the trauma was still present.

The study was particularly relevant given that local women's groups participated in the peace process in Northern Uganda following a 20-year civil war that impacted violently on the population. Many girls and women were abducted to serve in the Lord Resistance Army and were victims of severe gender-based violence and crimes; the war also produced internally displaced people (IDPs) who were the victim of violence in the IDP camps or while living in unprotected rural areas. Women's groups had identified dealing with the high level of trauma as a priority in the Peace, Development and Recovery Program, which has been implemented since 2007. In a recent study by the United Nations Development Program (UNDP), the focus on trauma has disappeared, despite the extremely high prevalence of post-traumatic stress (PTS) among women in Northern Uganda still today. About 85% of the respondents in this study reported experiencing high levels of PTS. Trauma among elderly women was higher than among younger women. Given the extremely high number of persons with PTS, and the severity of the level of PTS, it can be concluded that collective trauma has the potential to hinder programs promoting livelihoods in Northern Uganda.

This study was carried out in Amuria, Lira, Katakwi and Kitgum in Northern Uganda. A total of 475 participants were surveyed. In addition, seventy interviews and seven focus group interviews were conducted. The social protection programs included in this study are: the National Agricultural Advisory Services (NAADS), Northern Uganda Social Action Fund (NUSAF), Uganda Social Assistance Grants for Empowerment (SAGE), Restocking program, Community Driven Development (CDD) program, and Youth Livelihood Program.

In this study, the Social-Economic Resilience Scale (SER) was used to measure the economic improvement of the participants, defined in terms of livelihood, as set out by Chambers and Conway (1992):

> *[A] livelihood comprises the capabilities, assets (stores, resources, claims and access) and activities required for a means of living: a livelihood is sustainable which can cope with and recover from stress and shocks,*

> *maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation; and which contributes net benefits to other livelihoods at the local and global levels and in the short and long term.* (Chambers and Conway, 1992, p.6)

This definition is the basis of the formulation of the objectives of social protection programs. The SER was developed for this research and comprises the following six constructs, derived from this definition:

1. Perceived capabilities: Assets for running the household.
   - Financial capabilities: Is the budget sufficient for food, health and education?
   - Competences: Have my skills and knowledge increased?
   - Information capabilities: Do I have access to the information I need?
   - Social capabilities: Can I handle social issues in the household?
2. Income
   - Improvement of income opportunities
   - Self-determination regarding income
   - Realized improvement of (household) income
   - Realized financial buffer
3. Social inclusion
   - Attachment with community
   - Attachment with family
4. System: Feeling of security
   - Security regarding legal issues (rights and access to legal services)
   - Accessibility of medical and financial services
5. Empowerment: A change in agency and behavior
   - Self-determination
   - Self-worth
   - Change in transformative values
6. Experiencing less worry

In order to measure the cost versus benefit of providing relief for PTS on the effect of social protection for social-economic resilience (including income), an experimental design was set

up to measure the differences in effect. The first wave comprised four groups: (i) respondents who received only social protection (cash and in-kind); (ii) respondents who received social protection (cash/in-kind) and counselling to help address PTS; (iii) respondents who received both social protection (cash/in-kind) and counseling and (iv) the control group of respondents who did not receive any support.

The results of the first wave show that trauma has an independent effect on capability, income and empowerment and there is a positive relation between support for relief of PTS and enhanced scope of livelihood. The study explicitly found a positive relation between counseling programs and income. Support for relief trauma was found to have an independent effect on income and, whilst the social protection programs (cash/in-kind) also show a significant positive effect on income and social economic resilience more broadly, the independent effect of support for relief of PTS is significantly higher. Moreover, the combination of social protection support and support for relief of PTS provides the highest effect on income and on social economic resilience more broadly. This effect is significant.

The effect of support for the relief of trauma was independent and the hypothesis that support to trauma has a mediating effect on the effect of social protection on income and social economic resilience should be rejected. This study concludes that support for relief of trauma has its own effect on income and social economic resilience.

This study found that the effect of support for the relief of PTS on income and social economic resilience was higher than the effect of social protection programs. It can, therefore, be firmly concluded that supporting trauma relief is more beneficial than social protection programs in terms of improving income and social-economic resilience, even though social protection programs do also show a positive impact on income and social-economic resilience.

This conclusion justified the original prioritization by women in Northern Uganda, namely that relief of PTS should be urgently addressed within the recovery program.

The original research question of this investigation appears, therefore, to be extremely relevant, as it informs the further question: what would be an optimum cost-benefit package for offering relief to enhance social-economic benefits in Northern Uganda?

In order to consider this question, a number of issues were considered based on the analysis of the first wave. The conclusions drawn were that the existing counseling support programs are limited in terms of their ability to reach a large number of women; they are also time intensive and require the presence of a substantial number of mental health workers, which are not available in reality. The existing programs rely on external funding and resources and, as much of the support for trauma relief has been withdrawn, many of the women who participated in the study had never received any such support.

Another problem identified from the interviews was that the method of counseling required extensive re-narration of the traumatic events and that severely traumatized women could not be reached through such methods due to avoidance.

Taking all of these factors into account, a set of criteria was established by the research team to design a program to relieve PTS:

- Minimum cost for maximum benefit
- Upscalable (not dependent on trained health workers)
- Contextualized (for maximum impact)
- Availability of back up services for referral of patients if necessary

The program designed was called the Self Help Low Cost Post Traumatic Stress (SHLCPTS) program. This program relied on the Eye Movement Desensitization and Reprocessing (EMDR) self-help method, which was specifically designed to address PTS. A light version of the program was put together and contextualized with the help of local radio stations and translated into local language with a choice of wording that would appeal to people in the local communities. Recognizable local community voices were invited to provide the voice for the recordings. The result was a program of six sessions, divided into three main parts: (i) education about trauma; (ii) exercises (what to do about trauma); (iii) bringing participants back with agency into the families and communities where they live.

The program was implemented as an intervention in the four districts among selected groups with a post-measurement in-group design. The following groups were distinguished: (i) respondents who received only social protection (cash and in-kind); (ii) respondents who received social protection (cash/in-kind) and counselling; (iii) respondents who received both social protection (cash/in-kind) and counseling; (iv) the control group of respondents

who did not receive any support; (v) respondents who received social protection (cash and in-kind) and SHLCPTS; (vi) respondents who received social protection (cash/in-kind), counselling and SHLCPTS; (vii) respondents who received social protection (cash/in-kind) and counseling and SHLCPTS; and (viii) the respondents who received only SHLCPTS.

The respondents were assigned to SHLCPTS using purposive sampling and, therefore, the baseline of the two groups is slightly different. Compared next to each other, the two groups (with SHLCPTS and without SHLCPTS) show precisely the same results:

- Counseling and SHLCPTS have a higher positive effect on income and social economic resilience than social protection programs (cash/in-kind support);
- Social protection programs and counseling and SHLCPTS have an independent positive effect on income and social-economic resilience;
- Counseling and SHLCPTS do not have a mediating, but do have a direct effect, on income and on social economic resilience.

The SHLCPTS program has a very low budget design and has proved to be upscalable, including through radio programs. In fact, many radio stations included the sessions in their programming.

The conclusion of this research is that the inclusion of support for trauma relief in social protection programs is desirable to maximize impact on income and social economic resilience. Support for relief trauma should be prioritized over social protection programs given its higher significance in all three measures (Wave I and 2 and with SHLCPTS). Trauma relief has its own independent and higher effect on income and social economic resilience.

In terms of cost-benefit effectiveness, the program is certainly feasible given the cost-effective nature of the SHLCPTS program and its upscalability. In addition, the participants were found to be extremely happy with the program and its results and they reported extensively on the positive effects it had had in the interviews that were carried out and in public testimonies. Regarding the local district authorities, the program was positively reviewed and in some instances implemented (using funds sourced by the local authorities). This perception of, and eagerness to implement, the program triangulates the findings of the survey, in that the program was effective in supporting increased income and social economic resilience.

The interviews show various interesting elements that may help explain the success of the program. First, the participants reported that the program had triggered a sense of control over their lives. It was observed during the intervention that women who had passed the first phase of the intervention (the phase of education on trauma) had increased motivation to carry on with the sessions. This reported sense of control was further enhanced by the exercises, which stimulated the processing of the traumatic events. Although the researchers do not believe that the program alone is sufficient to enable participants to process their severe traumatic events, but within the isolated environment without any support or services, the simple exercises provided gave the participants an ability to start to control the effects of the PTS and begin processing it. In this way, the program is a 'game-changer': from a situation of hopelessness and lack of prospects, the women began to look towards the future.

The third phase of the program, bringing the women back into their families and communities, also had a magnifying impact. A few months later, the women reported that they were assisting other women, their husbands and their fellow community members to manage their PTS through the education and exercises that they had been given. Women who had participated in the program became positive agents of change within the community, providing support for the relief of PTS.

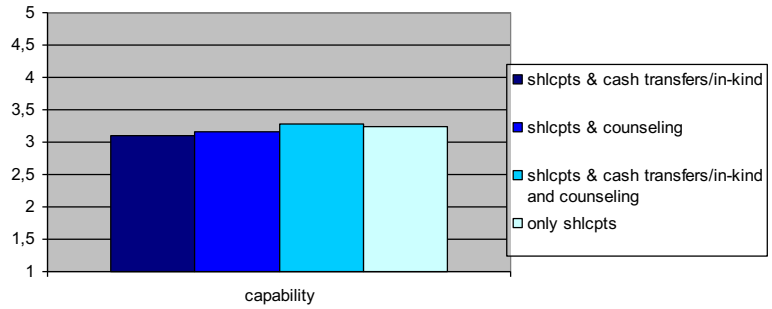
The Government of Uganda and the leaders of Lira district gave great tribute to the participants by organizing and attending the commemoration of the massacre in Barlonyo, recognizing the pain and suffering that took place in the past and providing the resources with which to strengthen the communities to move forward into the future. The counseling program provided mental healing and a window of change – it helped the women to see that it was possible to walk from the past into the future. Many asked to be able to participate in the SHLCPTS program, seeing the empowering effect it had on the participants.

Empowerment was found to be systematically related to the increase in income. This underscores the theoretical underpinning of this research, which is that negative feelings depress the positive results of social protection programs, limiting their ability to increase income. The empowering effect of the social protection programs and the relief programs for PTS explain the increased effect on income and social economic resilience. This is also the

case with the increase in capabilities, an important element of livelihood, and which systematically correlated in this research with the increase in income.

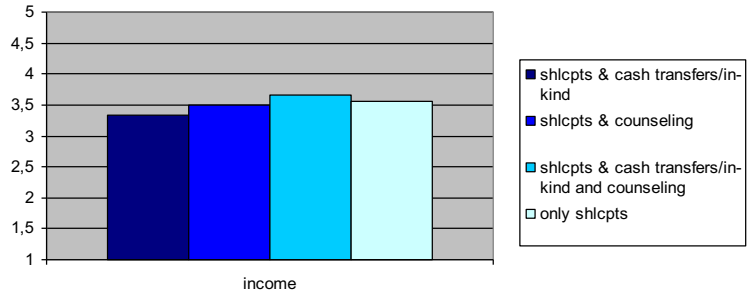
The main conclusion of this investigation is that the effect of support for the relief of trauma in severely traumatized communities is positive in terms of increased income and increased social economic resilience (capability and empowerment). The effect was significant in the three separate measures.

Graph a: Effect of programs on income (wave 1)

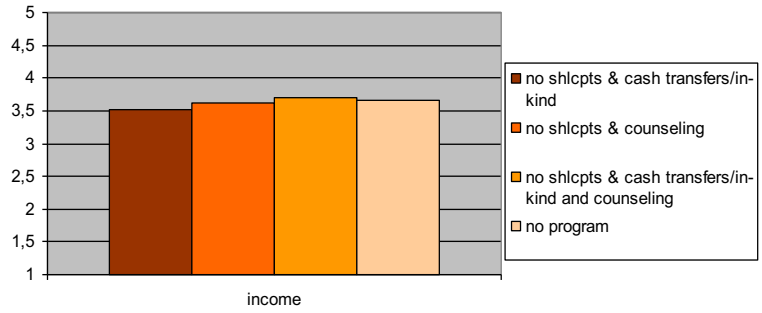


The groups (that received different programs) do differ significantly on capability. Those who received both cash transfer/in-kind as well as counseling score higher on capability (significant interaction effect $p < 0.05$).

Graph b: Effect of programs on income (wave 2, with SHLCPTS)



Graph c: Effect of programs on income (wave 2, without SHLCPTS)



The groups (that received different programs) do differ significantly on income. This difference can be attributed to counseling ($p=0.10$), SHLCPTS ($p=0.10$) and receiving both cash transfer/in-kind and counseling (significant interaction effect, $p<0.05$). Those who received counseling have higher expectations about income. Those who received SHLCPTS have lower expectations about income (due to sampling bias). And those who received both cash transfers/in-kind and counseling have higher expectations about income.

It can therefore, be firmly concluded that support to trauma relief in general and the SHLCPTS program in particular has had a significant positive effect on economic resilience. It is recommended that its workable elements are further investigated, including in other locations and contexts. Based on this research it can be expected that the integration of the SHLCPTS-program into Uganda's social protection policy will reduce its costs, while increasing impact on economic return.

PART I: CONTEXT AND BACKGROUND

2. Introduction

In June 2015, The Dutch Science organization program, NWO-WOTRO, awarded Tilburg University and its partners a two-year project entitled 'Cost-Benefit Analysis of Cash Transfer Programs and Post Trauma Services for Economic Empowerment of Women in Uganda (EWP-U)'. The consortium implementing the program consisted of Mbarara University of Science and Technology, Makerere University and Isis-WICCE. Mbarara University coordinated the study in Uganda. Makerere University provided expertise on the gender-related aspects of the trauma of women in Northern Uganda. The ethical approval was obtained by Mbarara University. Isis-WICCE provided trauma services and assisted in the identification of research sites and contacts and resource persons for carrying out the research.

This research is part of a program investigating the economic potential of social protection in developing countries. This particular research was carried out in Northern Uganda, a region in which the Government of Uganda has taken a particular interest in supporting rehabilitation. The region has suffered from years of conflict and the social protection programs of the Government of Uganda are particularly targeted to support the rehabilitation and reintegration of former abductees of the Lord's Resistance Army (LRA).

This research looks at the cost-benefit of introducing trauma services in the preparation of social protection programs in the region. The purpose is to solve the problem of many organizations active in Northern Uganda and in other post-conflict regions, which have experienced depressed uptake of social protection programs due to severe trauma among the population. This research aims to identify whether post-traumatic stress mediates the effects of social protection efforts on social-economic resilience.

Women have been particularly affected by trauma, which they experienced as abductees of the LRA and have been impacted on by sexual and gender-based violence. This study focuses on women, so as to carry out the research among the most severely-impacted population group and to investigate a more or less homogeneous group of respondents in terms of the nature of trauma experienced.

The NWO-WOTRO program has a strong emphasis on policy relevance and the Government of Uganda and other service providers have taken a keen interest in assisting with

rehabilitation in Northern Uganda since the defeat of the LRA. The dissemination and uptake is reported in a separate valorization and dissemination report, which describe all international and local conferences, meetings and presentations where the results of the project were presented.

This report is the first comprehensive write-up of the research, how it was implemented and its results. There are two small sets of data that are still being analyzed and which will be published: the analysis of change in values (inspired by the Barrett method) and the analysis of the long-term impact of the Self Help Low Cost Post Traumatic Stress (SHLCPTS) program on the Impact of Events Scale. Additional data on an extra control group will also be used to publish the data in academic public fora.

The atrocities committed in Northern Uganda have left serious scars and a highly traumatized and impoverished population, a situation that needs to be addressed, preferably in the most cost-effective way to maximize the positive results for the people in Northern Uganda, so that their hope of long-lasting peace and development can be realized.

3. History of the Conflict in North and Eastern Uganda

Uganda is a former British colony situated in Central Africa and a member of the East African Community. The country had a population of 37.7 million in 2017 (Uganda Bureau of Statistics, 2017). The largest ethnic groups are Baganda (16.5%), Banyankole (9.6%), Basoga (8.8%), Bakiga (7.1%), Iteso (7%), Langi (6.3%), Bagisu (4.9%), Acholi (4.4%), and Lugbara (3.3%), with other groups making up the remainder (32.1%) (2014 estimate) (Central Intelligence Agency (CIA), 2018). The Northern Ugandan provinces are populated by the Iteso, Langi, and Acholi, as well as the smaller ethnic group, the Karamoja.

3.1. **Civil war**

For over two decades, since the late 1980s, the Lord's Resistance Army (LRA) waged a war against the Ugandan People's Democratic Army and the people of Northern Uganda. The extreme brutality of the conflict resulted in the total destruction of the region and the displacement of over 1.5 million people, turning Northern Uganda into a humanitarian disaster zone. Tens of thousands of adults and children were abducted to serve as soldiers, porters, and sexual partners for the commanders (Fazel, Bains, & Doll, 2006).

The civil war in Northern Uganda began in 1986, when Uganda's current president, President Musevini, came to power. The National Resistance Army (NRA), later renamed the National Resistance Movement (NRM), took over power and the LRA decided to fight the new government (Apuuli, 2006). The LRA began as an evolution of 'the Holy Spirit Movement' led by Alice Lakwena. When Alice Lakwena was exiled, her nephew Joseph Kony took over as leader of the LRA. With the change of leadership, the rebel group lost regional support, which prompted Kony to engage in acts of self-preservation, characterized by stealing supplies and abducting children to fill his ranks. The rebels started a campaign of terror that included child abduction, mutilation, murder and general destruction. The conflict was at initially mainly concentrated in the districts that make up the Lango and Acholi ethnic sub-regions (*ibid.*).

The conflict in Teso sub-region can also be traced to around the same period of time, following the escape soldiers from the Tito Okello Lutwa (one of the former presidents of

Uganda) regime, which was defeated by the government forces of the NRA. The Teso region was attacked by other rebel groups, such as the Uganda People's Defense Force (UPDF), the Force Obote Back Group (FOBA), and the Holy Spirit Movement (HSM) led by Alice Lakwena, which advanced to Kampala from Northern Uganda through the Teso sub-region (*ibid.*).

3.2. **Abductions, killings and displacement**

The LRA attacks consisted of "abductions, killings, [the] burning and looting of villages and homes, and ambushes on vehicles", which escalated sharply in 2002 (Human Rights Watch (HRW), 2003a). Due to government displacement orders, 800,000 people were displaced, comprising 70% of the population (HRW, 2003a). The Operation Iron Fist launched by the UPDF in South Sudan failed to reduce the number of adductions of children by the LRA, which rose to a conservative estimate of 20,000 children (HRW, 2003b). The abduction of children and youth into armies has been a brutal and common feature of the conflict in Uganda. The United Nations suggested that during the prolonged civil war, a total of 25,000 children were forced to enlist as soldiers, with the girls forced into sexual slavery (UN News Centre, 2004). The children met with unspeakable brutality:

> *The LRA uses brutal tactics to demand obedience from abducted children. Children are forced to beat or trample to death other abducted children who attempt to escape, and are repeatedly told they will be killed if they try to run away. Children who fall behind during long marches or resist orders are also killed. Many others have been killed in battle or have died from mistreatment, disease and hunger. (HRW, 2003b, p. 4)*

The abduction of women and girls was also a particularly devastating and defining feature of the conflict. An estimated 10,000 girls became forced child mothers as a result of LRA abduction between 1988 and 2004. Another 88,000 girls, who were not abducted, became child-mothers due to conditions in the internally displaced person (IDP) camps, often as a result of rape (Akelo et al., 2013). Human Rights Watch (2003b) described the subjection of girl-children to gender based violence as follows:

> *Girls are used as domestic servants for commanders and their households. At age fourteen or fifteen, many are forced into sexual slavery as "wives" of*

> *LRA commanders and subjected to rape, unwanted pregnancies, and the risk of sexually transmitted diseases, including HIV/AIDS. (HRW, 2003b, p. 2)*

Children were afraid of abductions, but equally lured into the operations of the UPDF as child soldiers (HRW, 2003b). Vink, Phanc, and Stover (2007; 2009) reported that as a result of LRA activity in Northern Uganda, thousands of civilians were killed and mutilated and an estimated 52,000 to 75,000 people were abducted and served in the capacity of soldier, porter or sex slave.

3.3. **Expansion of operational areas of the Lord Resistance Army**

As a consequence of the military operations of the UPDF in Southern Sudan, the LRA was able to expand the area in which it operated from Gulu, Pader and Kitgum districts to the districts of Lira, Apac, Katakwi and Soroti (Apuuli, 2006). Civilians were crushed between the UPDF and the LRA and the number of IDPs rose to 1.2 million people (HRW, 2003a). The IDPs were vulnerable to attacks by the LRA and living in dangerous situations, exposed to unclean water and malnourished without access to health services (HRW, 2003b). In such situations, illnesses such as HIV/AIDS could rapidly spread. The LRA's widespread vicious attacks and abductions left Teso devastated. Thousands were killed or abducted, including children, and hundreds of thousands of civilians fled south. Unlike in the Acholi and Lango sub-regions, the LRA met such strong resistance in Teso that they were ousted by January 2004.

Unlike the Lango and Acholi sub-regions, which attribute much of the conflict they had in their districts to the LRA, in Teso other factors contributed to the situation. Following the defeat of the LRA, the Teso sub-region was affected by cattle-rustling groups from the neighboring Karamajong tribe. After the overthrow of Amin's regime in the Obote coup of 1979, fleeing soldiers left their armories open in Karamoja and the Karamajong replaced their spears with guns, enabling them to pursue their traditional practice of cattle raiding on a more extensive and devastating scale. This particularly affected Teso, as the Karamajong ravaged the area, destroying homes, schools and clinics, stealing their cattle and killing many people. The militarization, due to the UPDF's efforts to defeat the LRA, exacerbated tension between the Karamajong and Teso people (Bainomugisha, Okello, & Ngoya, 2007).

About 80,000 people from the Iteso ethnic group have now been living in camps for protection for up to 25 years. The Teso and Karamajong, who lived side-by-side for

centuries, have been living in conflict and uncertainty leading to impoverishment. The proportion of Karamoja people living in poverty of the highest in Uganda, with 82% of the population of Karamoja and 66% of the population of Teso living in poverty, according to the Ugandan Bureau of Statistics in 2006 (cited in: Chapman & Kagaha, 2009).

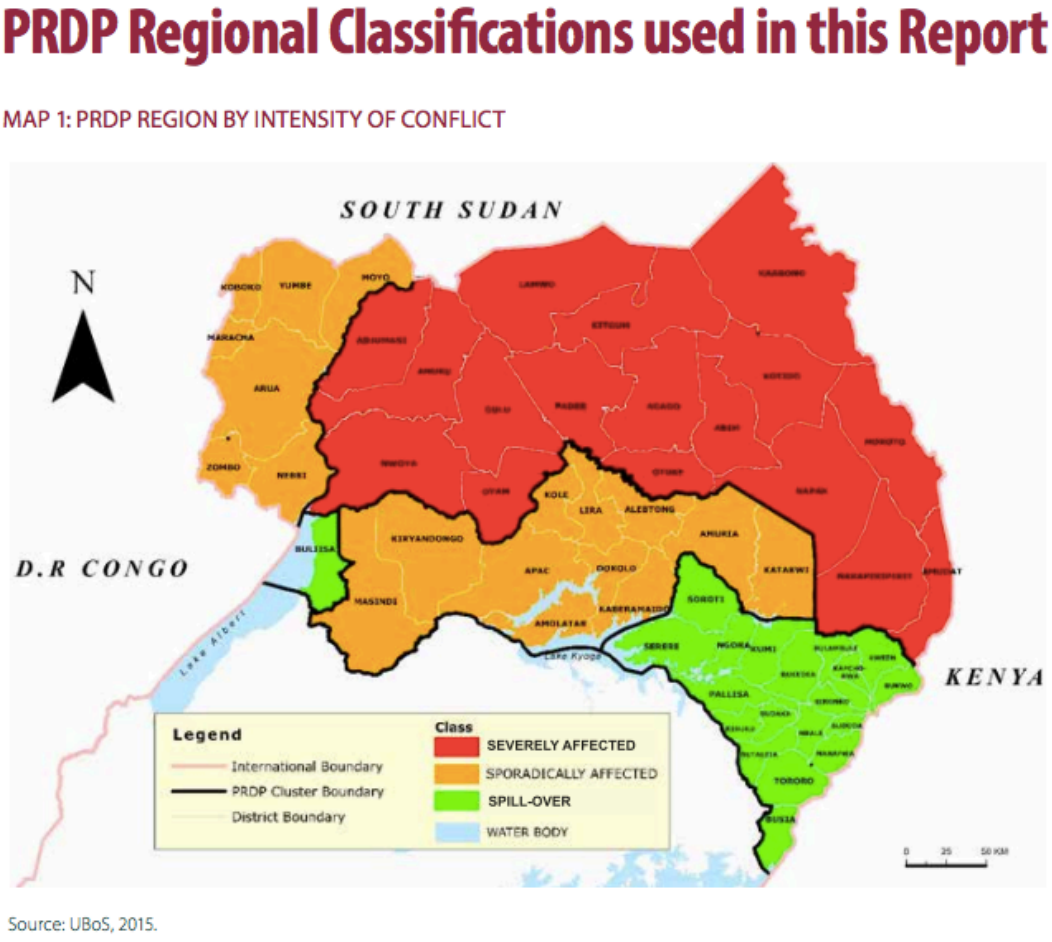
3.4. **Women's participation in the Peace, Recovery and Development Plan**

In 2006, peace talks started 1.8 million IDPs lived in camps. (United Nations, 2008). Formal peace negotiations began in 2005 in Juba under auspices of the United Nations during a time of relative 'calm', with the drafting of a Peace, Recovery and Development Plan (United Nations, 2008).

The Uganda Women's Coalition for Peace (UWPC) was formed to respond to the lack of women's voice in the peace negotiations, established in late 2006. The purpose of the coalition was to ensure that women's needs, concerns and priorities were addressed in the negotiations and subsequent rehabilitation efforts. The organization Isis - Women's International Cross Cultural Exchange (Isis-WICCE) participated in the coalition and collected information on women's priorities for peace through its existing networks of relations with women in Northern Uganda (Nakubeera-Musoke, n.d.).

The peace negotiations resulted in the first Peace, Recovery and Development Plan (PRDP) for Northern Uganda agreed in 2007. The PRDP aimed specifically at stabilization of Northern Uganda and the promotion of socio-economic development. It followed on the earlier government programs, with the distinction that it was focused on peace-building and on the relief of the trauma in the communities. This reflected the priorities from the communities communicated through the engagement of UWPC in the peace process (United Nations, 2008). The implementation of the PRDP began in 2009 and covers 55 districts in Northern Uganda. It has been supported by the Government of Uganda and development partners and resulted in the PRDP 2 and 3.

Figure 3-1. Map of Peace, Recovery and Development Plan (Uganda Bureau of Statistics, 2015, printed in UNDP, 2015)



Source: UBoS, 2015.

In a comprehensive assessment of the PRDP, UNDP (2015) analysis the program in terms of its impact on economic resilience. It also includes an analysis of its impact on gender equality. However, the UNDP assessment does not analyze the way in which trauma affects the PRDP and trauma as a component is no longer programmed in the PRDP. This begs the question as to whether the original call of women and women's groups in Northern Uganda has been satisfied.

Women's organizations have continued to raise the concern of PTS and its continued prevalence in Northern Uganda. In another research, we collected the practical experiences of women's organizations engaging in rehabilitation efforts in peace-building, including in Northern Uganda. This research project was carried out by Tilburg University resulting in a publication in 2015, entitled *Women's Leadership in Peace Building: Conflict Community and Care* (van Reisen, 2015). One of the contributions to this book specifically considered the priorities of women in the rehabilitation process in Northern Uganda. The analysis addressed

the relationship between programs focused on livelihoods in relation to addressing the need for healing of trauma in terms of enhancing the role of women in peace-building efforts. The author of this chapter, a practitioner in Northern Uganda wrote:

> *Livelihood oriented activities […] are also an important part of the peace building package. These provide women's communities with assets, skills and tools, which contribute to the improvement of their living conditions. Secular organizations such as Isis-WICCE, have also played a key role in the important area of trauma healing and in organizing international exchange for locally rooted community organizations.* (Ngeudjeu-Momekam, 2015, p. 375)

The concern raised in this research was the high prevalence of trauma among women and the observation of such trauma left unaddressed depressing the impact of the rehabilitation efforts. The question appeared of relevance not only to Northern Uganda but also to other post conflict situations, such as for instance Rwanda, South Sudan and Liberia (Van Reisen, 2015).

Hence, the research question identified for this research emerged from this question by practitioners, that in order to sustain the peace and strengthen of efforts towards the rehabilitation of Northern Uganda, both livelihoods and mental health needed to be enhanced. The research focuses on the way in which trauma impacts on livelihood programs and, more specifically, on whether efforts to support post-traumatic stress positively improve the effects of social protection programs aimed at improving livelihoods.

The aim of this research is to identify whether the claim if women's organizations working in Northern Uganda is right, which is that the impact of social protection support to women in Northern Uganda is depressed due to unaddressed PTS which women still suffer from.

Part II: RESEARCH QUESTIONS AND THEORETICAL FRAMEWORK

4. Research Questions and Design

4.1. **Research gap**

Initiatives on social protection have shown that even small amounts of money paid reliably and regularly can make an enormous positive impact on people's lives (Ministry of Gender, Labor and Social Development (MGLSD), 2010). According to the description of social protection, it has specific objectives, which are related to food security and nutrition, decent employment, and reducing overall inequality, especially gender inequality (see, for example, Food and Agriculture Organization (FAO), 2017). The objectives can also be framed in terms of better managing risks and active participation in all spheres of life (Holmes & Lwanga-Ntale, 2012).

On the basis of the definitions of social protection (for an overview, see section 4.11.1), the key objective of social protection is construed as enhancement of social and economic resilience or sustainable livelihoods.

The definition of livelihood provided by Chambers and Conway (1992):

> *"[A] livelihood comprises the capabilities, assets (stores, resources, claims and access) and activities required for a means of living: a livelihood is sustainable which can cope with and recover from stress and shocks, maintain or enhance its capabilities and assets, and provide sustainable livelihood opportunities for the next generation; and which contributes net benefits to other livelihoods at the local and global levels and in the short and long term." (Chambers and Conway, 1992, p.6)*

In this research, the focus is on the individual level of livelihood (not the family or community level).

Following from Chambers and Conway (1992), the Sustainable Livelihood framework (DFID, 1999), emphasizes that sustainable livelihood comprises of the expansion of choice, opportunities for self-determination and the flexibility to adapt over time. All of these characteristics refer to a positive, open mindset (requiring a context that enjoys a minimum level of peace). Consequently, it can be assumed that, at a theoretical level, the

improvement of (individual) livelihoods can be achieved by a change in mindset or values—from reacting to a hazard or danger to pro-active behavior that is future-oriented. This change in mindset has an effect on how people perceive opportunities and threats in their current situation, as well as their routine ways of evaluating situations and responding accordingly (referred to as agency).

Trauma can hinder the change in mindset that can be initiated by social protection. In a state of trauma, people are overwhelmed by negative emotions. These negative emotions affect the way people perceive and evaluate the social protection they receive. According to the feelings as information theory (Schwarz, 2010), people regard their feelings as a source of information. One usually assumes that the feelings that are experienced are 'about' whatever is the focus of one's attention, unless it is attributed to a specific incident (Schwarz, 2010). People who have been traumatized experience an intensive negative mood. As moods are not triggered by a specific incident, this negative state will also impact on how the social protection program is perceived. Consequently, the social protection is not regarded as a new start (a positive opportunity), but as temporally relieve of a bad situation. If trauma is not healed, people have trouble changing their mindset, despite the social protection that is offered.

The objective of social protection is that people feel more secure and perceive an expansion of all kinds of assets. Moreover, they gain a different orientation towards life. At a theoretical level, this different mindset can be captured in a change of values. The term 'value' has been defined as an enduring prescriptive or proscriptive belief that a specific end state of existence or specific mode of conduct is preferred to an opposite end state or mode of conduct for living one's life (Kahle, 1983; Rokeach, 1968; 1973) (see also section 4.11.1).

Values are understood by Barrett (2014) as shared perceived values of an individual and community. According to Barrett misalignment of values in an organizational system undermines its effectiveness. Barrett identifies that a culture and values transform functions best if there are quality relationships, and he argues that transformation begins with the conversations (about values) that happen within those relationships. An organizational system can be a company, a community or a society. When the values of the organization or community-system are more aligned, then the members of the community-system will be able to bring more effort and positive energy to contribute to it.

The distance between these perceived values can be measured and the distance between values is an indicator of the alignment of shared values within the system. Entropy is defined as the level of misalignment in perceived values, which undermines the effective functioning of a community and is seen by Barrett (*ibid.*) as a cause for the dysfunctionality of an organizational system, which he calls 'entropy'.

In line with the objective of social protection, the values of an individual should be less oriented toward (individual) survival and more toward self-actualization (self-determination), social inclusion and happiness. The same counts for the values that the individual perceives the community has. Consequently, these sets of values should be more in accordance with the objectives of social protection after social protection programs.

4.2. Operationalization of social and economic resilience

The effects of social protection show itself in social and economic resilience (see also section 4.11.1) and especially in empowerment (see section 4.12.2). In this research, the social and economic resilience tool was developed. This tool is suitable for the situation in Northern Uganda and consists of the following components:

4.2.1. Perceived capabilities: Assets for running the household.

- Financial capabilities: Is the budget sufficient for food, health and education
- Competences: Have my skills and knowledge increased
- Information capabilities: Do I have access to the information I need
- Social capabilities: Can I handle social issues in the household

4.2.2. Income

- Improvement of income opportunities
- Self-determination regarding income
- Realized improvement of (household) income
- Realized financial buffer

4.3. Social inclusion

- Attachment with community
- Attachment with family

4.3.1. System: Feeling of security

- Security regarding legal issues (rights and access to legal services)
- Accessibility of medical and financial services

4.3.2. Empowerment: A change in agency and behavior

- Self-determination
- Self-worth
- Change in transformative values

4.3.3. Experiencing less worry

This research will explore whether social and economic resilience increases due to the social protection implemented in Northern Uganda by the Government of Uganda. In addition, this research investigates the mediating effect of support in trauma relief on the positive impact of social protection on social and economic resilience is also investigated. The relationships between the different theoretical concepts mentioned are summarized in theoretical framework presented in Figure 4.1. (Ajzen, 1991; Barrett, 2014; Chambers & Conway, 1992; DFID, 1999. Kahle, 1983; Kahle, 1983; Rokeach, 1968; 1973.)

4.4. Objective of the study

The population in Northern Uganda has been impoverished as a result of the long civil war, which lasted from 1987 to 2006. The Government of Uganda is making a concerted effort to rehabilitate the affected regions. Social protection programs (including cash transfers) have been developed to support the rehabilitation efforts. The civil war also caused the population to suffer from post-traumatic stress (PTS), as diagnosed in various psychiatric studies (see chapters 6 & 7).

In a state of trauma, people are overwhelmed by a negative mood. This mood affects the way they perceive and evaluate the opportunities available (including social protection received) (Kahneman, 2011; Schwarz, 2012). In a traumatized state, people will not regard social protection as a new start (a positive opportunity), but they will see it as a temporary relieve of a bad situation. We can therefore assume that if trauma is not healed, people can be hindered from using social protection programs as a stepping stone to social-economic

integration. Therefore, it is probable that PTS can hinder the effectiveness of social protection programs for social and economic resilience (SER).

This study investigates the relationship between (1) social protection programs (cash-transfers or in-kind) and (2) trauma treatment, and (3) their impact on socio-economic integration in post-conflict areas. The study sought to determine the relationship between social protection programs (cash transfers or in-kind) and the social-economic development of individuals in post-conflict areas, as well as the impact of trauma treatment on the social-economic development of individuals in post conflict areas and the effectiveness of radio/social mediated programs for the support of post-traumatic stress in enhancing the effect of social protection on social economic resilience.

The main objective of the study is to establish the (mediating) effect of support for the relief trauma on social economic resilience from social protection support (see also Figure 4.1). The aim is to understand the beneficial effects of trauma counselling on the effectiveness of social protection in building social economic resilience. It is expected that the study will provide a cost-benefit analysis of trauma support as an additional component of social protection (which focuses only on supporting rehabilitation through support in the form of economic transfers, such as cash or in-kind contributions).

4.5. **Research question and sub-questions**

The overarching research question is:

> *Does support to relief trauma positively affect the relationship between social protection and social economic resilience?*

The sub-questions are:

1. *What is the prevalence of post-traumatic stress in the population of Northern Uganda (districts affected by the 20 years of civil war)?*
2. *What social protection programs have been initiated by the Government of Uganda for the rehabilitation of people in the districts in Northern Uganda?*
3. *What is the effect of social protection transfers on social economic resilience?*
4. *What is the effect of trauma support interventions on social economic resilience?*

5. *What is the combined effect of social protection and trauma support on social economic resilience?*
6. *What is the effect of the Self-help Low-cost Post Traumatic Stress (SHLCPTS) program to support trauma in post-conflict areas?*
7. *What is the impact of trauma support programs on trauma and how do traditional methods of counselling compare to the SHLCPTS program in terms of impact on lowering the impact of PTS?*
8. *What is the upscaleability of the SHLCPTS program?*
9. *What is the change in Value Transformation as a result of Social Protection and Trauma Services?*
10. *What are the costs of social protection programs and of trauma programs, and what is the most cost-effective solution to support rehabilitation in Northern Uganda?*
11. *What are the cost-benefits for Uganda of including Post-trauma stress relief programs to support the positive effects of social protection on social-economic resilience?*

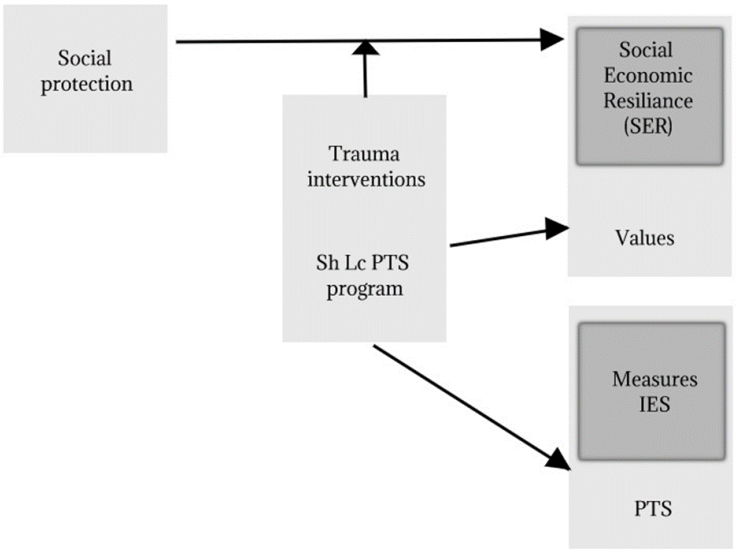


Figure 4-1. Relationship between the variables social protection, trauma and SER

In the framework (see Figure 4.1), it is assumed that support for trauma relief has an effect on social and economic resilience. Support for trauma relief decreases the (impact of) the negative emotional state caused by trauma. As a consequence, people adopt a more positive

mindset, making it possible for them to see the opportunities offered by the current situation (independent from social protection). Furthermore, trauma relief can make them view social protection as an opportunity to increase their social and economic resilience.

In other words, the framework assumes that support to trauma relief decreases trauma; this hypothesis underpins the main research question. It is posited that social protection support enhances the social economic resilience of recipients, but that the effect is mediated by the level of trauma, and that support for the relief of post-traumatic stress will improve social economic resilience.

4.6. **Hypotheses**

The hypotheses, regarding the research question, can be summarized as follows:

> **Hypothesis 1:** Social protection enhances social economic resilience
>
> **Hypothesis 2:** Support for trauma relief mediates the positive relationship between social protection and social economic resilience

In addition, this research will test the following hypotheses:

> **Hypothesis 3:** The level of trauma in Northern Uganda remains high (the norm is set according to Creamer, Bell & Failla, 2003, p. 1494)
>
> **Hypothesis 4:** The level of trauma is reduced by support on trauma relief

In order to test these hypotheses, the research made use of two scales:

> **Scale 1:** Social Economic Resilience Scale (SER) – developed for this research
>
> **Scale 2:** Impact of Events Scale (IES-R) – a highly validated scale used to measure the level of stress experienced as a result of previously experienced trauma

In order to examine the Cost-Benefit of inclusion of Relief-services to Post -Traumatic Stress an upscale able self-help and low cost post-traumatic stress (SHLCPTS) program was developed. The hypothesis was that this cost-effective program would significantly contribute to the positive impact of social protection programs on social-economic resilience. The research will test the following hypotheses:

> **Hypothesis 5:** SHLCPTS enhances social and economic resilience.

Hypothesis 6: SHLCPTS has a positive mediating effect on the relation between social protection and social and economic resilience.

Hypothesis 7: SHLCPTS has a positive effect on reduction of the level of trauma

Hypothesis 8: An upscalable form of Post-Traumatic Stress relief is a cost-beneficial solution for rehabilitation of Northern Uganda.

In order to test these hypotheses, the research made use of two scales:

Scale 1: Social Economic Resilience Scale (SER) – developed for this research

Scale 2: Impact of Events Scale (IES-R) – a highly validated scale used to measure the level of stress experienced as a result of previously experienced trauma

The research further expected values to change as part of the cultural transformation process initiated by the support programs (both cash transfer/in-kind social protection programs and Post-Traumatic Stress relief services):

Hypothesis 8: Respondents who received social support (compared to those who did not) have values that are more in line with the objectives of social protection.

Hypothesis 9: Respondents who received social support (compared to those who did not) think the values of the community are more in line with the objectives of social protection.

Hypothesis 10: The values of respondents who received social support are more in line with the values that respondents attribute to the community (compared to those who did not)

In order to test these hypotheses, the research will use a methodology, which was inspired by Barrett (2014), developed to measure Value Transformation and Entropy in Organizational Systems (Stokmans, Van Reisen and Landa, forthcoming). The methodology includes a qualitative and quantitative analysis. In order to test the hypotheses 9-10, it is necessary to:

- Define a list of values that reflect the objectives of social protection
- Develop a tool to capture the values of the individual and those that he/she attributes to the community

- Develop a similarity index that captures the correspondence between the values of an individual (and values attributed to the community) and the values that reflect the objectives of social protection

This procedure was developed and successfully applied in another research project and will be used to analyze the data concerning the values in this project. At present, a list of values is being developed that captures the objectives of social protection based on the list of values presented to respondents. The analysis of hypotheses 9-10 has not been completed and will be reported in the future.

4.6.1. Unit of analysis

The unit of analysis is the individual recipient of social protection support and of support to help relieve trauma. The analysis is carried out at a group level and a control group was included. The interactive effect of the individual change on the collective group change was controlled through an additional control group, which had no interaction with the research until the final measure. The comparison between the control group that participated in the research and the control group that only participated at the end will reveal the potential measurement effects of the study.

4.6.2. Timeline of the study

A literature review was conducted in order to scrutinize the available literature on the relationship between trauma, social protection and social economic resilience. The findings are provided in annex 2.

The research investigates the effect of existing government-initiated interventions for social support (cash or in-kind) and trauma counselling in Northern Uganda, next to the effect of a counselling program that was developed by one of the researches. The timeline of the research is summarized in Table 4.1. The effect of the social protection programs initiated by the government can be explore along the lines of a post-test only design, which encompasses two points of measurement (T1 and T2).

The program to provide support to people with post-traumatic stress was an intervention designed specifically for this research based on a set of criteria that emerged from the analysis of data from the first round of data collection (see section 4.9 and chapter 8).

Table 4-1. Summary of research activities by phase and time point

	Time points					
	T0: June- July 2015	T0: August 2015 – December 2015	T1: March/ April 2016	T2: Implementation September/ October 2016	T3: January/ February 2017	T4: July and November 2017
	T0	T0	T1	T2	T3	T4
Phase	**Phase 1:** Selection of sites according to research groups: 1. Cash 2. Counseling 3. Both cash and counseling 4. No support	**Phase 1:** Field preparation and scale development	**Phase 2:** Measurement of SER IES-R	**Phase 3:** 1. SHLCPTS – Program 2. No-SHLCPTS Program	**Phase 4:** Measurement of SER IES-R	**Phase 4:** Measurement of SER IES-R
Research activities			Survey Open Ended Interviews Observation	Training and implementation	Survey Open Ended Interviews Observation	Survey

SER = Social and Economic Resilience tool; IES-R = Impact of Event Scale-Revised

The effect of trauma support was measured in two ways. First, in T1, the effect of available programs by the government or other service providers was measured. T1 also provided the pre-measure for the experiment with the SHLCPTS program. Secondly, a support program was designed for the purpose of this research and offered to research participants through audio communication arranged with the help of local radio stations (and voices) (T2). The impact of both trauma support interventions was investigated through a post-test only design in T3 and T4).

4.7. **Experimental design and sampling of respondents**

The first phase of the project was for piloting tools and visiting study sites to establish contact with local women groups and local leaders. During this phase, the team reached out to the following districts: Soroti, Kaberamaido, Kitgum, Amuria, Oyam and Luwero.

There was a purposive assignment of respondents to the groups, as a real-life situation was being analyzed. The following groups were distinguished:

- cash (cash or in-kind, provided by the Government of Uganda)
- counselling (provided by NGO's or District)
- both cash and counselling (as above)
- no social protection (control group-

The second study (first and second wave) had a pre- and post-measure. Respondents were purposively assigned to the trauma support program developed by the researchers in collaboration with local authorities. The following groups were distinguished:

- SHLCPTS and cash/in-kind
- SHLCPTS and counselling
- SHLCPTS and both cash/in-kind and counselling
- SHLCPTS and no cash/in-kind nor counselling
- Only cash (cash/in-kind)
- Only counselling
- Both cash/in-kind and counselling
- No support (control group)

A second control group was added for post-measurement only in order to measure the potential impact of the research presence in the areas that may have affected the control group. The second control group participated in the survey only once and was unrelated to other locations included in the research and did not participate in any programs.

The Self-help Low-cost Post Traumatic Stress (SHLCPTS) program was prepared for the research — and it is described in Chapter 8. The SHLCPTS was provided through local radio broadcasts (made available during the research only to the participating groups).

The local authorities selected communities where the program could be administered. Those communities were selected because the authorities believed they suited the purpose of the study well, due to high level of trauma and low social and economic resilience. This somewhat diminishes the comparability of the results between the groups but does not affects the results within groups.

4.8. **Research design: Experimenting in real-life situations**

This research project can be characterized as a study to explore the effectiveness of an existing intervention in a real-life setting in rural Northern Uganda. A (quasi-)experimental set-up was used, as advised when the study's objective is to understand the causal effect of an intervention. The design of this study aims to isolate the intervention from other extraneous variables so that a link between effects can be established based on the theory that provides the hypotheses for a causal relationship. In a positivist approach, all variables are controlled and consequently causal conclusions are drawn. Although it is the most appropriate way of drawing causal conclusions, a controlled environment has the disadvantage that it removes from the experiment the knowledge of the effect of the intervention within a real-life situation. A controlled environment, thus, runs the risk of creating artificial situations that are not always representative of real-life situations.

Carrying out an experiment in a real-life situation has the important advantage that the intervention can be studied in its natural environment. The findings can, therefore, inform the researchers about the way in which the intervention responds within a real-life setting, which is not the case if the study is undertaken in an isolated environment. This is particularly relevant when the experiment is carried out in the environment that has a particular interest in the findings of the study, as was the case with this research.

A real-life set-up responds to an increasing demand for the research to be beneficial to society. The problem identified by many policymakers, who are interested in evidence-based decision making, is that research tends to be carried out in a sterile experimental set-up, which undermines understanding of what may be expected of an intervention in the real-life situation that policymakers are concerned with. It is, therefore, necessary to consider the research advantages and possibilities of studying interventions in a real-life context.

Before carrying out research on an intervention, critical questions need to be asked, such as: Is it possible to study the intervention?' If yes, is it possible to adhere to ethical standards to ensure validity of the research outcome? Is there any advantage in studying the intervention in question? Such critical questioning before conducting research on an intervention is carried out is peremptory as it helps us to identify and understand the limitations of a real-life methodology.

To advance a justification for the implementation of experiments in a real-life experimental setting, it should be acknowledged that this creates a complex study design. This is because questions on the sensitivity and sensibilities—questions that are critical in any research that involves humans—often arise. The purpose of this note is to articulate the benefits that the study in real-life situation can give and to propose the qualifications that need to be considered in this approach.

Usually, questions regarding the effectiveness of interventions are approached by obeying the rules set for an experimental design as much as possible (Shadish, Cook, & Campbell, 2001). In order to be able to make causal claims (the intervention caused the improvement), three important rules should be met:

- Respondents can be randomly assigned to treatment and control groups
- The treatment should be designed by a researcher on the basis of theory
- The treatment should be under the control of the researcher and therewith equal for each individual assigned to a specific group

The question that arises in view of these three rules is: Can respondents be fully assigned randomly in a real-life situation? Experienced researchers in research concerning human beings are usually aware that in real-life intervention studies, these rules often cannot be followed in a narrow sense. This is on account of their being dissociative and impractical in many real-life intervention studies.

The first rule, about the random assignment of individuals, for example, is complicated, as participation in research with humans (as emphasized by many ethical research committees is always on a voluntary basis. As underlined in research ethics around the world, persons who agree to participate in the intervention, and in the research linked to the intervention, are able to change their situation any time they deem necessary. In fact, in real-life

situations, research participants are given the opportunity to change their situation so that they are motivated to participate in the research. Otherwise, they will choose not to, thereby making the whole exercise futile. Thus, it is unavoidable to have such a research bias, as highlighted in any research with humans, and the research must take proper note of such dynamics.

In addition to motivational issues, it is often not the call of the researcher to decide who gets what kind of intervention (or none at all). As is the case in this research project, an external organization, not the researcher, set the criteria and selected the individuals who received cash and/or those who received trauma counselling, or no support at all. In real life, social interventions are not distributed at random to the target population; people should be informed about the intervention, people have to apply (motivational issue), and a commission has to decide who can, and is in fact eligible, to participate. Due to these facts, treatment groups and control groups will probably not be similar on all relevant variables exogenous to the intervention. This makes research with humans even more complicated and indeed challenging.

Furthermore, a unique assignment of individuals to a specific group is hard to realize in real life settings. This is because, by virtue of them being *zoon politikons* (Aristotle) and social by nature, people talk among themselves: they share their concerns. Moreover, the effect of an intervention on the participants (emotional, social and even the economic improvement of an individual's situation) affects other people in the social network or the community of the participant. This is because man (and woman) is never an island unto himself/herself. We are all part of the whole, which makes it even more complicated to deal with interventions, at least in a manner that would satisfy all. As in the case of this research, the fact that participants could participate in the social protection program, affected the economy of the community, and the fact that participants talked about the trauma counseling intervention, made this intervention (partly) available to other people (and the whole community) as secondary intervention effect.

The second point relates to the rule that an intervention should be based on a theory. While this rule should be met as closely as possible, a similar problem as the one noted above also arises the moment you try to apply theory to real-life situations. In real-life situations, interventions are often designed by a specific agent to implement a particular policy and

researchers are asked to evaluate the effectiveness of these interventions (as is the case in this project). In such cases, the treatments do differ between and among groups. But, quite often, these differences in treatment are not inspired by theory that indicates why a specific intervention will work in one particular situation, or not in another. These treatments are the result of the implementation of policy and partly based on agenda setting by policymakers and those who implement the agreed policy, while the treatment may provide a policy window for bringing in new ideas on the policy agenda with, importantly, an unpredictable element regarding when ideas may move onto the policy agenda (Kingdon, 1995). As a consequence, the research objective is not to test causal relations between specific variables of a theory (the intention of an experiment within the positivistic empirical approach), but to establish the effectiveness of an intervention (which consists of a whole set of undefined variables) in a real-life situation.

The third rule of an experiment is that the intervention or the treatment is under the control of the researcher, and that this is equal for each individual in a particular (treatment) group. This rule is particularly hard to realize in real-life interventions. In real-life, interventions occur in a social situation, never in a vacuum. Participants, as well as those who execute the intervention, work with an intervention in a specific context. They have their own ideas of how the intervention should be applied in a situation. More so, they have their own expectations of what will work (and not), under what conditions, as is dictated by their context. Therefore, in this socially-defined context, the participants and those executing the intervention, will unavoidably adjust the intervention to the physical, social, and cultural situation at hand. Furthermore, multiple projects are often implemented at the same time in the same location by different initiators. In the case of this research, churches also offer social support as well as counselling, for example. And, more generally, life goes on and may affect respondents in different ways. So, a researcher should realize that the intervention is just one of the events that is happening to the respondents and that those other events can have different impacts on different respondents.

Drawing on the analysis here, governed by the rules of causal claims and interventions, it can be concluded that it is often practically impossible to follow the methodological rules set for a true or even a quasi-experimental design to study the effectiveness of a social intervention or an intervention taking place within a social reality. Dealing with and researching people

remains a mammoth challenge for researchers across the board, be it in the natural sciences, social sciences or humanities.

This does not mean that the effectiveness of an intervention cannot be studied (Snow, et. al., 2003). However, it does mean that one should be thorough and meticulous when carrying out research on an intervention. This can be achieved by committing oneself to sensitivity (or responsiveness) to the research situation at hand and applying different research methods (triangulation) in order to have data to verify and validate the results of the testing of the effect of the intervention.

A possibility is to elaborate a natural design (Shadish, Cook & Campbell, 2001) in which all important key variables may not be known. In a natural design, variables may be identified based on several different scenarios or a combination of those. Variables may be identified based on the following reasons:

(i) Developed hypotheses concerning the workable elements of the intervention that is expected to cause the effect (based on theory);
(ii) Understanding of the nature of a particular version of the treatment as it was applied in the natural life environment;
(iii) Understanding of the blending of different treatments applied in one community; and
(iv) Understanding of the extent to which treatments will have an effect at the collective community level and, therefore, also affect the control group (in that community).

Such a design demands specific requirements of a study, such as being responsive to what is taking place in the environment and documenting carefully all the contextual specifics taking place before, during, and after the intervention or treatment is applied.

The suggestion to be responsive to the research situation in its real-life context is counterintuitive to the traditional positivistic empirical research. This research tradition prescribes that a researcher should behave as an objective (outsider) observer, who does not interfere with the research situation. This argument can be countered by considering the reality that the researcher is doing this research in a social context with humans whose sensibilities or values need to be seriously considered from both the perspective of research

ethics and human rights. The point, thus, is that the researcher gathers specific information, which necessarily and unavoidably makes him/her a part of the social reality in which the intervention takes place (Burawoy, 1998).

The EWP-U research project is conducted in a real-life setting, more specifically in a rural area, in which researchers are a unique, extraordinary phenomenon. People have expectations of what researchers will be doing and how to approach them. Moreover, the researcher has to approach and interact with local authorities, participants and non-participant of the research according to proper (local) social norms. This has, as a consequence, that the researcher realizes that he/she is not an objective, outsider observer, but an engaged researcher who is trying to discover an appropriate way to improve the social situation at hand for a particular group of people. According to a positivistic logic, such an expectation concerning the research itself should not exist. But in the reality of the research, the social situation is present and can never be avoided at any given moment. Methodologically, it is more sound to acknowledge the effects of the social embedding of a research, rather than artificially deny the existence of the social specific interaction of the real-life experiment with its environment.

By researching the effect of an intervention for a defined group (women in Northern Uganda, in the case of this project), one helps this particular group (and, therefore, not another group), even though the findings for this research can be applicable partly or wholly in similar contexts elsewhere. This choice can trigger envy. In the researchers' experience, the men in the community (spouses, fathers, and sons) were asking to be included in the intervention. Such a reaction by a community indicates that doing research is not an objective act that can be located outside the social situation in which the intervention takes place. It shows that research is an integral part of the social situation in which the intervention takes place. In this study, the broader community and the participants of the different research groups were all given access to the SHLCPTS program. Local radio broadcast on the program was sought to provide broader benefit from the intervention to the community as a whole after the research was ended so as not to interfere with the experimental set up of the study.

In a positivist design, such factors would be removed, but making the outcome of the experiment irrelevant to a real-life social situation is not practical, as the intervention or

treatment would always take place within its social context. It can, therefore, be argued that it is more advantageous to implement interventions or treatments that have a place in the social context in question. Strategies to implement such interventions can be better studied by acknowledging the effect of real life in a context. By letting go of the fixed idea of being objective, one opens the path of becoming more acquainted and familiar with the people, as well as the community in which the intervention takes place.

In order to study an intervention or treatment in a natural situation, the researchers are required to pay full attention to the specifics of the social context. This is an important step, as researchers are often not familiar with the social, cultural and historical situation of the context in which they are to carry out research. A lack of shared experiences and background knowledge would then hamper the validity of the information gathered. If a researcher is not familiar and asks only standardized questions, and accepts only recorded (standardized) answers, the probability that the question, as well as the answer, is misunderstood by the respondent and the researcher is high. It is, therefore, imperative to understand the context, and to study how the social context interacts with the experiment.

This line of reasoning leads to the conclusion that an experimental method that is used to research an intervention or treatment in a social situation should be enhanced by science notions emerging from ethnographic research traditions. This type of research differs from positivistic research (among other things) in the following respects:

- The researcher is more engaged with respondents and the community in order to overcome differences in language use, norms and values that are expressed in (social) expectations and reactions (cognitive, emotional and behavioral), as well as evaluations (what is a good, appropriate, and bad reaction) (symbolic interactionist base).
- The researcher is sensitized to the context of the research setting. Social research, unlike natural science research carried out in laboratories, is always situated in a specific context that can be described in terms of a physical, social, economic, cultural, and historical entirety.
- The research focuses on social processes (what people are doing and why they are doing it; how the intervention is handled in this community), as well

as the outcomes of social processes (the effect of the intervention on specific variables of interest).

The position of an ethnographically-informed research methodology is that the effect of the social intervention or treatment is the result of social processes in a specific context. The processes emerging from the intervention or treatment will then be located at, minimally, three levels:

1. Individual level (perceptions, feelings, opinions, and competences)
2. Social interaction of people involved in the intervention
3. Effect of the behavior of the people involved in the intervention on the community

These social processes take place within a specific context, which specifies the physical, economic, social, cultural and historical conditions in which the intervention takes place. This broader context is not noise, as positivist assume, but reality (Burawoy, 1998). It is, therefore, essential to include reality in the research.

When a researcher realizes that the results of a certain intervention always emanate from social processes in specific social situation, certain standard rules for experimental design can be modified.

The rule to pick representative cases is no longer relevant, as representative cases, as such do not exist in a real-life situation, as all contexts are different and specific and, therefore, not representative. The urge to generalize the results to a wider context (other populations, other social circumstances) needs to be modified by the understanding of the researcher of the specific interaction with the social reality in his/her experiment. This does not mean that it is not possible to identify results at more aggregate levels. The researcher is prompted to search for more abstracting general tendencies across different implementation contexts and can so develop an abstract theory of the working elements of the intervention or treatment. This theory can then be used as a guideline to develop (and study) similar interventions or treatments in other context and to validate or reject the theory.

In order to come to more abstract knowledge (theory) about why and how an intervention works, one should study the process of implementation, as well as reactions to different

versions of an intervention at different moments in time (for example, before, during, after, half-a-year later, and so on) in different social settings (or communities). By describing the context, the social processes, the intervention or treatment, as well as the effects of the intervention or treatment (on individual, interpersonal, and community level), the researcher develops an idea of how (what social processes) and why (what key variables trigger the appropriate social processes) these interventions work in general (theory). This theory will then indicate what version(s) or which elements of an intervention or treatment have (what) effects within the real-life implementation and informs the researcher of the practical applicability of an intervention, as well as the expected improvement in the effect of variables, in specific settings.

4.9. Research activities and detailed time-line

For this research seventy interviews and focus group meetings were carried out in the following order:

4.9.1. Focus group meetings and interviews with resource persons on social protection and trauma – 2015

Focus group meetings (n=7) were held during the preparatory phase in: Kaberamaido (9 July 2015) Amuria & Dokolo (9 July 2015), Kitgum, Katakwi (add 9 -11 July 2016), Soroti (10 July 2015), Kitgum (10-11 July 2015), Amuru & Oyam - Gulu (12 July 2015) by researchers Primrose Nakazibwe, Mirjam van Reisen, junior researchers (meetings Kampala 8 July 2015). Focus groups comprised of women respondents from 18 – 60 years of age. The number of women included in the groups was between 15 – 25 women. A translator was used during the meetings. The meetings were open conversations on the situation in the community, the needs of the women, their access to social protection and cash transfer programs and their well-being. In addition, open structured interviews were held with women leaders and district authorities in the places visited. A preparatory visit took place to Luwero (November 19th, 2015) but the researchers found that trauma-relief in Luwero was no longer a priority for the community. It was decided not to include Luwero in the research.

4.9.2. First data collection (Wave 1) and interviews on access and participation to social protection – 2016

Survey-assistants were trained and the first data collection by survey (SER and EIS-R) was implemented from March to May 2016 and during this time interviews (n= 20) were done by

Researcher Primrose Nakazibwe and junior researchers (Lira, 1st-6th March 2016; Katakwi and Amuria, 7th-11th March 2016; Kitgum, 21st March to 21st May 2016). The format was open interviews related to aspects of access and participation protection programs.

4.9.3. Meetings with local contact persons and radio stations for SHLCPTS – 2016

Meetings were held with local contact persons of the research to follow up on the first round of data collection in from 27 April – 5 May 2016). The following areas were visited: Kampala: 27 – 29 April; Kaabong and Kitgum 30 April – 2 May; Soroti & Lira 3 May, Kampala 4 May.

4.9.4. Second data collection (Wave 2) Interviews on trauma and SHLCPTS

Second round of data were collected in January 2017) Individual interviews (n=48) were held during data collection by researcher Primrose Nakazibwe, Mirjam van Reisen and Selam Kidane (second round of data collection, 24 - 27 January 2017, 25 January Lira, 26, January Kitgum, 27 January, Gulu) (interviews on impacts of SHLCPTS).

4.9.5. Public testimonies

- Public individual testimonies (n=3) at dissemination meetings in Barlonyo (21 February 2016) and in Kampala.

4.9.6. Other research activities

Other research activities comprised of the following support and preparation:

- Training Barret Method, by Jolanda Asmeredjo in Kampala for Team (05th to 08th January 2016)
- Identification and meetings with local radio stations (preparation of SHLCPTS) Preparation and Training SHLCPTS in Lira by Selam Kidane coordinated by Primrose Nakazibwe (Lira, 18th to 20th July 2016)
- Implementation of SHLCPTS, location and dates:
    - Lira District
        - Barlonyo Agweng Sub County - 25th August to 3rd October 2016
        - Ogur Sub County - 25th August to 10th October 2016.
    - Katakwi District
        - Usuk Sub County - 7th September to 17th October
        - Ngarium Sub County - 8th September to 18th October

- Amuria District
  - Orungo - 7th September to 23rd October 2016
- Kitgum
  - Amida Sub County - 27th August to 24th October 2016
  - Tumango Parish-Akwang Sub County - 27th August to 24th October 2016

Other reporting activities:

- Borlonyo Commemoration and radio dissemination (21 February 2017)
- Liberia International Colloquium (March 7-8, 2017) (workshop and presentation at high level meeting by Mirjam van Reisen, Primrose Nakazibwe)
- CSW (March 12- 15 2017) (workshop Isis-WICCE, Primrose Nakazibwe, Zamina Malole)

4.9.7. Analysis of interviews and focus groups

The interview transcripts were written by the interviewees during the interview. The notes were digitalized in a coding/labeling overview by the researchers, according to pre-fixed labels. New labels were added, where they appeared relevant and added to the overviews. The respondents were anonymized and the interview information was inserted in one excel file, with an encrypted password protection and saved on the Tilburg University surfdrive.

4.10. Quantitative data preparation and statistical approach

Data were collected through surveys SER and IES-R (see sections4.9.2) The data were collected in three rounds. Round 1 took place in March - May 2016, round 2 took place in February 2017). A third round took place in October/November 2017.

Before the data were analyzed, they were examined for out-of-range numbers and for respondents with more than 25% missing answers. In the first wave, 472 respondents took part in the interview and in the second wave 357 respondents took part. Due to item non-response (of more than 25%), one respondent from the first and one from the second wave was removed from the analysis. The other respondents (first and second wave) answered the questionnaire with an item non-response of is less than 10% on average.

Due to the large number of respondents (wave 1, n= 472; wave 2, n= 357), it can be assumed that the data on each of the variables has a normal distribution (central limit theorem; see, for example, Hays, 1973).

Since the validity and reliability of the scales used was not yet established for Northern Uganda, each scale (and its corresponding subscales) were examined by means of:

- An item-analysis
- A reliability analyses (internal consistency)
- An analysis to determine the discriminant validity of the different subscales of a construct

The results of these analyses are reported in chapter 12 and 13. Appendix 3 includes the questionnaire used at T1 and T3.

In order to examine the hypotheses regarding the main research question, the differences between the social protection groups were examined by means of analysis of variance. Two different analyses were performed.

An analysis of variance (ANOVA) was conducted to explore the effects of the social protection modes (cash and trauma support) on social and economic resilience. This analysis also looks for the interaction effect between cash and trauma support, in other words does trauma relief the effect of cash? The ANOVA also examined whether the differences between the social protection groups on social and economic resilience still hold if age (as a covariate), educational level, and employment are taken into account.

These analyses were done for the first and second wave separately, to examine the effect of trauma support on the social and economic resilience tool.

In order to test the additional hypotheses regarding trauma, the level of trauma in the first wave was examined to establish the percentage of people who are highly traumatized and the effect of trauma support on the level of trauma reported (IES); social and economic resilience (SER) was also looked at.

4.11. **Definition of terms**

4.11.1. Social protection

Social protection has emerged as a key policy framework for addressing poverty and vulnerability in many developing countries (Barrientos, 2011). Social protection is the first action of goal one (end poverty in all its forms everywhere) of the Sustainable Development Goals (SDGs). The Food and Agriculture Organization (FAO) sees social protection as critical for rural development and it has adopted a Social Protection Framework to promote rural development for all in which it states:

> *Three quarters of the chronically undernourished and those living in poverty reside in rural areas. Many of them are not covered by adequate social protection, rely predominantly on natural resources for their livelihoods, and are particularly vulnerable and exposed to multiple risks. Yet, they play a critical role in ensuring global food security in the long term, and in sustainably managing the natural resource base in the most fragile ecosystems. Ensuring their access to social protection is not only a social imperative, but it is critical to ensure their participation as partners in development and economic growth. (2017, p. xii).*

Social protection schemes have proven to play a significant role in tackling the problem of poverty and vulnerability, and these schemes have been viewed as powerful tools for governments, policymakers and donors to address certain problems, such as fuel and food crises, aggregate shocks, and other economic crises (Waqas & Awan, 2017). authorities.

In development discourse, the concept of social protection first emerged in the late 1980s and in the early 1990s as a critical response to the discourse about 'safety nets' (Devereux, & Sabates-Wheeler, 2004). Many authors came to use the concept to draw attention to the wider nature of poverty and its nature as a multi-dimensional problem—hence, the differing definitions of social protection. International donor agencies, academic authors, regional political bodies and specific countries have come up with various definitions of the concept of social protection as outlined below.

Conway, de Haan, & Norton (2000) define social protection as

> *Public actions taken in response to levels of vulnerability, risk and deprivation which are deemed socially unacceptable within a given polity or society. (p. 2)*

The World Bank states that

> *Social protection is a collection of measures to improve or protect human capital, ranging from labor market interventions, publicly mandated unemployment or old-age insurance to targeted income support. (2003, online).*

It goes on to say that "Social protection interventions assist individuals, households, and communities to better manage the income risks that leave people vulnerable" (ibid.). The International Monetary Fund's (IMF) Government Finance Statistics Manual defines social protection as "the systematic intervention intended to relieve households and individuals of the burden of a defined set of social risks" (IMF, 2014, p. 4), where social risks are defined as "events or circumstances that may adversely affect the welfare of households either by imposing additional demands on their resources or by reducing their income" (IMF, 2014, p. 4).

The Asian Development Bank focuses on social protection as a poverty reduction strategy and, thus, defines the concept as "the set of policies and programs designed to reduce poverty and vulnerability by promoting efficient labor markets, diminishing people's exposure to risks, and enhancing their capacity to protect themselves against hazards and interruption/loss of income" (Asian Development Bank, 2003, p. 1). Within this conceptual framework, social protection consists of five major elements: (i) labor markets, (ii) social insurance, (iii) social assistance, (iv) micro and area-based schemes to protect communities and (v) child protection (*ibid*.).

The definitions of the IMF, World Bank and Asian Development Bank fit well in the perspective of a western developed society. In advanced, industrialized countries, social protection constitutes a set of integrated institutions and programs, including social insurance, social assistance, and employment protection and promotion (Barrientos, & Hulme, 2009). Due to the many constraints in developing countries, there is a growing debate about the meaning of social protection from the perspective of developing countries.

Barrientos and Hulme (2009) notes that there is a growing consensus around the view that social protection constitutes an effective response to poverty and vulnerability in developing countries, and an essential component of economic and social development strategies. Hence, there has been an effort to understand social protection from the African perspective. Nevertheless, there is no distinct definition of the concept that can be described as African (Holmes & Lwanga-Ntale, 2012). A study commissioned by the African Union defines social protection as "a range of public (government funded) measures that gives support to all citizens and helps individuals, households, and communities to better manage risks and participate actively in all spheres of life" (ibid).

In the Ugandan context, the National Social Protection Policy defines social protections as a system that is comprised of two pillars, namely: social security and social care and support services (Republic of Uganda, 2015; 2016). The social security pillar hereby refers to protective and preventive interventions to mitigate factors that lead to income shocks and affect consumption, while the social care and support services refer to a range of services that provide care, support, protection and empowerment to vulnerable individuals who are unable to fully care for themselves.

Social protection has been classified into four major categories: social assistance, social insurance, labor market interventions and community based social protection. For the purposes of this study, more focus was paid to social protection programs, such as cash transfers and in-kind transfers (including inputs and food items) from both the government and NGOs. Cash transfers include both conditional and unconditional grants from the government, as enshrined in different government programs. In-kind transfers included all the food, inputs (seedlings) and livestock received as part of the program.

4.11.2. Cash transfers

Slater (2011), while explaining social protection, recognized that cash transfers form an important and growing part of social protection programming in many developing countries. Similarly, Barrientos and Hulme observed increased interest for implementation of programs of cash transfer schemes, provided to the poorest and vulnerable individuals, in the context as of promotion of more permanent social protection programs. (Barrientos & Hulme, 2009)

Cash transfer programs can be defined as initiative which provide 'noncontributory cash grants to selected beneficiaries to satisfy minimum consumption needs' (Garcia & Moore, 2011, pp. 32-33). A non-contributory aspect of cash transfer is interpreted in a way 'that beneficiaries do not pay into a system that later awards them the transfers' (ibid, p. 33). In practice, cash transfers may be conditional or unconditional. While unconditional cash tranfer is provided to all eligible individuals, conditional cash transfer is granted upon fulfillment of prescribed responsibilities and conditions. Conditions may vary from one program to another. Study which researched impact of conditional cash tranfers on maternal and newborn health shows that beneficiaries have to comply with several health, education or nutrition conditions in order to be eligible. (Glassman, Duran, & Koblinsky, 2013) There are ongoing debates as to the usefulness of conditionality within the domain of cash transfers. According to Schubert and Slater conditional programmes are often perceived as more acceptable by policy-makers and tax-payers. (Schubert & Slater, 2006, p. 573)

In the context of this study, unconditional cash transfer programs have been analyzed. In particular, the government of Uganda has developed the Social Assistance Grants for Empowerment (SAGE) through which unconditional cash transfer mechanism has been utilized. **T**he Senior Citizens Grants were granted to individuals, aged 65 or older, without constituting any further conditions. Similarly, the Vulnerable Family Grants provided direct income support for vulnerable households with low labor capacity and a high dependency ratio.

4.11.3. Trauma

The individual distress and enduring pain and suffering, including post-traumatic stress disorder (PTS) and comorbid disorders, such as depression, caused by mass traumatic events like war, torture and human rights violations, are well evidenced (e.g., Maresella et al., 1996; Turner, Bowie, Shapo, & Yule, 2003). However much of this discussion focuses on individual distress, ignoring the collective nature of the aforementioned calamities. This individualized focus on trauma limits our ability to conceptualize the problems and address them appropriately (Collier et al., 2003; Wessells & Monteiro, 2001).

While, undoubtedly, individual victims of atrocities such as torture might experience PTSD and would clearly benefit from individual intervention and support, this type of intervention does not address the structural context that enabled such atrocities to occur in the first place, nor does it address resultant problems, such as mistrust and the low social cohesion that often stems from the social, political and economic contexts that are incorporated into the collective consciousness, making the traumatic events become ingrained and inherent to the collective and, if left unattended, leading to them happening cyclically (Johnson, 2006). In addition, without a broad and collective approach to trauma and healing, practitioners often fail to respond to the reality on the ground, when the most overwhelming concern for survivors is not past memories, as such, but the stress of daily living in situations where their social support networks have collapsed.

4.11.4. Collective trauma and healing

The acknowledgement of the simultaneously private and social nature of post-war trauma, in contexts such as the civil war in Uganda, allows us to go beyond symptoms such as PTSD to address collective trauma focusing on communal memories and group narratives that can be passed from one generation to the next. Here group trauma is interwoven into collective identity, to become the new context within which healing (including healing at the personal level) ought to take place.

Collective trauma is the impact of an experience, which becomes a keystone in a group's narrative, a set of beliefs and identity, both for the current generation and across generations. Collective trauma involves a socially-constructed process with an impact on the identity of the group and its individual members. The impact on the narrative and on the identity of the group can be present even when individual members do not have (or no longer have) signs of physical or psychological damage. Unlike individual trauma, which can be experienced by a small percentage of people, with most recovering within a given period of time, collective trauma does not necessarily refer to symptoms of traumatic stress, but is an outcome that includes the response to the traumatic event, as well as the way it is constructed into the beliefs, decisions, behaviors and narratives of the collective (Shamai, 2015). It is defined as the effect felt by many in the aftermath of a tragedy (traumatic event). It is a blow to the basic tissue of social life and damages the bonds attaching people together, impairing the prevailing sense of community (Erikson, 1991).

Communities impacted by trauma will often react violently towards others. Unresolved trauma is among the most important root causes for modern-day conflicts that take place. The perpetration and escalation of violence can be partly attributed to this very phenomenon (Levine, 1997). Indeed, research has shown that the attitudes to reconciliation and peace building were negatively impacted on by the high prevalence of unresolved trauma in Ugandan (and Rwandan) communities (Bayer, Klasen, & Adam, 2007; Pham et al., 2009).

Collective trauma also leads to new traumatic events, through the intergenerational transmission of trauma and coping style (Danieli, 1998). Additionally, collective trauma impairs the ability to react to patterns of threats and opportunity, causing people to become trapped in cycles of vulnerability, leading to systems of abuse.

The additional advantage of including the healing of collective trauma as a framework, in post-conflict communities, such as Northern Uganda, is that it is more readily accommodative of the total devastation and societal collapse experienced by members of the community, regardless of their individual trauma levels. Such impacts are more than just the aggregation of the individual PTSD, but include the suffering associated with the structural violence and ongoing issues, such as: exclusion, deprivation and lack of access to basic services.

4.12. **Definition of concepts of effect**

In this section the definitions of concepts of effects are defined.

4.12.1. Resilience

The concept of resilience is derived from the Latin word *resilire*, which means to leap back, to recover from and position elastically following a disturbance of some kind. It construes resilience as the bouncing back of a system following a shock to its pre-existing state or path (Martin & Sunley, 2014). The term resilience has been used by sociologists to explain the human ability to return to its normal state after absorbing some stress or after surviving some negative changes (Surjan, Sharma, & Shaw, 2011, p. 17–18)

Social protection has been viewed as a new strategy to achieve resilience for people living in poverty. FAO (2017) acknowledges the fact that “social protection is now being recognized

as instrumental in both poverty eradication and rural transformation, as well as an integral component of effective humanitarian response and resilience building efforts" (p. 2).

4.12.2. Empowerment

Page & Czuba (1999) defines empowerment a "a process that fosters power (that is, the capacity to implement) in people, for use in their own lives, their communities, and in their society, by acting on issues that they define as important" (p. 10). Thus, women's empowerment is a process of gender equality which gives women an opportunity to gain more power and control over their own lives (European Parliament, 2016). In the context of this study, women's empowerment is the process through which women are able to recover from war emotionally and physically disturbing situations to be able to regain themselves out of these shocks to undertake economic decisions aimed at improving their own lives.

4.12.3. Impact of events

The Impact of Events Scale (IES-R) has been the most widely used self-report measures of PTSD. The Scale was developed in 1979 before the DSM-III, as a short self-report measure for assessing degree of symptomatic response to a specific traumatic experience, taking place in the previous seven days (Horowitz, Wilner, & Alvarez, 1979). Its development draws from the understanding of responses to traumatic stress responses to the realms of intrusion and avoidance as the primary domain of measurement of measurement.

In the initial report (Horworth et al., 1979), data supported the existence of homogeneous clusters of intrusion and avoidance as measured by Cronbach alpha (0.79 for intrusion and 0.82 for avoidance). The correlation between subscales was small, allowing for independence of the subscales (18% of the variance). And reliability was satisfactory too (coefficients of 0.87 for intrusion and 0.79 for avoidance).

Zilberg, Weiss and Horowitz (1982) conducted a comprehensive replication and cross-validation of psychometric characteristics of the scale and its conceptual model. The result revealed that all items were endorsed frequently (44% to 89% of the pooled sample), suggesting that content of experience following traumatic events as represented in the IES item pool was similar across types of events and different populations (e.g., patients and non-patient population).

Sundin and Horowitz (2002) presented a summary of 18 studies on the correlations between a variety of other measures of symptoms and intrusion and avoidance. The correlations with general symptoms were larger than the average relationship of the two subscales.

However the IES was still an incomplete assessment of PTSD, without tracking the responses to the domain of hyper arousal, and so beginning with data from a longitudinal study of responses of emergency service personnel to traumatic events including a major earthquake, researchers developed a new revised version of the Scale (IES-R) by adding a set of additional 7 items to tap hyperarousal (Weiss, Marmar, Metzler, & Ronfeldt, 1995). These additional items that were interspaced with the existing items and the splitting of one double barreled question brought the IES-R parallel with DSM-IV criteria (Weiss & Marmar, 1997). Crucially the revised version was developed with a view to maintaining compatibility with the original, the instruction on the one-week timeframe was maintained as was the original scoring scheme. The internal consistency of the three subscales, the pattern of item-total correlations; test-retest stability and communality of the interim correlations were all satisfactory (Weiss & Marmar, 1997). Additionally, in response to the experience of frequent answering of questions with the response 'sometimes' and 'often' respondents were asked to report on degree of distress rather than frequency of symptoms, this modified the format of response. Sub-scale scoring is now the mean of responses (as opposed to total) (Weiss, 2004).

Due to its effectiveness and simplicity the IES-R has become the tool of choice for many researchers worldwide. It has been translated to many languages including, Chinese (Wu and Chan 2003), French (Brunet, St. Hilaire, Jehel, & King, 2003), German (Maercker & Schuetzwohl, 1998), Japanese (Asukai et al., 2002), Spanish (Baguena et al., 2001) and Italian (Giannantonio, 2003), there is a Dutch version too (Weiss, 2004). A Bosnian version has been used in a study, comparing refugee and non-refugee populations (Hunt & Gakenyi, 2005). Veronese G., Pepe A. (2013) used an adapted shorter version of IES, in Arabic, normally used with children (CRIES) to accurately measure vicarious trauma on professional social workers and emergency workers operating in war contexts.

In addition to effectiveness in identifying levels of trauma IES-R has also been used to measure effectiveness of interventions. For example Zang et al. (2013) used the Chinese version of IES- R (along with several other measures) to assess the efficacy of Narrative

Exposure Therapy (NET) as a short-term treatment for PTSD for Chinese earthquake survivors. Similarly Kim et al. (2005) Used IES-R and other scales to investigate the effectiveness of mirtazapine during the 24-week continuation treatment in patients with PTSD in Korea.

However having drawn attention to the complexities of comprehensively assessing trauma in different cultures and contexts (e.g., war and disruption) Veronese and Pepe contend that while the response to trauma may be considered universal, there is lack of univocal evidence regarding how best to assess and classify this response, especially in non-Western contexts (Giacaman et al., 2007), this is due to the fact that, there is considerable evidence indicating that cultural differences govern the emotional and behavioral response to distress in the aftermath of traumatic experiences (Rahman, Iqbal, Bunn, Lovel, & Harrington, 2004).

Additionally, war and political violence affect well-being, not only at an individual level but also at the collective and community level (Giacaman et al., 2007). For instance, in the case of the Palestinian population, humiliation, lack of dignity, and the inability to operate freely and safely often constitute forms of war trauma, hence, there is a need to include these dimensions in an exhaustive assessment of trauma (Giacaman et al., 2007; Veronese, 2012). In our context of war affected Northern Uganda this means, measuring trauma such as IES-R, should be supplemented additional instruments assessing various domains.

Despite the challenges mentioned above and others associated with accuracy of language usage and the limited and specific time frame specified in the tool, IES-R offers the advantage of an effective, short and easily understood measure of distress, ranging from normal stress response to PTSD as experienced in the week preceding the test. Specifically, in this research the scale will not be used to provide diagnosis but to track change over time and trace the levels of symptoms of PTSD and to give a snapshot of symptomatic status at the specific times of testing.

4.13. Definition of theoretical concepts explaining change

This section defines the concepts used in this research to explain processes of change.

4.13.1. Livelihood

The first definition of livelihood is broadly accredited to Chambers and Conway's working definition (for exact citation see section 4.1). Their definition was accepted and adapted by

the Department for International Development (DFID), among others. The DFID recognized in the set of Guidance Sheets (DFID, 1999) that a livelihood is comprised of the capabilities, assets and activities required for a means of living. A livelihood is sustainable when it can cope with and recover from stress and shocks and maintain or enhance its capabilities and assets both now and in the future, while not undermining the natural resource base. (Chambers & Conway, 1992, p. 6). This definition acknowledges the complexity of the livelihood concept and implies that securing livelihoods may entail e.g. access to water, land, health care, education, or even services protecting legal rights. (de Silva, 2013, p. 5)

In order to increase efforts to reduce poverty and conduct in-depth analysis of livelihood, the DFID has built upon the working definition and introduced the Sustainable Livelihood Framework (SLF) which has become one of the most widely applied frameworks within development programs. The SLF introduces main factors affecting livelihoods and close linkages between them. As the livelihood approach promotes people-centered picture, it seeks to understand the people's strengths (assets) that through effective utilization can lead to positive livelihood outcomes. Therefore, the SLF also draws attention to the particular assets, upon which livelihoods are built, and core influences and processes that shape the use of these assets. (DFID, 1999) Stemming from the Chambers and Conway's working definition, assets are recognized as resources, stores, claims and access which person possess and can use towards a livelihood. (Chambers & Conway, 1992, p. 25) The SLF distinguishes both tangible as well as intangible assets and categorizes them into five distinctive groups – human, social, physical, natural and social capital. (DFID, 1999)

In emergencies that lead to people become destitute, it is often the case that large-scale loss of livelihood assets could be saved by providing timely assistance to save these assets. Livelihood support in emergencies, therefore, consists of actions taken to protect the assets that are essential to people's livelihoods, and to support people's own priorities and strategies. It relates to any activity that aims to restore people's dignity and ensure adequate living conditions (Caverzasio, 2001).

4.13.2. Agency

For purposes of this study, the concept of agency refers to "the ability to define one's goals and act on them, encompassing both 'power within' and 'power with', thus emphasizing the

value of individual and collective decision-making" (Jones & Shahrokh, 2013, p. 10). Agency is more than observable actions, although it tends to be operationalized as decision-making, but can also take a number of forms (Kabeer, 1999). Kabeer (1999, p. 438) explains that agency takes many forms, including: "bargaining and negotiation, deception and manipulation, subversion and resistance as well as more intangible, cognitive processes of reflection and analysis and it can be exercised by individuals as well as by collectives" (p. 438). Meyers (2002) adds that agency is about defining yourself, without necessarily focusing on one's goals. She focuses on the debate that agency is an innate skill that helps an individual to exercise her own will and that women can discover themselves through their 'agentic skills'. Thus, agency is not a given virtue that someone acquires through external intervention (Nakazibwe, 2015). Meyers defines agency in terms of skills that may be improved upon. Therefore, the understanding and application of agency in this study identifies women as chain actors who pursue conscious and unconscious goals to determine their life through interpretative and narrative frameworks that help them make sense of their world.

4.13.3. Values and value entropy

In the theoretical model that guides this research, the concept of values refers to an enduring prescriptive or proscriptive abstract belief that a specific end state of existence (terminal value) or specific mode of conduct (instrumental value) is preferred to an opposite end state or mode of conduct for living one's life (Kahle, 1983; Rokeach, 1968; 1973). The enduring state does not mean that values cannot change, but that they will change only gradually due to accumulated experiences. According to Barrett (2014, p. 3) values are "a shorthand method of describing what is important to us individually or collectively at any given moment in time". They are, therefore, universal in that they transcend context (and time) (Barrett, 2010, p. 3). Values are more abstract and universal than attitudes (opinions about consequences of behavior, see for example Ajzen, 1991). In this research, social and economic resilience can be regarded as an attitude (with which to approach specific situations). Barrett emphasizes that values-systems can be measured in terms of their coherence or incoherence and their changes over time.

Value Entropy is defined as the situation of dysfunctionality characterized by an organizational system in which perceived values among different levels of the system are

incoherent (Barrett, 2014). Cultural transformation is a process that enables human behavior to support processes of change in the organizational system that is characterized by high entropy (*ibid*.).

4.13.4. Policy window

A policy window (Kingdon, 1984) is a concept that encompasses a moment in time, which has a starting point and an end point, during which new ideas can enter an agenda; a policy window usually opens unexpectedly and provides for a time in which (big) change can take place, as opposed to incremental change processes, which only slowly build on what already exists. Policy windows, on the other hand, explain how entirely new ideas can emerge and drive change. The policy window conceptualizes a moment in which change can occur.

5. Description of Study Population

This study was conducted among the Nilotic ethnic groups in Uganda, which occupy much of the Northern and Eastern districts in Uganda. The Nilotic people commonly use a Nilotic language, which distinguishes them from other ethnic groups, such as the Bantu in the South. The Nilotic language speakers probably entered Northern and Eastern Uganda at the beginning of about C.E. 1000. Thought to be the first cattle-herding people in the area, they also relied on crop cultivation, which is the main economic activity and is still carried out to date. The largest Nilotic populations in Uganda are the Iteso and Karamajong ethnic groups, who speak Eastern Nilotic languages, and the Acholi, Langi, and Alur, who speak Western Nilotic languages. The Western Nilotic language groups together account for roughly 15% of the population, or about 3.4 million people, with the Langi contributing 6% (1.4 million), the Acholi 4% (900,000), and the Alur about 2% (460,000).

The Ateso people live mainly in Teso sub-region districts of Amuria, Soroti, Kumi, Katakwi, Ngora, Serere, Pallisa, Bukedea and Kaberamaido, as well as in the districts of Tororo and Busia. They number about 3.2 million (9.6% of Uganda's population). The people of Teso, Langi and Acholi traditionally live in scattered homesteads or villages, as they call them, each homestead being surrounded by their land, which they cultivate and use for cattle grazing. This pattern of life was seriously disrupted in the 1980s and 1990s, because of the dangers from cattle raiders and then rebels, which forced people to move close to trading centers or institutions such as schools, hospitals and administrative headquarters.

Traditional Teso settlements consist of scattered homesteads, each organized around a stockade and several granaries. Several groups of lineages form a clan. Clans are only loosely organized, but clan elders maintain ritual observances in honor of their ancestors. Men of the clan consult the elders about social customs, especially marriage. Much of the agricultural work is performed by women. Women may also own land and granaries, but after the introduction of cash-crop agriculture, most land was claimed by men and passed on to their sons (Photius, 2004) The Iteso also share responsibility among themselves for resolving disputes within their settlement or among their neighbors.

5.1. **Description of study sites**

The study was carried out in Amuria Lira, Katakwi, and Kitgum. Amuria and Katakwi districts, are located in the Teso sub-region; Lira district is located in the Lango sub-region; and Kitgum district is located in the Acholi sub-region. All these districts were classified by the Government of Uganda as areas that suffered armed rebellion and, thus, have a specific development plan, called the Peace Recovery and Development Plan (PRDP).

Uganda's neighboring countries are Rwanda, Kenya, the Democratic Republic of the Congo (DRC) and South Sudan. In relation to the research site, the most important border is the border with South Sudan (previously Sudan), which was the main operation area of the LRA. The LRA moved across the border with the DRC. The Karamajo region is located in the East and Northern parts of the country, bordering South Sudan and Kenya.

Figure 5-1. Map of Uganda and its neighbors

Source: https://www.dreamstime.com/uganda-political-map-capital-kampala-national-borders-most-important-cities-rivers-lakes-illustration-english-labeling-image103226090

Figure 5-2. Political map of Uganda

Source: https://www.ezilon.com/maps/africa/uganda-maps.html

Figure 5-3. Ethnographic map of Uganda

Based on Minority Rights Group International's 'Ethnic Groups and Tribes of Uganda', Uganda: The Marginalization of Minorities (2001).
Boundaries are not definitive but are intended to show traditionally inhabited areas.

Source:
https://reliefweb.int/sites/reliefweb.int/files/resources/25056AF8C870901EC1256F2D0047FCE8-uganda_ethno.jpg

5.2. **Kitgum**

Kitgum district is situated in Northern Uganda (Republic of Uganda, 2012). The district is bordered by Lamwo district in the north, the Republic of Southern Sudan in the north east, Kotido district in the east, Agago in the south east, Pader district in the south and Gulu district in the northwest. Two sub-counties were selected from the district for this study: Labong Amida and Labong Akwanga. The district covers a total area of 4,042 square kilometers. The National Population Census projected a population of 259,840 by 2013, of which 126,910 (49%) were males and 132,930 (51%) were females. The district has an estimated growth rate of 4.1%, which is higher than the national figure of 3.6%. According to

the District Development Plan (2012), the district has one county of Chua and 9 sub-counties, 1 urban council and 2 town boards. The sub-counties have 53 parishes and 605 villages, while the urban council has 7 parishes and wards.

The main economic activities in Kitgum district are agriculture and animal husbandry. However, the majority of the population (86%) depends on subsistence agriculture for its livelihood. The major crops grown are maize, cassava, beans, millet, sweet potatoes, ground nuts and cotton. The main livestock kept are cattle, goats, sheep, pigs and poultry. The district has a few people engaged in fish farming, beekeeping and produce trading. The district also records a high rate of adult illiteracy, with women being the worst affected with only 32% being able to read and write. The district also has a high school dropout rate of 56%, which is attributed to the insurgency. The insurgency caused loss of property, livestock and infrastructure leading to household food insecurity and high poverty levels. The state of Uganda Population 2010 reported that Northern and Eastern Uganda have suffered recurrent exposure to transitory food insecurity (Republic of Uganda, 2010). A study conducted by Investing in Peace (2008) reported that 79.9% of the population in Kitgum stopped cultivation as a result of the insurgency, while 14.3% experienced grievous harm and theft of their livestock (Investing in Peace, 2008, p. 15).

The government programs extended to different categories of the population in Kitgum district include the Production and Marketing Grant (PGM), Community Driven Development (CDD), Operation Wealth Creation (OWC) (formerly the National Agricultural Advisory Services, NAADS), Functional Adult Literacy (FAL), Schools Facilities Grant, Northern Uganda Social Action Fund (NUSAF), Peace, Recovery and Development Plan (PRDP) and the Agricultural Livelihood Recovery Programme (ALREP).

5.3. **Lira**

Lira district is part of the greater Lango sub-region located in Northern Uganda (Republic of Uganda, 2011). The district was formed out of Lango district in 1974 and is mainly occupied by the Lango ethnic group. Lira borders Pader and Otuke districts in the north east, Elebtong district in the east, Dokolo in the south, and Apac in the west. The Langi are believed to have originated from Abyssinia in Ethiopia around 1800 and 1890 and are part of the Nilo-Hamites, just like the neighboring ethnic tribes of Ateso and Karamajong. Traditionally,

before the coming of the colonial British government, the Langi were administered through chieftainships organized around clans. The district covers a total area of 1,326 square kilometers. The study covered 2 out of the 9 sub-counties: Agweng and Ogur sub-counties.

The main economic activity for people in Lira is agriculture with 81% of the population involved in subsistence farming. Of the rest of the population, 3.1% are involved in agro-processing industries, while 15.9% are engaged in commercial and banking activities. The people of Lango take pride in cattle, which was a sign of wealth for a long time, until numbers drastically declined due to constant cattle rustling and theft by neighboring tribes and the war by the LRA, which lasted nearly 20 years, from 1987 to 2006. A study by Investing in Peace (2008) indicated that 77.9% of the population of the district stopped cultivation, while 11.6% lost their livestock, due to grievous harm and theft (Investing Peace, 2008: 15). The district is among the northern districts that are suffering aftermath effects of the war, with a very high poverty rate—71% of the population live below the poverty line.

5.4. **Katakwi**

Katakwi district is in Teso sub-region in Eastern Uganda (Republic of Uganda, 2014). The district lies at between 1,036 m and 1,127 m above sea level. The district population of Katakwi, according to the 2002 census, was 118,928, of which 57,401 (48.3%) were male and 61,527 (51.7%) were female (Republic of Uganda Census, 2002). The district borders the districts of Napak in the north, Nakapiripirit in the east, Amuria in the west and northwest, Soroti in the southwest, and Kumi and Ngora in the south. It has two counties, Toroma and Usuk, and ten sub-counties. Two sub-counties, Usuk and Ngarium, were selected for this study.

The district population draws its livelihood from pastoralism and crop production, with a few people involved in non-farm activities arising from increased urbanization in the district. The district experienced the civil strife due to the LRA insurgency and cattle rustling raids due to their proximity to the Karamajong. The civil war killed many people, disintegrated many families and destroyed a lot of property, leaving the district economically impoverished. About 64% of the district population live in poverty due to the effects of war, continued cattle rustling and environmental events, such as flooding and drought. The weather in Katakwi district is unpredictable, with too much rain at times, causing flooding, and not

enough rain at other times, leading to some prolonged dry spells—all of which has led to poor crop yields.

5.5. **Amuria**

Amuria district is in Teso sub-region and located 40 kilometers northeast of Soroti town. It is made up of two counties, Amuria and Kapelebyong, with 9 sub-counties, 47 parishes and 388 villages (Justice and Reconciliation Project, 2012). Amuria district, which was carved out of Katwaki district in 2005, is situated in Eastern Uganda in Teso sub-region and borders the districts of Katakwi in the east, Soroti in the south, Keberamaido in the west, Napakto in the northeast, and Alebtong, Otuke and Abimto in the north. The district's total area is estimated at 2,613 square kilometers. The district has a population of approximately 270,601 people (Republic of Uganda Census, 2002). It was originally comprised of 10 sub-counties, of which this study sampled only two: Orungo and Obalanga sub-counties.

Amuria district was also affected by the LRA insurgence in Teso sub-region. The rebels used Amuria as a base to attack the rest of the Teso region, which left many people in the district displaced with property destroyed. One of the sub-counties selected from this district, Obalanga, experienced a mass massacre, in which over 365 people were killed and buried in a mass grave. The district was also home to over 40,000 IDPs (Justice and Reconciliation Project, 2012, p. 6).

PART III: SOCIAL PROTECTION INTERVENTIONS

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6. Overview of Social Protection in Uganda

6.1. **Poverty in Northern Uganda**

There are ample reasons for the rehabilitation of Northern Uganda to have a focus on social protection through livelihoods programs. The share of the population living below the poverty line fell from 55.7% in 1992 to 19.7% in 2012/13 (Uganda Human Development Report, 2015; p21), but Northern and Eastern Uganda still record a high incidence of poverty with 34.7% (Acholi), 17.6% (Lango) and 40.5% (Teso) of the population living in conditions of poverty (Uganda National Household Survey, 2017; p. 85). So many factors are responsible for poverty in Uganda, including, among others, conflict, unfavorable demographic characteristics, and the chronic nature of poverty. The State of Population Report 2010 pointed to a need for an overall social protection framework with program to improve incomes, education and health as a way to mitigate poverty-related vulnerability (Republic of Uganda, 2015). Notwithstanding the fact that Uganda endorsed the Maputo Declaration in 2003, committing itself to adopt sound policies on agricultural and rural development, and to allocate at least 10% of its national budget to the sector by 2009, Eastern and Northern Uganda have the highest percentage of poverty in the country.

Northern Uganda was greatly affected by the LRA insurgency. The LRA revolt against the government, which lasted for over 20 years, displaced people and destroyed property; many people lost their lives, while those who survived remain severely traumatized (Ondoga, 2012; Okello et al, 2013). The majority of the population in Northern Uganda has remained impoverished due to the post-war effects, exacerbated by poverty due to income insecurity, lack of education or poor education, lack of access to good health services, social deprivation, and cultural practices that have prevented some people in the communities from accessing wealth and land due to their gender (Garber, 2013). This has rendered many households vulnerable and economically fragile. Women, older persons, persons with disabilities and children are particularly affected.

6.2. **Social protection policy in Uganda**

According to various studies conducted in Uganda, Social Protection would give vulnerable persons an opportunity to improve and sustain their livelihoods and welfare (MGLSD, 2015).

This would enable people and their dependents to maintain a reasonable level of income through decent work and have access to affordable healthcare, social security and social care services. In the context of Uganda, social protection refers to public and private interventions aimed at addressing risks and the vulnerabilities that expose citizens to income insecurity and social deprivation, leading individuals to live undignified lives (MGLSD, 2015).

Social protection is not new in Uganda; the poor and vulnerable have always been cared for by their families and community systems. However, unfortunately as Uganda has become more modernized and more urban, traditional social protection systems have been over-stretched. Despite the reduction in poverty levels and steady economic growth experienced by Uganda in recent years, nearly 31% of the population still live in poverty and 26% of all the households remain in chronic poverty, characterized by vulnerable people (such as older people, children, people with disabilities), with many more falling into poverty as a result of illness, unemployment, death of family members, and the effects of internal conflicts and insecurity, which affects standards of living (Equal Opportunities Commission (EOC), 2016). The Uganda Employment Policy 2011, notes that less than 5% of the economically-active population is covered by the main pension schemes—the National Social Security Fund and the Public Service Pension Scheme.

Social protection has been widely recognized as a key instrument for poverty reduction and improved livelihoods among vulnerable groups and people, not only in Uganda, but the world over (UNICEF, 2015). At the regional level, countries across Africa have developed formal social protection systems as one of the core components of their national development strategies. In line with the national obligations and objectives outlined in the Constitution of the Republic of Uganda, the government has taken important steps in this regard. In 2006 it signed the Livingstone Call to Action, which sets out commitments to social protection. The government is also a signatory to the African Union Social Policy Framework (2008), which requires member countries to recognize that social protection is a state obligation (MGLSD, 2011). In 1987, Uganda ratified the International Covenant on Economic, Social and Cultural Rights and, in 2002, it adopted the Madrid Plan of Action on Ageing (MIPAA, 2002), which calls on signatory nations to ensure that social protection systems respond to the needs of older persons. Uganda is a signatory to the Universal Declaration of Human Rights (1948), which recognizes social security provisions.

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Acknowledging the development challenges the country currently faces, the Government of Uganda, through its Social Protection Policy (2015), has recognized the importance of reaching out to vulnerable and excluded sections of the population, thereby achieving inclusive, sustainable and pro-poor equitable development. The Uganda Vision 2040 identifies the need for the development and implementation of social protection systems to respond to the needs of vulnerable groups, such as the elderly, orphaned children, and the disabled, among others. The vision further recognizes the development of a universal health insurance system through public-private partnerships.

Social protection was first integrated into Uganda's Poverty Eradication Action Plan (PEAP) and Social Development Investment Plan (SDIP) in 2004. Social protection was also strongly reflected in the first National Development Plan (NDP I), and its importance was further emphasized in NDP II and SDIP 2 (MGLSD, 2011). The implementation social protection initiatives are supported by a wide range of legislations, which, among others, include: The Pension Act (1946), National Social Security Fund Act (1985), Children's Act (2015), and Equal Opportunities Act (2007).

Public and private institutions have addressed the tasks embedded in social protection services in many ways. The various interventions range from national policies—originally designed to achieve broader goals, but also encompassing social protection aspects through to ad-hoc social protection programs.

The social protection framework for Uganda defines the social protection system as comprising two pillars: Social Security and Social Care and Support. Social Security (the first pillar) is a preventive intervention to mitigate income shocks and is, in turn, classified into: Direct Income Support (cash transfers) and Social Insurance. Direct Income Support provides regular and reliable transfers of money to vulnerable people. It is non-contributory, which means that the beneficiaries don't contribute to it. Direct Income Support covers those extremely vulnerable people and households without any form of income security. The Social Care and Support (the second pillar) aims at providing a wide range of services to the poor and vulnerable.

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6.3. **Social protection programs implemented in Uganda**

The Government of Uganda has implemented various social protection interventions over the years such as the National Social Security Fund, National Pensions Scheme, the Northern Uganda Social Action Fund (NUSAF), the Orphans and Vulnerable Children (OVC) program, Universal Health Services, Cash for Work Schemes and the Parliamentary Pension Scheme. However, with the increase in urbanization, acute unemployment levels, conflict, drought and the impact of HIV/AIDS, the fabric of social systems continues to wear thin (Republic of Uganda, 2015). In addition, the Universal Primary Education (UPE), Universal Secondary Education (USE) have been implemented.

At the core of the Ugandan Social Protection system is the Direct Income Support programs, which provide small, but regular, transfers targeting individuals and households to provide them with a minimum level of income security. These include the Social Assistance Grant for Empowerment (SAGE), under which are the Senior Citizen Grants and Vulnerable Family Grants (VFG), Community Driven Development (CDD) Programme, Agricultural Livelihood Recovery Programme (ALREP), Karamoja Livelihood Improvement Programme (KALIP) and Northern Uganda Social Action Fund (NUSAF). The social protection programs are implemented at the national and local government levels. The beneficiaries use the cash transfers received as they wish (MGLSD, 2016). According to the report by the Ministry of Gender, Labor and Social Development (MGLSD) on the first pilot of direct cash transfers under SAGE, it was indicated that the benefiting households and groups used the cash on accessing health services, education, purchasing food and basic necessities, and investing in small businesses.

For example, the NUSAF program required young adults from the same town or village to organize into groups and submit a proposal for a cash transfer to pay for: (i) fees at a local technical or vocational training institute of their choosing, and (ii) tools and materials for practicing the craft. Like many participatory development programs, the objective was not only to enrich, but also to empower young adults. On average, successful groups received a lump sum cash transfer of USD 7,108 to a jointly held bank account, which breaks down to roughly USD 374 per group member, at market exchange rates. The average group had 22 members, and 80% of groups ranged from 13 to 31 members in size, according to pre-intervention group rosters.

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Table 6-1. Summary of social protection programs in Uganda

Name of program	Target group/	Started	Provider	District(s)	Category of program	Focus trauma healing	Gender focus
Expanding Social Protection (ESP)		2010	Government of Uganda under the MGLSD, funded by DFID, Irish AID and UNICEF				
1. Social Assistance Grants for Empowerment (SAGE) – regular, unconditional cash transfer							
Senior Citizens Grant (SCG)	Elderly (65 years and above) 60 years in the disadvantaged Karamoja region	July 2010	Department for International Development (DFID), Irish AID and UNICEF and the Ministry of Gender, Labor and Social Development	Apac, Kole, Amudat, Moroto, Nakapiripirit, Napak, Kiboga, Kyankwanzi, Kaberamaido, Katakwi, Kyegegwa, Kyenjojo, Nebbi, Zombo and Yumbe	Direct Income Support UGX 50,000 (USD 20) every two months	None	None
Vulnerable Families Grant (VFG)	Vulnerable households with low labor capacity and a high dependency ratio		Department for International Development (DFID), Irish AID and UNICEF and the Ministry of	Apac, Kole, Amudat, Moroto, Nakapiripirit, Napak, Kiboga, Kyankwanzi, Kaberamaido, Katakwi, Kyegegwa, Kyenjojo,	Direct Income Support (social pension)	None	None

			Gender, Labor and Social Development	Nebbi, Zombo and Yumbe.			
Expanding Social Protection Phase 2	Elderly	2015	Ministry of Gender, Labour and Social Development	New districts in FY 2015/16: FY 2016/17, FY 2017/18: FY2018/19	Direct Income Support UGX 50,000 (USD 20) every two months	None	None
2. Public Works Program							
Northern Uganda Social Action Fund (NUSAF) (Community Development Initiatives)	Community mobilization	2002–2008	Government of Uganda	Wider north covered by PRDP	- Cash for work - Creation of community assets - Provision of food items - Empowering communities	None	Gender is not a criterion for participation in the intervention
Northern Uganda Social Action Fund (NUSAF) **- Household Income Support Program (HISP)**	Poor and underemployed youth, aged roughly 16 to 35 in local terms	2009–2013	Government of Uganda	Wider north covered by PRDP	- Cash for work - Creation of community assets - Provision of food items	None	None

- Public Works Program (PWP)							
Northern Uganda Recovery Programme (NUREP)		2007–2010	European Union	Acholi, Lango and Teso and Karamoja sub-regions in 19 districts	Cash for work		
Karamoja Livelihoods Improvement Programme (KALIP) **(replaced NUREP)**	Extremely vulnerable individuals (landless or without labor)				- Creation of community assets - Provision of food items - Transfer of cash		
Agricultural Livelihoods Recovery Programme (ALREP)	Extremely vulnerable individuals (landless or without labor)				- Creation of community assets - Provision of food items - Transfer of cash		
3. World Food Program (WFP) initiatives (programs considered as social protection)							
Protracted Relief and Recovery Operations (PRRO)	Based on circumstances	2005 to date	WFP		- Food distribution, - Cash vouchers in post-harvest season		

					- Supplementary and therapeutic feeding		
Karamoja Productive Assets Program (KPAP)		2011	WFP		- Cash for work - Food for work		
Restoration of Agricultural Livelihoods in Northern Uganda (RALNUC) and Development Assistance to Refugee Hosting Areas (DAR)	RALNUC – IDPs returning to own land. DAR – Increasing agricultural production	2005–2008 for phase 1 and 2009–2012 for phase 2	DANIDA	Northern Uganda districts	Labor intensive and payment is through vouchers rather than cash, but in some areas has shifted to cash		
Livelihoods and Economic Recovery in Northern Areas (LEARN)	IDPs	2008	Norwegian Embassy	LRA affected areas	Cash transfers	None	None
Youth Venture Capital Fund	Youth		Ministry of Gender, Labour and Social Development	Whole country	Cash and material transfer	None	Yes

6.4. **Social protection schemes in Northern Uganda**

The Government of Uganda has undertaken many programs for the Restoration of peace and development through the Peace, Recovery and Development Plan (PRDP). In 2007, The Peace Recovery and Development Plan (PRDP) was launched by the Government of Uganda but did not start in full scale implementation 2009. The overall goal of this program was to stabilize Northern Uganda and lay a firm foundation for recovery and development through specifically promoting socio-economic development of the communities. A number of national agencies were expected to align their interventions frameworks to PRDP (UN, 2009). Much of the development that was undertaken by the government of Uganda with its partners was mainly visible recovery and development activities with minimum focus paid on trauma/emotional recovery for the victims of the more than 20 years of conflict (Internal Displacement Monitoring Centre (2012)

It's in this line that government implemented additional programs such as National Agricultural Advisory Services (NAADS) later renamed as Operation Wealth Creation, Northern Uganda Social Action Fund (NUSAF), Uganda Social Assistance Grants for Empowerment (SAGE), the restocking program, the Community Driven Development program, and Youth Livelihood Program. These were supplemented by other programs that were being implemented by development partners such as; USAID's Northern Uganda Development of Enhanced Local Governance Infrastructure and Livelihoods (NUDEIL), the European Union's million Agricultural Livelihood Recovery Project (ALREP), the UN launched a three-year Peace building and Recovery Programme (UNPRAP). However, by the time of this study, many of these programs had closed and only just of them were still functional. Thus the participants in this study identified National Agricultural Advisory Services (NAADS) later renamed as Operation Wealth Creation, Northern Uganda Social Action Fund (NUSAF), the Uganda Social Assistance Grants for Empowerment (SAGE), the restocking program, the Community Driven Development (CDD) program, and Youth Livelihood Program.

During our study, the following programs were still functional;

- National Agricultural Advisory Services (NAADS)
- Northern Uganda Social Action Fund (NUSAF),
- The Uganda Social Assistance Grants for Empowerment (SAGE),

- Restocking program,
- The Community Driven Development (CDD) program, and
- Youth Livelihood Program.

6.4.1. National Agricultural Advisory Services (NAADS)

National Agricultural Advisory Services (NAADS) later renamed as Operation Wealth Creation: NAADS/Operation Wealth creation is a national program that benefits farmers from 18 years and above. Both men and women benefit from this program as individuals or as a community based organized group. Initially, the NAADS program was designed to build the capacity of farmers to form and operate farmer associations, demand advisory services and adopt improved agricultural technologies and practices through demonstration of the technologies by model farmers in the community (Okoboi et al., 2013). Membership to the program depends entirely on the willingness of an individual to be part of the community based group and ready to work as a team to collectively address problems within their communities. The guidelines for implementation of NAADS program is based on guidelines which indicate that participation of farmers in NAADS is supposed to be through the self-selection of farmers through their farmer groups (NAADS, 2007). Thorough the NAADS program, implementation of the program involves the disbursement of funds to district and sub counties where activities are implemented who transfer the funds to the people who are supposed to benefit from the program as free or subsidized inputs. Thus all the districts that were part of this study benefited from this program. The program was meant to target vulnerable populations and well as other categories of population. Thus, household headed by a female, youth or a Person Living with Disability (PLWD) were supposed to be targeted. The beneficiaries of this program are categorized in three clusters and each cluster benefits from the program according to the resources available and priorities for each district. For example, the farmers in Teso region (Katakwi & Amuria, date) received fruit seedlings to boast production.

6.4.2. Northern Uganda Social Action Fund (NUSAF)

The Northern Uganda Social Action Fund (NUSAF) combines different types of interventions, such as temporary employment schemes through public works, household asset-building and community infrastructure programs. It has been in place since 2003 and has implemented in three phases (NUSAF1, NUSAF2 and NUSAF 2). The first phase focus on

peace and reconstruction, the second phase on basic services while the third phase focused on building a stronger focus on resilience building and disaster risk financing. By the time of this study, the government was finalizing the implementation of phase two. NUSAF 2 provided social protection to the people in the northern and eastern Uganda through temporary employment schemes with the aim of providing cash support during the lean season. The NUSAF 2 asset transfer program provided households with productive items such as goats and seedlings to be kept as savings and provide food security. The program covered all the districts in Northern and Eastern Uganda that were affected by the war. The local leaders identify people who are supposed to benefit from this program. Unlike other government programs that support communities through bureaucratic procedures, NUSAF provides its grants directly to communities although the responsibility for managing these funds is decentralized to community level institutions. The rationale of direct transfer of funds to communities is to enhance community action, enable communities to articulate and prioritize their needs leadership development and resource mobilization.

6.4.3. The Uganda Social Assistance Grants for Empowerment (SAGE)

The Senior Citizens is the first social protection program to target a particular group of people under the Expanding Social Protection Programme through the Social Assistance Grants for Empowerment (SAGE). The Senior Citizens Grant is meant to support older persons of 65 years and above and 60 for the more vulnerable older persons in Karamoja. The program has not been rolled out in the whole country but still being implemented in 15 districts in. For this study out of the four districts, it is only Katakwi District that was among the district supported by the program. Each of the older persons is supposed to receive regular 25,000 Uganda Shillings. This money is meant to enable them access basic services and to start income generating activities. Apart from age, selection of the beneficiaries is based on level of vulnerability among the old in each sub county. Thus, old women, persons with disability and those supporting a big number dependents are given priority.

6.4.4. Restocking Program

The Restocking Program covers the greater Northern Uganda especially West Nile, Acholi, Lango and Teso sub regions, thus all the four districts included in this study were part of this program. Before the LRA invasion, people in these areas had livestock keeping as one of their major economic activity and a sign of wealth. When these sub regions went through

harm conflict for over 20 years, they were subjected to looting from the rebels and people lost their valuable assets such as livestock. The areas were affected by cattle wrestling by the Karamojongs. By the end of the war and disbarment process in Karamoja, the communities that derived their income from livestock keeping become vulnerable to poverty. As one the strategies to rehabilitate the people in these areas, PRDP2 included restocking program in its 2013/2014 financial year. The program is administered by the Office of the Prime Minister and targets elderly and person with disabilities, widows/widowers, PLWAs, Orphans, Ex-combatants, former abductees, female headed households, child mothers, unskilled and unemployed youth. The beneficiaries are selected by community leaders together with community leaders. The local government officials procure the animals which they distribute to the individuals. These animals are given to individuals within households who are supposed to account for them.

6.4.5. Community Driven Development (CDD) program

All the local governments in Uganda are implementing the Community Driven Development programs as a way of giving control of decisions and resources to community groups. The local councils operate at five councils with the Local Council five (LC5) (here in referred to as District) being the highest level in the district. However, Local Council three (LC3) (herein referred to as the Sub County) implement this program through approving community based projects. The Local Council two (LC2) (here referred to as a parish) support the communities in preparing development plans which they submit to LC3 for funding. Individuals organize themselves in groups in which a third must be women to apply for funds to implement their project. This program replaces the Local Government Development Programme which was also formally implemented by the Ministry of Local Government. This community driven development program is intent to bring public decisions closer to the people.

6.4.6. Youth Livelihood Program

This program was initially managed by the Ministry of Finance, Planning and Economic Development (MFPED). This program was handed over to Ministry Gender, Labour and Social due to the central role played this Ministry in regard to youth matters in the country. The program targets individual youth as well as the youth organized in groups. The program gives soft loans to the youth with no interest rate and are expected to return the money so that the other youths access the money. The program finances small scale business ventures

which have been in place for about two to three years. The beneficiaries of this program are selected by the Sub County local leaders who through reviewing the applications sent in by the different groups in a sub county choose the successful individuals and groups. The group members then choose either to start a joint enterprise or share the money for each member to do their own individual project. The sub county may procure the items required by the groups and distribute it to the groups or allow the youth to manage their funds.

6.5. **Local government support to women's participation in social protection programs**

The local governments have come up with different strategies to help women participate in the government social protection programs. These strategies include;

- Due to limited funds received from the central government to support district activities, local governments have patterned with civil society organizations to meet the gaps that are created with limited funds. In Lira district, the government has put in place a domestic violence shade where women who have been battered are kept as the local authorities investigate and find a solution to the problem.
- The districts have also and sub-county officers have supported women only groups with their own local funds which they generate locally. They started affirmative action groups for women as way of preparing them to compete for national and regional social protection programs.
- Some districts have appointed female staff in the various district and sub-county offices to allow grass root women to interact their leaders through female staff. One of the local leaders in Lira district explained that he is proud to have about 35% of their staff being women (39/14/03/L)

However, one of the female local leaders from Orungo sub-county-Amuria District (40/22/02/Or) indicated that some of the male leaders don't support women to benefit from these government programs. She noted that some of their male counterparts in leadership charge their stamps when women submit their application for such funds yet in most cases they cannot afford. Thus men benefit more than women because they can afford to pay for the stamp before the funds are given.

PART IV: TRAUMA RELIEF INTERVENTIONS

7. Trauma in Northern Uganda

7.1. **Prevalence of trauma in Northern Uganda**

An epidemiological survey carried out in 2004, by the Ministry of Health in Uganda, found rates of up to 50% for depression in the most conflict-affected districts (such as Northern Uganda), compared to 8% in districts not severely affected by war (Kinyanda, 2004). Betancourt et al. (2009) carried out a qualitative study that looked at local perceptions of psychosocial problems among children and adults from the Acholi ethnic group, who had been displaced by war, in Northern Uganda. The study, carried out using previously developed rapid ethnographic assessment methods, found several locally-defined syndromes that correspond to depression/dysthymia, anxiety and behavioral problems.

Other studies have found high rates of PTSD, depression and anxiety disorders. Ovuga, Oyok, & Moro, (2008) found, in a study of 58 girls and 44 boys, that 87.3% had experienced ten or more war-related traumatic events, 55.9% suffered from PTSD and 88.2% suffered from depression. However, the study also identified that symptoms weren't restricted to individual children, there was a wider context of mental health problems in their families too. Nearly half of the children (42.2%) reported a positive family history of severe mental illness; 10.8%, reported a family history of suicide; 22.5%, a family history of attempted suicide; and 45.1%, a family history of alcohol abuse.

In a cross-sectional study of 2,875 individuals in 8 districts in Northern Uganda, Pham, Vinck, & Stover, (2009) found that over half (56%) of all the respondents and over two-thirds of those who experienced abduction met the criteria for symptoms of PTSD and female participants were more susceptible than males. Older men were more susceptible to depression. Additional symptoms of mental health difficulties were observed in people with: a low score on a social relationship scale, high incidence of general traumatic event exposure, high incidence of forced acts of violence, and problems reintegrating into communities after abduction.

Roberts et al. (2008) conducted a survey in IDP camps using survey instruments designed to measure physical and mental components, as well as a trauma scale (the Harvard Trauma Questionnaire) and found poor physical and mental health, with frequency of exposure to trauma being a very strong indicator of poor health and mental health outcomes.

Muldoon et al. (2014) analyzed the mental health status and reintegration of abductees, using a locally-developed and validated scale called the Acholi Psychosocial Assessment Instrument (APAI), developed using free listing interviews with youth, local adults and key informants to identify and describe signs of mental health syndromes affecting Acholi youth. The study found that in the sample of 400 young women sex workers, a total of 129 (32.2%) women had been abducted by the LRA, of these (56.6%) had self-reintegrated and the rest had accessed at least one reintegration program ranging from a traditional cleansing ceremony (67.9%), to receiving amnesty (37.5%), or being registered and lodged at a reception center (28.6%), and receiving a re-insertion package (12.5%). Although the study did not find a between group difference, indicating that the mental health status of abductees who accessed reintegration programs were significantly different from those who self-reintegrated, the research highlighted the complex relationships between exiting 'bush life' and reintegration into 'normal' society in Northern Uganda.

All of the studies above are indicative of how the devastation of war has caused widespread mental health problems, including PTSD, on a scale that affects not only individuals and their families, but entire communities.

Studies, in other post-conflict communities have highlighted the need to develop and provide mental health intervention, not just to support and alleviate the pain of individuals, but to enable healing and reconstruction of entire communities. In a national population based mental health survey in Afghanistan, Cardozo et al. (2004) found that 62% of participants (in a sample total of 799 adults) reported having experienced at least 4 episodes of traumatic events in the 10 years leading to 2002 and these resulted in the prevalence of extremely high levels of mental health problems, particularly depression, anxiety and PTSD, making the provision of mental health care an utmost priority for the reconstruction effort in the country as a whole.

In addition to being an impediment to development, PTSD has also been found to negatively impact on efforts for reconciliation. When people are traumatized, their systems remain aroused, they become hyper vigilant, but are unable to locate the social threat. This causes fear and reactivity to escalate and leads to re-enactment in search of an enemy. Unhealed traumatic societal events can, therefore, lead to cycles of violence.

Bayer, Klasen, & Adam (2007) conducted a study of 169 former child soldiers in Uganda and Congo, who reported to being recruited violently at a young age and exposed to high levels of potentially traumatic events. The youngsters who scored high on the Child Posttraumatic Stress Disorder Reaction Index (CPTSD-RI) showed significantly less openness to reconciliation. Among those former child soldiers, PTSD symptoms were associated with less openness to reconciliation and more association with revenge.

In an assessment of the association of trauma levels and PTSD symptoms to attitudes towards reconciliation in post-1994 Rwanda, Pham, Weinstein, & Longman (2004) found that of the 2,074 participants, over 2,000 had been exposed to traumatic events and 518 (24.8%) met the criteria for PTSD, as measured by the Civilian PTSD Checklist. Those respondents with PTSD were less likely to have positive attitudes towards the Rwandan national trials, were less likely to have a belief in community and less likely to have interdependence with other ethnic groups.

In a paper published in 2004, Audergon, based on her work in Croatia, explains that post war trauma is more than an individual experience, but rather whole communities are traumatized with impacts that can even change the course of history. To this end the paper urges that a more comprehensive understanding of post-war trauma is one in which both the personal, communal and political aspects are taken aboard. The paper explains how when whole communities suffer atrocity, trauma stays in the fabric of the family, community and society for generations unless it is healed.

7.2. **Trauma interventions in Northern Uganda**

Until early 2007, community and international humanitarian organizations in Northern Uganda operated 12 reception centers for LRA abductees who were either captured in battle or managed to flee their captors (Pham, Weinstein, & Longman, 2004). Upon arrival, former abductees were given a medical examination and treated for diseases and other ailments. Those suffering from war wounds were sent to hospitals and health centers in their home districts and referrals were made to the National Referral Hospital, Mulago in Kampala. Most returnees stayed at the centers for two to six weeks and participated in a range of activities, including counselling. However the violence in LRA-affected territories affected not only the abducted, who are forcibly taken by the group, but also other members of affected

communities, who were not necessarily abducted, highlighting the need for a more comprehensive approach to trauma healing in the region. The mental health status of people in Northern Uganda and the impact of the many years of torment have become not just concerns of national magnitude, but regularly feature as issues of concern globally.

The population surveys conducted after the civil war indicated a high prevalence of depression and post-traumatic stress symptoms (Nakimuli-Mpungu et al., 2013). Thus, before the commencement of the EWP-U, women in these districts were still traumatized by the effects of the war, with little or no support to help them overcome this.

This study investigates how services to address post-traumatic stress impacted on efforts of social protection (cash and in-kind transfers) provided by the Government of Uganda. The trauma services were provided by local government or Non-Governmental Organizations in Northern Uganda. In this study, these services are referred to as 'counselling'. Specific mention is made to the counselling efforts by Isis-WICCE and sister organizations as the effect of this service was specifically investigated in this research.

7.3. **Trauma support by local government**

The study findings indicate that many local governments lack health facilities to help community members who are traumatized. There is no single district or sub-county that had an independent vote account to address trauma in all the districts visited. Many of these local governments indicated that they had tailored trauma interventions to their other activities with votes to support reported cases. The office of the district and sub-county community development was singled out to play a role as far as trauma intervention is concerned. The officers from this office paid home visits to persons reported to be traumatized and these counselled or made referral to health facilities within the district or sub-county.

The districts and sub-counties mentioned that they have been able to lobby non-government organization that operate in their areas to take on trauma management during their interventions in the community. In Agweng sub-county-Lira District, an organization TPO which is supported by Plan Uganda, has been instrumental in supporting and counselling traumatized people. Isis-WICCE has also been working with many community based organizations to in conjunction with all the four districts to train and support traumatized women. USAID, SEWICO and World Education Trust have played a good role in Lira District.

The Government of Uganda, through the Ministry of Health, has been involved in the treatment of people diagnosed with mental-related health risks through the Butabika National Referral Hospital in Kampala. In order to enhance the mental health service delivery in the northern districts, the Ugandan government institutions (the Ministry of Health, Butabika National Referral Hospital, and the Makerere University Department of Psychiatry) and the Peter C. Alderman Foundation (PCAF) initiated a public-private partnership in which four districts (Arua, Kitgum, Gulu & Soroti) benefited from the establishment of four PCAF trauma clinics (Nakimuli-Mpungu et al., 2013). The clinics were based on group counselling intervention for those experiencing depression and post-traumatic stress symptoms.

7.4. **Interventions by women's organizations**

Isis-Women's International Cross Cultural Exchange (Isis-WICCE) set out to work with communities affected by armed conflict in 1993, working with women (and men) in Luweero (Central Uganda), Gulu, Kitgum, Lira, Pader, Soroti, Katakwi, Amuria, Kumi (North Eastern Uganda) and Kasese, Bundibugyo in South Western Uganda. One of the key issues that stood out was the fact that despite government designing post conflict reconstruction programs, the aspect of trauma management and healing for survivors was lacking.

The key approach that Isis-WICCE started with was breaking the isolation that survivors of the war were living in, by organizing women friendly spaces for survivors to share the pain and ordeals of the war (such as rape, sexual violence, abduction and torture) and how they were coping. This enabled them to speak out, cry and counsel each other. Isis-WICCE also organized exchange visits for women to interface with fellow women in other post conflict districts with similar challenges. This opened their minds that the suffering they were experiencing was the same despite the ethnic divide, and they were able to build friendships and networks for peace.

Isis-WICCE further organized specialist-facilitated training for selected women leaders and health workers from the affected districts on trauma management. This enabled them to understand and connect the pain they were experiencing as linked to the traumatic experiences of war, and to gain skills on identifying and managing trauma at the individual, family and community levels. This process was comprehensive and time-consuming. On returning to their communities, the trained women leaders started providing support to

women who were returning from captivity and those who had been terribly affected by war. They eventually formed community-based groups, including the Kitgum Women Peace Initiative (KIWEPI) in Kitgum, Women Peace Initiative-Uganda (WOPI-U) in Lira, and Teso Women Peace Activists (TEWPA) in Katakwi and Amuria. It should be understood that the women that Isis-WICCE trained were ordinary women, with not much formal training in psychiatric treatment. So they took a non-medical approach to dealing with trauma and worked through self-help groups to support women survivors to achieve collective healing. These women's groups made a few referral cases to Isis-WICCE, which organized some medical camps to respond to both physical healing (sometimes involving surgery clinics) and psycho-social support.

In Soroti and neighboring districts, TEWPA mobilized women into a movement of peace animators and peace committees, and young boys and girls in school into peace clubs. Working in this set up, women were provided basic tips for counselling and moved from house to house and organized healing spaces for counselling and support (providing food to those who needed and accompanying others to access health care), enabling traumatized women to regain their self-worth.

On the other hand, KIWEPI opened a space that received formerly abducted girls together with their babies born out of rape. Most of these girls were stigmatized and rejected by their families. Through counselling and attaching these girls to foster homes, hope was restored. This, in addition to community sensitization to enable communities to accept and combat stigma has contributed to the re-integration of girls back into the community.

It should be noted that KIWEPI, TEWPA and WOPI-U introduced a theatre component for development as a means of counselling and also to provide entertainment to enable community members to regain some happiness. The sessions were followed by a public dialogue and debate on the issues discussed. This helped those in pain to come forward and seek support. Otherwise, these women counselled each other and shared stories of what had happened to them during the war. The anger and vengeance felt by the women was deep. The leaders of the organizations started to explain to the victims how the offenders never intended to harm them, but the circumstances of the war forced them. The importance of forgiving was much emphasized as a component of healing. Thus, religious leaders were

invited to take part in the counselling sessions so that the value of forgiveness could be understood.

The women were also taught basic skills like cooking and sowing to empower them to start some income generating activities. Some of the women managed to reintegrate in the community and a few returned to their families. The organizations such as KIWEPI also used music to talk about peace and to make women feel happy. KIWEPI also used the community parliament, which is locally called a *Baraza* (an assembly where community members assemble to talk about issues that affect them collectively), where they involved district leaders to come and speak about peace.

Despite the counseling provided, women continued being confronted with the burden of poverty in their homes. There was need to address livelihood concerns within the counseling model and this was introduced. The women survivors and formerly abducted girls were equipped with skills in tailoring, baking, farming, entrepreneurship and provided with startup kits. And groups of women who had contracted HIV were facing a double burden of stigma and were provided start up grants to improve their nutrition and engage in economic activities. They bought heifers to enable them have milk for improved nutrition and self-esteem.

Isis-WICCE working with TEWPA, KIWEPI, and WOPI-U have been engaging leadership to prioritize the post-conflict needs of women, especially in relation to trauma healing. Through community parliaments (*Barazas*) and meetings, a dialogue has been initiated with district and national leadership, highlighting and reminding power holders that development without addressing trauma healing is retrogressive. Some gains have been made, e.g., the Uganda Peace, Recovery Development Plan 2 recognized and incorporated providing psychosocial support and counselling to traumatized community members and abductees as one of the key components; the Lira district local government passed a bylaw reducing drinking hours and banned some types of liquor that they felt was escalating the problem.

The psychosocial burden remains high, with increasing reports of suicide, alcoholism, gender based violence, loss of hope due to unemployment among youths and high levels of poverty in the community. These are all associated with low attention to trauma healing. During the pilot interviews with the leaders and some of the victims of war (formally abducted child

soldiers and captured wives who escaped), it was clear that these women had indeed been traumatized by so many terrible incidents they had endured during the war. These women shared their stories ranging from torture, rape, forceful killing of close family members and friends, carrying heavy loads and many awful personal stories. Women reported being fearful of associating with other community members, as the wounds of their actions reminded fresh in the hearts of those people who had lost their dear ones in war and who had decided to apportion the blame to some of these women. Young mothers continued to look after the children they produced out of rape, without any support from their relatives. Their children were not welcome in many of the families and communities, as they were regarded as 'children of the enemy'.

Despite these interventions, these women still feel anger and grief. Some of them feel the need for revenge and would kill if they got the opportunity. One of the women interviewed explained that "the man who raped me is passing here every day and I wished I had a gun, I would shoot him". They are still very upset with their own communities, who failed to protect them, but instead haunted them. One of the women leaders noted that "their society was still living in yesterday" and, hence, did not consider themselves yet in a post-conflict situation. During the pilot studies, many members of the community still reported cases of suicide and even killings. The youth born in IDP camps had many problems and had not received much counselling to help them overcome the trauma they experienced in these camps.

Despite the counseling provided, women continued being confronted with the burden of poverty in their homes. There was need to address livelihood concerns within the counseling model and this was introduced. The women survivors and formerly abducted girls were equipped with skills in tailoring, baking, farming, entrepreneurship and provided with startup kits. And groups of women who had contracted HIV were facing a double burden of stigma and were provided start up grants to improve their nutrition and engage in economic activities. They bought heifers to enable them have milk for improved nutrition and self-esteem.

The psychosocial burden remains high, with increasing reports of suicide, alcoholism, gender based violence, loss of hope due to unemployment among youths and high levels of poverty in the community. These are all associated by Isis-WICCE to low attention to providing trauma healing.

7.5. **Need for a new intervention**

During the first round of data collection, a sample of 470 respondents were selected to participate in this study. These were grouped under four categories; those who had received cash transfers, those who had received counselling, those who had received both counselling and cash transfers and those who had not received nether of the two. The preliminary findings from the first round of data collection indicated that almost all the participants in this study reported regardless of whether they had received counselling before or not still depicted a high to very high degree of trauma.

The stories shared by the participants from individual interviews confirmed the findings of the study from the first round. The local leaders and individual women interviewed expressed that there was common occurrence of traumatic behaviors in their communities. Many people in their communities were known to behave in ways that required counselling. However, many communities lacked facilities where traumatized people would seek assistance. The local leaders identified the war to be the main cause of trauma among the communities, although they acknowledged that there are also new events that create similar impact such as domestic violence. The participants of this study through their own statements acknowledged being traumatized from the events of the war and thereafter.

8. Development of the SHLCPTS Program

This chapter outlines the process that led to the development of a six-week Self-Help Low-Cost Post-Traumatic Stress (SHLCPTS) Program that addresses both the individual and collective trauma caused by the many years of atrocities in Northern Uganda.

When considering trauma healing in Northern Uganda, the veracity of universalized psychological interventions, often developed in Western contexts and focusing solely on individual trauma, should be carefully considered. In the Ugandan context, such interventions should be assessed with an understanding of collective cultures and the impacts of collective trauma. These aspects shape the context of the traumatic experiences in Northern Uganda, as well as the impacts that healing should address.

Simply focusing on individual trauma decontextualizes the collective suffering in post-conflict communities. The context for such collective suffering, after all, is the social and historical fabric, and leaving this out of the healing process, leads to further atrocities such as human rights violations (Lykes, 2001; Van Reisen & Munyaradzi, 2017), as well as hampering the recovery of those who are already suffering from PTSD and other mental health problems. On the other hand, the wider focus, locating trauma in the community as well as in any individuals who are suffering symptoms of traumatic stress will give opportunities for practitioners to focus on the community-wide potential to effect healing (Bonano, 2004; Kidane, 2015).

8.1. **Trauma and the human brain**

The development of the EMDR-based therapy intervention tool and its integration to simultaneously address the impacts of the trauma on individual victims and communities, is based on a comprehensive understanding of trauma and its physiological underpinning. Trauma affects a person in a way that results in the reconfiguration of the nervous system. Traumatized people become stuck and stop growing and developing as they become unable to integrate their traumatic experiences into their ongoing life. Instead they continue to organize their lives as though the trauma is still going on. Energy is focused on suppressing the inner chaos and attempting to maintain control over unbearable physiological reactions, rather than spontaneous involvement in their own lives (Van Der Kolk, 2014).

The human brain is organized into three sections and connected to the body in such a way that enables automatic triggering of a physical escape plan in the event of emergency. This system is operated from the oldest part of the brain (the animal brain). However, the process that triggers this reaction and enables the body to run, hide or freeze shuts down our conscious mind (or higher brain). If the emergency mode succeeds in averting danger, the brain is then able to regain internal equilibrium and gradually begin to operate as usual. However, if for some reason the response triggered does not result in successful escape or aversion, if for example the person is prevented from taking effective action, the brain will continue to fire stress reactions (and the chemicals associated), sending signals to the body to escape a threat that may no longer exist.

As the human brain's main function is ensuring survival, survival is always given precedence. The sensory input that enters the brain is routed via the thalamus (in the reptilian brain) and then to the amygdala (in the limbic brain) (Cozolino, 2002; van der Kolk, 2014). The neural pathway from the thalamus to the amygdala is extremely fast. The amygdala filters information coming in, if there is any threat or perceived threat, the hypothalamus is immediately stimulated to respond by triggering the release hormones (cortisol and adrenaline), which prepare the body to defend itself (Cozolino, 2002), and by alerting the system to become highly aroused and ready (Siegel, 2001). Information is also relayed to the hippocampal and cortical circuits for further evaluation (LeDoux, 1996). The findings of the hippocampus and cortex are then relayed back to the amygdala, this process is much slower and produces a more considered response, often encouraging the system to calm down.

In danger situations, higher brain functions are overwhelmed (Siegel, 2003) and the brain is focused on immediate survival (Cozolino, 2002). Oxygen is diverted away from the brain to the body and hormones are released activating the body for the 'fight-flight-freeze response (Van der Kolk, 2014). When a person is able to successfully avert a threat, employing the strategy described above, they are less likely to be traumatized by the experience (Herman 1992). However, this structure of the brain also results in lack of integration and may result in the dissociation that we see in victims of trauma (Cozolino, 2002); if the active responses are unsuccessful in averting danger, then the passive responses, such as dissociation, ensue. "In trauma, dissociation seems to be the favored means of enabling a person to endure experiences that can normally be beyond endurance" (Levine, 1997: 138). If the traumatic

event is repeated or becomes on going, then the activation is prolonged resulting in potential structural disintegration of complex trauma, where the trauma victim continues to act and react, often re-victimizing themselves by being engaged in self-injuring behaviors, such as self-harming. In some instances victims resort to externalizing the trauma by victimizing others (van der Kolk & McFarlane, 1996).

It is believed this vicious cycle is formed by the creation of neural pathways or the wiring and firing of neurons in such a way that the person continues to re-experience the traumatic event due to their inability to modulate their aroused state (Siegel, 1999). This impairment to brain functioning also affects the vital role of the brain in mediating memory, causing traumatic experiences to be stored predominantly as less adaptable, context free emotional memory (Cozolino, 2002).

Without intervention, a trauma victim can, potentially, continue to live their lives as if they are still in danger, weeks, months, years even decades after the traumatic experience. This is particularly the case for victims of events that were of 'human design' (APA, 2000), it is believed that the element of betrayal entailed in these events makes traumatization more likely (van der Kolk et al., 2007) and recovery complicated (Salter, 1995).

Understanding this impact of trauma on processes in the brain is essential when developing interventions for supporting victims of atrocities perpetrated by the LRA that were designed to torment and terrorize entire communities. In a sense, trauma treatment is essentially helping victims overcome the imprints of the traumatic experiences, which keep being re-activating resulting in the fight-flight-freeze responses to the slightest trigger. Given that disintegration of brain functioning and dissociation are problematic in the aftermath of war trauma, treatment based on creating and embedding associations and restoring integration is highly desirable. Eye Movement Desensitization Reordering (EMDR) is a therapy approach that has been highlighted for effectively integrating of traumatic memories in PTSD sufferers.

8.2. **EMDR as a trauma healing intervention**

EMDR works by getting victims of traumatic stress to focus intensely on the emotions, sensations and meaning of their traumatic experiences from a safe setting, while engaging them in a bilateral stimulation. The approach was first developed by Francine Shapiro in 1988 and has since been found to be an effective treatment for PTSD across many fields (Chemtob

et. al 2000), including in working with refugees (Mooren et al. 2014). EMDR is approved as top-level evidence based therapy by the World Health Organisation (WHO, 2013).

EMDR's effectiveness in healing trauma across many contexts and cultures makes it an ideal choice of an approach to address trauma among LRA victims in Northern Uganda. Indeed this is not the first time that therapists have seen the potential of EMDR as an approach for trauma treatment in the Ugandan mental health system (Masters et al., 2017). In 2008, there was an initiative with the objective of developing a core group of Ugandan therapists skilled to practice EMDR, as well as to teach the techniques to others.

Encouraged by the success of EMDR in treating PTS across many cultures and contexts, as well as the fact that other therapists in Uganda had already explored the potential, the objective of this current initiative became to develop sustainable community-based support using EMDR techniques.

Due to the impossibility of providing trained clinicians (even at basic levels) to provide intervention and support at the rate and in the locations, it is required, it was decided to model the intervention on the self-help guide developed by Francine Shapiro. The main objective of Shapiro's self-help guide is enabling people to understand why they are the way they are and then learn what they can do about pain and negative reactions. Techniques are designed to enable people to attain wellbeing by taking control over choices made on a daily basis. In accordance, the model developed for work in Northern Uganda had to have psycho-education as well as techniques for addressing traumatic memories and dealing with distress. However, because this form of trauma healing is new to the potential recipients and due to the fact that people will still require a level of support to go through the program, it was necessary to recruit support workers to coach people in the various techniques and encourage them to persist when difficulties arose. The role of support workers here will not be to provide opportunities to talk through the trauma but to demonstrate techniques and provide support if, for instance participants suffered demotivation following the activation of traumatic memories, hence, the specialization and training required is minimal. In addition to being cost effective and sustainable, this approach also leaves the agency in the community enabling people to train and support each other using the techniques they have mastered for their own use.

PTS shatters its victims' sense of trust of others and particularly in relation to the events that made them frightened in the extreme or ashamed. It is, therefore, also very important to create a context in which those undergoing the intervention are not stigmatized, but celebrated for their courage to face their experiences and overcome them. As mentioned above, ICTs can support interventions such. The opportunity that ICTs provided in Northern Uganda was to use community radio personalities to deliver the education and information element of the intervention and also provide support and encouragement via messages, on podcasts and radio broadcasts. These messages reinforced and promoted the need to address and overcome trauma and the collective and individual benefits thereof, encouraging healing both at the individual and collective levels, enabling whole communities to support the healing of the most vulnerable while being aware of the community wide impacts and generating therapeutic conversations at a wider scale.

In addition to the radio broadcasts and podcasts, the program also includes opportunities for community wide celebrations of the steps towards healing that participants of the program have taken and their contribution to collective healing. These events were supported by community radio broadcasters and community elders who were invited to commend and acknowledge the courageous steps taken by victims of atrocities to heal themselves and their communities. These events are intended to address the collective trauma suffered by whole communities, including children who were not yet born during atrocities, but have been brought up by the adults who bore the brunt.

8.3. **Multilevel healing of trauma in post-war contexts**

This leads to the conceptualization of trauma healing as supporting the many individuals with symptoms of traumatic stress, while at the same time addressing collective trauma, enabling both the traumatized community and traumatized individuals within it the opportunity to heal and move on to post-traumatic growth. If collective trauma represents the disruption of relationships at many levels of the human system, recovery should also involve collective processes of adaptation and the mobilization of capacities across all these levels (Saul 2014). Therefore, healing trauma simultaneously at the individual and collective levels is crucial for post-conflict recovery, and neglecting trauma healing has detrimental impacts not only on the wellbeing of individuals, it also hampers post-conflict reconstruction and peace building and the impacts of collective trauma will affect subsequent generations as traumatic memories and reactions are passed on through collective narratives, norms and societal structures, extending the cycles of violence and vulnerability.

Having justified the need for multilevel healing in post-conflict communities, the challenge of providing such support becomes evident. This is particularly the case given the devastation caused to the human and material resources available to the community and the prioritization of other needs over the needs for psychological healing, be it individual or collective. Gelbach and Davis (2007) state that, although the treatment of psychological distress in individuals and families is generally believed to expedite community recovery, the provision of effective and affordable psychotherapy is not yet a priority in post-disaster support. Although there are many other reasons for this, including the timing of interventions, as well as the type and effectiveness of some of the available techniques, a recurring concern, particularly in non-western cultures, is whether psychotherapy in itself is culturally biased and stigmatizing, pathologizing normal responses to danger and labelling trauma survivors as mentally ill (Miller & Rasco, 2004).

EMDR Humanitarian Assistance Programs (HAP) assert that clinicians trained in EMDR, have overcome some of these difficulties to develop a post-disaster treatment method that focuses on supporting the brain's natural capacity to reprocess disturbing information to an adaptive resolution (HAP volunteers, 2005). In addition, HAP found that training local clinicians helps to circumvent the problems caused by delayed international responses to traumatic events and builds sustainable resources in communities plagued by natural disasters or the effects of

violent conflict. The positive outcomes of HAP EMDR interventions have been published in several peer-reviewed articles (e.g., Jarero et al., 1999; Adruiz et al., 2009; Fernandez, Gallinari, & Lorenzetti, 2004; Jarero et al., 2006; 2010; Zaghrout-Hodali et al., 2008). More details on the impact of trauma on the brain and how interventions like EMDR work is provided below. Here, it will suffice to say that EMDR techniques have been effectively used and training local clinicians to deliver them has been effective.

However, in the context of poor post-disaster contexts, such as Uganda, even this successful and relatively cost-effective technique is not easy to implement due to the unavailability of clinicians. This is particularly the case given the extent of the traumatization and the deprivation of the region affected. If EMDR-based techniques are to be effectively implemented to address individual and collective trauma in rural Northern Uganda there is, a need to find a realistic and sustainable medium to facilitate accessibility.

One of the features of communities in current day Africa is the fast expansion of ICTs, this is both a challenge and an opportunity (Van Reisen & Gerima, 2016). For our purposes, it is important to discuss the opportunities for utilizing technology to facilitate the cost effective and sustainable provision of trauma intervention in resource-deprived communities such as the ones in consideration here.

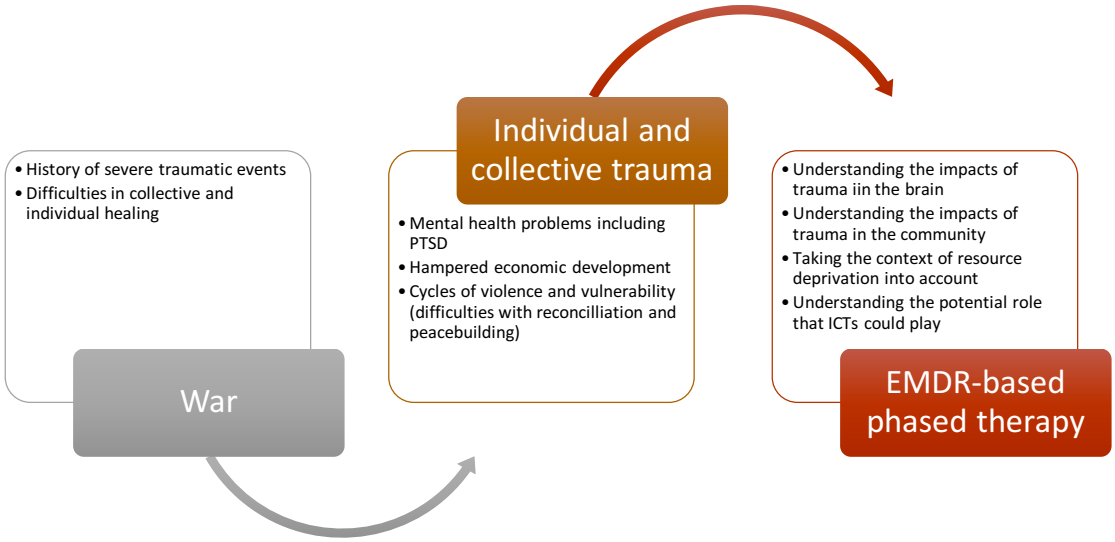
8.4. **Contextualizing and enlarging the impact of trauma support through radio**

A defining component of mass trauma, such as the trauma that took place in the years of the civil war in Uganda, is the betrayal of social trust, which leaves victims devalued and humiliated, undermining their sense of communal trust and decency (Saul, 2014). Restoring social trust is, therefore, a foremost task of any intervention. In fact, without restoring trust, an intervention will not have a chance of making any meaningful impact on recovery, as recipients will not access or engage with it.

The media plays an important role in building post-conflict recovery, as it can facilitate collective narration, which can shape the meaning ascribed to traumatic events, as well as providing resources and solutions to difficult challenges (Saul and Landau, 2004). With this in mind, the project undertook extensive liaisons with local, trusted media personalities, using podcasts with information for participants, as well as additional community-wide information on trauma and recovery for the wider public to promote trust and build confidence by creating

platforms for the creation of common meaning and understanding, allowing community members to open up to each other and express their needs, views and attitudes.

Figure 8-1. Impact of war on collective trauma



8.5. **Development of the SHLCPTS program**

Based on the conclusions of the analysis of wave 1 data (chapter 15 and 16) the SHLCPTS program was designed by the team (led by Selam Kidane) to develop a therapy based on the following criteria:

- Based on self-help activities to make it sustainable within the low resource setting of the communities;
- Foster to improve understanding of trauma and avoid re-narration so as to limit the possibility of re-traumatization;
- Ensure highly contextualized to create a level of trust and relevance for severely traumatized communities;
- Include a strong collective community base for the support program, including support from community leadership and families;
- Provide practical tools for Post-Traumatic Stress reduction based on scientific understanding of the effect of trauma programs in post –war and conflict settings;
- Integrate contemporary knowledge of psychiatric treatment of Post-Traumatic Stress;
- Set program in realistic boundaries of a low-cost setting with few health workers;

- Set program up in a sustainable and upscalable manner that can be conducive to dissemination by available media, such as radio.

8.6. **Outline of the six sessions of the SHLCPTS program**

The above discussion outlines how the trauma intervention was designed to take into account the neurobiology of trauma, as well as the impact of collective trauma on healing and post-traumatic growth. There is, increasingly, recognition that working to engage all areas of the brain is a key to reintegrate the post-traumatic body, mind and brain, and integrate emotions, sensations, awareness and thoughts. These are the connections that are often disrupted by complex trauma (Cozolino, 2006; Ogden, 2006; Siegel, 2001).

A number of key international bodies and clinicians treating either complex PTSD or PTSD in a survey report, endorsed a phased approach (Cloitre et al., 2012), which was reflected in the development of the SHLCPTS.

In accordance with guidance and good practice examples, a three-phase approach was followed to address the extensive impact of complex trauma in Northern Uganda. The phases of treatment are outlined in the Table 8.1.

Given the severe limitations of resources and the risk of losing client motivation endemic to the context, the intervention was much shorter than the average recommended under such circumstances. Much of the work was, thus, directed towards education and coaching of specific coping and processing skills and then a session was dedicated to psychosocial rehabilitation.

The SHLCPTS program was developed as an intervention offered in six sessions, covering the following aspects:

Session 1-2: psychosocial education, understanding trauma and the brain

Session 3-4: learning active exercises to control impact of trauma

Session 5-6: preparing a reorientation towards a supportive community

The sessions are detailed in the table below.

Table 8-1. Outline for a six week SHLCPTS program for victims of traumatic stress

Session number	Objective of session and activities	On Podcast	Through Live facilitators
1.	Introduction session to outline: 1. introduction to breathing techniques 2. What is trauma? 3. What is PTSD and what are the symptoms? 4. What is Complex Trauma and what are the symptoms? 5. What is collective trauma? 6. What does trauma do to the brain? 7. What is EMDR what does it do and how? 8. Safe place	The explanation in audio using accessible language and relevant examples An explanation of a safe calm place and the audio of instructions for it	Welcome and answer any questions and deal with logistics and practicalities and create a safe place for people Breathing techniques Use the circles to show how trauma affect individuals, families, community and society Use the brain model to embed the description of how trauma affects the brain. Use busy desk analogy. Support women to remain focused on creating the safe calm place and accessing it using their word. Practice that several times and embed it.
2.	This session is aimed at identifying the negative feelings, words and reactions that people want to address, remembering the touchstone memories that anchor those feelings and reactions and make a plan for support with this	Exercises: 1. SUDs 2. Touchstone Memories 3. Safe Calm Place	Welcome and answer any questions and deal with logistics and practicalities and create a safe place for people checking with people if they have been using their breathing technique Guiding and supporting SUDs and touchstone memories Finishing with a safe calm place
3.	Introducing people to bilateral stimulation	1. Introduction to bilateral stimulation and rationale 2. Quick SUD and Touchstone recap 3. Butterfly hug 4. Safe place	Welcome and answer any questions and deal with logistics and practicalities and create a safe place for people checking with people if they have been using their breathing and safe calm place exercises Guiding and supporting Suds and touchstone memories and butterfly hugs checking with SUDs again and repeating butterfly hugs. Finishing with a safe calm place
4.	Introducing people to bilateral stimulation	1. Introduction to bilateral stimulation and rationale 2. Quick SUD and Touchstone recap	Welcome and answer any questions and deal with logistics and practicalities and create a safe place for people checking with people if they have been using their breathing and safe calm place exercises

		3. Butterfly hug 4. Safe place	Guiding and supporting Suds and touchstone memories and butterfly hugs checking with SUDs again and repeating butterfly hugs. Finishing with a safe calm place
5.	Preparing for closure and thinking about sustainability of the techniques planning community event	1. Four elements exercise	Welcome and answer any questions and deal with logistics and practicalities and create a safe place for people checking with people if they have been using their breathing and safe calm place exercises as well as bilateral stimulation (butterfly hugs) Have a discussion on the importance of sustainability and about the fact that the women can have control over their emotion and memories using simple techniques especially when they are overwhelmed or when they fear being overwhelmed. Plan a community event when the women get to celebrate their achievements in working through these difficult events. Support people to do the four elements and encourage them to use it regularly in combination to other techniques or on their own
6.	To hold a community celebration where the whole community comes to celebrate the women and their achievements	Radio announcement of the events and acknowledgement of the work undertaken by the women and their support workers and how important this is for the whole community (a light explanation of trauma and collective trauma)	Preparing something that the women can take with them as a memento and/or a certificate of the work that was undertaken. Helping the women organize a community event. Receiving T-shirts with messages on how participants have become aware of trauma and treatments.

8.7. **Contextualizing SHLCPTS and preparation of radio dissemination (recordings)**

A total of 27 participants from the various communities and organizations in these districts were invited to attend a preparatory meeting for three days held in Lira (see 4.9). These were radio presenters and producers, representatives of community based organizations in the four districts, the project team members from Mbarara University of Science and Technology, Local government leaders, organizations in the four districts working with women related issues, and Isis-WICCE which organized the training on behalf of the project team. The participants were introduced to the SHLCPTS program by Selam Kidane from Tilburg University

A team of journalists from local celebrated journalists was selected from each region (Lango, Acholi and Teso) from leading local radio stations to participate in the training. After the training, the journalists invited for the training from Radio Tembo in Kitgum, Voice of Teso in Soroti and Voice of Lango from Lira were expected to translate the content of the training, collect interviews from local people and integrate the production of training package in local languages (Langi, Acholi and Ateso). The participants in the training provided a valuable input in the production of the training script by providing translation of key words such as trauma which was debated and finally agreed to mean; Ajiji in Acholi, Aitapasuna na Adam in Iteso and Ngat Awie Orucere in Langi.

After the training, the journalists prepared a script which detailed the outline of the sessions to be used in training of the community members. A discussion was held with each of the journalists about the breakdown of each of the six sessions to make sure that the content of the training and the program outline were clearly understood before they went on to translate the content of the training, collect interviews from local people and integrate the production.

A discussion was held with the journalists and other trainees about finding lexical, cultural and situational equivalence for the EMDR based PTSD management concepts for local language broadcast. Journalists who write and produce for small languages and communities in developing societies face language challenges when trying to express complex or abstract modern concepts. The relatively very short literary and printed history of such languages makes it extremely difficult for journalist to find equivalence to express complex and abstract scientific and technological concepts. The extensive use of imported words and expressions

might usually leave most of the audience in such communities confused about the exact meaning of the production.

If a six session radio broadcast about EMDR based PTSD management training is to be effective in communicating the concepts and ideas it desires the community to understand and benefit from the programs the content should be communicated in the easiest and yet most effective and precise manner possible. Being able to find expressive and easy to adopt lexical equivalents for words like trauma, finding local proverbs, sayings, idioms, folk stories and common traditional experiences means that the journalist can find locally digestible expression and structure to communicate the message clearly while also not ignoring the need for the precise transfer of the core ideas. The recordings were prepared with popular radio voices to ensure that the people in local communities felt a local relevance and ownership.

After the realization of the recording the trainers were trained to implement the treatment in the community and the selection process of participants was explained. The treatment was explained to local health/mental health service providers, so that in case of any need for follow up of assistance, this could be provided.

The approach was intended to leave as much of the agency/resources and control with the former victims and their communities, enabling them to regain control over an aspect of their life (i.e., their continued healing). The emphasis was on participants being able to envision themselves in an empowered state able to use EMDR-based techniques as and when needed to initiate healing and maintain it.

Photo 1: Participants of the EMDR training of trainer's workshop

8.8. **Implementation of the SHLCPTS intervention**

Six sub counties (Amida, Akwanga-Tumango, Usuk, Ngarium, Agwenge-Barlonnyo, Ogur and Orungo) were selected to participate in the training leaving the other sub counties (Obalanga, Agweng and Akwanga) as control groups for the subsequent rounds of data collection. However, after the third round of data collection, the participants from the remaining control group were also offered the intervention (as part of the ethical procedure).

The SHLCPTS was conducted at sub county headquarters and other common community gatherings. The treatment, which lasted for about five hours, started with participants taking a refreshment to help them relax as many of them came from long distances. The first session of the trainings started with an explanation as to why the team had returned to communities after to the participants the first round of data collection and the explained the purpose of the visit. It was indicated that the research project had carried out its research and promised to return to make a follow up on the findings of the study. The trainers mentioned that the main purpose of the team visit was to offer a simple treatment which participants could use in their day today life for their own benefit and to the benefits of their family and community members at large. Members of the community introduced themselves and each of them stood up to mention their names and where they come from. The trainers also informed the members that they were selected as on the basis that they participated in first round of data collection which was carried out by EWP-U project.

PART V: QUALITATIVE RESULTS: IMPACT OF SOCIAL PROTECTION

9. Participation in Social Protection Programs

This chapter reports the results of interviews held on the participation of women in social protection programs in Northern Uganda.

The government of Uganda has implemented many programs which have been introduced to support people returning from the post conflict LRA war. Many of these programs specifically target the regions affected with the war while others are national programs targeting people living in poverty.

9.1. **NAADS/Operation Wealth Creation**

The National Agricultural Advisory Services Organization is a semi - autonomous public agency within the Ministry of Agriculture Animal Industry and Fisheries (MAAIF), responsible for public agricultural advisory/extension services. This program is a national wide program intended to improve livelihoods of people through small and medium agricultural enterprises. NAADS objectives are as follows:

- To promote food security, nutrition and household incomes through increased productivity and market oriented farming
- To empower all farmers to access and utilize contracted agricultural advisory services
- To promote farmer groups to develop capacity to manage farming enterprises.
- To create options for financing and delivery of agricultural advice for the different types of farmers.
- To catalyze the participation of the private sector to fund agricultural advisory services.

The NAADS program does not specifically target women. The program also works with groups of farmers and only reaches out to individual farmers who are regarded as commercial farmers. This program supports farmers with seedlings and cash transfers. The role of local leaders is to mobilize local leaders and assist them in organizing themselves in groups. They are then given training in group dynamics, enterprise selection and help them with registration at sub-county level. NAADS supports three categories of farmers who include;

food security farmers, market oriented farmers and commercialized farmers. The commercial farmers are required to contribute 10% of their enterprise budgets. farmers supported in this way are mainly men who grow crops at large scale. Men also constitute the majority of market oriented farmers. This is because these two categories of famers require big size of land, capital and labor which many rural female farmers still lack in Uganda.

One of the local leaders interviewed in Ogur sub-county had this to say:

> *…our societies are still very patriarchal in nature and men still control much of the resources at home. Men dominate the groups that come to sub-county offices to look for opportunities and information on what is going on compared to women. This is because women's movement is restricted and many of the religious teaching keep women in subordinate positions. (32/05/04/K)*

A female respondent from Usuk sub-county added:

> *…most decisions made by women are disregarded as men openly compete with their women. Men don't want women to out compete their decisions and will despise a man whose wife is known for competing with men in a community meeting. A husband feels embarrassed when his wife is involved in an argument in a community meeting and will go back to rebuke her. So many of the decisions that work in this community are brought by men who benefits from them. (30/19/02/U)*

Women dominate the first category of NAADS - food security support, because they constitute the majority of food security farmers. Women are charged with the responsibility of providing food in homes and thus take the burden of producing food for their household. Thus food production becomes their first priority in the event of small size of land. Unlike men, women only take up commercial farming after ensuring that their households are food secure.

One of the female respondent in Ngarium noted:

> *…how on earth can you think of planting oranges and mangoes when you children don't have food to eat? How do you sacrifice the little land you have to grow crops you can't put on a plate to serve your children? When they*

brought us mangoes and oranges to plant at the sub-county, many women did not go pick them. They had nowhere to plant them leaving men as the only beneficiaries of the program. (31/19/03/N)

9.2. **Northern Uganda Social Action Fund Project**

The Northern Uganda Social Action Fund Project (NUSAF) is a government funded program that was designed for northern Uganda with the aims to empower communities by enhancing their capacity to systematically identify, prioritize, and plan for their needs and implement sustainable development initiatives that improve socio-economic services and opportunities. It is implemented under the Prime Minister's Office. The Northern Uganda Social Action Fund Project has been implemented in three phases. The development objective of the Third Northern Uganda Social Action Fund Project for Uganda is to provide effective income support to and build the resilience of poor and vulnerable households in Northern Uganda. The Northern Uganda Social Action Fund was implemented in three phases; Community Infrastructure Rehabilitation (CIR), Household Income Support program (HISP) and Public Works Program (PWP). The program no longer recruits new members but supervision is still on going. However, this study focuses on the experiences of the NUSAF 2 which was being phased out by the time this fieldwork was being carried out.

The Household Income Support program (HISP) targets a community and explain to them the role of NUSAF 2. The community then identifies the beneficiaries and the assessment of beneficiaries follows. This procedure targets the most vulnerable members of the community. The second procedure of HISP is to bring people together in groups and 30% of these should be women as members of the group but also in leadership positions. Just like the experiences of CDD, many of women included in these groups are purposely for winning the grants than actual beneficiaries.

One of the local leaders commented that:

…men look for their female relatives to participate in the groups. These are selected because they have control over them and they can't dispute the decisions they make once the money comes. As local leaders, we don't have authority to decide the composition of the members of the community

groups and since participation is based on will, we can't force other women to participate. (32/05/04/K)

9.3. **Restocking Program**

After the end of the war in North and Eastern Uganda, many people in these areas had lost many of their livestock to the hands of the rebels and many people who took advantage of the war to robe them while people lived in internally displaced camps. The government introduced the restocking program with the aim of supporting the people whose livelihood depended on livestock to resume their practice. The assessment criteria does not consider women as a category, much as they benefit as members who qualify in the set categories per sub-county. In many sub-counties visited, local leaders target vulnerable population as the beneficiaries of the restocking program that leaves out many abled women from participating in this program. In many of these communities, the vulnerable population include; people with disabilities, single parents, formally abducted people, widows, HIV/AIDS persons, children with disability and the elderly. Each of the selected household gets one cow or bull depending on the supply.

In some districts like Katakwi, the criteria for benefiting from the program benefits women to access the cows/bulls for the restocking program. The program targets vulnerable persons and because of gender inequalities rooted in these societies, women constitute the majority of women who are vulnerable in many districts. For instance, in Ngarium sub-county, Katakwi District, 8 out of the 12 beneficiaries selected in the first quarter of financial year /2015/2016 were widows. In Orungo sub-county-Amuria District, out of the 42 cows received in the same period of time, 19 women were given to women.

However, the leaders from local authorities who implement this program do not consult the community in the process of selection and don't seek their opinion on what they want to receive. Many of the cows received by these vulnerable members of the communities had died or sold because the beneficiaries could not manage to maintain them. Medication is difficult because people veterinary services are generally very expensive and many vulnerable people cannot afford them.

One of the local leaders from Ogur sub-county noted that:

> *…one of the mistake made by leaders is to implement government program without consulting the community members. Their needs are not considered. We are implementing governments programs for which leaders we never participate in their design and hence follow written criteria. (29/14/01/O)*

Women in various sub-counties indicated the local leaders do not consult them before giving them the cows. They indicated that if they would seek their opinion, they would suggest something else that benefits them better. One of female respondent in Ngarium sub-county noted:

> *…we prefer sheep to cows because they bring peace in community compared to cows. The government sends us cows, but these bring more tension as the Karamajongs still invade our communities to steal our cows. No sooner the animals are delivered than the Karamajongs attack and steal them. So we prefer sheep, because the attackers don't have any interest in them. Women in female headed households cannot put up enough defense for their animals and hence end up losing them to male relatives who sometimes never return them to the owners. (33/19/03/N)*

A local Leader in Ngarium sub County explained that:

> *…we don't have enough security in the sub-county to protect all the property. As sub-county, we have only three police officers deployed in the sub-county police post. We cannot sufficiently protect the animals we give to community members and thus when the Karamajongs come, they take away almost all the animals stocked. (34/30/03/N)*

Another female respondent from Usuk said:

> *…for us women we prefer sheep or goats for they have a higher multiplication effect when received as a group. A sheep gives birth twice a year with a possibility of having more than one ram, which makes it easier for women to share them unlike a cow that delivers one calf in almost two years. (35/20/03/U)*

The study further revealed that women still struggle with access and control powers in homes for them to the able to benefit from the restocking program. Women do not have access to land and are not meant to own resources in their households. Items such as cows bring a lot of conflicts in homes where they are given.

A female respondent in Ngarium said:

> *…women prefer sheep to cows because they exercise more authority with them than cows more especially in homes where the husbands own cows. Women exercise more powers for small animals in homes compared to big ones in homes. Owning a sheep gives a woman an opportunity to meet her personal needs as a husband may express less interest in the money generated from its sell. I can sell a sheep without consulting my husband, but how do I sell a cow?? (36/19/03/N)*

The focus group discussion with men from Obalanga sub-county-Amuria made similar revelation about women's ownership of items procured from the government. The confirmed that women are not supposed to own any property accumulated in home unless their husbands consent.

One of the male participant of the focus group discussion mentioned that:

> *Women a woman receives a cow from the sub-county, it is definitely mine and the whole family can claim it. Women acquire property for their families who in this case includes a husband and children. (37/21/03/Ob)*

One male participant , however, disagreed stating that:

> *It is easy for a woman to own the transfers received in a family because many men in their communities is likely to miss use it in case of polygamous families. In our community, many men fight for women property because of their polygamous nature and unless they cling on their wives property, they will end up with nothing. (38/21/03/Ob)*

Thus, the restocking program was noted to be one of the government program that has instigated domestic violence in many communities where this program has been

implemented. The government requires that the cows given must stay for at least five years, but in many incidences, these cows are sold before the required time. Some local leaders indicated as a move to ensure that beneficiaries do not sell these animals after receiving them, they hand over animals to women in homes who are charged with the responsibility of looking after them. Thus, the husband must get an approval from the wife before selling the animals. Women who refuse to give their husband consent to sell are prone violence from their spouses. Men pull out of supporting the women to look after these animals which leads to their death.

9.4. **Community Driven Development**

The Community Driven Development (CDD) program is implemented as a national program through the office of district and sub-county development office. The program requires that members of the community organize themselves in groups and write a project to be funded to the tune of funds available. This program like the restocking program does not specifically support women as a single category, but rather as a percentage of project team or a quarter basis. Hence their involvement is a part of assessment requirement for all the projects supported.

The idea of women involvement being a requirement for a group to win funds has brought a disadvantage for women to benefit from this program. Women are only included just to meet the criteria and once the funds come, they are given nothing or very little from the funds which makes it difficult for them to improve on their lives. Women's inability to read and write means that men in these groups take on the key positions of the team which marginalizes women's ability to question and account for the funds received. This marginalizes women further and they resent their participation in the program as the benefits don't come through to attract their future involvement.

Despite these short comings, the local leaders in the districts visited indicated that women prefer to participate in CDD program compared to other programs. One of the local leaders from Ogur sub-county-Lira said:

> *…women prefer to participate in CDD program because many of the projects funded target household development. Women put in extra effort to ensure that their teams win these funds because they will be able to improve their*

homes. Men tend to participate in the government programs that will improve their incomes as individuals, but CDD focuses on those problems the community identifies to improve their homes. (29/14/01/O)

The focus group discussion with men in Obalanga sub-county-Amuria complements the submission of the local leader in Ogur sub-county, Lira District that more women are likely to benefit from the CDD because it is located close to where they are. The men agreed that it easier for women to attend meeting that organized close to home than when they are distant say at the districts. Many of the CDD projects are village based, so women are likely to attend village meetings than meetings organized far from their home.

The local government authorities have used community Driven Development program to improve to implement other government programs that benefit women indirectly. Some of the local governments require that for a team to benefit from these funds, they need to have immunization cards for their children below 5 years, report cards for their primary going children, possession of sanitation items such as toilets and one of their house hold member must have registered for functional adult education. These requirement pushes men to become more responsive to the women's needs in homes which improves the quality of their life and that of their children.

9.5. **Youth Livelihood Funds**

The youth livelihood program targets youth between 18 years and 35 years. This program, just as CDD and NUSAF does not consider women as special category to benefit. Young women and girls are still excluded from this programs by forces of male dominancy, cultural and religious factors. The boys take advantage of marginalization of girls by the negative cultural forces to dominate the leadership of the groups and thus only invite girls to meet the selection criteria. The local leaders noted that there is a lot of misuse of funds and in this case boys are likely to take the money and the girls loose out. A case in one of the sub-counties was reported where the boys withdrew the money and disappeared leaving the girls behind to account for the funds they never used. Just like women, young girls can't move to the sub-county offices to look for information regarding the availability of opportunities for their own development.

9.6. **Social Assistance Grants for Empowerment**

The Social Assistance Grants for Empowerment (SAGE) is government of Uganda social protection program scheme under the Expanding Social Protection Programme. This scheme was initially piloted two types of direct income support grants: the Senior Citizens Grants and the Vulnerable Family Grants. The Senior Citizens Grant targeted older persons of 65 years and above while the Vulnerable Family Grant on the other hand was paid to poor and vulnerable households that lacked labor capacity. By the time we carried out this study, only Katawki district was a beneficiary of this program. In Ngarium sub-county where this study was carried out, about 300 people were beneficiaries of this program of these about 180 were women. An individual is entitled to 25,000 UGX.

9.7. **Conclusion**

Women have been able to organize themselves into groups doing cash round circles and farming groups. Women in Ogur, Barlonyo and Obalanga decided to start small projects to supplement both their household and their communities. One of the groups visited six months after the training indicated that they were needed to be given functional adult education and trees so that they are able sustainably support their communities.

> *ring more tension as the Karamajongs still invade our communities to steal our cows. No sooner the animals are delivered than the Karamajongs attack and steal them. So we prefer sheep, because the attackers don't have any interest in them. Women in female headed households cannot put up enough defense for their animals and hence end up losing them to male relatives who sometimes never return them to the owners. (33/19/03/N)*

A local Leader in Ngarium sub County explained that:

> *…we don't have enough security in the sub-county to protect all the property. As sub-county, we have only three police officers deployed in the sub-county police post. We cannot sufficiently protect the animals we give to community members and thus when the Karamajongs come, they take away almost all the animals stocked. (34/30/03/N)*

Another female respondent from Usuk said:

> *…for us women we prefer sheep or goats for they have a higher multiplication effect when received as a group. A sheep gives birth twice a year with a possibility of having more than one ram, which makes it easier for women to share them unlike a cow that delivers one calf in almost two years. (35/20/03/U)*

The study further revealed that women still struggle with access and control powers in homes for them to the able to benefit from the restocking program. Women do not have access to land and are not meant to own resources in their households. Items such as cows bring a lot of conflicts in homes where they are given.

A female respondent in Ngarium said:

> *…women prefer sheep to cows because they exercise more authority with them than cows more especially in homes where the husbands own cows. Women exercise more powers for small animals in homes compared to big ones in homes. Owning a sheep gives a woman an opportunity to meet her personal needs as a husband may express less interest in the money generated from its sell. I can sell a sheep without consulting my husband, but how do I sell a cow?? (36/19/03/N)*

The focus group discussion with men from Obalanga sub-county-Amuria made similar revelation about women's ownership of items procured from the government. The confirmed that women are not supposed to own any property accumulated in home unless their husbands consent.

One of the male participant of the focus group discussion mentioned that:

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families. In our community, many men fight for women property because of their polygamous nature and unless they cling on their wives property, they will end up with nothing. (38/21/03/Ob)

Thus, the restocking program was noted to be one of the government program that has instigated domestic violence in many communities where this program has been implemented. The government requires that the cows given must stay for at least five years, but in many incidences, these cows are sold before the required time. Some local leaders indicated as a move to ensure that beneficiaries do not sell these animals after receiving them, they hand over animals to women in homes who are charged with the responsibility of looking after them. Thus, the husband must get an approval from the wife before selling the animals. Women who refuse to give their husband consent to sell are prone violence from their spouses. Men pull out of supporting the women to look after these animals which leads to their death.

PART VI: QUALITATIVE RESULTS: IMPACT OF TRAUMA RELIEF INTERVENTIONS

10. Participation in Trauma Relief Programs

This study investigates how services to address post-traumatic stress impacted on efforts of social protection (cash and in-kind transfers) provided by the Government of Uganda. The trauma services were provided by local government or Non-Governmental Organizations in Northern Uganda. In this study, these services are referred to as 'counselling'. Specific mention is made to the counselling efforts by Isis-WICCE and sister organizations as the effect of this service was specifically investigated in this research.

10.1. **Interviews of women suffering from post-traumatic stress**

This section presents the results of the qualitative data on the prevalence of trauma in the community, including women who had participated in the counselling support program (the results of which are presented in the analysis of the first wave in chapter 17 and 18). In this chapter interviews are presented to illustrate the experience of trauma in the community. The local leaders and individual women interviewed expressed that behaviors associated with trauma were common occurrence in their communities. Many people in their communities were known to behave in ways that required counselling. However, many communities lacked facilities where traumatized people would seek assistance. The local leaders identified the war to be the main cause of trauma among the communities, although they acknowledged that there are also new events that create similar impact such as domestic violence.

Several women from all the districts through their own statements acknowledged being traumatized from the events of the war and thereafter. A few of war related trauma stories are shared here.

10.1.1. Living in trauma from the past (first wave)

The interviews revealed the problem that women suffering from post-traumatic stress identified that the trauma of the past still dominated their current lives. They expressed ho the experiences were still very real today in terms of the memory and the effects this had on them. The trauma of the past was the source of mental and physical suffering in the present.

A female respondent aged 35 years from Amida sub-county revealed that:

> *…I was almost becoming a mad woman, I lost my mother when I was very young she was abducted was raped and then killed and ever since everything*

has been difficult for me. Every time I remember her I get a terrible headache and I feel like killing myself too. I wished I was dead. (41/26/01/A)

A female respondent aged 45 years in Barlonyo narrated that:

…In 2003 we were attacked, they were actually inside my house and ordered me out. I tried to ran away but they caught me and took me to Ocholi land and they made me carry their loot. On the way I spilled something because I was very tired and they beat me up so badly and cut my ear. Later I got the opportunity to escape them and came back here. In 2004 the rebels came back again and the soldiers also made this their barracks. The soldiers told us to stay indoors and so the rebels burnt our houses. Many people died, I only escaped because I fell on dead bodies and hid there. It is after all this that I discovered I contracted HIV. Over the years since then I didn't sleep much, I had dreams and very vivid memories (flashbacks), and if I slept I never could sleep in doors. I could see blood everywhere, the wells and when it got too much I used to run through the village sometimes screaming. (42/25/01/B-Ag)

Picture 1: A participant sharing her story with the rest of the participants

Another female respondent 50 years from Ogur related that:

….I had three boys, I lost two during the war and their father too. My one remaining son sustained some injuries and so I am responsible for looking after the grandchildren now. The rebels came and attacked people in this side and burnt our houses and only those who were able to ran away survived, but even then we were caught and I sustained injuries as a result I was raped too, to date my body is weak all over as a result. When I dropped

the luggage, they had me carry they tore my stomach open, I have a great cut across my stomach as a result. Sometimes I hear trucks running inside my head, I can hear things, I think about my husband and sons all the time. (43/25/01/O)

A female respondent aged 46 from Ogur narrated said:

….from 2001 to 2006, we lived a very hard life, in 2001 our home was attacked we run away and hid in the bushes. We were very scared, we came back later but we were still scared and had to sleep in the bush. On the 18th of Nov 2002, we went to camp after my mother in law was shot and killed we were in that crowded and dirty camp until 2006. And there the children saw many things they shouldn't have seen. In December 2006, we came back and I honored my pledge to give my life to God upon my return. I prayed a lot and that helps me, but I still had bad dreams and up to now I worry that the rebels will come back for example last month they were talking massacres and that made me think about all that bad time we had. (44/25/01/O)

A female respondent 50 years from Amida-Kitgum stated:

… Actually our troubles go back to 1979 at least, during Edi Amin time, we have been experiencing problems ever since. We have had no experience of peace… not much during president Museveni years it was insurgence and LRA. All we know is cattle raids, abductions of children. Our ears were cut off, our people were killed and then we had to go to the camp. We lost everything. The camp in many ways was worse than the insurgence. Our movements were restricted and so we were confined. We had meagre food supply, there was a lot of illnesses, and children didn't go to school. The HIV epidemic also took hold then, spreading very fast with more devastation. In 2008 we moved from the main camp to a satellite camp which was a bit better we had a bit of freedom there, three years later we moved back home. We started settling back, setting up our homes and returning back to the camp until everything is ready. We tried setting up associations and

> *grouping ourselves so we supported each other. I was really happy to be back home after many years, but it is hard to manage a home and children and accessing your own means after many years. I also had a lot of anxiety and used to be easily frightened, had nightmares. Often times I felt like I was back in the war and used to get really frightened. (45/26/01/A)*

In the interviews, local leaders mentioned that unmanaged trauma among women had negative impacts to their participation in community development programs and their social life. Women who were regarded by the community and local leaders as suffering from severe trauma hardly participated in any government program and even when they did, the trauma was seen as affecting the benefit of the program to them. Women with trauma had problems getting married because many men in the community consider them 'mad' and mentally unstable which is seen as an obstacle to manage a home. Thus, many of the severely traumatized women are single mothers. They experience sexual abuse while the violators don't want to be associated with them. The women remain unmarried. Some women end up with what they describe as 'any man that comes their way', out of disparate situations.

The condition of Post-Traumatic Stress identified in the Impact of Events Scale is confirmed with the interviews. The women report nightmares, mental and physical discomfort resulting from the memories, desire to push the memories away, anxiety and traumatic triggers of stress. The analysis of the interviews confirms the assessment of the Impact of Events Scale, that the women population in the Northern Ugandan districts included in this study are suffering from high degrees of post-traumatic stress. The interviews demonstrate that the past is very present in women's lives and that the presence of the trauma in the present is experienced as a very negative hold on the women's lives. The trauma is keeping traumatized respondents in a negative emotional state, causing a negative processing of information. The traumatized emotional state provided a living of the trauma and fear from the past situation in the present.

These interviews were undertaken after the counselling programs by non-governmental organizations and government had been carried out. The interviews show that the needs for mental health support is still very much needed.

The interviews point to the following problems emerging from the inadequate treatment of trauma in the region:

- The impact of support offered through Social Protection programs are not maximized due to the detrimental impact of trauma;
- The narrative-based counseling techniques may cause a problem of re-traumatization through the re-narration component of the counseling methods used;
- Traumatized participants seemed to lack understanding of trauma and they lacked methods to help control the negative emotions of fear and anxiety when trauma was triggered;

The stories of collective experiences of trauma within highly traumatized communities appeared to suggest a potentially high level of collective trauma within the communities.

10.1.2. The impact of violence and beliefs of spiritual possession on health and poverty

The end of war does not necessary mean the end of conflict. While women who had experienced the war returning home, hoping to resurrect their lives from the effects of war and starting a new life free from the effects of war, new violence emerged in their lives. Local leaders reported new challenges emerging which had further traumatizing effects on the women. Many interviews illustrate this. The stories of two respondents are shared here to illustrate this point. These narratives illustrate how a general context of extreme poverty and neglect has impacted on the psychological state of the women, including feelings of loneliness, depression and powerlessness, including a sense of worthlessness based on their gender. Experiences of loss and lack of control have exacerbated these emotions. The impact of belief systems of spiritual possession is also illustrated in the narratives.

A female respondent from, Orungo sub-county – Amuria narrated that:

> *…My entire life has been full of misery, soul and pain. I lost my mother when I was two years old and life has never been easy. I have lived a life of hard work, torture and suffering. Everywhere I go I am not loved and people believe I move with bad luck. I got married at an early age thinking that this will save me but instead I found more suffering with a very abusive husband who used to beat me every day. When the beating got worse, I decided to run away and stay with my brother who lives in Kenya. Even there my-sister-*

in-law was not very receptive. One time her dress got lost and she accused me of stealing it. Everything bad that happened in that house (my brothers') I was accused. One day I decided to fast and pray but my-sister-in-law accused me of refusing to eat because she was the one cooking. I decided to return to Uganda though my brother was not happy that I left. I needed to live and find some peace but still I did not find that peace. Wherever I go people point fingers at me that I came back with a 'Genie (ghosts)' and that whoever associates with me will have bad luck. Even at church, the pastor told the congregation that I was possessed and that no one should move with me until I receive cleansing. It was very worse with my neighbors, no one came to my home even if something fell in my compound no one comes to pick it since they don't want to come close to me. Even when I am walking people keep a distance. I feel so lonely, neglected and abandoned. One time I felt like committing suicide. (46/27/01/Or)

Another female respondent from Orungo sub-county – Amuria narrated that:

….I was forced to get married to a man who never provided anything for the home (be it food, clothing or medication). I gave birth to my first child and had the second one during the insurgency in Teso. Unfortunately, the second child died a few days later and I had to throw her body in the pit latrine because I had nowhere to bury this child. We were always on the run. After a while I fell sick, was diagnosed with tuberculosis and spent nearly 5 months on treatment and in hospital bed-ridden. On return, my husband had married about three women and rumor had it that one had bewitched him thus could not function sexually any more. Being a faithful wife I wanted to stay with my husband since I already had a child with him. However, after some years I felt I needed to have a normal marriage and have more children. I requested to be allowed to find another man but my husband and his family refused. I later moved on and found another man and we have seven children. However, I have not had any peace at heart. The pain of losing my child and not having given her a proper burial has always haunted me and is a heavy load that I carry every day and wherever I go. Even

> *community members are always pointing a finger at me, laughing and emphasize that I am not officially married. I am a laughing stock and have lost my worth. I feel I should take my life. (47/22/09/Or)*

Women explained that untreated trauma has had devastating effects when it comes to HIV/AIDS control in the northern region of Uganda. One of the local leaders noted with concern that:

> *…it is very difficult to control the spread of HIV/AIDS with traumatized populations. People who have lost the will to live adopt sexual behaviors that put everyone in the community in danger. Parents who are traumatized don't care to protect their children and thus we have a lot of early pregnancy in our area of which many of the children are also now contracted with HIV/AIDS. Adult people sexually interact without any form of protection which leads to spread of the diseases in the community rampantly. (48/14/01/Ag)*

Another local leader explained that:

> *…people who are traumatized have a very negative mind. They don't see anything positive from this government and are very quick to criticize any faults. They don't respond to development calls within their communities and after missing out on these programs, they criticize those who have been keen to take them up. They remain stagnant in the community which further marginalize them and keep them in poverty conditions. They don't care about what leaders do or say. (49/20/03/U)*

These are just some illustrations of the many stories narrated by the women respondents to the researchers, often heart-breaking stories. Focus group meetings and individual interviews gave an extensive account of the way in which the community break-down resulted in severe cycles of violence and serious health problems, especially regarding HIV/AIDS.

The importance of these narrations is in that these clarify that the general context of poverty and powerlessness (including gender-based lack of power) factor into the situation of

trauma and provide a context in which healing is complicated by the contextual challenges. The cycles of violence emerging from poverty and belief systems make healing hard in such a context. The violence among severely traumatized communities is resulting in an increased exposure to the risk of contracting severe health problems, such as HIV/AIDS. The consequences of the cycles of violence, aggravated by belief systems are elements of a poverty trap, that provide a difficult condition for Social Protection programs to succeed.

10.2. **Living in the past (second wave)**

This is a report of interviews that were conducted as part of a field study in January 2017. The interviews followed a series of trainings given to women in Northern Uganda who were suffering from severe trauma following many years of war and conflict in the region. The interviews comprised of both in-depth individual interviews with 29 women and focus group discussions in the following sites: Barlonyo (two sites), Ogur , Amida and Usuk.

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The transcripts of each individual interview and group discussion was analyzed under the following labels:

I. When the rebels came
   - The traumatic experiences faced by the women, their families and communities as a result of the many years of conflict in the region
   - The types of loss and suffering experienced by the women

II. The rebels will come back
   - The impacts of the traumatic stress suffered by the women, their families and communities after the rebels left or they escaped from them, including the many years of uncertainty in the IDP camps
   - Symptoms of traumatic stress described during the interview

III. The rebels are not coming back
   - The impact of the trauma support (training) on individual stress levels
   - Examples of healing within the family
   - The examples of wider community healing

In the sections below I outline the findings of the interviews under each of the above headings.

10.2.1. When the rebels came

I remember the first time the rebels came, there were no camps then so we had to hide in the bushes it was very scary. The second time they came we had camps so we ran there. I was eighteen years old and was married. I lost my mother in-law who is one of the people buried in these grounds here. (07/24/01/B (aged 29))

The women described a wide range of extremely traumatic events and a lot of loss and devastation associated with not just the immediate impact of the conflict but the extremely stressful life they are leading as a result of the devastation and its aftermath.

About half of the women described the war years and particular incidences, while the remainder either just mentioned it in passing or not at all (perhaps PTSD induces avoidance of traumatic material). The most dominant theme of these descriptions is loss.

Loss of loved ones, loss of health and well-being, loss of a home and loss of livelihoods. There wasn't a single participant who didn't report loss and wasn't suffering from the devastative consequence of that loss.

Those who were young at the time lost their parents at an early age and have lived with no one taking care of them and continue to feel the loss and abandonment. A respondent (28) from Barlonyo said:

> *I have four children aged 10,8, 4 and one; after so much trouble with my husband I left him and came back to this village. I lost my parents and have no one to take care of me or the children (*03/24/01/B)

Another one from Usuk described her multiple loss as follows:

> *In 1986 the rebels attacked out home they beat and killed people, they tied my father up and raped my mother, and took me and my siblings with them, they also took 3 sacks of grain and destroyed everything we had. (22/27/01/U)*

During the focus group discussion in Amida, a man (age 35) said:

> *I lost my mother when I was very young she was abducted was raped and then killed and ever since everything has been difficult for me. Every time*

I remember her I get a terrible headache and I feel like killing myself too. I wished I was dead. (16/26/01/A)

There were many who spoke about the loss of children, siblings, and husbands. Each of these losses represents not just the loss of a loved one but also the loss of status in the community as well as protection making the damage immense.

A respondent reports getting feverish and collapsing every time she remembered the dead.

…my husband told me not to think about the dead and about dying all the time as he believed that if you think about the dead a lot, they draw you to them and that was why I was having the fever and collapsing, I just couldn't help but think about all that, all the time. (16/26/01/A)

A women, aged 50, described the loss of her children and the implications of that as follows:

I had three boys, I lost two during the war and their father too. My one remaining son sustained some injuries and so I am responsible for looking after the grandchildren now. (08/24/01/B)

An elderly mother (aged 61) from Barlonyo described the enormity of the death of her husband who was ill and bedridden since the end of the war.

My husband died and left me 20 children, biological and adopted all are male except one. My husband was ill and bedridden for a long time and then he died and I used to worry about the fact that I had no one to help me after his death. I used to also think a lot about the war years and all the pain. (04/24/01/B)

Others continued to mourn entire generations of their family:

I used to constantly think about the death of the elders and it was such an evil thought that disturbed me. It caused me pain in the chest. I used to fight people a lot when I have those thoughts and I used to cry remembering my mum, my father and my grandparents (A young 18 year old mother 02/24/01/B)

The other big and devastative loss was the loss of a place, a home and the status associated with a home and piece of land that one can cultivate. This was described both in terms of having to ran away in the chaos and then having to go into the IDP camps that were described as even more harsher due to the constant problems of security as well as basic provisions.

In Ogur, a Women (46) described her life between 2001 and 2006 as follows

> *From 2001 to 2006 we lived a very hard life, in 2001 our home was attacked we run away and hid in the bushes. We were very scared, we came back later but we were still scared and had to sleep in the bush.*
>
> *On the 18th of Nov 2002 we went to camp after my mother in-law was shot and killed we were in that crowded and dirty camp until 2006. And there the children saw many things they shouldn't have seen. (09/25/01/O)*

Similarly in Ogur, another women(21) said:

> *Even at the camp many people died. My brothers were caught and were taken with them [the rebels]. I was with my parents but then my father was killed by the rebels. A lot of people killed and it is difficult not to think about that. (12/25/01/O)*

In Amida a respondent (50) puts her experiences in the camp in the context of a long history of loss and devastation going back to the 1979.

> *Actually our troubles go back to 1979 at least, during Edi Amin time, we have been experiencing problems ever since. We have had no experience of peace… not much during Museveni years it was insurgence and LRA. All we know is cattle raids, abductions of children. Our ears were cut off, our people were killed and then we had to go to the camp. We lost everything.*
>
> *The camp in many ways was worse than the insurgence. Our movements were restricted and so we were confined. We had meagre food supply, there was a lot of illnesses, children didn't go to school. The HIV epidemic also took hold then, spreading very fast with more devastation. In 2008*

> *we moved from the main camp to a satellite camp which was a bit better we had a bit of freedom there, three years later we moved back home. (14/26/01/A)*

Loss of livelihood was another type of loss that was a constant theme across the sites. This was particularly devastative for the women who were forced to return home to their families empty handed when the cattle that were their dowry were raided and looted. In Usuk many families suffered double devastation as they were not just affected by the rebels but also by the *Karamoja* warrior nomads who raided their cattle and looted them, during the chaos of the conflict.

A respondent in Usuk talked about what happened to her at a very young age.

> *In 1980 the Karamoja came and raided our house and they killed my father, I was still a little girl but was taken by them and was raped, many people were raped. On the way we ran away from them and some good people helped us and took as to the mission and we got a lot of help there. Things were a bit better for a while, I grew up and got married but then the rebels came there too…(21/27/01/U)*

Similarly, another women from Usuk narrated the double devastation as follows:

> *Karamojas and rebels both affected my life. Karamojas took all our cattle including those that were my dowry and so my husband sent me back home and my parents sent me back to him. Me and my 5 children were in limbo but then my husband died and I went back to my family with three children, but they didn't accept me and refused to give me any land.* (23/27/01/U)

The looting and material loss affects prospects for the future too, below is how a respondent described it.

> *When the Karamojas attacked, and took all our cows there was nothing left for my schooling (and that of my siblings). They took cows and nuts and chickens and left us nothing at all and they also used us, as servants*

and we had to do all they asked. School and studying became an impossibility and I was depressed. (25/27/01/U)

In addition to all the losses suffered alongside the rest of the community, there were specific gender-based atrocities that many of the women suffered, namely rape and abductions for domestic and sex slavery. During the abductions many suffered mutilations and physical injuries as well as contracting HIV and other sexually transmitted diseases and unwanted pregnancies.

A woman (45) from Barlonyo described her predicament as follows:

In 2003 we were attacked, they were actually inside my house and ordered me out. I tried to ran away but they caught me and took me to Ocholi land and they made me carry their loot. On the way I spilled something because I was very tired and they beat me up so badly and cut my ear. Later I got the opportunity to escape them and came back here.

In 2004 the rebels came back again and the soldiers also made this their barracks. The soldiers told us to stay indoors and so the rebels burnt our houses. Many people died, I only escaped because I fell on dead bodies and hid there. It is after all this that I discovered I contracted HIV. Over the years since then I didn't sleep much, I had dreams and very vivid memories (flashbacks), if I slept I never could sleep in doors. (09/24/01/B)

A respondent (50) also from Barlonyo had her stomach cut open as a punishment for dropping things she was carrying for the looting rebels.

The rebels came and attacked people in this side and burnt our houses and only those who were able to ran away survived, but even then we were caught and I sustained injuries as a result. I was raped too, to date my body is weak all over as a result. When I dropped the luggage they had me carry they slit my stomach open, I have a great cut across my stomach as a result. (08/24/01/B)

10.2.2. The rebels will come back

> *In Dec 2006 we came back and I honored my pledge to give my life to God upon my return. I prayed a lot and that helps me, but I still had bad dreams and up to now I worry that the rebels will come back for example last month they were talking [about] massacres and that made me think about all that bad time we had (09b/25/01/O)*

Even many years after the events described above nearly all the women interviewed, were suffering from a range of symptoms that indicate post traumatic stress disorder (PTSD). The table below lists the range of symptoms described by the women.

These symptoms affected the whole family including children who weren't born or were to0 young to actually remember the events themselves.

> *The children were worried too, they used to say that the rebels are still out there and they can come any time. One day my girl dreamt that they had actually come back and came into the house and she started screaming in terror (10/25/01/O (aged 44))*

Table 10-1. Symptoms described by the women interviewed on Trauma (see section 4.9.2)

PTSD Symptoms	Description
Hyper arousal	
Physical reactions	When anxious, my heart beats fast (12/25/01/O, 21, from Ogur)
Reduced tolerance to noise	When I hear loud noise that sounds like gun shots I go into a panic (11/25/01/O, 48, from Ogur)
Panic attacks depression	I also had a lot of anxiety and used to be easily frightened, had nightmares. Often times I felt like I was back in the war and used to get really frightened (14/26/01/A, 50, from Amida)
Difficulty falling or staying asleep	I didn't sleep much, I had dreams and very vivid memories (flashbacks), if I slept I never could sleep in doors (09/24/01/B, 45 from Barlonyo)
Difficulty concentrating	I was forgetful, my memory since the problems we had here wasn't so good (01/24/01/B from Barlonyo)

	But even here we were worried I used to imagine that one day the rebels would come back again maybe from Barlonyo. The children were worried sick too, they wanted to study and do good at school, but they were too unsettled (11/25/01/O, 48, from Ogur)
Being easily moved to tears	I cried a lot, I cried all the time (17/26/01/A, 45, from Amida)
Anger aggressive behavior	I was very short tempered and quarreled a lot with people (17/26/01/A, 45, from Amida)
Tensing of muscles	I was so angry and I would feel my muscles tense (21/27/01/U, from Usuk)
Avoidance and Numbing	
Frequent periods of withdrawal	I have a lot of worries and many problems that make me sad (03/24/01/B 28, from Barlonyo) Since long ago I used to always get preoccupied with thoughts of the war and sometimes dream about being back there and dream about all the people who died there (12/25/01/O, 21, Ogur)
Inability to remember important aspect of the experience	My memory isn't good as I tend to forget things since the war and all my injuries (08/24/01/B, 50, from Barlonyo)
Re-experiencing	
Flash backs	I could see blood everywhere, the wells and when it got too much I used to run through the village sometimes screaming (09/24/01/B, 45 from Barlonyo) When I dropped the luggage they had me carry they slit my stomach open, I have a great cut across my stomach as a result. Sometimes I hear trucks running inside my head, I can hear things, I think about my husband and sons all the time (08/24/01/B, 50, from Barlonyo) and felt like someone was calling my name even when there was no one (17/26/01/A, 45, Amida)

	Every time I am stressed I see the mutilated body of my father (23/27/01/U, 22, from Usuk)
Nightmares	I used to also think a lot about the war years and all the pain. Running from place to place losing a lot of people and also losing your place and home. I used to get bad dreams and sometimes flashbacks it was frightening (04/24/01/B and elderly woman of 61 from Barlonyo) After we came back I used to have nightmares about burning homes and being chased. I used to get worried that the rebels are coming and fear a lot (10/25/01/O, 44, from Ogur)
Feelings of intense distress when reminded of trauma	I used to constantly think about the death of the elders and it was such an evil thought that disturbed me (a young mother of 18 years, from Barlonyo) I used to also always think about how I have lost everyone and was only left with my husband and our children. That used to put me into this deep mood that would stay with me all day. (04/24/01/B, 35 Barlonyo)
Other symptoms	
Feeling suicidal	I was almost becoming a mad woman, I lost my mother when I was very young she was abducted was raped and then killed and ever since everything has been difficult for me. Every time I remember her I get a terrible headache and I feel like killing myself too. I wished I was dead (16/26/01/A. 35, Amida) My life had a lot of stress and stress took over my life, I often thought about killing myself but worried about how much worse it would be for the children if I did that (24/27/01/U, from Usuk)
Exhaustion	we were caught and I sustained injuries as a result I was raped too, to date my body is weak all over as a result (08/24/01/B 50, from Barlonyo)
Physical aches and pain	I used to have vivid dreams about those times and used to also get a very sharp pain in my chest. (07/24/01/B, 29 from Barlonyo) I had a constant headache (17/26/01/A, 45, from Amida)

11. Results of SHLCPTS Program Reported by Participants

This section presents the results of the SHLCPTS program. In this chapter interviews are presented to illustrate the experience of trauma in the community after the implementation of the SHLCPTS program, reported in relation to the phases of implementation of the program.

11.1. **Outcomes of intervention sessions**

11.1.1. Breathing exercises

Trainers then introduced the participants to the breathing techniques and took them through the exercise. The participants did about four rounds of breathing exercise followed by a small break of about five minutes in between. After about 30 minutes, the participants were asked to reveal how they felt after the exercise they gave some of the following comments;

- I came with body aches, but I now feel much better
- I came with head ache, but I feel relived now
- I came feeling emotionally bad, but now I feel much better
- I was feeling a heat burn, but now it's gone

11.1.2. Safe place and bilateral stimulation

The groups listened to a recording on safe place and bilateral stimulation and after shared as below:

- They appreciated the butterfly hugs as the enable one feel comforted, loved and know that they are not alone.
- The breath-in and out exercise as a good mechanism for relaxing and the comfortable sitting which enables blood flow.
- The safe places helping one feel safe and forget about their problems.
- The importance of forgiveness which leaves the person relieved and light at heart.

Photo: Participants exercising a safe calm place

Photo: Participant's exercising the butterfly hug

After the training in calm and bilateral stimulation, participants shared their experiences during in the next sessions and some of these are captured below;

A female respondent from Ngarium narrated that:

> *I had a problem in my family last week. My elder son had taken off with someone's daughter and the young son had also made some girl pregnant. As if that wasn't enough my daughter had gone to report the father at child protection unit for failing to pay school fees. When I went home after the training last week, first of all I was confused and didn't know how to proceed. Early the next morning the people of the girl that my son had made pregnant came demanding dowry. I was disturbed a lot but good enough I had attended*

the training so she remembered applicability of breathing technique and safe calm place. I sat inside her house contemplating committing suicide but then she remembered what she had learnt during the sessions and went inside her house to practice the breathing technique. I slept and when I woke up I knew exactly what to do. The training had given me courage and thus, I gathered elders to help me resolve the conflict. I talked to her apparent in-laws and set a proper date for meeting them and finally went to family protection unit on behalf of her husband and promised she would take her daughter back to school. All in all the exercise calmed me down and guided my decision making. (50/21/09/N)

A female respondent from Barlonnyo stated:

At this beginning of this week, something happened that upset me so much. I was on my way to well when I found one of the ladies with whom we have had some misunderstandings. This woman abused me so much that I thought I should to fight her. I decided not to fight her but she kept on provoking me. I decided to ignore her and move up to the way to bring water to my home. But the anger in me was boiling like food on fire. I decided to go back to the well to fetch more water and on that day, I went back to the well until I even almost filled all the cups at home. When I realized that I did not have any other place to pour the water, I entered the house and locked myself in. I cried for such a long time that my children got so concerned and started knocking the door terribly for me to open. All along, it had not occurred to me that I could use the breathing exercises to feel much better. When my children insisted on knocking the door, I realized I needed to do something to cool down. Then it occurred to me that I could actually do the exercises we were taught. So I did the breathing exercises and after doing around four rounds of breathing exercises, I decided to also go to my calm place and I felt much relaxed. I opened the door and all my children were asking me what happened. I felt so relaxed that I did not want to go through the stories again, so just continued with my day's chores. I even did not find it difficult later to sleep in the night as it has been all along after such incidents. I am grateful to the training. (51/01/09/B-Ag)

Another female respondent from Barlonnyo added that:

> *I have been haunted by the memories of the massive killings that happened in our village (Barlonnyo Village houses the massive grave where 121 people were killed at once and buried in a mass grave at the site where we meet). I have been feeling very much sad and I would not stop thinking about it. Sometimes when I would be moving around the village, I would get lost in these thoughts and find myself stopping suddenly when am going somewhere. But since I started the doing the exercises, I have overcome these memories and all the bad feelings. I feel much happier now than previously. (52/25/08/B-Ag)*

11.1.3. Subjective units of distress (SUD)

The participants were then invited to undertake a SUD ranking every after a training session with ranking starting from 1-10. After the first session, the rankings were made as a follow-up of the previous session.

Speaking about SUD, a female Respondent narrated that:

> *Before the training I was forgetful, my memory since the problems we had here wasn't so good, but now I am not as forgetful as I used to be. My SUD during the training was 5-6 at the start and then it came down to 1-2, I think I have stayed at 1 or 2 since then too. The breathing exercises help a lot, I have been breathing in and out and it helps. Although I have not taken any medication for it the pain in my chest is now gone. People ask me why I smile a lot and also how I managed to change myself like this. They notice that I wash and look after myself better these days. I have taught the breathing and knee tapping to my family and they say it works too. (53/25/01/B-Ag)*

11.1.4. Use of skits

The illustrations of the sessions was done with use of stories and skits that were organized by the trainers depending on the session. These skits helped that people to identify themselves with the realities around their day to day life and how this impacted on their

psychological behaviors. One of the examples of the skit used in the training in Arungo Sub County is captured here below;

Poster were shared with different labels such as: 'Family'; 'Local Council leaders'; 'Government'; 'Defiler'; 'Land grabber'; 'Civil Society' and 'clan leaders'. The participants were then encouraged to each choose the category they would wish to belong to. The play rolled out as below:

The family was for a widowed woman who struggled to look after her three children. One day a drunkard youth defiled her youngest daughter. The family rushed to the Local Council leaders but the case kept dragging and when they reached out to the clan leaders they just added injury as they reminded the widow to leave their son's land with her children. When the land grabbers came home the family still reached out to the Local Council leaders and when they were not fully helped they reached out to government. During that same period, a civil society organization visited the community educating them on issues of rights and trauma healing. The family was very grateful for this information and the healing introduced to them. They were also encouraged to continuously engage the decision and law makers.

11.1.5. What the participants learnt from the skit

1) Land grabbing is not very good as it deprives the widow and her children a home and place for gardening.
2) The abuse of widow's rights.
3) Trauma caused to the widow with all the suffering.
4) The torture and unfairness of the in-laws who want to take over property of their deceased son.
5) The slow reaction from the law.
6) The importance of engaging various stakeholders.
7) The group was advised on issues of rights such as land grabbing; child protection, and engaged to use law to address these issues.
8) The widow was also encouraged to learn to forgive and forget to live a peaceful, fruitful and trauma free life.
9) Neighbors were encouraged to be helpful to such families as they are grieving, they should try to be close to them to help them overcome their soul and traumas

11.1.6. Community event

Participants still were given an opportunity to share their experiences with the whole community which was a learning experience and a chance for those who didn't attend the sessions to clearly understand what the project was all about. These were done in collaboration with community leaders and families of those who had been trained. A certificate of participation was issued to the participants of the training which they received along with their family members and friends. The photo below shows a group of participants from Usuk Sub county-Katakwi District during their community event sessions.

Photo: Participants from Usuk about to entertain their guests

b) Commemoration of Barlonyo Attack

Barlonyo meaning "field of wealth" in Luo, is a village in northern Uganda near Lira town. Many of its residents are internally displaced people (IDPs) from many parts of northern Uganda. The area is one of the worst hit by the 20-year of LRA insurgency. It is in Lira District about 45-minute drive from Lira town. On February 21, 200 Barlonyo became the site of a massacre. LRA rebels attacked from dusk to dawn killing over 300 people according to the local residents (121 people, according to the official figure on the memorial mark stone). This memorial site was the site of this field study as well as the site where the trauma support training was provided to women from the area.

Lira District Local Government together with Development Partners working in the District organized the above annual event on Tuesday 21st February 2017 at Barlonyo War memorial

site, Agweng Sub County Lira District. The memorial prayers was attended by an estimated 1500 people including men, women and children. The Participants were drawn from Districts of Lira, Alebtong, Katakwi, Amuria, Soroti and Kitgum among others. The theme of the year was "**Social Protection and Trauma Healing for Empowerment**." The event was presided over by the State Minister for Internal Affairs Hon. Obiga Kania. During this event, the women from all the regions met to share with each the experiences they had derived from the intervention as part of the celebration. Women carried messages of hope on their T-Shirts in their languages as part of community dissemination of what they had learn from EMDR light Treatment. The messages were translated from a phrase "I have learnt to heal myself, come to me for help". For the example, the T-Shits in Ateso read: "Esisia Ngo Aisinapikin aomisio ka obia mama ajai engarak".

11.2. **Impact of SHLCPTS program on the family**

The interviews carried out after the intervention showed positive impact on the lives of people training, their families and community at large.

- Increased self-esteem and social participation
- Decrease in domestic violence and community conflict
- Increased ability to address conflicts
- Desire to continue the self-help exercises and regular use
- Training and coaching of other members of the community
- Requests from other members of the community and family members (including husbands and men in general) to be included in the research as well

Individual personal stories are shared here for illustration;

A young mother of 18 Years narrated that:

> *The deep breathing and eye movement exercises I remember the most. Before the training I used to constantly think about the death of the elders and it was such an evil thought that disturbed me. It caused me pain in the chest. Now when I start drifting to the thought about death I do my breathing and eye movements with my finger a guide and it calms me down. Before I used to fight people a lot when I have those thoughts and I used to cry remembering my mum, my father and my grandparents. Now I feel I am*

stronger than before and I don't fight with others or cry as much when I remember the elders who died. (54/25/01/B-Ag)

A younger mother of 21 Years also narrated that:

…Since long ago I used to always get preoccupied with thoughts of the war and sometimes dream about being back there and dream about all the people who died there. I lost many people. Even at the camp many people died. My brothers were caught and were taken with them [the rebels]. I was with my parents but then my father was killed by the rebels. A lot of people killed and it is difficult not to think about that. The training helped; the knee taps, butterfly hugs and eye movement all helped. And the breathing exercises too are helpful. When I get anxious and my heart is beating fast I do one of them and calm myself down. I am very happy and I don't cry as much I feel free and I don't worry as much as I used to. Now the feeling of happiness and freedom is there even when something bad happens I can stay calm and free even then. I live with my mother in law and she sees the difference, I don't quarrel with her much anymore. We have a better relationship now. My husband as well, we have started sharing everything with each other. (55/25/01/B-Ag)

Another female participant added that:

…I have been haunted by the memories of the massive killings that happened in our village (Barlonyo Village houses the massive grave where 121 people were killed at once and buried in a mass grave at the site where we meet). I have been feeling very much sad and I would not stop thinking about it. Sometimes when I would be moving around the village, I would get lost in these thoughts and find myself stopping suddenly when am going somewhere. But since I started the doing the exercises, I have overcome these memories and all the bad feelings. I feel much happier now than previously. (56/15/09/B-Ag)

The SHLCPTS program received by the women who participated in this study did not only have an impact on their state of mind, but rather the whole family in some cases benefited

from the changes that were happening to their wives, sisters and daughter in law. The members of their families were able to notice the changes in behaviors and reactions when they were upset. A few women reported to that trained their own children and husband using the SHLCPTS exercises. During the focus group discussions women shared their own experiences within their homes. These were also supplemented by the husbands and other family members during the six session when the trainees invited them to participate in the community event. Some of the participants in this study shared their stories below.

A younger mother from Barlonyo (who came with uncombed hair with unclean baby during her first three weeks) had this to say during the firth week of the training;

> *…When I came for training during the first week, I did not understand what was taught. When I returned during the second week, I heard women sharing that they had seen changes in their bodies because of the breathing exercises. I have been battling with headache for a very long time and I had tried all the medicines, but without much help. This continuous headache could not allow me to comb my hair and even cutting it off was equally painful. After the second week, when I went home, I made it a point to try out the breathing exercises by myself. I felt some relief and repeated the exercises when I was going to sleep. Since then, I can now sleep more comfortably as the head ache disappeared. I can now comb my hair and also realized I learnt that keeping myself clean is important as my husband commented that the training has changed me a lot. Last Friday, two women from my knighthood where involved in the fight and I intervened to stop the fight. They respected me and I sat them down to trained them the breathing exercises and by the time I left, they felt better and requested that I take them to the training. (57/25/08/B-Ag)*

One of the female participant narrated that:

> *…I am so grateful to the person who invented the idea of these exercise. I have been having fights with my husband for some time and everyone in my village knows that. But last week after the training, I went home and as usual, my husband started his fights. I was so annoyed that I started*

contemplating if I can attack him and we fight, but I remembered what we were taught, I entered into the house, did my exercises and I was able to overcome the anger. I came out and passed him when I was very quiet and resumed my work. That night I did the breathing exercises before I went to sleep and I am so happy that I was able to sleep, which has not been the case previously. Since then, we have not had a fight with my husband, because I have learnt to manage my tempers. My husband could not believe that were not fighting. My mother in-law is very happy that finally there is peace in my home. (58/01/09/0)

Another woman also mentioned that:

…I am married and live close to my mother in laws home. My mother in law stays with some grandchildren who belong to my sister in law who is married somewhere else. She also used to abuse me from time to time and she keeps on calling me a failure whom his son helped to marry. A few weeks back, I went to my garden only to find that children had uprooted my cassava yet, I had also sent them cassava at home to cook. I was so annoyed and decided to go and speak to my mother in law about it. When she saw me coming, she entered her house and refused to come out to speak to me. When I returned home, my husband had also come home and I tried to explain to him what had happened. He never answered anything back and also refused to go the garden to see the damage. I was so annoyed that I went into the house to cry. I cried for some time, but later remembered the exercises. I did the breathing exercises and also went to my safe clam place. After a while, I came out of the house feeling much better and was also able to overcome the anger. I went out and resumed my duties. My husband noticed the change and called me to ask me why I was not over reacting as I usually do and I did not even have the energy to explain to him anymore. I have learnt to keep quiet and ignore the children and the mother in law because of the exercise which help keep calm all the time. Since then, both my mother in law and husband have found out that I learnt this anger management from here, so they asked me to train them. (54/25/01/B-Ag)

11.3. **Impact of SHLCPTS program on their communities**

The women who participated appreciated the techniques they learnt from this training. The women expressed that knowledge in application of the touch stone memories and safe calm place as trauma healing technique presented them with skills that they would share with the rest of the community with those people whom they would identify with trauma symptoms. They also said they were using the trauma healing techniques at home for themselves, used it to help other friends and members of their communities. Going back to the communities after six months after training, this what a few randomly selected sample of participants had to say.

A respondent explained:

> *…I lost my two children to sickle cells after the end of the war. They were everything that I had in my life and everyone in the village knew how much I loved them. When my last child, I was emotionally broken down and I almost become mad. I changed completely and adopted a culture of fighting with whoever annoyed or rebuked me. Anyone who would do anything to remind of my children would face it rough with me. I went to the market and bought a new trouser which I used to put on when am going to fight [lifting up and pictures of her children] and everyone in this village knows these two items. I move around the village putting on this trouser and everybody knew what I was up to. I want to that the people who brought this training because they rescued my life from fighting. I want to tell this community that I have decided to hang my photo to the wall in my sitting room, because the training helped me to overcome the many tears I cried for them. Everyone in this community is surprised that weeks have passed without hearing my fights. I have shared with many women in my family the techniques of the training and many of them are happy as well. I have also come to tell the people in this community that I will never appear in the community wearing this trouser. [There is a loud applause from the rest of the participants in the training] (58/01/09/O)*

During the community event in Ogur, the Community Development Officer noted that there is a lot of improvement in the behaviors of the women involved in the training and he commented about Matilda's testimony;

> *…We want to thank Mbarara University of Science and Technology and their partners for bringing this training in Ogur. Women in this community who have been trained have changed a lot. If you get a report that Matilda has not fought in more than a week, you are sure that this training has been a changing factor. We request that more women are given an opportunity to be trained for a sustained peace in the community. I request that those who have been trained try as much as possible to train others as the message on your T-shirts reads. (29/14/01/0)*

One of the female participant who was a teacher narrated:

> *… Before the training I was so angry and I would feel my muscles tense up so much and begin to hurt. But now I am not very angry anymore. I tell myself all the time that I am actually able to handle my difficulties if I stay calm. I don't first go to fight and quarrel with people, I calm myself down as much as I can and then go and sort out whatever needs sorting out. I have trained my fellow teachers and they were amazed I knew these techniques. We have also taught some of these techniques to the children at school and the children in my family too. My children's eating habits have improved, now they eat better and are healthier. (60/27/01/U)*

Kot (not real names) (the oldest members of the group) had this to say to the congregation at Barlonyo dissemination:

> *…During the third meeting of training, I went home. After doing the touch stone memory I was feeling very emotional. When I when I went to sleep, I had this dream, where two tortoises were chasing after me. I have been having such threatening dreams for quite a number of years since the war ended and we came back home. I was so scared, so when I woke up, I prayed, but could not feel any difference. I had never shared my story with the rest of the women in the past two weeks. I did not understand the knowledge we*

were receiving had power to help overcomes these dreams. I thought the stories women were sharing were based on minor problems that had experienced. I remembered the exercise and the testimonies people were giving and decided to give them a try. However, I decided to give myself a chance to do the exercises to find out if they would help me too. When I did the breathing exercise and butterfly hug, I started feeling much better and before long, I started dozing. I was able to sleep and since that day, I do the exercises before I go to sleep and since then I have not experienced any scaring dreams. My neighbors tell that I have put on weight and looking very good. They have suggested to find for me a husband to wed me in church [Laughs out loud]. Now I want to go to Kampala, to see it with my eyes and after that go back to school. I don't want anyone in this community to worry about me anymore. (61/25/08/O)

During the training, the trainers counselled women on some of the basics of home management. They would encourage women to take on more productive work to improve on their income. Women were encouraged to spare more time to take care of themselves and encouraged young mothers to ensure that they do their best to look after the children. The trainers would put emphasis on the women's outlook and explained how this was equally important for their healing process. The trainers emphasized that the community would be able to relate with their recovery if they are able to notice some changes in their life and also this will help them to act as change agents.

During the dissemination meeting in Barlonyo one of the respondents shared that;

…When I returned from the bush, everyone in this community thought that I was actually mad. The excommunicated me from many political and economic programs in this community. I never used to comb my hair and sometimes I would not wash or bother at all. I went through a difficult life being known to be mad which traumatized me completely. My experience is not so different from the rest of the girls who were abducted, but my scenario was quite different. Everywhere I passed, the children would scream, "there she comes AK the mad woman. But when the study was brought to my village, I was invited to participate in this because they

needed women who were known to be traumatized. Fortunately, my life changed drastically. I started washing and combing my hair. Everyone in the community asks me what happened and when I tell them about these magic exercises. I can't believe that that AK (referring to herself) in my simple life could become such a useful person to my community. (62/21/02/B-Ag)

11.4. **Impact of training on perceptions of women's health and well being**

During the training and after the training, many women expressed that the exercises would result in relief on some of health challenges they have been facing. These ranged from simple daily headaches to more complex chronic pain problems that women had suffered from for a long a time.

A female respondent who experienced headache shared that she had started to look after herself and reported that she had a much greater sense of well-being:

I am married to a man who drinks quite a lot and he comes home late almost every day. I reached a point to leave the door open so that I don't have to wake up to open for him, but still he bangs the door until you feel your heart id dropping out. I have been nursing this anger for a long time and I developed a head ache to the point I could not comb my hair. Sometimes I would not even bother. I have been so annoyed with everything that happens around me. When I came here, I did not even bother to understand what was being taught in the first week. During the second week, the recordings played and the exercises we did that day, made me feel better. So when I went home, I tried them on my own and realized they were indeed helpful. I have tried them several times and my life has greatly changed. I have been able to comb my hair after a long time and I have also smeared Vaseline. I now even bathe several times a day, sometimes even in the morning before I go the garden. I have healed from all the memories that have been haunting me. (59/25/08/B-Ag)

Another respondent explained that the support had positive impact on relieving pain in her body:

I have been having a back ache and pain around my neck for some time. Sometimes when the pain would get worse, I would even feel it swollen. I have also been very emotional and would get very upset over very minor issues. I have been taking medication for my back ache for a long time. But in the past three weeks when I started doing the exercises, I feel much better and now I have even stopped taking any medication for these body aches. I feel much happier and my tempers have greatly improved. (63/25/08/B-Ag)

Another respondent added that she had a much-increased sense of well-being after completing the exercises:

…I have been having a heartburn for some time used to eat a lot of magnesium. Since I started doing the exercises in the past two weeks, I have noticed the changes in my body, I no longer feel the heartburn and I have stopped swallowing the medicine even when I eat food that I thought were causing it. I wonder what kind of magic is in this therapy. Could it be a spiritual intervention and you don't explain that to us!! The recovery is more else a miracle to me. (64/25/08/B-Ag)

Another respondent further noted that bodily discomfort and pain was relieved following the exercises:

First of all, I will tell you that when I came here, I had back ache when I came for the meeting last time. When I came here and we did the exercises, I felt much better and by the time we went home, the pain had greatly recued. When I went home, I continued with the exercises and the pain went away completely. I have also been getting paralyzed when something annoys me. I would feel some of my body parts have been taken away from me. However, when I started using these exercises in the past three weeks, I have not felt this in any part of my body and I feel happy about these changes. I have also been very upset with some of our local leaders who took us to support the program of malaria control. For several months now, they have never paid us. Every time I would need to buy something from the shop and I don't have that money, I would get very annoyed. But since we started

doing the exercises, I have not felt this anger again. I am happy and I want to thank you for the program. (65/25/08/B-Ag)

This participant also identified a much greater sense of self-awareness in relation to her rights and how she was treated.

11.5. **The rebels are not coming back**

The main objective of the intervention was to enable participants to learn strategies to help them overcome the traumatic stress affecting their day- to-day functioning. Achieving this, has had a lot of positive effect on individual participants' physical and psychological wellbeing, their relationship within their respective families as well as their functioning and role within the wider community. It has enabled them to look forward rather than always look back in fear of the rebels coming back. A Respondent aged 45, from Balornyo described it:

Everyone sees the difference it has made to all of us. We work together and are happier working together. Before I used to think back and feel that rebels would come back but now we look forward to life, we even have a dance group and have had the opportunity to go to different villages to perform. (09/24/01/B)

As mentioned above there was improvements to both physical and psychological wellbeing reported as a result of the intervention. A women from Barlonyo said:

*The breathing exercises help a lot, I have been breathing in and out and it helps. Although I have not taken any medication for it the pain in my chest is now gone. (*01/24/01/B)

Several women reported healthy weight gain, this is a crucial indicator particularly for those who are HIV positive as it indicates their physical health is in better shape following the mental health support they received.

I showed my children and they like it, they can see I am less stressed and have put on weight too, because I am not too worried about things like before. I used to tell them about the training even during the training but now they can see it both in the way I am and how I look too. (09/25/01/O (age 46))

I am more positive about things now, I have a safe place under a tree and if things get really bad I take myself there and calm myself down. I am healthier and my weight is also healthy I have gained a lot of weight (15/26/01/A (age26))

The relief from stress related chest pain and the attainment of healthy weight actually led a women from Usuk to conclude that the intervention probably saved her life.

I was so thin at the time, I would say malnourished, I was in a lot of pain too, all that has changed, I have since put on weight and also my chest pain is gone. The training probably saved my life. (24/27/01/U)

Interestingly several participants used the Subjective Unit of Distress (SUD- a 0-10 scale of emotional disturbance) to report back on levels of anxiety and stress – a technique that was taught during the training.

During the training my SUD was 10 maybe even more now I feel it is one and maybe two sometimes but not more. I am very grateful for the training it saved me from a lot of difficulties and pain. (07/24/01/B (aged 29)).

When we were training at the start my SUD was 10 and more if I could do more, and then gradually it became eight and then five and now there are days when I can say it is 1 or even 0. (14/26/01/A (aged 50))

During the training my SUD became 6 first and then 3 (20/26/01/A (26))

Another recurring theme was the reduction in quarrelling and violent outbursts

The training helped; now when I am at home and these frightening things happen I know how to handle them. Even with other things like when someone quarrels, I breath in and out properly before responding. When I am agitated I go to my safe calm place and I feel free there.

One day someone was quarrelling and I got really annoyed I just walk back in doors and got myself into my quiet calm place and did my breathing there and I felt relieved. (10/25/01/O (aged 44))

I live with my mother in-law and she sees the difference, I don't quarrel with her much anymore. We have a better relationship now. My husband as well, we have started sharing everything with each other.

My husband saw how different I am, I can sit calmly and talk about things and we don't quarrel a lot like before, he says this training has been good for me (12/25/01/O (aged 21))

I don't get into many quarrels around the village anymore as I am able to handle things better. (15/26/01/A)

In many cases this led to a calmer family atmosphere and improved relationships with children, husbands and in-laws.

As a result of this training my family is calmer and is a role model for the whole community. Before we used to have a lot of trouble and quarrels and even violence at home, now we get invited to community gatherings to share our experiences and even at church. Even my appearance has changed, I have put on weight and wash more and look after myself better. The children are proud of this and I am happy. (14/26/01/A (aged 50))

My husband even came and told the group leaders how things are a lot better now and how the house is at peace now. The children are a lot happier too, even if it meant that when I was at the training I was away from them (16/26/01/A (35))

I have been living with my current husband for many years but we never married, but after the training he saw how I had changed and how happy we all were and wanted to make that permanent and so he suggested we got married in a church I agreed and we got married. Everyone from my training group came to support me and we were happy to have them around.

I don't get frustrated a lot like before and my daughters see this too they have learnt the breathing and safe calm place (15/26/01/A)

The improvements in wellbeing and family relationships have also had a positive impact on the wider community who have noticed the changes and have started to ask to be trained too, giving the women opportunities to train others.

It [the training] makes my brain think about other things, other than the war and death of my family. The rest of the family see that I don't cry all the time and so do our neighbors and everyone else too. We all feel like we can now think about ourselves and not just about the war. (08/24/01/B (50))

Participants understand that the problems are shared across the community and want to have an input into the healing of the whole community and use every opportunity to share their new skills with their neighbors.

I tell my neighbors all about it and teach them the exercises, they see how it helps us with many bad memories. My grandfather was killed in the war and also we had to run away a lot. It is not easy, being shot at is all I can remember clearly these were the things that made living very difficult. (13/25/01/O (aged 28))

People ask me why I smile a lot and also how I managed to change myself like this. They notice that I wash and look after myself better these days.

I have taught the breathing and knee tapping to my family and they say it works too. (01/24/01/B)

The women are so pleased with the impact of the training for themselves, their families and communities, that they are now looking for ways to expand its impact and are also developing ways for sustaining it.

we have developed like a cooperative and we pull money together and buy things and then we sell that. We discuss and agree on what we invest in and then sell. (09/24/01/B (aged 45))

We have only got about 20 women trained and we do our best to support each other and others too but many people ask us for help and we try but it would have been good if there were more of us trained as the

community is big and with many people that need this training. (14/26/01/A (aged 50))

Mama Anna (group leader) is working on making the group permanent as the women seem to be getting a lot of support from each other and have also been supporting others (20/26/01/A (aged 26))

PART VII: CONSTRUCTION AND ANALYSIS OF IES-R AND SER SCALES

12. Impact of Events Scale

In this study, the revised Impact of Event Scale was used. This scale consists of three subscales: intrusion (8 items), avoidance (8 items) and hyperarousal (6 items). The scale values of the items ranges from 0 (not at all) to 4 (extremely) (0= not at all, 1= a little bit, 2= moderately, 3=quite a bit, 4- extremely). For each subscale, a mean is calculated to get an index of the scale. The total score of the scale is calculated by summing the three subscales (minimum 0 and maximum 12).

In order to explore the effect of different modes of social support on the IES-R, the statistical properties of scale items are first described. The scale is analyzed for the first and second wave, separately, in order to obtain some idea of its reliability. An item analysis is then conducted for each of the subscales, which consists of inter-item correlations and the internal consistency of the scale (Cronbach's alpha). Then the correlations between the items and the scales are identified; the correlation of the item with its own scale (with the item removed) and with the other IES-R scales is explored. In the ideal case an item is higher correlated with its own scale than with the other scales. Finally, any correlations between the subscales are reported. It is not possible to give test-retest reliability statistics due to the fact that the different modes of social support have different impacts on the reported trauma.

12.1. **Statistics of items in IES-R subscales**

Table 12-1 gives the mean, standard deviation and percentage of missing cases on each item for the intrusion, avoidance and hyperarousal scale for the first wave. Table 12-2 gives the same statistics for the second wave. Both tables indicate that the level of post-traumatic stress in the first and second wave, is rather high; all items on all subscale score above the level 2 what indicates moderate stress. Furthermore, the respondents score highest on intrusion with a value of above 2.5 for all items.

Moreover, in the first wave the standard deviation for all of the items is above 1, what is substantial for a 5-point scale. It indicates that the level of post-traumatic stress reported varies quite a lot across the respondents. For the second wave, the standard

deviations seem to be somewhat smaller, although still around 1. The last interesting statistic is the percentage of missing values. In the first wave, for most items, zero respondents have a missing value. In general, respondents missed only 1 or 2 items of the total scale. In the second wave the percentage of missing is higher. But still for most items only a few respondents did not answer it, and respondents most often missed only 1 item of the total scale.

Table 12-1. IES-R: Statistics for items per subscale, first wave (n=471)

Subscale/item **(scale value: 0 (not at all) – 4 (extremely)**	**Average**	**Standard deviation**	**% Missing**
Intrusion			
Any reminder brought back feelings about it	2,92	1,20	0
I had trouble staying asleep	2,68	1.24	0
Other things made me think about it	2,76	1,17	0
I thought about it when I didn't mean to	2,36	1,18	0
Pictures about it popped into my mind	2,71	1.21	2 (0.8%)
I found myself acting/feeling like I was back at that time	2,43	1,22	2 (0.8%)
I had waves of strong feelings about it	2,59	1,23	0
I had dreams about it	2,67	1,26	0
Avoidance			
I avoided letting myself be upset when I thought about it or was reminded of it	2,37	1,23	2 (0.8%)
I felt as if it hadn't happened or wasn’t real	2,25	1,26	0
I stayed away from reminders of it	2,21	1,20	0
I tried not to think about it	2,18	1,23	0
I was aware that I had a lot of feelings about it	2,50	1,17	2 (0.8%)
My feelings about it were numb	2,04	1,16	0
I tried to remove it from my memory	2,21	1,18	0
I tried not to talk about it	2,28	1,19	0
Hyperarousal			
I felt irritable and angry	2,78	1,24	2 (0.8%)
I was jumpy and easily startled	2,30	1,22	0
I had trouble falling asleep	2,64	1,27	2 (0.8%)
I had trouble concentrating	2,45	1,19	2 (0.8%)
Reminders of it caused me to have physical reactions such as sweating, trouble breathing, nausea or a pounding heart	2,66	1,33	2 (0.8%)
I felt watchful and on-guard	2,33	1,17	0

Table 12-2. IES-R: Statistics for items per subscale, second wave (n=356)

Subscale/item **(scale value: 0 (not at all) – 4 (extremely)**	**Average**	**Standard deviation**	**% missing**
Intrusion			
Any reminder brought back feelings about it	2,79	1,04	0
I had trouble staying asleep	2,73	1.07	0
Other things made me think about it	2,68	0,99	3 (0,08%)
I thought about it when I didn't mean to	2,34	1,13	1 (0,03%)
Pictures about it popped into my mind	2,59	1.12	2 (0,05%)
I found myself acting/feeling like I was back at that time	2,39	1,11	7 (2,0%)
I had waves of strong feelings about it	2,60	1,03	4 (1,1%)
Avoidance			
I avoided letting myself be upset when I thought about it or was reminded of it	2,72	0,81	1 (0,3%)
I felt as if it hadn't happened or wasn’t real	2,30	1,14	2 (0,5%)
I stayed away from reminders of it	2,61	0,95	3 (0,8%)
I tried not to think about it	2,54	0,97	2 (0,5%)
I was aware that I had a lot of feelings about it	2,40	1,14	4 (1,1%)
My feelings about it were numb	2,13	1,10	3 (0,8%)
I tried to remove it from my memory	2,66	0,93	2 (0,5%)
I tried not to talk about it	2,42	1,08	1 (0,3%)
Hyperarousal			
I felt irritable and angry	2,66	1,11	3 (0,8%)
I was jumpy and easily startled	2,35	1,11	5 (1,4%)
I had trouble falling asleep	2,68	1,09	2 (0,5%)
I had trouble concentrating	2,63	1,08	3 (0,8%)
Reminders of it caused me to have physical reactions such as sweating, trouble breathing, nausea or a pounding heart	2,74	1,18	6 (1,7%)
I felt watchful and on-guard	2,96	1,25	3 (0,5%)

12.2. **Correlation between items in the IES-R**

Regarding the first and second round, all items in a specific scale correlated quite well with one another, as the Cronbach's alpha (Table 12-3) indicates, although the Cronbach's alpha for the avoidance scale for the second wave is only moderate (0.63). For the first and second wave, the average value of each subscale is about 2.5, so respondents feel moderate to quite a bit stress. Regarding the standard deviation, Table 12-3 indicates that those are higher in the first wave and in the second wave. Furthermore, it can be assumed that the distribution of the scales values approximates a normal distribution (skewness and kurtosis are between -1 and 1, except for the skewness of intrusion in the first and second wave, the skewness of hyperarousal in the second wave and the kurtosis of intrusion in the second wave. All are a little bit higher than 1).

Table 12-3. IES-R: Characteristics of the subscales, first and second wave

Wave	Subscale	Cronbach's alpha	# items	Average (range 0–4)	SD	Skewness	Kurtosis	Missing
First wave (n=471)	Avoidance	0,916	8	2,26	0,96	-0,56	0,23	0
	Intrusion	0,948	8	2,64	1,04	-1,07	0,58	0
	Hyperarousal	0,952	6	2,53	1,11	-0,85	-0,24	0
Second wave (n=356)	Avoidance	0,628	8	2,47	0,52	-0,51	0,69	0
	Intrusion	0,869	8	2,54	0,78	-1,18	1,12	0
	Hyperarousal	0,867	6	2,50	0,87	-1,17	0,93	0

In order to explore the different subscales and their inter-correlations more thoroughly we will look at the correlation of the item with its own scale (with the item removed), and with the other IES-R scales (see Table 12-4 for the first wave and Table 12-5 for the second wave).

Regarding the first wave, Table 12-4 indicates that all items correlate sufficiently with their own scale (corrected item total correlations are all above 0.35). But, it also indicates that all items have a rather high correlation with the other scales (above about 0.5) and some items have even a higher correlation with the other IES-R than with their own scale (they are marked yellow). These results indicate that, in the first wave, the subscales are intertwined and will correlated substantial.

Table 12-4. IES-R: Correlation of items with own scale and other scales, first wave (n=471)

Subscale/item	**Corrected item total correlation**	**Correlation avoidance**	**Correlation hyperarousal**
Intrusion			
Any reminder brought back feelings about it	0,86	0,71	0,82
I had trouble staying asleep	0,84	0,73	0,87
Other things made me think about it	0,87	0,74	0,83
I thought about it when I didn't mean to	0,68	0,75	0,65
Pictures about it popped into my mind	0,79	0,65	0,74
I found myself acting/feeling like I was back at that time	0,80	0,69	0,84
I had waves of strong feelings about it	0,87	0,72	0,91
I had dreams about it	0,76	0,61	0,74
Avoidance	**Corrected item total correlation**	**Correlation intrusion**	**Correlation hyperarousal**
I avoided letting myself be upset when I thought about it or was reminded of it	0,74	0,62	0,57
I felt as if it hadn't happened or wasn’t real	0,70	0,68	0,65
I stayed away from reminders of it	0,77	0,60	0,59
I tried not to think about it	0,75	0,52	0,50
I was aware that I had a lot of feelings about it	0,65	0,83	0,80
My feelings about it were numb	0,65	0,65	0,63
I tried to remove it from my memory	0,65	0,61	0,60
I tried not to talk about it	0,75	0,69	0,70
Hyperarousal	**Corrected item total correlation**	**Correlation avoidance**	**Correlation intrusion**
I felt irritable and angry	0,87	0,70	0,88
I was jumpy and easily startled	0,74	0,74	0,75
I had trouble falling asleep	0,89	0,71	0,88
I had trouble concentrating	0,88	0,74	0,84
Reminders of it caused me to have physical reactions such as sweating, trouble breathing, nausea or a pounding heart	0,88	0,69	0,84
I felt watchful and on-guard	0,86	0,73	0,84

Table 12-5. IES-R: Correlation of items with own scale and other scales, second wave (n=356)

Subscale/item	**Corrected item total correlation**	**Correlation avoidance**	**Correlation hyperarousal**
Intrusion			
Any reminder brought back feelings about it	0,76	0,36	0,72
I had trouble staying asleep	0,78	0,35	0,78
Other things made me think about it	0,79	0,38	0,75
I thought about it when I didn't mean to	0,13	0,46	0,06
Pictures about it popped into my mind	0,69	0,34	0,70
I found myself acting/feeling like I was back at that time	0,68	0,46	0,73
I had waves of strong feelings about it	0,71	0,33	0,75
I had dreams about it	0,56	0,32	0,63
Avoidance	**Corrected item total correlation**	**Correlation intrusion**	**Correlation hyperarousal**
I avoided letting myself upset when I thought about it or was reminded of it	0,32	0,13	0,11
I felt as if it hadn't happened or wasn't real	0,34	0,40	0,27
I stayed away from reminders of it	0,28	0,04	0,07
I tried not to think about it	0,39	0,11	0,09
I was aware that I had a lot of feelings about it	0,39	0,69	0,62
My feelings about it were numb	0,32	0,34	0,21
I tried to remove it from my memory	0,33	0,21	0,19
I tried not to talk about it	0,22	0,14	0,23
Hyperarousal	**Corrected item total correlation**	**Correlation avoidance**	**Correlation intrusion**
I felt irritable and angry	0,76	0,38	0,77
I was jumpy and easily startled	0,60	0,40	0,59
I had trouble falling asleep	0,71	0,34	0,79
I had trouble concentrating	0,66	0,34	0,71
Reminders of it caused me to have physical reactions such as sweating, trouble breathing, nausea or a pounding heart	0,79	0,31	0,76
I felt watchful and on-guard	0,49	0,32	0,50

For the second wave, similar results were found for the avoidance and hyperarousal scale. However, one item of the intrusion scale, 'I thought about it when I didn't mean to', did not

correlate well with its scale. For the avoidance scale we see that most items have a rather low correlation with its own scale. If we look at the correlation of an items with the other scales, we see that most items of the intrusion scale (except 'I thought about it when I didn't mean to') have rather high correlation (above about 0,5) with the hyperarousal scale. For the hyperarousal scale we see that all items have rather high correlation with the intrusion scale. For the avoidance scale we see that most items (except 'I was aware that I had a lot of feelings about it') are not correlated with the intrusion nor the hyperarousal scale. Moreover, some items have even a higher correlation with the other IES-R than with their own scale. This suggests that the scales are intertwined.

Table 12.6 gives the correlation between the scales for the first and second wave separately. This table shows a rather high inter-correlation between the subscales in the first wave; all correlations are about 0.8 or higher. In the second wave the inter-correlations are substantially lower due to the avoidance scale; this scale correlates about 0.5 with intrusion and hyperarousal. Intrusion and hyperarousal are still highly correlated, about 0.90.

Table 12-6. IES-R: Correlation between subscales, first and second wave

Wave		**Intrusion**	**Hyperarousal**
First wave	Avoidance	0,815 (n=471)	0,796 (n=471)
	Intrusion		0,936 (n=471)
Second wave	Avoidance	0,520 (n=356)	0,449 (n=356)
	Intrusion		0,887 (n=356)

12.3. **Conclusions about IES-R**

On the basis of these results, it is concluded that the intrusion and hyperarousal are reliable and highly correlated. They are probably measuring the same underlying construct. Regarding avoidance the results are mixed. In the first wave the scale seemed internal consistent, but in the second wave the internal consistency was rather weak. Furthermore, in the first wave, it correlated high with the other scales, but in the second wave these inter-correlations were weak. Consequently, it is not clear what the items of the avoidance scale are measuring. One should be careful in interpreting effects of the social support on avoidance.

13. Social and Economic Resilience Tool

The Social and Economic Resilience (SER) tool consists of Likert scales on six scales: Social (5 items), Capability/Human Capital (6 items), Improvement of Actual Income/Economic (13 items), Women's Empowerment (12 items), Structural/System (2 items), and Worry (10 items).

The scale values of the items ranges from 1 (not at all) to 5 (extremely) (1 = strongly disagree, 2= disagree, 3=neutral, 4= agree, 5= strongly agree). Most statements are stated positively (high score indicate a positive mindset), however, for the subscale worry a high score indicates more worry (a negative mindset).

The SER scale is analyzed as the IES-R: the analyses is done for the first and second wave separately. To explore the reliability of the scale, an item-analysis is conducted on each of the scales, which consists of the statistics of the items, and the internal consistency of the scale (Cronbach's alpha). Then the correlations between the items and the scales are examined.

13.1. **Statistics for items in the SER tool**

In this section, the statistics of each subscale of the SER-tool will be described.

13.1.1. Social

Tables 13-1 gives the mean, standard deviation, and number of cases for whom the item is not applicable and the number of missing cases on the items of Social scale for the first and second wave.

Table 13-1. SER: Statistics for items in Social scale, first and second wave

Social (first wave n=471) **(1= strongly disagree, 5 = strongly agree)**	**Average**	**Standard Deviation**	**Not applicable**	**Missing**
I feel I trust my community	3.99	0.859	0	0
I feel attached to my family	4.159	0.756	0	0
I feel my contact with the leadership in my community has improved	3.896	0.815	0	0
I feel my relationship with the rest of the community has improved	3.898	0.743	0	1

My participation in the groups has improved	3.845	0.967	27	0
Social (second wave n=356)	**Average**	**Standard deviation**	**Missing**	
I feel I trust my community	4.01	0.88	0	
I feel attached to my family	4.32	0.73	0	
I feel my contact with the leadership in my community has improved	4.02	0.63	0	
I feel my relationship with the rest of the community has improved	3.99	0.72	0	
My participation in the groups has improved	Not included in the second wave			

All items of the Social scale score above the scale midpoint (3) and have a rather small standard deviation (smaller than 1). Furthermore, it seems as if the scores in the second wave are somewhat higher than in the first wave. This indicates that most respondents are neutral or positive about their integration in the community and that they feel that their relationship with their community is improving. The item non-response of the scale is good (less than 5%), since almost all respondents answered every item of the scale if it was applicable to them. No5 is that 'I feel my relationship with the rest of the community has improved' was marked as not applicable by 27 respondents. This item was, therefore, removed for the second wave.

13.1.2. Capability

Tables 13-2 gives the mean, standard deviation, and number of cases for whom the item is not applicable and the number of missing cases on the items of Capability scale for the first and second wave.

Table 13-2. SER: Statistics for items in Capability scale, first and second wave

Capability (first wave n=471) **(1=strongly disagree, 5= strongly agree)**	**Average**	**Standard Deviation**	**Not applicable**	**Missing**
I feel my ability to pay for medication has improved	2,45	1,18	0	1
I feel my capacity to pay school fees has improved in the last 6 months	2,32	1,10	1	2

I feel I can get information about anything I want	2,85	1,10	0	0
I feel I have skills to enable me improve my life	2,78	1,15	1	0
I feel I have acquired new productive skills to improve my life	2,76	1,13	2	1
I feel change in the amount of knowledge hold	2,85	1,08	1	0
Capability (second wave n=356)	average	Standard deviation	missing	
I feel my ability to pay for medication has improved	2,97	1,06	3	
I feel my capacity to pay school fees has improved in the last 6 months	2,67	1,13	1	
I feel I can get information about anything I want	3,34	0,87	2	
I feel I have skills to enable me improve my life	3,45	0,87	2	
I feel I have acquired new productive skills to improve my life	3,41	0,95	1	
I feel change in the amount of knowledge hold	3,55	0,86	1	
I feel I am able to handle misunderstandings in my household (new)	3,89	0,77	4	
My husband seeks my opinion on matters related to our household (new)	2,80	1,46	25	
I have been able to space my children (new)	3,70	1,12	20	

In the first wave, the items about Capability all score below the scale midpoint and have a rather large standard deviation. In the second wave, the scores seems somewhat higher and the standard deviation somewhat lower. This indicates that, in the first wave, respondents feel they do not have the capabilities to manage life, however large differences exist between respondents but that most respondents feel that their capabilities have improved. In the first wave, the item non-response of this scale is good (less than 5%), since almost all respondents answered every item of the Capability scale. However, in the second wave the last two new items ‘My husband seeks my opinion on matters related to our household’ and ‘I have been able to space my children’ had a rather high non response (> 0,05%).

13.1.3. Improvement of actual income

Tables 13-3 gives the mean, standard deviation, and number of cases for whom the item is not applicable and the number of missing cases on each item of the Improvement of actual income scale for the first and second wave. In the first wave, the items regarding improvement of actual income show a defuse picture. The items about the income position as it is, score above the scale midpoint, but the items about the future or improvement of assets score beneath the scale midpoint. Consequently, these items were removed in the second wave.

Table 13-3. SER: Statistics for items in Improvement of Actual Income scale, first and second wave

Improvement of actual income (first wave n=471) **(1= strongly disagree, 5=strongly agree)**	**Average**	**Standard Deviation**	**Not applicable**	**Missing**
I am able to save money	3,23	1,20	1	1
My income will continue to improve in the next 6 months	2,75	1,01	11	0
I will have employment in the next 6 months	2,32	0,97	21	0
I will be able to own a business in the next 6 months	2,66	1,06	8	0
I have market for my produce	3,08	1,07	4	0
I am able to market my own produce	3,17	1,10	4	2
I am able to contribute to household income	3,29	1,05	1	1
My personal assets have improved	2,65	1,02	0	0
My access to household assets has improved	2,80	1,07	1	1
I am able to survive in hardship times	3,51	1,00	0	1
I am able to manage my own income	3,36	1,05	0	1
I am able to make decisions on income in your household	3,37	1,03	1	2
I am able to adopt new production technologies	2,74	1,09	1	1
I am able to save money	3,23	1,20	1	1

Improvement of actual income (second wave n=356)	average	Standard deviation	missing
I am able to save money	3,59	1,03	0
My income will continue to improve in the next 6 months	Not included in the second wave		
I will have employment in the next 6 months			
I will be able to own a business in the next 6 months			
I have market for my produce	3,59	0,89	0
I am able to market my own produce	3,74	0,93	1
I am able to contribute to household income	3,82	0,86	0
My personal assets have improved	3,16	0,90	0
My access to household assets has improved	3,16	0,91	0
I am able to survive in hardship times	3,89	0,68	0
I am able to manage my own income	3,93	0,67	0
I am able to make decisions on income in your household	3,97	0,68	3
I am able to adopt new production technologies	Not included in the second wave		
I will be able to own a business in the next 6 month?(new)	3,21	1,07	0
I will be able to improve production (new)	3,43	0,94	6

In the second wave, the scores of the improvement of actual income scale seems somewhat higher and the standard deviation somewhat lower. The item non-response of the scale (in the first and second wave) is good (less than 5%), if the items are regarded as applicable to the respondent. Notable is that 21 respondents regarded the item 'I will have employment in the next 6 months as not applicable to them. This is another reason why these items were not included in the second wave.

13.1.4. Women's empowerment

Tables 13-4 gives the mean, standard deviation, and number of cases for whom the item is not applicable and the number of missing cases on the items of the Women's Empowerment scale for the first and second wave.

Table 13-4. SER: Statistics for items in Women's Empowerment scale, first and second wave

Women empowerment (first wave n=471) **(1=strongly disagree, 5= strongly agree)**	**Average**	**Standard Deviation**	**Not applicable**	**Missing**
I am able to take up new initiatives independently	2,90	1,10	1	1
I am able to make decisions more independently	2,91	1,10	2	0
My hours of household work have been able to reduce	2,68	1,183	1	1
Have you been able to gain more time for productive activities	2,71	1,17	0	1
Has your freedom of movement improved	3,21	1,13	0	0
I feel improvement in my self-worth	3,31	0,99	1	0
feel there has been change in my values	3,35	0,98	0	0
I feel I am in charge of my body	3.42	1,06	2	0
I feel I am able to make decisions about contraceptive use	3,00	1,19	70	0
My household relations have improved	3.29	1,01	28	0
There has been change in the way I resolve conflicts in my household	3,43	0,93	32	0
There has been a change in my husband's attitude towards me	3,27	1,05	154	2
Women empowerment (second wave n=356)	average	Standard deviation	missing	
I am able to take up new initiatives independently	3,66	0,80	2	
I am able to make decisions more independently	3,75	0,77	2	
My hours of household work have been able to reduce	3,45	0,91	0	
Have you been able to gain more time for productive activities	3,61	0,87	1	
Has your freedom of movement improved	3,90	0,76	0	
I feel improvement in my self-worth	3,99	0,77	1	

feel there has been change in my values	3,96	0,69	1
I feel I am in charge of my body	4,21	0,75	1
I feel I am able to make decisions about contraceptive use	Not included in the second wave		
My household relations have improved			
There has been change in the way I resolve conflicts in my household			
There has been a change in my husband's attitude towards me			

Regarding the first wave of the women empowerment items, all items scale score about the scale midpoint and have a rather small standard deviation (< 1). Furthermore, the item non-response of the scale is good (less than 5%) it the items are applicable. Notable is that 4 items are regarded as not applicable by a substantial proportion of the respondent (>0,05%). Quite a lot of these items regard relationship to the family. The rather high non-response suggests that these items are not comprehended, not applicable, or too offensive

These items were not included in the second wave.

Regarding the second wave, it seems as if the scores on women empowerment are somewhat improving and their standard deviation seems to be somewhat less. These results suggest that most respondents have a positive attitude toward life, and act in accordance with it yet and that this attitude improved in the second wave.

13.1.5. Structural/system

Table 13-5 gives the mean, standard deviation, and number of cases for whom the item is not applicable and the number of missing cases on the items of the Structural/System scale for the first and second wave.

Table 13-5. SER: Statistics for items in Structural/System scale, first and second wave

Structural/system (first wave n=471) **(1=strongly disagree, 5=strongly agree)**	**Average**	**Standard Deviation**	**Not applicable**	**Missing**
I feel I am able to exercise my rights	3.36	1.27	0	1

I am able to access legal services much easier	2,84	1,24	0	0
Structural/system (second wave n=356)	**Average**	**Standard deviation**	**Missing**	
I feel I am able to exercise my rights	3.98	0,75	3	
I am able to access legal services much easier	3,42	0,86	3	
I am able to seek and access medical services? (new)	3,25	1,01	3	
I am able to access financial services? (new)	2,54	1,50	15	

In the first wave, the two items about structural/system suggest that respondents have a global positive attitude toward the (formal) community, but are less sure about specific services and rights. The item non-response of the scale is good (less than 5%). In the second wave the scores on structural/system seem somewhat improved and their standard deviation to be somewhat less.

In order to improve this scale, two new items were added. One of the new items about Structural/System (I am able to access financial services) scores below the scale midpoint, and this item has also a rather large standard deviation (1.50). The item non-response of the scale is good (less than 5%). These results suggest that respondents have a global positive attitude toward the (formal) community, but are less sure about financial services.

The last scale regarding worry indicates that all scores are above the scale midpoint, and most items have a standard deviation of about 1. The item 'I am worried that the government will not address my needs' has a standard deviation of about 1.7. These results suggest that most respondents worry al lot. The item non-response of the scale is good (less than 5%), if the items are regarded as applicable to the respondent. Notable is that 41 respondents regarded the item 'I am worried I may not find a job' as not applicable to them.

In the second wave all mean scores are still above the scale midpoint, and most items have a standard deviation of just about 1. This suggest that little improvement was made. The items 'I am worried that conflict may happen again in my society' and 'I am worried of hostility from members of my community' have a rather high standard deviation (1.44 and 1.22 respectively). These results suggest that most respondents worry al lot. The item non-response of the scale is good (less than 5%) in the second wave.

13.1.6. Worry

Tables 13-6 gives the mean, standard deviation, and number of cases for whom the item is not applicable and the number of missing cases on the items of the Worry scale for the first and second wave.

Table 13-6. SER: Statistics for items in Worry scale, first and second wave

Worry (first wave n=471)	**Average**	**Standard Deviation**	**Not applicable**	**Missing**
I am worried that conflict may happen again in my society	3,29	1,22	0	0
I am worried that I will fail to provide for my family	3,51	0,97	3	1
I am worried I may not find a job	3,55	1,11	41	0
I am worried of hostility from members of my community	3,00	1,08	0	0
I am worried I may not get enough money	3,68	0,91	0	0
I am worried that my leaders will not address the needs of my community	3,59	1,06	0	1
I am worried that climate change will affect food production	4,09	1,03	0	0
I am worried that the government will not address my needs	3,73	1,69	0	0
I am worried my psycho-social status will worsen if not treated	3,38	1,11	1	0
I feel confident that I can overcome challenges I have experienced in the past	3,54	1,02	0	0
Worry (second wave n=356)	**Average**	**Standard deviation**	**Missing**	
I am worried that conflict may happen again in my society	3,03	1,44	0	
I am worried that I will fail to provide for my family	3,46	1,06	0	
I am worried I may not find a job	3,31	1,11	1	

I am worried of hostility from members of my community	2,79	1,22	0
I am worried I may not get enough money	3,66	1,00	3
I am worried that my leaders will not address the needs of my community	3,50	1,07	3
I am worried that climate change will affect food production	4,35	0,94	3
I am worried that the government will not address my needs	3,81	1,03	1
I am worried my psycho-social status will worsen if not treated	Not included in the second wave		
I feel confident that I can overcome challenges I have experienced in the past			

Table 13-6 indicates that all score are above the scale midpoint, and most items have a standard deviation of about 1. The item 'I am worried that the government will not address my needs' has a standard deviation of about 1.7. These results suggest that most respondents worry al lot. The item non-response of the scale is good (less than 5%), if the items are regarded as applicable to the respondent. Notable is that 41 respondents regarded the item 'I am worried I may not find a job' as not applicable to them.

In the second wave all mean scores are still above the scale midpoint, and most items have a standard deviation of just about 1. This suggest that little improvement was made. The items 'I am worried that conflict may happen again in my society' and 'I am worried of hostility from members of my community' have a rather high standard deviation (1,44 and 1,22 respectively). These results suggest that most respondents worry al lot. The item non-response of the scale is good (less than 5%) in the second wave.

13.2. **Correlation between the items in the SER scale**

As the SER scale is recently developed, the correlation of an item with its own scale will be explored as well as it correlation with items of the other scales. This will be done for the first and second wave separately. Tables 13-7 to 13-10 give the correlations for the first wave.

Table 13-7. SER: Correlation of items on Social and Capability scales with own scale and other scales, first wave

	Corrected item total correlation	Correlation				
		Capability	Income	Empowerment	System	Worry
Social						
I feel I trust my community	0,477	0,146	0,183	0,183	0,067	-0,074
I feel attached to my family	0,421	0,114	0,062	0,070	-0,083	-0,057
I feel my contact with the leadership in my community has improved	0,535	0,292	0,288	0,223	0,192	-0,018
I feel my relationship with the rest of the community has improved	0,581	0,244	0,347	0,266	0,111	0,049
My participation in the groups has improved	0,347	0,042	0,320	0,193	-0,068	0,175
Capability	**Corrected item total correlation**	**Social**	**Income**	**Empowerment**	**System**	**Worry**
I feel my ability to pay for medication has improved	0,664	0,139	0,414	0,320	0,405	-0,220
I feel my capacity to pay school fees has improved in the last 6 months	0,672	0,116	0,383	0,309	0,437	-0,209
I feel I can get information about anything I want	0,714	0,259	0,516	0,479	0,510	-0,191
I feel I have skills to enable me improve my life	0,750	0,242	0,543	0,430	0,419	-0,107
I feel I have acquired new productive skills to improve my life	0,733	0,226	0,523	0,435	0,360	-0,085
I feel change in the amount of knowledge hold	0,769	0,303	0,592	0,514	0,479	-0,122

Inspection of Table 13-7 regarding the Social scale indicates that the item ’my participation in the groups has improved’ have a low correlation with the own scale (0.347), and even lower with the other scales (<0.32). This item is included in the scale for the first wave,

however, not asked for in the second wave. Regarding the Capability scale, Table 13-8 indicates that all items correlate sufficient with its own scale and to a lesser extent to the other scales.

Table 13-8. Correlation of items on Income scale with own scale and other scales, first wave

	Corrected item total correlation	Correlation				
		Social	Capability	Empowerment	System	Worry
Income						
I am able to save money	0,551	0,293	0,378	0,328	0,170	0,006
My income will continue to improve in the next 6 months	0,704	0,243	0,509	0,473	0,316	-0,087
I will have employment in the next 6 months	0,491	0,197	0,424	0,323	0,122	-0,142
I will be able to own a business in the next 6 months	0,718	0,241	0,532	0,444	0,329	-0,126
I have market for my produce	0,765	0,278	0,428	0,492	0,334	-0,026
I am able to market my own produce	0,758	0,260	0,422	0,506	0,336	-0,004
I am able to contribute to household income	0,741	0,285	0,424	0,535	0,265	-0,006
My personal assets have improved	0,652	0,233	0,522	0,487	0,367	-0,086
My access to household assets has improved	0,624	0,243	0,497	0,469	0,292	-0,046
I am able to survive in hardship times	0,542	0,267	0,246	0,364	0,039	0,091
I am able to manage my own income	0,697	0,133	0,317	0,582	0,289	0,066

I am able to make decisions on income in your household	0,651	0,232	0,325	0,597	0,333	0,062
I am able to adopt new production technologies	0,490	0,177	0,544	0,536	0,458	-0,013

For the Income scale, Table 13-8 shows that all items correlate sufficiently with their own scale. But the item 'I am able to adopt new production technologies' correlates higher with the Capability and Empowerment scale. In the first wave, all Income items are included in the Income scale.

Table 13-9. SER: Correlations of the items on Women's Empowerment and Systems scales with own scale and other scales, first wave

	Corrected item total correlation	**Correlation**				
		Social	**Capability**	**Income**	**System**	**Worry**
Women's Empowerment						
I am able to take up new initiatives independently	0,634	0,246	0,428	0,563	0,349	-0,052
I am able to make decisions more independently	0,636	0,193	0,373	0,509	0,334	0,003
My hours of household work have been able to reduce	0,345	0,101	0,330	0,292	0,343	-0,045
Have you been able to gain more time for productive activities	0,709	0,143	0,511	0,517	0,550	0,005
Has your freedom of movement improved	0,584	0,163	0,368	0,458	0,508	-0,026
I feel improvement in my self-worth	0,689	0,152	0,242	0,471	0,365	0,072

	Corrected item total correlation	Correlation				
		Social	**Capability**	**Income**	**System**	**Worry**
feel there has been change in my values	0,733	0,188	0,314	0,533	0,447	0,078
I feel I am in charge of my body	0,687	0,126	0,300	0,472	0,416	-0,003
I feel I am able to make decisions about contraceptive use	0,679	0,159	0,363	0,514	0,426	-0,021
My household relations have improved	0,660	0,254	0,293	0,406	0,262	-0,021
There has been change in the way I resolve conflicts in my household	0,586	0,292	0,251	0,412	0,229	0,017
There has been a change in my husband's attitude towards me	0,493	0,380	0,321	0,375	0,186	-0,002
System	**Corrected item total correlation**	**Social**	**Capability**	**Income**	**Empowerment**	**Worry**
I feel I am able to exercise my rights	0,712	0,029	0,425	0,340	0,534	-0,003
I am able to access legal services much easier	0,712	0,083	0,566	0,400	0,488	-0,108

Table 13-9 gives the correlation between the items of the Women's Empowerment and Systems scales. Inspection indicates that, in the first wave, all items correlate sufficiently with their own scale (corrected item total correlations are all above 0.35) and to a lesser extent with the other scales.

Table 13-10. SER: Correlation of items on Worry scale with own scale and other scales, first wave

	Corrected item total correlation	Correlation				
		Social	Capacities	Income	Empowerment	System
Worry						
I am worried that conflict may happen again in my society	0,431	0,083	-0,061	-0,031	-0,018	-0,127
I am worried that I will fail to provide for my family	0,545	-0,043	-0,293	-0,167	-0,120	-0,152
I am worried I may not find a job	0,475	-0,031	-0,283	-0,160	-0,097	-0,161
I am worried of hostility from members of my community	0,380	-0,198	-0,026	-0,064	-0,010	0,137
I am worried I may not get enough money	0,583	0,133	-0,001	0,101	0,111	0,130
I am worried that my leaders will not address the needs of my community	0,460	0,022	-0,074	0,046	0,003	-0,012
I am worried that climate change will affect food production	0,391	0,107	-0,087	0,137	0,117	-0,027
I am worried that the government will not address my needs	0,474	0,052	-0,147	-0,014	0,000	-0,069
I am worried my psycho-social status will worsen if not treated	0,264	0,010	0,227	0,234	0,231	0,392
I feel confident that I can overcome challenges I	-0,011	0,263	0,292	0,290	0,203	0,100

	Corrected item total correlation	Correlation				
		Social	Capacities	Income	Empowerment	System
have experienced in the past						

The correlations for the last scale, Worry, are presented in Table 13-10. This table reveals that all items except 'I am worried my psycho-social status will worsen if not treated' and 'I feel confident that I can overcome challenges I have experienced in the past' correlate sufficiently with its own scale and to a less extent to the other scales. The item 'I am worried my psycho-social status will worsen if not treated' correlates higher with the system scale than with its own scale. While the item 'I feel confident that I can overcome challenges I have experienced in the past' does not correlate sufficiently with the own scale, neither the other scales (<0.35). Both items are removed from the Worry scale in the rest of the analyses.

On the bases of these inter-item correlations as well as the extent specific items were not applicable, some items were not included in the second wave. In order to improve the SER-scale, some new items were introduced in the second wave. The differences between first and second wave are indicated in Table 13-7 to 13-10. Next, we will explore the correlations in the second wave, of an item with its own scale as the correlation of an item with the other scales.

As Table 13-11 indicates the items of the Social scale are the same for the first and second wave. As in the first wave, all items of the Social subscale correlate sufficiently with its own scale and to a lesser extent to the other scales.

For the Capability scale, three new items were included in the second wave. Table 13-11. shows that the new items 'I feel I am able to handle misunderstandings in my household', 'My husband seeks my opinion on matters related to our household' and 'I have been able to space my children' correlate insufficiently with its own scale (< 0.35). The item 'I feel I am able to handle misunderstandings in my household' correlates sufficiently with the social, Income and Empowerment scale. The item 'I have been able to space my children' correlates

sufficiently with the Income and Empowerment scale. All three items are removed from the Capability scale in the second wave.

Regarding the Income scale three items were dropped and two new items were added. In the second wave, all items of the income scale correlate sufficiently with its own scale (see Table 13-12). But the item 'My access to household assets has improved' correlates higher with the Capability scale than its own scale. And both the items 'I am able to survive in hardship times', and 'I am able to make decisions on income in your household' correlate higher with the Empowerment scale than its own scale. Still, all income items are included in the Income scale in the second wave.

Table 13-11. SER: Correlations of items from Social and Capability scales with own scale and other scales, second wave

	Corrected item total correlation	Correlation				
		Capability	Income	Empowerment	System	Worry
Social						
I feel I trust my community	0,600	0,312	0,334	0,303	0,313	-0,148
I feel attached to my family	0,447	0,289	0,296	0,186	0,247	-0,110
I feel my contact with the leadership in my community has improved	0,563	0,320	0,469	0,412	0,340	-0,001
I feel my relationship with the rest of the community has improved	0,590	0,273	0,373	0,379	0,337	-0,071
I feel my ability to pay for medication has improved	0,510	0,181	0,407	0,211	0,060	-0,423
I feel my capacity to pay school fees has improved in the last 6 months	0,509	0,145	0,415	0,170	0,074	-0,350

	Corrected item total correlation	Correlation				
		Capability	Income	Empowerment	System	Worry
I feel I can get information about anything I want	0,618	0,308	0,429	0,293	0,137	-0,359
I feel I have skills to enable me improve my life	0,641	0,417	0,576	0,351	0,310	-0,238
I feel I have acquired new productive skills to improve my life	0,676	0,347	0,589	0,316	0,276	-0,228
I feel change in the amount of knowledge hold	0,646	0,440	0,515	0,314	0,303	-0,229
I feel I am able to handle misunderstandings in my household (new)	0,335	0,350	0,421	0,375	0,318	-0,003
My husband seeks my opinion on matters related to our household (new)	0,261	0,089	0,202	-0,038	-0,011	0,001
I have been able to space my children (new)	0,215	0,213	0,347	0,231	0,139	-0,137

Table 13-12. SER: Correlation of items from Income scale with own scale and other scales, second wave

	Corrected item total correlation	Correlation				
		Social	Capability	Empowerment	System	Worry
Income						
I am able to save money	0,561	0,342	0,415	0,388	0,253	-0,043

	Corrected item total correlation	Correlation				
		Social	Capability	Empowerment	System	Worry
I have market for my produce	0,718	0,397	0,506	0,442	0,360	-0,084
I am able to market my own produce	0,694	0,478	0,488	0,458	0,358	-0,124
I am able to contribute to household income	0,702	0,407	0,451	0,545	0,247	-0,169
My personal assets have improved	0,513	0,173	0,476	0,308	0,198	-0,295
My access to household assets has improved	0,422	0,118	0,429	0,253	0,094	-0,248
I am able to survive in hardship times	0,431	0,335	0,277	0,529	0,315	0,076
I am able to manage my own income	0,535	0,356	0,309	0,502	0,356	-0,031
I am able to make decisions on income in your household	0,535	0,380	0,286	0,570	0,341	-0,079
I will be able to own a business in the next 6 month?(new)	0,628	0,263	0,516	0,267	0,197	-0,159
I will be able to improve production (new)	0,656	0,344	0,564	0,407	0,226	-2,78

Table 13-13. SER: Correlations of items from Women's Empowerment scale with own scale and other scales, second wave

	Corrected item total correlation	Correlation				
		Social	Capability	Income	System	Worry
Women's Empowerment						
I am able to take up new initiatives independently	0,474	0,269	0,314	0,440	0,367	-0,133
I am able to make decisions more independently	0,587	0,326	0,152	0,372	0,300	0,039
My hours of household work have been able to reduce	0,444	0,101	0,175	0,245	0,077	0,053
Have you been able to gain more time for productive activities	0,545	0,227	0,365	0,495	0,195	-0,147
Has your freedom of movement improved	0,516	0,306	0,195	0,355	0,312	-0,039
I feel improvement in my self-worth	0,654	0,369	0,298	0,517	0,329	-0,109
feel there has been change in my values	0,657	0,349	0,247	0,489	0,320	-0,053
I feel I am in charge of my body	0,511	0,370	0,169	0,395	0,329	-0,0,60

Table 13-13 gives the correlation of items from the Women's Empowerment scale for the second wave. For this scale, four items were dropped in the second wave. The remaining items correlate sufficiently with own scale (corrected item total correlations are all above 0.35) and to a lesser extent with the other scales.

Table 13-14. SER: Correlations of items from System scale with own scale and other scales, second wave

	Corrected item total correlation	Correlation				
		Social	Capability	Income	Empowerment	Worry
System						
I feel I am able to exercise my rights	0,156	0,438	0,151	0,343	0,458	0,024
I am able to access legal services much easier	0,392	0,256	0,254	0,304	0,239	-0,102
I am able to seek and access medical services? (new)	0,408	0,216	0,351	0,393	0,324	-0,274
I am able to access financial services? (new)	0,257	-0,055	0,221	0,191	0,104	-0,050

For the System scale two new items were added in the second wave. Table 13-14 reveals that in the second wave, the items 'I feel I am able to exercise my rights' (old item) and 'I am able to access financial services' (new item) do not correlate sufficiently with its own scale. The item 'I feel I am able to exercise my rights' correlates sufficiently with the social, income and empowerment scale. Due to consistency with the first wave and the height of the correlations between the items, the System scale consists of the old items 'I feel I am able to exercise my rights' and 'I am able to access legal services much easier', although this scale has a rather weak reliability (see Table 13-16).

The correlations of the second wave for the last scale, Worry, are presented in Table 13-15. For the second wave, two items were dropped. Table 13-15 reveals that all included items correlate sufficiently with its own scale and to a less extent to the other scales, except the item 'I am worried that climate change will affect food production' which correlates insufficiently with its own scale. Due to consistency with the first wave, all Worry items are included in the Worry scale.

Table 13-15. SER: Correlation of items from Worry scale with own scale and other scales, second wave

	Corrected item total correlation	Correlation				
		Social	Capability	Income	Empowerment	System
Worry						
I am worried that conflict may happen again in my society	0,414	-0,067	-0,247	-0,124	-0,087	-0,162
I am worried that I will fail to provide for my family	0,621	-0,101	-0,348	-0,240	-0,107	-0,064
I am worried I may not find a job	0,530	-0,088	-0,347	-0,214	-0,104	-0,111
I am worried of hostility from members of my community	0,461	-0,247	-0,214	-0,132	-0,043	-0,178
I am worried I may not get enough money	0,633	-0,014	-0,322	-0,136	-0,030	0,050
I am worried that my leaders will not address the needs of my community	0,628	-0,192	-0,315	-0,197	-0,154	0,008
I am worried that climate change will affect food production	0,301	0,158	-0,093	0,088	0,205	0,216
I am worried that the government will not address my needs	0,557	0,019	-0,209	-0,064	-0,042	0,096

13.3. **Internal consistency of the SER**

On the bases of the inter item correlations of the first wave, all items of a specific scale, except the last two items of the Worry scale (which correlated quite low (< 0.35) with the rest of the scale (see Table 13-15) were included in the scale for the first wave. Cronbach's alpha (see Table 13-16) for the Social and Worry scales indicates that the scales are less homogeneous than the other scales, although a value of above 0.60–0.70 is reached, which is deemed the lower limit of acceptability (Hair et al., 1998).

For the second wave, the new items of the Capability scale, two items of the system scale, and one item of the Worry scale do not correlated quite well with their own scale, as the item correlations indicate (< 0.35, see Table 13-11). In order to be consistent with the first wave, it was decided to remove the three new items of the Capability scale, to include the two old items in the system scale and to keep all 8 items in Worry scale. This resulted in the Cronbach's alpha as reported in the lower part of Table 13-16. This table indicates that the reliability of all scales are appropriate (> 0,70; Hair et al., 1998), except of the System scale.

Table 13-16. SER: Characteristics of the subscales, first and second wave

Wave	Scale	Cronbach's alpha	# items	Average (range 1–5)	SD	Skewness	Kurtosis	Missing
First wave	Social	0,707	5	3,96	0,56	-0,17	-0,06	0
	Capability	0,894	6	2,67	0,91	0,35	-0,25	0
	Income	0,916	13	2,99	0,74	0,14	0,001	0
	Empowerment	0,882	12	3,13	0,77	0,25	-0,26	0
	System	0,832	2	3,10	1,16	-0,29	-0,60	0
	Worry	0,764	8	3,55	0,66	-0,37	0,05	0
Second wave	Social	0,748	4	4,08	0,56	-0,91	1,59	0
	Capability	0,845	6	3,12	0,72	-0,35	-0,31	0
	Income	0,874	11	3,59	0,59	-0,96	1,69	0
	Empowerment	0,822	8	3,82	0,53	-0,55	2,21	0
	System	0,585	2	3,70	0,68	-0,64	0,35	0
	Worry	0,799	8	3,48	0,71	-0,42	0,13	0

For the first and second wave, the mean scores of the (answered) items of a subscale are regarded as an index of that scale. When inspecting the average scores of each subscale it turns out that the respondents in the first wave, have a positive opinion toward the informal community (social), a neutral opinion towards their income position, empowerment, and the

formal community (system), a negative opinion about their capacities, and that they worry a lot. For the second wave, the scores seem to improve for all subscales.

Furthermore, Table 13-16 reveals that all subscales are normally distributed (skewness and kurtosis are within the range -1 – 1) and seem to have a smaller standard deviation in the second wave than in the first wave.

13.4. **Correlations between the subscales**

The correlations of the items with the other scales as reported in Table 13-11 to 13-15 suggest that the subscales are somewhat intertwined. Table 13-17 gives the correlations between the scales for the first and second wave separately. It reveals that, for the first and second wave, the Social and Worry scales are not correlated with the other scales (< 0.5). The Capability scale correlates with the Income scale in the first and second wave, and with the Women's Empowerment and System scale in the first wave. Furthermore, the Empowerment scale is correlated with the Income scale in the first and second wave, and with the System scale in the first scale.

Table 13-17. SER: Correlations between the subscales, first and second wave

	Social		**Capability**		**Income**		**Empowerment**		**System**	
	Wave									
	1st	**2nd**	**1st**	**2nd**	**1st**	**2nd**	**1st**	**2nd**	**1st**	**2nd**
Capability	0,264	0,393								
Income	0,348	0,477	0,610	0,643						
Women's Empower-ment	0,272	0,415	0,509	0,352	0,660	0,605				
System	0,060	0,405	0,535	0,245	0,400	0,383	0,553	0,406		
Worry	0,025	-0,117	-0,191	-0,409	-0,032	-0,204	-0,004	-0,081	-0,06	-0,051

PART VIII: QUANTITATIVE RESULTS

14. Description of Respondents

14.1. **Description of participants in first wave and districts**

In total 472 respondents took part of the interview. Due to item non-response (more than 25%) one respondent was removed from the analysis. Other respondents answered the questionnaire quite well; In general item-nonresponse is less than 10%.

The districts in which the respondents are living are (see also Table 14.1): Lira (25.7%), Katakwi (27.8%) Amuria (10.4%) and Kitgum (36.1%). Those districts are locate in the north east of Uganda.

Table 14-1. Geographic area of the respondents

District	Number of respondents
Amuria	73
Lira	118
Katakwi	174
Kitgum	106

The next table indicates how the different programs are distributed across the districts. Chi-square analysis revealed that the programs are not distributed equally across the districts (Ch1-square= 116,11, df=9, p<0,05).

Table 14-2. Geographic distribution of the programs

District	Programs			
	Cash/in-kind only	counseling only	Both cash and counseling	No program
Amuria	3	5	37	4
Lira	28	5	50	32
Katakwi	30	48	12	41
Kitgum	25	50	38	57

On average the age of the respondents is 42 year (s.d. 15.55). An analysis of variance (one-way) indicates that the groups differ in age ($F(3,459)=5.52$, $p< 0.05$). Post hoc analysis revealed that the cash only group is significantly older (47.99) than the trauma only group (40.60), the cash and trauma group (41.94) and the no program group (39.86).

Table 14.3 indicates that most respondents received less that secondary education (almost 88%) and a Chi-square test indicate that educational level is not equally distributed across the groups (Chi-square = 20,08, df = 9, p< 0,05).

Table 14.4 indicates that most respondents are famers (almost 84%) and a Chi-square test revealed that occupation is not equally distributed across the groups (Chi-square = 18.71, df = 9, p< 0.05).

Table 14-3. Educational level of the different groups

Kind of program	Educational level			
	Never been to school	Attended Primary education	Attended secondary education	Tertiary institution
Cash/in-kind only	39	41	4	2
Trauma counseling only	30	62	13	3
Both cash transfer and trauma counseling	35	75	20	6
No program	52	72	9	1

Table 14-4. Occupation/employment of the different groups

Kind of program	Employment/occupation			
	farming	business	Professional job	none
Cash/in-kind only	77	4	1	4
Trauma counseling only	88	10	5	4
Both cash transfer and trauma counseling	109	14	9	5
No program	119	4	1	10

Due to the differences between the groups, we will explore the effects of age, educational level, and occupation next to the effects of the programs in the chapters that report of the effects of the programs.

14.2. **Description of respondents second wave and districts**

In total 357 respondents took part of the interview in the second wave. Due to item non-response (more than 25%) one respondent was removed from the analysis. Other respondents answered the questionnaire quite well; In general item-nonresponse is less than 10%.

The districts in which the respondents are living are (see also Table 14.5): Amuria (18.0%), Lira (29.8%), Katakwi (20.5%) and Kitgum (31.7%). Those districts are located in the north east of Uganda.

Table 14-5. Geographic area of the respondents

District	Number of respondents
Amuria	46
Lira	104
Katakwi	121
Kitgum	113

The next table shows how the different programs (cash/in-kind, trauma counseling (not SHLCPTS)) are distributed over the districts. Chi-square analysis revealed that the treatment groups are not distributed equally across the districts (Ch1-square= 43.461, df=9, $p<0.05$).

Table 14-6. Geographic distribution of the programs

district	programs			
	Cash only	counseling only	Both cash and counseling	none
Amuria	2	16	36	10
Lira	25	30	32	19
Katakwi	13	30	18	12
Kitgum	22	17	36	38

On average the age of the respondents is 42 year (s.d. 14.705). An analysis of variance (one-way) indicates that the groups differ in age ($F(3,352)=5.29$, $p< 0.05$). Post hoc analysis revealed that the both cash and counseling group is significantly older (45.63) than the no

program (first wave) group (37.82; p<0.05), the trauma only group (40.50; p< 0.10), but not the cash only group (43.40).

Table 14.7 indicates that most respondents received less that secondary education (87%) and a Chi-square test indicate that educational level is equally distributed across the treatment groups (Chi-square = 6.811, df = 9, p> 0.10).

Table 14.8 indicates that most respondents are famers (almost 86.7%) and a Chi-square test revealed that occupation is equally distributed across the treatment groups (Chi-square = 12.46, df = 9, p > 0.10).

Table 14-7. Educational level of the treatment groups

Kind of program	**Educational level**			
	Never been to school	Attended primary education	Attended secondary education	Tertiary institution
Cash transfer only	25	33	4	0
Trauma counseling only	26	52	11	3
Both cash transfer and trauma counseling	43	59	15	4
None (no cash transfer nor trauma counseling	24	46	7	2

Table 14-8. Occupation/employment of the treatment groups

Kind of program	**Employment/occupation**			
	Farming	Business	Professional job	None
Cash transfer only	57	2	0	3
Trauma counseling only	72	14	3	2
Both cash transfer and trauma counseling	105	10	3	3
None (no cash transfer nor trauma counseling	72	5	1	1

15. Levels of Trauma (Wave 1)

In this research, trauma was operationalized with the revised Impact of Events Scale (IES-R). This scale reflects the DSM-IV criteria for post-traumatic stress disorder. Regarding the first wave we will explore the differences in levels of trauma between the groups who received some type of support (cash/in-kind: yes/no; counseling: yes/no) on the subscales of the IES-R and is total score. Is the population traumatized to a large extent? This question is relevant as it is assumed in the theoretical model that high levels of trauma are hindering the probability that social protection increases livelihood.

15.1. **Levels of self-reported trauma**

Table 15-1 gives the statistics of the total mean IES-R score for each group of respondents. It indicates that for all groups the average post-traumatic stress is about 7 (IES-R-total, sum of the three subscales; minimum 0 maximum 12, higher more trauma).

Table 15-1. IES-R: Total mean score for each group of respondents (cash/in-kind and/or trauma counselling)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only	86	7,58	2,57	-0,69	-0,18
Counseling only	108	7,26	2,86	-0,88	0,45
Both cash/in-kind and counseling	137	7,30	3,29	-0,82	0,10
No program	134	7,57	2,95	-1,40	1,40
Total	465				

According to Creamer, Bell & Failla, (2003, p. 1494) a person experiences high levels of trauma, if the total mean IES-R is higher than 1.5. Table 15-2 indicates how many respondents in the first wave had a score higher than 1.5 on the IES-R. It turns out that about 84% of the respondents experience high levels of trauma.

Table 15-2. IES-R: Number of respondents with high trauma in the first wave

	Low /moderate trauma (IES-R ≤ 1.5) (n=76)	**High trauma (IES-R > 1.5) (n=388)**
Cash/in-kind	13	73
Counseling	21	86
Cash/in-kind and counseling	26	112
No program	17	117
Missing	7	

15.2. Impact of counseling trauma's on reduction of trauma

In order to test whether counseling programs reduce trauma, the differences between the groups for the total mean score of the IES-R were explored first and then the differences for the subscales.

Table 15.3 reveals that the group that received only counseling as well as the group that received both cash and trauma counseling have the lowest scores on the total mean IES-R. When testing the differences between the groups with an ANOVA (see Table 15-3), none of the programs turned out to account for differences in group means.

Table 15-3. IES-R: Effect of programs on the total mean of IES-R

Group (N=465)	**F-value**	**p-value**
Cash/in-kind	F(1,460) = 0,008	0,93
Counseling	F(1,460) =1,093	0,296
Cash/in-kind*counseling	F(1,460) = 0,002	0,962

The newt question investigated is whether or not the socio-economic background variables affect differences between the groups is explored. Table 15-4 gives the results when taking age (as a covariate), educational level and employment into account.

Table 15-4. Effect of the programs on the total mean of IES-R when controlling for age, educational level and occupation

Group (N=465)	F-value	p-value
Cash/in-kind	F(1,450) = 0,036	0,85
Counseling	F(1,450) =0,397	0,53
Cash/in-kind*counseling	F(1,450) = 0,285	0,59
Age	F(1, 450)= 3,995	0,046
Educational level	F(3, 450) = 4,19	0,006
Employment	F (4, 450)= 2,51	0,058

The results of Table 15-4 suggest that post-traumatic stress disorder is not related to the kind of program received. However, the level of post-traumatic stress is related to age (the older the higher the score, the higher the post-traumatic stress), educational level (the lower the educational level the higher the scores, the higher the post-traumatic stress) and kind of employment (women with a business have higher scores than those without occupation/employment and report higher post-traumatic stress).

Next the differences between the groups for each of the subscales is explored separately. Table 15-5 gives the statistics for the Avoidance scale for each group of respondents. It indicates that for all groups the average avoidance is about 2 (minimum 0 maximum 4, higher more trauma) and that the group who received no program reports the lowest amount of avoidance.

Table 15-5. IES-R: Avoidance for each group of respondents (cash/in-kind and/or trauma counselling)

Avoidance	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only	86	2,31	0,83	-0,13	-0,22
Counseling only	108	2,27	0,94	-0,55	0,20
Both cash/in-kind and counseling	137	2,27	1,08	-0,52	-0,15
No program	134	2,20	0,93	-0,84	0,65

Total	465				

When testing the differences between the treatment groups with an ANOVA (see Table 15-6), none of the programs turned out to account for differences in group means.

Table 15-6. IES-R: Effect of programs on the Avoidance scale

Group (N=465)	**F-value**	**p-value**
Cash	F(1,460) = 0,376	0,540
Counseling	F(1,460) =0,027	0,870
Cash*counseling	F(1,460) = 0,489	0,485

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the social program modes, avoidance is still not affected by social protection (see also Table 15-7). However, avoidance is related to age (the older the higher the score, the higher the post-traumatic stress), educational level (the lower the educational level the higher the scores, the higher the post-traumatic stress) and marginally to kind of employment (however when testing the differences between the types of employment no significant differences appeared).

Table 15-7. IES-R: Effect of programs on the Avoidance scale when controlling for age, educational level and occupation

Group (N=465)	**F-value**	**p-value**
Cash	F(1,450) = 0,065	0,80
Counseling	F(1,450) =0,167	0,68
Cash*counseling	F(1,450) = 0,080	0,777
Age	F(1, 450)= 5,935	0,015
Educational level	F(3, 450) = 3,158	0,025
Employment	F (3, 450)= 2,146	0,094

Next the differences between the interventions and the Intrusion scale are explored.

Table 15-8 gives the statistics of Intrusion scale for each group of respondents. It indicates that for all groups the average Intrusion is about 2.6 (minimum 0 maximum 4, higher more trauma). Table 15-8 suggests that the groups that received counseling or cash and counseling score lower on Intrusion.

Table 15-8. Statistics for the intrusion subscale for each group of respondents (cash transfer/in-kind and/or trauma counselling)

Intrusion	N	Average	SD	Skewness	Kurtosis
Cash only	86	2,66	0,91	-0,78	-0,26
Counseling only	108	2,60	0,99	-1,04	0,68
Both cash and counseling	137	2,56	1,15	-0,88	0,01
No program	134	2,74	1,05	-1,45	1,48
Total	465				

When testing the differences with an ANOVA (see Table 15-9) no differences between the groups are significant.

Table 15-9. IES-R: Effect of programs on Intrusion subscale

Group (N=465)	F-value	p-value
Cash	F(1,460) = 0,320	0,57
Counseling	F(1,460) =1,592	0,208
Cash*counseling	F(1,460) = 0,022	0,883

When the socio-economic background variables, age (as a covariate), educational level, and employment are taken into account next to programs, Intrusion is still not affected by the type of program received (see also Table 15-10). However, it is marginally related to age (the older the higher the score, the higher the post-traumatic stress), educational level (the lower the educational level the higher the scores, the higher the post-traumatic stress) and marginally to kind of employment (having a business goes with the most intrusion reported).

Table 15-10. IES-R: Effect of programs on the Intrusion subscale when controlling for age, educational level and occupation

Group (N=465)	F-value	p-value
Cash/in-kind	F(1,450) = 0,694	0,405
Counseling	F(1,450) =0,593	0,442
Cash/in-kind*counseling	F(1,450) = 0,430	0,512
Age	F(1, 450)= 3,355	0,068
Educational level	F(3, 450) = 4,343	0,005
Employment	F (3, 450)= 2,439	0,064

The last subscale to be analyzed is Hyperarousal. Table 15-11 gives the Hyperarousal scale for each group of respondents. Table 15-11 suggests that the counseling only group as well as the cash and counseling group experiences the least amount of hyperarousal.

Table 15-11. IES-R: Hyperarousal for each group of respondents (cash transfer/in-kind and/or trauma counselling)

Hyperarousal	N	Average	SD	Skewness	Kurtosis
Cash only	86	2,60	0,99	-0,64	-0,51
Counseling only	108	2,39	1,09	-0,64	-0,51
Both cash and counseling	137	2,48	1,20	-0,73	-0,46
No program	134	2,64	1,13	-1,19	0,38
Total	465				

When testing the differences with an ANOVA (see Table 15-12) counseling showed a marginally significant effect ($p<0.10$). Post hoc analyses revealed that the counseling group scored somewhat lower compared to the no program group (experienced lesser hyperarousal).

Table 15-12. IES-R: Effect of programs on Hyperarousal subscale

Group (N=465)	F-value	p-value
Cash	F(1,460) = 0,054	0,816
Counseling	F(1,460) =3,040	0,082
Cash*counseling	F(1,460) = 0,351	0,554

When the socio-economic background variables, age (as a covariate), educational level, and employment are taken into account next to the program modes, hyperarousal is not affected by the programs (see also Table 15-13). However, it is related to educational level (the lower the educational level the higher the scores, the higher the post-traumatic stress), and marginally related to employment (having a business goes with more hyperarousal compared to having no job) but not with age.

Table 15-13. IES-R: Effect of programs on the Hyperarousal scale when controlling for age, educational level and occupation

Group (N=460)	F-value	p-value
Cash	F(1,450) = 0,002	0,961
Counseling	F(1,450) =1,713	0,191
Cash*counseling	F(1,450) = 1,104	0,294
Age	F(1, 450)= 2,231	0,136
Educational level	F(3, 450) = 4,097	0,007
Employment	F (3, 450)= 2,567	0,054

15.3. **Conclusion**

The main findings regarding the level of trauma can be summarized as follows:

- About 85% of the respondents experience high levels of trauma. Consequently, it can be concluded that collective trauma can hinder programs promoting livelihoods.
- However, the analyses revealed that the groups that received different types of support (or none) did not differ in the trauma levels experienced.

16. Effect of Social Protection on Social and Economic Resilience (Wave 1)

In this research, Social and Economic Resilience was operationalized with the SER-tool, which consists of six subscales: Social, Capability/Human Capital, Improvement of Actual Income/Economic, Women's Empowerment, Structural/System, and Worry. This chapter explores whether or not there are differences between groups that received some type of social protection (cash: yes/no; counseling: yes/no) on the subscales of the SER-tool.

16.1. **Social**

Table 16-1 gives the statistics of the social scale of the SER. It shows that the mean score is about 4 (on a five-point scale). Furthermore, it suggests that the mean scores are about the same across the groups.

Table 16-1. SER: Scores on the Social scale for each group (cash transfer/in-kind and/or trauma counselling)

Social	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only	86	3,96	0,533	-0,208	0,189
Counseling only	107	3,95	0,544	-0,074	0,491
Both cash/in-kind and counseling	137	3,92	0,604	-0,291	0,156
No program	134	3,93	0,566	-0,168	-0,817
total	464				

When testing the differences on the social subscale with an ANOVA (see Table 16-2) no differences between the groups are significant.

Table 16-2. SER: Effect of programs on the Social scale

Group (N=464)	F-value	p-value
Cash/in-kind	F(1,460) = 0,370	0,543
Counseling	F(1,460) =1,488	0,223
Cash/in-kind*counseling	F(1,460) = 0,745	0,389

Do the socio-economic background variables, in addition to the programs, affect the Social subscale of the SER. Table 16-3 gives the results when taking age (as a covariate), educational level and employment into account.

Table 16-3. SER: Effect of programs on the Social scale when taking age, educational level and occupation into account

Group (N=461)	F-value	p-value
Cash/in-kind	F(1,450) = 0,162	0,687
Counseling	F(1,450) = 0,272	0,602
Cash/in-kind*counseling	F(1,450) = 0,617	0,433
Age	F(1, 450)= 0,161	0,688
Educational level	F(3, 450) = 0,058	0,982
Employment	F (4, 450)= 3,389	0,018

The results of Table 16-3 suggest that the scores on the Social scale are not related to type of program received, age nor educational level. However, it is related to kind of employment (women with a business, a professional job or farming have higher scores than those without occupation/employment).

16.2. **Capability**

Table 16-4 gives the statistics of the Capability subscale of the SER. It shows that the mean score is about 2.6 (on a five-point scale) what indicates moderate levels of Capability. Furthermore, it suggest that the group who received no program scores lowest on the capability subscale.

Table 16-4. SER: Capability scores for each group of respondents (cash/in-kind and/or trauma counselling)

Capability	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only	86	2,668	0,821	0,566	0,071
Counseling only	107	2,687	0,847	0,418	0,111
Both cash/in-kind and counseling	137	2,775	1,012	0,391	-0,505

No program	134	2,552	0,898	0,138	-0,496
Total	464				

When testing the effect of the programs with an ANOVA (see Table 16-5) no differences between the groups are significant.

Table 16-5. SER: Effect of the programs on the Capability scale

N (464)	**F-value**	**p-value**
Cash/in-kind	F(1,460) = 1,29	0,256
Counseling	F(1,460) =1,51	0,177
Cash/in-kind*counseling	F(1,460) = 0,114	0,736

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, capacity is still not affected by the programs (see also Table 16-6). However, it is related to educational level (the lower the educational level the lower the scores) and kind of employment (women with a business or a professional job (but not farming) have higher scores than those without occupation/employment), but not to age.

Table 16-6. SER: The effect of programs on the Capability scale when taking age, educational level and occupation into account

N (461)	**F-value**	**p-value**
Cash/in-kind	F(1,450) = 1,165	0,281
Counseling	F(1,450) =0,00	0,998
Cash/in-kind*counseling	F(1,450) = 0,296	0,587
Age	F(1, 450)= 0,406	0,525
Educational level	F(3, 450) = 5,411	0,001
Employment	F (4, 450)= 3,916	0,009

16.3. **Income**

Table 16-7 gives the statistics of the Income scale for each of the groups. The average score is about 3 (on a five point scale) which indicates that respondents perceive moderate income opportunities. Moreover, it suggests that the groups who received no program scores lowest on perceived income opportunities.

Table 16-7. SER: Income scores for each group of respondents (cash transfer/in-kind and/or trauma counselling)

Income	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only	86	2,950	0,742	0,204	-0,266
Counseling only	107	3,069	0,662	0,395	0,509
Both cash/in-kind and counseling	137	3,131	0,806	0,022	-0,048
No program	134	2,827	0,708	-0,008	-0,228
Total	464				

When testing the effect of programs on the perceived Income opportunities with an ANOVA (see Table 16-8), counseling reveals a significant (positive) effect (cash only and the interaction effect between cash and counseling had no significant effect).

Table 16-8. SER: Effect of programs on the Income scores

N (464)	F-value	p-value
Cash/in-kind	F(1,460) = 1,776	0,183
Counseling	F(1,460) =9,248	0,002
Cash/in-kind*counseling	F(1,460) = 0,193	0,661

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, the perceived Income opportunities are still (positively) affected by counseling (see also Table 16-9). Moreover, educational level has a (marginally) significant effect on the income scale (the higher the educational level the higher the score on income), as well as occupation (the group with no

job has a lower score on income compared to farming, business and professional job and farming has a lower income that business and professional job), but age has no effect.

Table 16-9. SER: Effect of programs on the Income scores when taking age, educational level and occupation into account

N (461)	F-value	p-value
Cash/in-kind	F(1,450) = 1,386	0,240
Counseling	F(1,450) =3,533	0,061
Cash/in-kind*counseling	F(1,450) = 0,238	0,626
Age	F(1, 450)= 0,071	0,790
Educational level	F(3, 450) = 2,191	0,088
Employment	F (4, 450)= 7,031	0,000

16.4. **Empowerment**

Table 16-10 gives the statistics of Empowerment scale for each of the groups. The average score is about 3 (on a five-point scale) which indicates that respondents perceive moderate levels of empowerment. Moreover, it suggests that the group who received no program scores lowest on empowerment.

Table 16-10. SER: Empowerment scores for each group of respondents (cash/in-kind transfer and/or trauma counselling)

Empowerment	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only	86	3,134	0,799	0,465	-0,062
Counseling only	107	3,111	0,675	0,154	0,225
Both cash/in-kind and counseling	137	3,291	0,802	0,215	-0,386
No program	134	2,987	0,774	0,134	-0,580
Total	464				

When testing the effect of programs on Empowerment with an ANOVA (see Table 16-11), cash and counseling both have a positive significant effect (interaction effect between cash and counseling had no significant effect).

Table 16-11. SER: The effect of programs on Empowerment

N (464)	F-value	p-value
Cash/in-kind	F(1,460) = 5,708	0,017
Counseling	F(1,460) =4,252	0,040
Cash/in-kind*counseling	F(1,460) = 0,126	0,723

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, Empowerment is still (positively) affected by cash/in-kind and counseling (but the interaction effect is not significant) (see also Table 16-12). Furthermore, we see that age has a marginally significant effect (the higher the age the more empowerment), but both educational level and employment do not have a significant effect on Empowerment.

Table 16-12. SER: The effect of programs on Empowerment when taking age, educational level and occupation into account

N (461)		p-value
Cash/in-kind	F(1,450) = 3,591	0,059
Counseling	F(1,450) =3,106	0,079
Cash/in-kind*counseling	F(1,450) = 0,332	0,565
Age	F(1, 450)= 3,368	0,067
Educational level	F(3, 450) = 290	0,832
Employment	F (4, 450)= 1,184	0,315

16.5. **System**

Table 16-13 gives the statistics of the System scale for each groups. The average score is about 3 (on a five-point scale) which indicates that respondents perceive moderate levels of

security. Moreover, it suggests that the groups who received only trauma counseling is least satisfied with the system.

Table 16-13. SER: System scores for each group of respondents (cash/in-kind transfer and/or trauma counselling)

System	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only	86	3,389	1,001	-0,462	0,225
Counseling only	107	2,869	1,135	0,080	-0,759
Both cash/in-kind and counseling	137	3,095	1,254	-0,363	-0,726
No program	134	3,086	1,125	-0,342	-0,479
Total	464				

When testing the effect of programs on the System subscale with an ANOVA (see Table 16-14), cash and counseling both have significant effect (interaction effect between cash and counseling had no significant effect). It turns out that those who received cash score higher on System, and those who received counseling scores lower on System.

Table 16-14.SER: The effect of programs on the System subscale

N (465)	F-value	p-value
Cash/in-kind	F(1,460) = 3,796	0,052
Counseling	F(1,460) =6,300	0,012
Cash/in-kind*counseling	F(1,460) = 0,000	0,989

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, System is still (negatively) affected by counseling but not by cash (nor the interaction effect is not significant) (see also Table 16-15). Furthermore, we see that age has a significant effect (the higher the age the higher the score on system). But, educational level and employment do not have a significant effect on System.

Table 16-15. SER: Effect of programs on the System subscale when taking age, educational level and occupation into account

N (461)	F-value	p-value
Cash/in-kind	F(1,450) = 2,272	0,132
Counseling	F(1,450) = 5,725	0,017
Cash/in-kind*counseling	F(1,450) = 0,148	0,700
Age	F(1, 450)= 10,346	0,001
Educational level	F(3, 450) = 1,081	0,357
Employment	F (4, 450)= 1,439	0,231

16.6. **Worry**

Table 16-16 gives the statistics of Worry scale for each of the group. It indicates that counseling group score lowest on Worry, while the cash and counseling group scores highest on Worry.

Table 16-16. SER: Worry scores for each group of respondents (cash transfer/in-kind and/or trauma counselling)

System	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only	86	3,543	0,542	-0,518	1,365
Counseling only	107	3,365	0,704	-0,450	-0,260
Both cash/in-kind and counseling	137	3,685	0,695	-0,362	-0,001
No program	134	3,584	0,616	-0,157	-0,734
Total	465				

When testing the effect of programs on Worry with an ANOVA (see Table 16-17), receiving cash has a (positive) significant effect (those who received cash worried more), receiving counseling does not decrease Worry (has no significant main effect). However, the interaction effect between cash and counseling is also significant indicating that when receiving both cash and counseling, Worry increases.

Table 16-17. SER: The effect of programs on Worry

N (465)	F-value	p-value
Cash/in-kind	F(1,460) = 5,201	0,023
Counseling	F(1,460) =0,385	0,535
Cash/in-kind*counseling	F(1,460) = 8,708	0,003

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, worry is still (positively) affected by cash, not affected by counseling and the interaction effect between cash and counseling is still significant indicating that when receiving both cash and counseling, Worry increases. Furthermore, age, educational level, nor occupation have a significant effect on Worry.

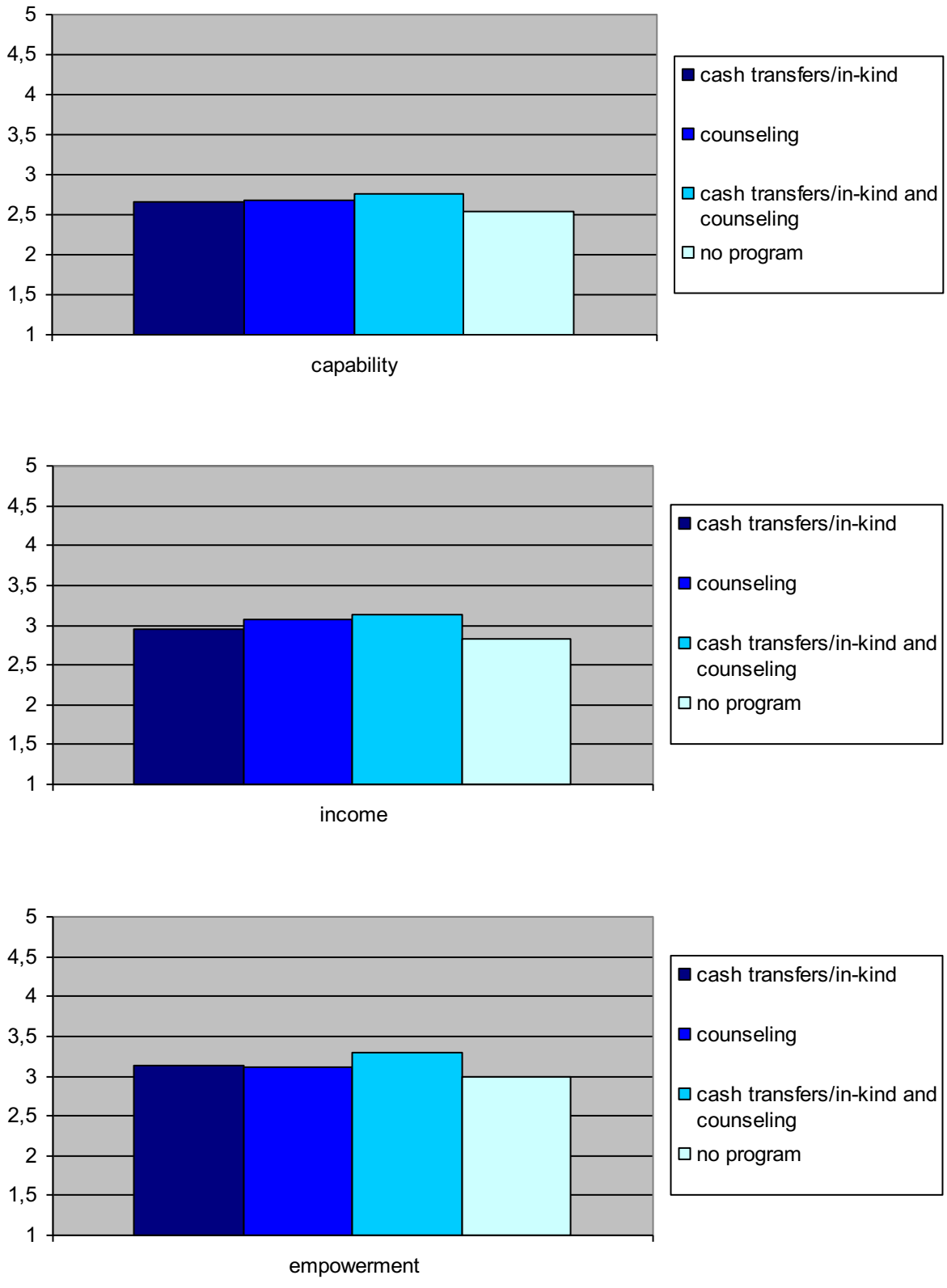
Table 16-18. SER: Effect of programs on Worry when taking age, educational level and occupation into account

N (461)		p-value
Cash/In-kind	F(1,450) = 4,938	0,027
Counseling	F(1,450) = 0,496	0,481
Cash/in-kind*counseling	F(1,450) = 8,261	0,004
Age	F(1, 450)= 0,280	0,597
Educational level	F(3, 450) = 1,086	0,355
Employment	F (4, 450)= 0,623	0,601

16.7. **Conclusion: Impact of programs on capability, income and empowerment**

The following graphs illustrate the positive effect of the programs on Social Economic Resilience, particularly as showing in capability, income and empowerment. The graphs show that the social support programs (indeed as 'cash') have a significant positive impact on all three parameters. The counseling program has a higher significant positive impact on the three parameters and the combination of social protection (indexed as 'cash') and counseling (trauma support) had the highest significant positive effect on capability, income and empowerment.

Figure 16-1. Mean scores on Capabilities, Income and Empowerment (first wave)



The main findings regarding the effect of the programs through cash/in-kind transfers on social and economic resilience can be summarized as follows:

For receiving cash/in-kind the results indicate that:

- Receiving cash/in-kind has no effect on Social, Capability, improvement of actual Income
- Receiving cash/in-kind has a positive effect on Women's Empowerment and System
- Receiving cash/in-kind has a negative effect on Worry (it increases worry)

For receiving counseling, the results indicate that:

- Receiving counseling has no effect on Social, Capability and Worry
- Receiving counseling has a positive effect on improvement of actual Income and Women Empowerment
- Receiving counseling has a negative effect on System

Furthermore, the interaction effect between cash/in-kind and counseling is significant for Worry: when receiving both cash and counseling, Worry increases.

17. Effect of the SHLCPTS Program on Social and Economic Resilience (Wave 2)

In this chapter, the focus is on the effect of the SHLCPTS program on Social and Economic resilience. In reading this report, one should realize that the time between finishing the SHLCPTS program and this measurement was only a few months. Consequently, the reported effectiveness of the SHLCPTS program in increasing social and economic resilience may be underestimated. Furthermore, the program was probably not assigned at random to members of a community, but to specific communities that could benefit most from it. Consequently, those respondents who did receive the SHLCPTS program probably scored lower in terms of social and economic resilience compared to those who did not receive it, when starting the program.

In this research, social and economic resilience was operationalized by means of the SER-tool that consists of six scales: Social, Capability/human capital, improvement of actual Income/economic, Women Empowerment, Structural/System, and Worry. In the research, the SHLCPTS program was implemented for the groups that received cash/in-kind only, or counseling only, or both cash/in-kind and counseling, or no program in the first wave. This results is eight different groups of respondents (see also section 4.7). This design allows us to study the direct (main) effect of SHLCPTS program, the lagged (main) effect of cash/in-kind and the lagged (main) effect of counseling (offered before the first wave). Moreover, the analyses allow us to investigate the interactions between the different types programs (cash/in-kind, counseling, and SHLCPTS program). In order to explore all these effects, we will go into the differences between the eight groups on each of the subscales of the SER-tool successively.

17.1. **Social**

Table 17-1 gives the statistics for the Social scores for each group of respondents. It shows that these scores range from 3.96 to 4.26 (on a five-point scale). The group that received cash but no SHLCPTS program has the lowest score, while the groups that received both cash and counseling but no SHLCPTS program as the highest score.

Table 17-1. SER: Scores on the Social scale for each group of respondents (cash transfer/in-kind, trauma counselling, SHLCPTS program)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only and SHLCPTS	25	3,96	0,70	-1,27	1,17
Counseling and SHLCPTS	56	3,99	0,54	-1,12	2,07
Cash/in-kind, counseling and SHLCPTS	85	3,99	0,63	-0,98	1,87
Only SHLCPTS	21	4,00	0,54	-0,71	-0,42
Cash/in-kind only and no SHLCPTS	37	4,14	0,47	-0,13	0,50
Counseling only and no SHLCPTS	37	3,99	0,61	-0,62	0,83
Both cash/in-kind and counseling, no SHLCPTS	37	4,26	0,40	-0,18	1,95
No program	58	4,15	0,52	-0,37	-0,25
Total	356				

When testing the differences on the social subscale with an ANOVA (see Table 17-2), it turns out that SHLCPTS program has a marginal negative significant effect. Furthermore, the interaction between cash and SHLCPTS program is also significant (receiving cash and SHLCPTS program decreases the scores on the Social subscale (see Figure 17.1).

Table 17-2. SER: Effect of the programs on the Social scale

N (356)	F-value	p-value
Cash/in-kind	F(1,349) = 0,031	0,861
Counseling	F(1,349) =0,111	0,740
SHLCPTS	F(1,349) =3,419	0,065
Cash/in-kind*counseling	F(1,349) = 0,704	0,402
Cash* SHLCPTS	F(1,349) =4,250	0,040
Counseling* SHLCPTS	F(1,349) =0,600	0,439

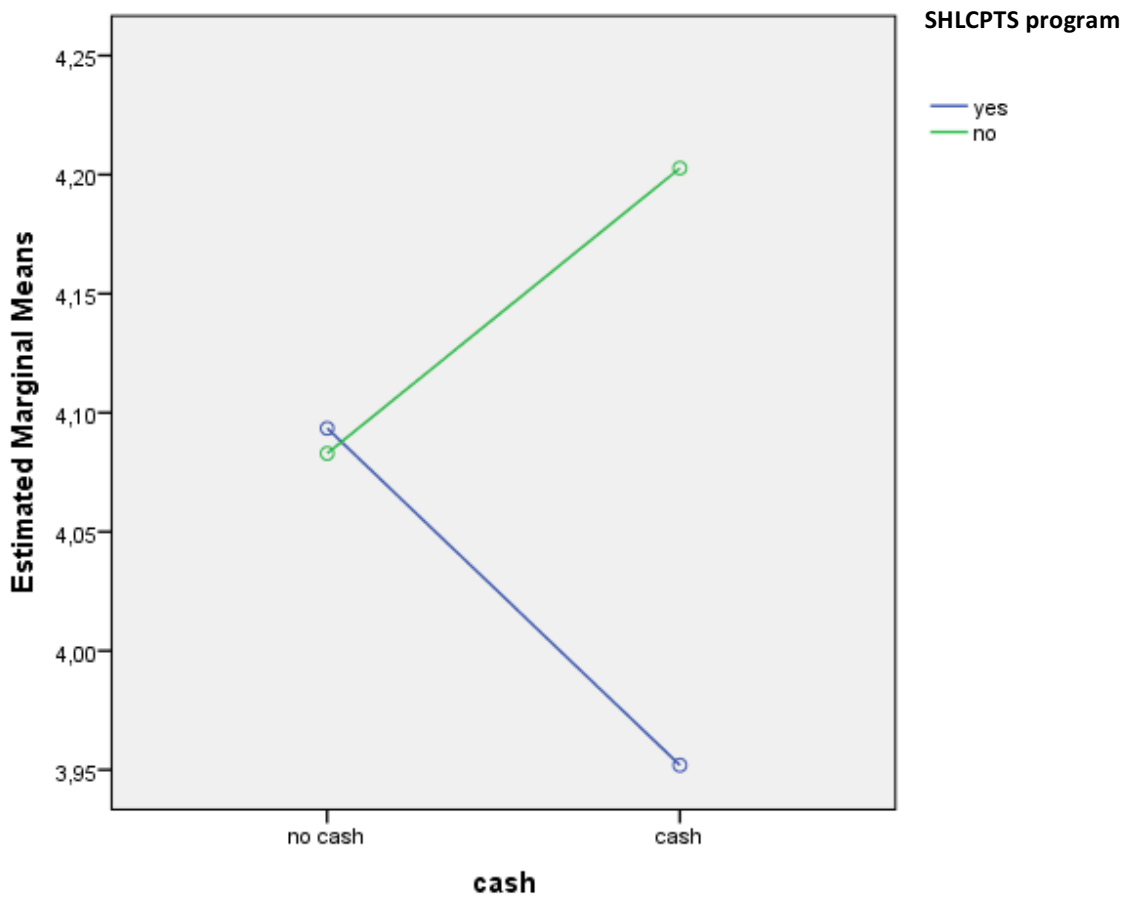


Figure 17-1. Interaction effect between cash/in-kind and SHLCPTS program on the Social scale

Next whether or not the socio-economic background variables affect the differences between the groups will be explored. Table 17-3 gives the results when taking age (as a covariate), educational level and employment into account.

Table 17-3. SER: Effect of programs on the Social scale when controlling for age, educational level and occupation

N (351)	**F-value**	**p-value**
Cash/in-kind	F(1,337) = 0,009	0,924
Counseling	F(1,337) =0,306	0,581
SHLCPTS	F(1,337) =3,39	0,066
Cash*counseling	F(1,337) = 0,380	0,538
Cash* SHLCPTS	F(1,337) =2,635	0,105

Counseling* SHLCPTS	F(1,337) =0,112	0,739
Age	F(1,337) =0,028	0,867
Educational level	F(3,337) =0,205	0,893
Occupation	F(3,337) =3,528	0,015

The results of Table 17-3 suggest that the scores on the social scale are related to SHLCPTS program (the program decreases scores on the social subscale). Now the interaction between cash and the SHLCPTS program is marginally significant (receiving case and the program decreases the scores on the Social subscale). Moreover, the kind of employment is also related to the social score (women with a business, a professional job or farming have higher scores than those without occupation/employment).

17.2. **Capability**

Table 17-4 gives the statistics for Capability of the SER for each group respectively. It shows that these scores range from 3.09 to 3.39 (on a five-point scale). The group that received cash but no SHLCPTS program has the lowest score, while the groups that received both cash and counseling but no SHLCPTS program as the highest score.

Table 17-4. SER: Scores on the Capability scale for each group of respondents (social protection: cash transfer, trauma counselling, SHLCPTS program)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only and SHLCPTS	25	3,10	0,79	-0,40	-1,31
Counseling and SHLCPTS	56	3,17	0,72	-0,17	-0,84
Cash/in-kind, counseling and SHLCPTS	85	3,29	0,73	-0,66	0,36
Only SHLCPTS	21	3,25	0,66	-1,22	0,59
Cash/in-kind only and no SHLCPTS	37	3,17	0,66	-0,10	-0,78
Counseling only and no SHLCPTS	37	3,09	0,76	-0,04	0,44
Both cash and counseling, No SHLCPTS	37	3,39	0,74	-0,56	0,49
No program	58	3,26	0,70	-0,06	-0,62
Total	356				

When testing the differences on the capability scale with an ANOVA (see Table 17-5), it turns out that none of the main effects are significant. The interaction between cash/in-kind and trauma counseling is significant (receiving cash/in-kind and trauma counseling increases the scores on the Capability subscale; see Figure 17.2).

Table 17-5. SER: Effect of programs on Capability

N (356)	**F-value**	**p-value**
Cash/in-kind	F(1,349) = 0,259	0,611
Counseling	F(1,349) =0,188	0,665
SHLCPTS	F(1,349) =0,101	0,751
Cash/in-kind*counseling	F(1,349) = 3,97	0,047
Cash/in-kind* SHLCPTS	F(1,349) =0,557	0,456
Counseling* SHLCPTS	F(1,349) =0,037	0,848

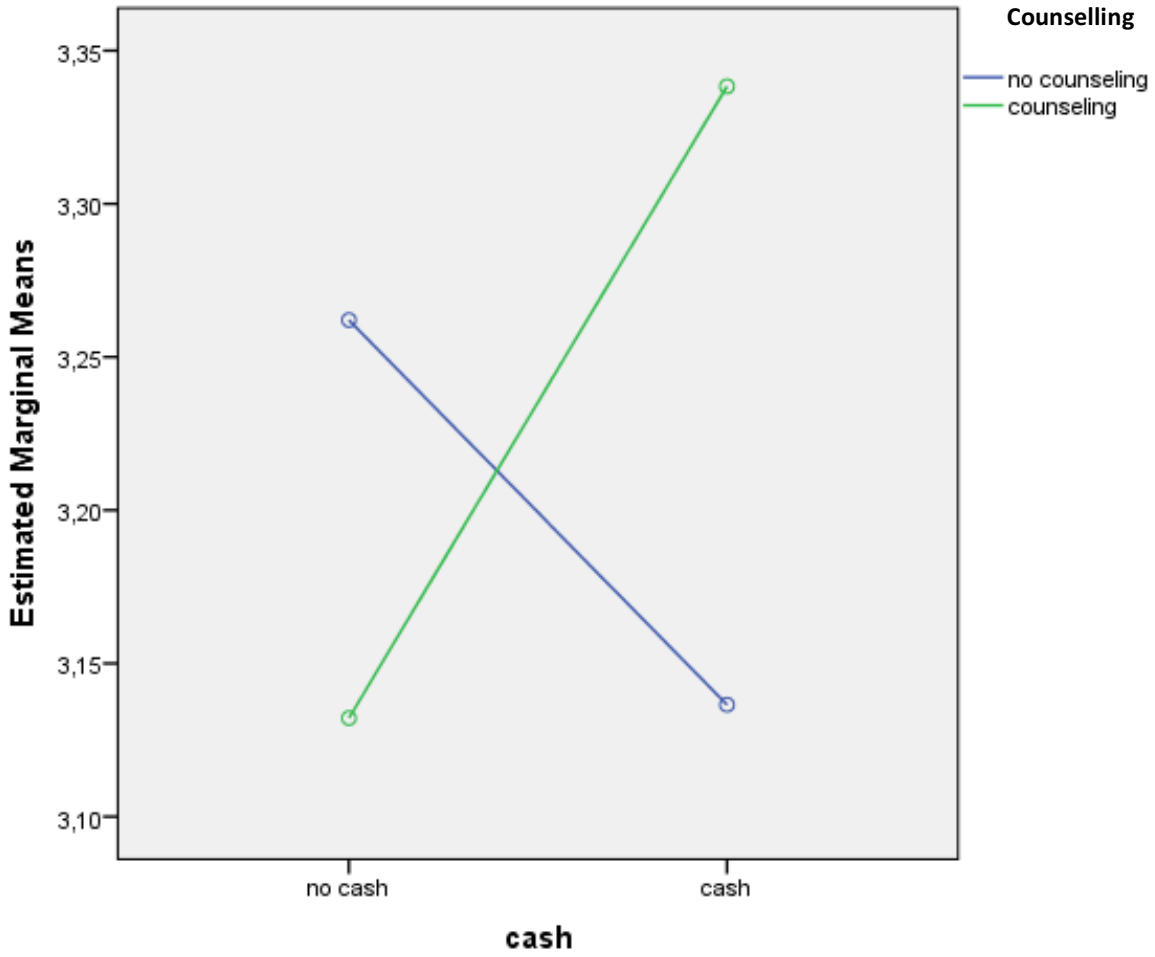


Figure 17-2. Interaction between cash/in-kind and trauma counselling on the Capability scale

When the socio economic background variables, age (as a covariate), educational level and employment are taken into account next to the different programs, the ANOVA analysis indicates that none of the main effects are significant. Again, the interaction between cash/in-kind and counseling reveals a significant effect (receiving cash and trauma counseling increases the scores on the Capability scale, and age is marginally related to capacity (younger women report higher Capability).

Table 17-6. SER: Effect of the programs on Capacity when controlling for age educational level and occupation

N (351)	F-value	p-value
Cash/in-kind	F(1,337) = 1,776	0,183
Counseling	F(1,337) =0,061	0,805

SHLCPTS	F(1,337) =0,078	0,781
Cash/in-kind*counseling	F(1,337) = 4,185	0,042
Cash/in-kind* SHLCPTS	F(1,337) =0,858	0,355
Counseling* SHLCPTS	F(1,337) =0,0,25	0,874
Age	F(1,337) =4,322	0,038
Educational level	F(3,337) =0,875	0,454
Occupation	F(3,337) =1,844	0,139

17.3. **Income**

Table 17-7 gives the statistics for Income of the SER for each group respectively. It shows that these scores range from 3.34 to 3.71 (on a five-point scale). The group that received cash and SHLCPTS program has the lowest score, while the groups that received both cash and counseling but no SHLCPTS program as the highest score.

Table 17-7. SER: Scores on the Income scale for each group of respondents (cash transfer/in-kind, trauma counselling, SHLCPTS program)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only and SHLCPTS	25	3,34	0,79	-1,08	1,51
Counseling and SHLCPTS	56	3,50	0,63	-0,59	-0,23
Cash/in-kind, counseling and SHLCPTS	85	3,65	0,59	-1,38	3,02
Only SHLCPTS	21	3,56	0,29	-1,18	2,25
Cash/in-kind only and no SHLCPTS	37	3,51	0,52	-0,41	-1,02
Counseling only and no SHLCPTS	37	3,62	0,65	-1,07	3,71
Both cash and counseling, no SHLCPTS	37	3,71	0,57	-0,50	1,28
No program	58	3,65	0,48	-0,39	0,20
Total	356				

When testing the differences on the income subscale with an ANOVA (see Table 17-8), it turns out that both counseling and SHLCPTS program have a marginally significant main effect (receiving counseling goes with higher scores and receiving SHLCPTS goes with lower scores on the Income subscale). The interaction between cash and counseling is also significant (receiving cash/in-kind and trauma counseling increases the scores on the Income subscale; see Figure 17.3).

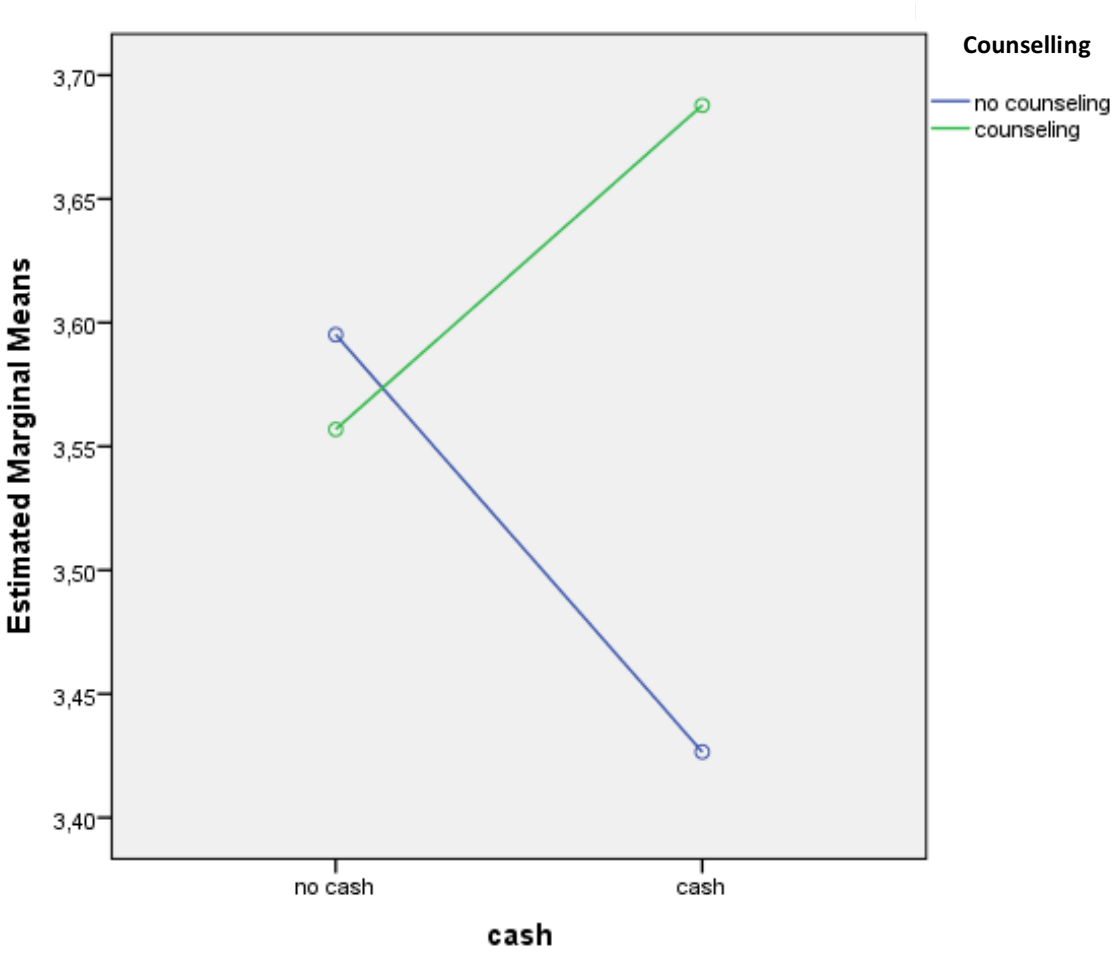


Figure 17-3. SER: Interaction effect between cash/in-kind and trauma counselling on the Income scale

Table 17-8. SER: Effect of the programs on the Income scale

N (356)	F-value	p-value
Cash/in-kind	F(1,349) = 0,084	0,772
Counseling	F(1,349) =2,680	0,102
SHLCPTS	F(1,349) =2,592	0,108
Cash/in-kind*counseling	F(1,349) = 4,816	0,029
Cash* SHLCPTS	F(1,349) =0,004	0,947
Counseling* SHLCPTS	F(1,349) =0,094	0,759

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, the analysis indicates that counseling has a significant effect (counseling goes with a higher score). The SHLCPTS program has a marginally significant effect on Income (but receiving SHLCPTS program goes with a lower score). Moreover, occupation has a significant effect (being unemployed goes with lower scores of the Income subscale).

Table 17-9. SER: Effect of programs on Income when controlling for age, educational level and occupation

N (351)	F-value	p-value
Cash/in-kind	F(1,337) = 0,207	0,650
Counseling	F(1,337) = 2,265	0,133
SHLCPTS	F(1,337) =2,826	0,094
Cash/in-kind*counseling	F(1,337) = 4,094	0,044
Cash/in-kind* SHLCPTS	F(1,337) =0,046	0,830
Counseling* SHLCPTS	F(1,337) =0,020	0,889
Age	F(1,337) =1,734	0,189
Educational level	F(3,337) =1,362	0,254
Occupation	F(3,337) =4,910	0,002

17.4. **Empowerment**

Table 17-10- gives the statistics for Empowerment of the SER for each group respectively. It shows that these scores range from 3.54 to 3.92 (on a five-point scale). The group that received cash/in-kind and SHLCPTS program has the lowest score, while the groups that received both cash and counseling but no SHLCPTS program as the highest score.

Table 17-10. Scores on the Empowerment scale for each group of respondents (cash/in-kind transfer, trauma counselling, SHLCPTS program)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only and SHLCPTS	25	3,54	0,82	-1,24	2,95
Counseling and SHLCPTS	56	3,86	0,47	0,29	-0,23
Cash/in-kind, counseling and SHLCPTS	85	3,85	0,48	-0,66	0,82
Only SHLCPTS	21	3,82	0,43	-0,456	1,343
Cash/in-kind only and no SHLCPTS	37	3,72	0,52	-0,15	-0,11
Counseling only and no SHLCPTS	37	3,83	0,56	-0,01	-0,05
Both cash/in-kind and counseling, no SHLCPTS	37	3,92	0,56	-0,04	0,19
No program	58	3,83	0,47	0,19	0,74
Total	356				

When testing the differences on the Empowerment subscale with an ANOVA (see Table 17-11), it turns out that counseling has a significant main effect (receiving trauma counseling goes with higher scores on the Empowerment subscale). Furthermore, the interaction between cash/in-kind and counseling is also significant (receiving no cash/in-kind and no trauma counseling decreases the scores on the Empowerment subscale, see Figure 17.4).

Table 17-11. SER: Effect of programs on Empowerment

N (356)	F-value	p-value
Cash/in-kind	F(1,349) = 1,480	0,225
Counseling	F(1,349) =5,453	0,020

SHLCPTS	F(1,349) =0,878	0,350
Cash/in-kind*counseling	F(1,349) = 3,628	0,058
Cash/in-kind* SHLCPTS	F(1,349) =1,100	0,295
Counseling* SHLCPTS	F(1,349) =0,397	0,529

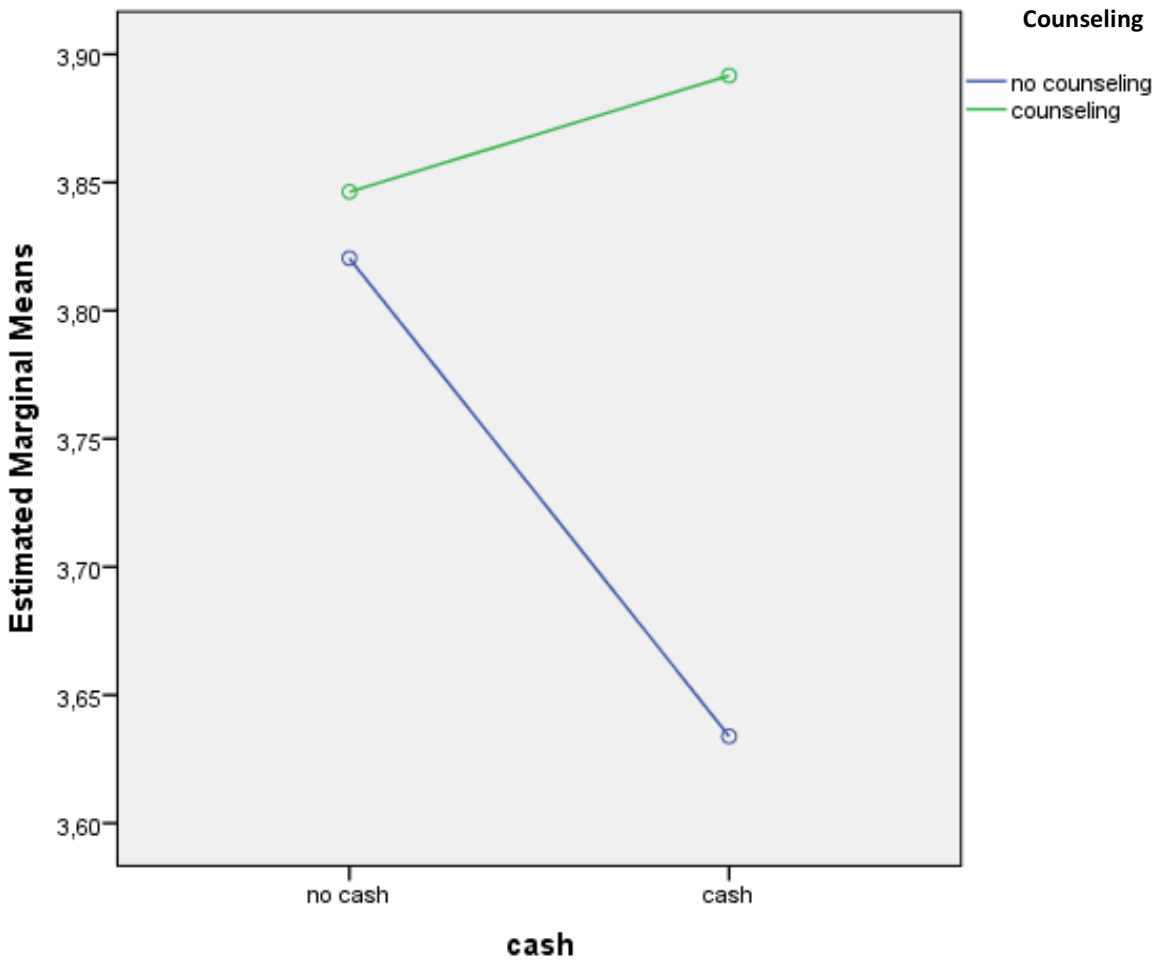


Figure 17-4. SER: Interaction effect of cash and counselling on the Empowerment scale

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account together with to the programs, the analysis indicates that counseling has a significant main effect (receiving counseling goes with higher scores on the empowerment subscale). The interaction between cash/in-kind and trauma counseling is still marginally significant (receiving no cash/in-kind and no counseling decreases the scores on the Empowerment subscale. Moreover, neither age, educational level nor kind of occupation have a significant effect on Empowerment.

Table 17-12. SER: Effect of programs on Empowerment when controlling for age educational level and occupation

N (351)	F-value	p-value
Cash/in-kind	F(1,337) = 1,397	0,238
Counseling	F(1,337) = 5,512	0,019
SHLCPTS	F(1,337) =0,935	0,334
Cash/in-kind*counseling	F(1,337) = 3,174	0,076
Cash/in-kind* SHLCPTS	F(1,337) =0,584	0,445
Counseling* SHLCPTS	F(1,337) =0,105	0,746
Age	F(1,337) =0,838	0,361
Educational level	F(3,337) =0,419	0,740
Occupation	F(3,337) =0,863	0,361

17.5. **System**

Table 17-13 gives the statistics for System of the SER for each group respectively. It shows that these scores range from 3.50 to 3.76 (on a five-point scale). The group that received cash and SHLCPTS program has the lowest score, while the groups that either received counseling and SHLCPTS program or counseling and no SHLCPTS program have the highest score.

Table 17-13. SER: Scores on the System scale for each group of respondents (cash/in-kind transfer, trauma counselling, SHLCPTS program)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only and SHLCPTS	25	3,50	0,87	-0,31	-0,85
Counseling and SHLCPTS	56	3,76	0,57	-0,61	1,18
Cash/in-kind, counseling and SHLCPTS	85	3,73	0,69	-1,07	0,87
Only SHLCPTS	21	3,71	0,58	-0,54	-0,76
Cash/in-kind only and no SHLCPTS	37	3,70	0,75	-0,59	0,99
Counseling only and no SHLCPTS	37	3,76	0,48	0,36	0,03
Both cash/in-kind and counseling, no SHLCPTS	37	3,74	0,73	-0,38	-0,12

No program	58	3,61	0,73	-0,44	-0,31
Total	356				

When testing the differences on the System subscale with an ANOVA (see Table 17-14), it turns out that none of the programs has an effect on the scores of the System subscale.

Table 17-14. SER: Effect of programs on System

N (356)	F-value	p-value
Cash/in-kind	F(1,349) = 0,059	0,808
Counseling	F(1,349) =2,435	0,120
SHLCPTS	F(1,349) =0,080	0,778
Cash/in-kind*counseling	F(1,349) = 0,029	0,866
Cash/in-kind* SHLCPTS	F(1,349) =0,616	0,433
Counseling* SHLCPTS	F(1,349) =0,111	0,739

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, the analysis indicates that still none of the programs has an effect on System. The same counts for the socio-economic background variables; educational level, nor occupation have an effect on System scores.

Table 17-15. SER: Effect of programs on System when controlling for age, educational level and occupation

N (351)	F-value	p-value
Cash/in-kind	F(1,337) = 0,007	0,932
Counseling	F(1,337) = 2,212	0,138
SHLCPTS	F(1,337) =0,171	0,680
Cash/in-kind*counseling	F(1,337) = 0,027	0,869
Cash/in-kind* SHLCPTS	F(1,337) =0,369	0,544
Counseling*program	F(1,337) =0,028	0,866
Age	F(1,337) =0,397	0,529

Educational level	F(3,337) =0,919	0,432
occupation	F(3,337) =0,390	0,760

17.6. **Worry**

Table 17-16 gives the statistics for Worry for each group respectively. It shows that these scores range from 3.27 to 3.75 (on a five-point scale). The group that received both cash/in-kind and counseling but no SHLCPTS program has the lowest score, while the group that received counseling and no SHLCPTS program has the highest score.

Table 17-16. SER: Scores on the Worry scale for each group of respondents (cash/in-kind transfer, trauma counselling, SHLCPTS program)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only and SHLCPTS	25	3,50	0,72	-0,28	0,37
Counseling and SHLCPTS	56	3,42	0,73	-0,38	-0,34
Cash/in-kind, counseling and SHLCPTS	85	3,44	0,72	-0,64	0,32
Only SHLCPTS	21	3,71	0,39	-0,19	0,61
Cash only and no SHLCPTS	37	3,57	0,75	0,21	-0,54
Counseling only and no SHLCPTS	37	3,75	0,70	-0,40	-0,19
Both cash and counseling, no SHLCPTS	37	3,27	0,80	-0,73	-0,18
No program	58	3,46	0,69	-0,17	-0,02
Total	356				

When testing the differences on the system subscale with an ANOVA (see Table 17-17), it turns out that none of programs has an effect on Worry.

Table 17-17. SER: Effect of programs on the Worry

N (356)	F-value	p-value
Cash/in-kind	F(1,349) = 0,925	0,337
Counseling	F(1,349) =0,706	0,401
SHLCPTS	F(1,349) =0,019	0,891

Cash/in-kind*counseling	F(1,349) = 1,646	0,200
Cash/in-kind* SHLCPTS	F(1,349) =1,249	0,264
Counseling* SHLCPTS	F(1,349) =1,013	0,315

The question whether or not socio-economic background variables age (as a covariate), educational level, and employment in addition to the programs affect Worry is explored (see also Table 17-18). The results indicate that still none of the programs has an effect on Worry. Only age has a marginally significant effect on the Worry subscale; the older a woman the higher the score on the Worry scale (the more she worries).

Table 17-18. SER: Effect of social protection on Worry when controlling for age educational level and occupation

N (351)	F-value	p-value
Cash/in-kind	F(1,337) = 1,901	0,169
Counseling	F(1,337) = 0,714	0,399
SHLCPTS	F(1,337) = 0,003	0,960
Cash/in-kind*counseling	F(1,337) =1,605	0,206
Cash/in-kind* SHLCPTS	F(1,337) =0,910	0,341
Counseling* SHLCPTS	F(1,337) =0,939	0,333
Age	F(1,337) =3,019	0,083
Educational level	F(3,337) =0,190	0,903
Occupation	F(3,337) =0,491	0,689

17.7. Conclusion: Impact on capability, income and empowerment (wave 2)

Figure 17-5. Mean scores on Capability, Empowerment and Income for those who received the SHLCPTS-program

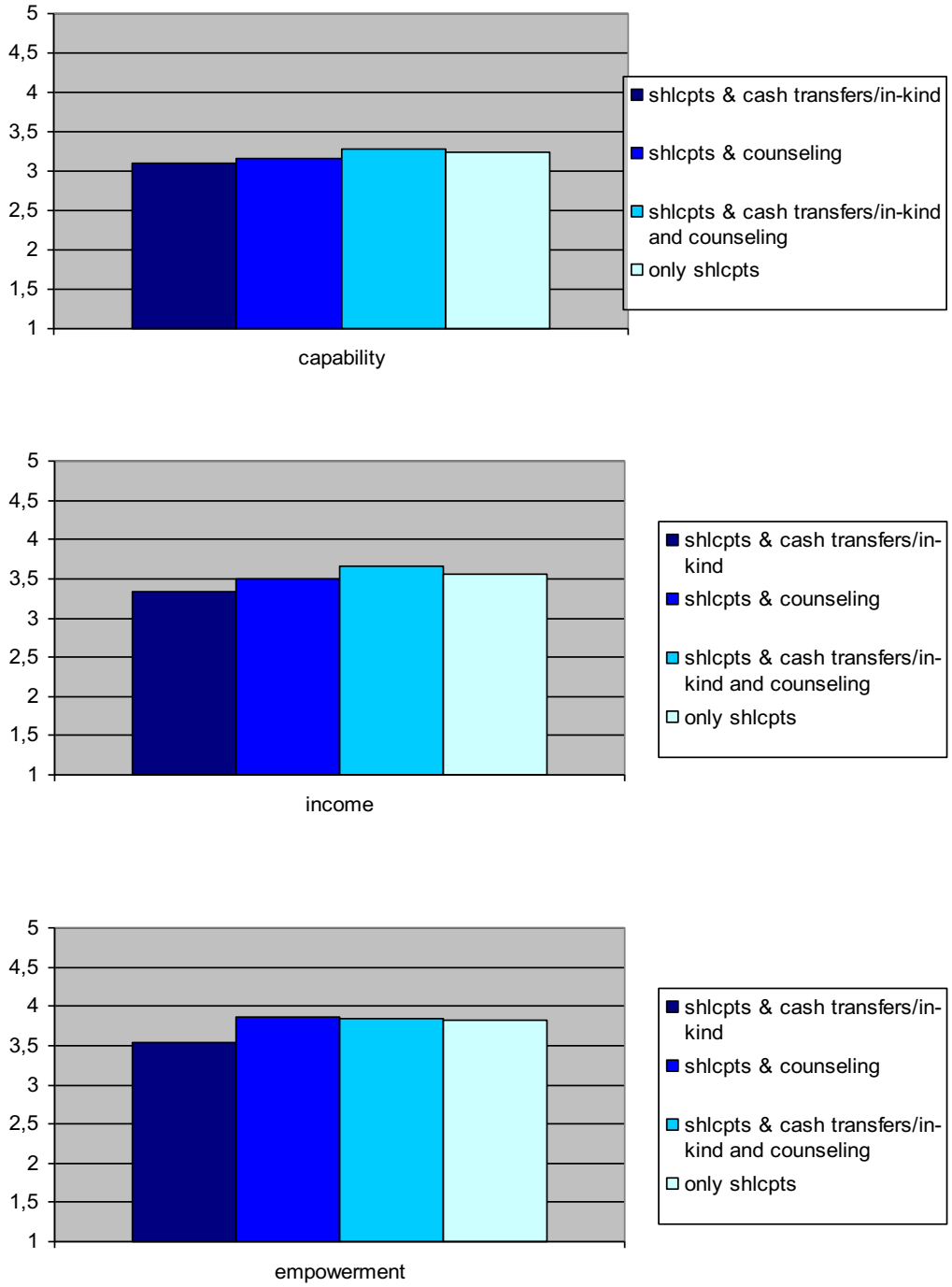
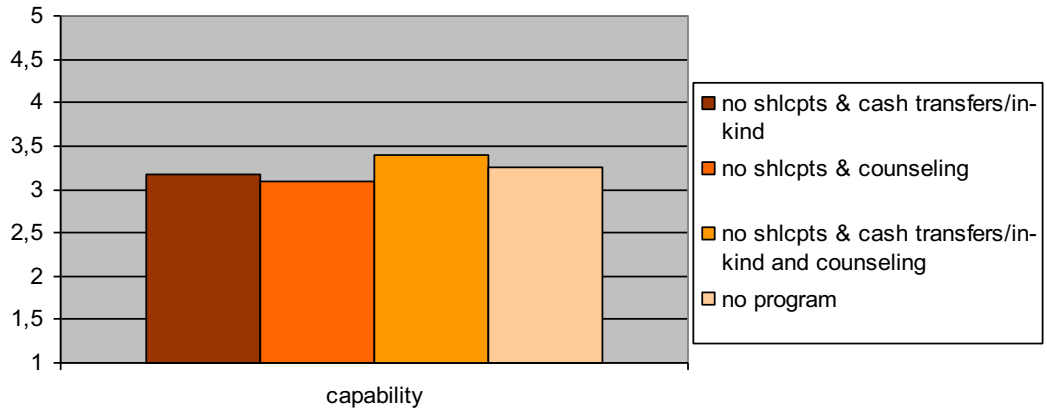
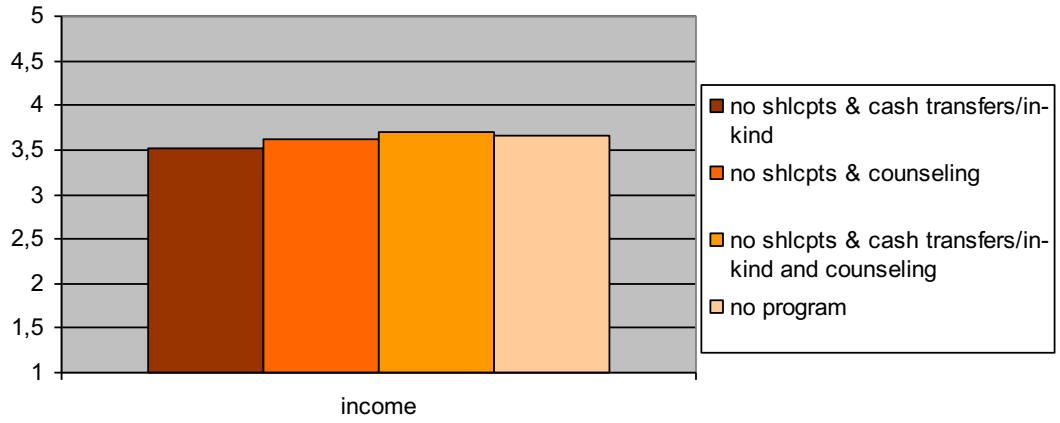
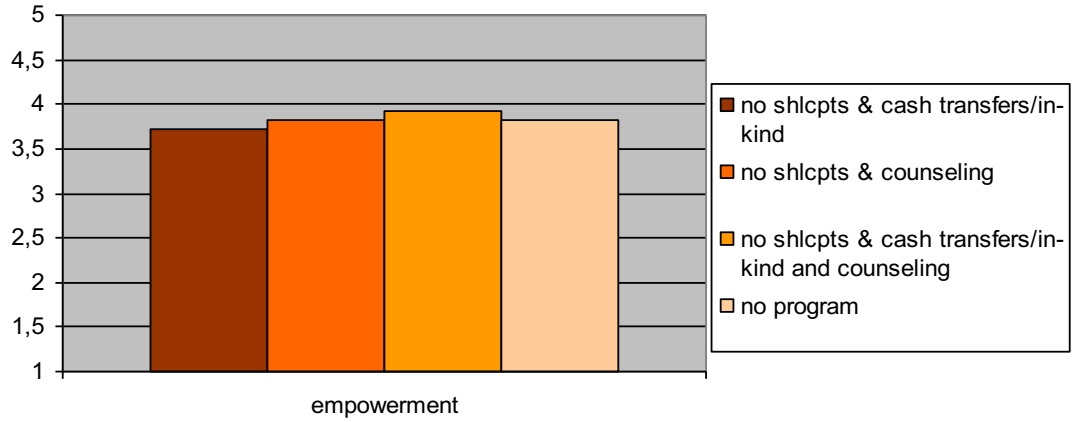


Figure 17-6. Mean scores on Capability, Empowerment and Income for those who did not received the SHLCPTS-program (wave 2)







The main findings regarding the effectiveness of programs in increasing social and economic resilience are:

- Receiving cash/in-kind has no effect on any of the subscales of SER.
- Receiving counseling has a positive effect of the Income and Empowerment scores.
- Receiving both cash/in-kind and counseling increases the Capability and Income scores, but lowers Empowerment scores.

The effect of SHLCPTS are preliminary, due to the short time period between finishing the program and the questionnaire. Furthermore, one should realize that the SHLCPTS program was not assigned randomly to an individual. There was a selection of communities that were expected to benefit most of the program. Consequently, at the start of the program, those respondents who did receive the SHLCPTS program probably scored lower on Social and Economic Resilience compared to those who did not receive it.

The results of the analyses indicate that:

- Receiving SHLCPTS program goes with lower scores on the Social and Income scale.
- Those who received SHLCPTS program do not differ on Capability, Empowerment, System, and Worry (although this might be expected based on the fact that those who received SHLCPTS program were most in need for trauma support).
- Receiving both cash and SHLCPTS program goes with lower scores on the Social scale.

If these results are viewed from the perspective that those respondents who did receive the SHLCPTS program probably scored lower on Social and Economic Resilience compared to those who did not receive it, the results can be regarded as positive. The backlog in SER is reduced due to the SHLCPTS program. This interpretation is in line with the qualitative results of the SHLCPTS program.

18. Effect of SHLCPTS on Reduction of Trauma? (Wave 2)

In this chapter, the focus is on the effect of the SHLCPTS program on trauma. In reading this report, one should realize that the time between finishing the SHLCPTS program and this measurement was only a few months. Consequently, the reported effectiveness of the SHLCPTS program in reducing trauma may be underestimated. In this research trauma was operationalized with the revised Impact of Events Scale (IES-R). In the research, the SHLCPTS program was implemented in the groups that received cash only, or counseling only, or both cash and counseling, or no program at all in the first wave. This results in 8 different groups of respondents (see also section 4.1). This design allows us to study the direct (main) effect of SHLCPTS program, the lagged (main) effect of cash and the lagged (main) effect of counseling. Moreover, the analyses allow us to investigate the interactions between the different types of programs (cash/in-kind, counseling, and SHLCPTS program). In order to explore all these effects, we will first analyze the total means score of the IES-R and then each of the subscales separately.

18.1. **Total mean IES-R**

Table 18-1 gives the statistics regarding the total mean IES-R for each group of respondents. It indicates that for all groups the average post-traumatic stress is about 7 (IES-R-total: sum of the three subscales; minimum 0 maximum 12, higher more trauma). This is quite similar to the stress level reported in the first wave.

Table 18-1. IES-R: Total mean IER-S score for each group of respondents (cash/in-kind transfer, trauma counselling, SHLCPTS program)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only and SHLCPTS	25	7,03	2,20	-0,53	-0,27
counseling and SHLCPTS	56	7,81	1,66	-0,78	0,32
Cash/in-kind, counseling and SHLCPTS	85	7,67	1,74	-0,87	0,93
Only SHLCPTS	21	7,95	1,41	-1,43	1,61
Cash/in-kind only and no SHLCPTS	37	6,76	2,37	-0,53	-0,61
Counseling only and no SHLCPTS	37	7,90	1,79	-1,35	2,15
Both cash/in-kind and counseling, no SHLCPTS	37	7,00	2,09	-1,31	0,84
No program	58	7,68	1,98	-1,24	1,49
Total	356				

When testing the differences between the groups with an ANOVA (see Table 18-2), receiving cash/in-kind turned out to make a difference in group means in the sense that when receiving cash post-traumatic stress disorder has decreased.

Table 18-2. IES R: Effect of programs on the mean total IES-R

N (356)	F-value	p-value
Cash/in-kind	F(1,349) = 9,89	0,002
Counseling	F(1,349) =1,43	0,233
SHLCPTS	F(1,349) =1,69	0,194
Cash/in-kind* SHLCPTS	F(1,349) = 0,709	0,400
Cash/in-kind* SHLCPTS	F(1,349) =1,15	0,285
Counseling* SHLCPTS	F(1,349) =0,004	0,947

Next whether socio-economic background variables affect differences between the groups is explored. Table 18-3 gives the results when taking age (as a covariate), educational level and employment into account.

Table 18-3. IES-R: Effect of programs on the total mean IES-R when controlling for age educational level and occupation

N (351)	F-value	p-value
Cash/in-kind	F(1,337) = 10,58	0,001
Counseling	F(1,337) =1,74	0,188
SHLCPTS	F(1,337) =1,20	0,274
Cash/in-kind*counseling	F(1,337) = 0,416	0,519
Cash/in-kind* SHLCPTS	F(1,337) =1,62	0,204
Counseling* SHLCPTS	F(1,337) =0,038	0,846
Age	F(1,337) =0,284	0,594
Educational level	F(3,337) =0,240	0,868
Occupation	F(3,337) =0,949	0,417

The results of Table 18-3 suggest that post-traumatic stress disorder is related to the programs provided. Receiving cash/in-kind turned out to make a difference in group means in the sense that when receiving cash/in-kind post-traumatic stress disorder has decreased. Moreover, the analysis indicates that age, educational level and occupation are not related to post-traumatic stress disorder.

18.2. **Avoidance**

Table 18-4 gives the statistics for avoidance scale for each group of respondents. It shows that for all groups the average avoidance ranges between 2.3 and 2.6 (minimum 0 maximum 4, higher more trauma). It suggests that the groups who received cash only and SHLCPTS program has the lowest scores.

Table 18-4. IES-R: Avoidance for each group of respondents (cash transfer, trauma counselling, SHLCPTS program)

	N	average	SD	skewness	kurtosis
Cash/in-kind only and SHLCPTS	25	2,31	0,53	-0,13	1,04
counseling and SHLCPTS	56	2,53	0,48	-0,44	0,45
Cash/in-kind, counseling and SHLCPTS	85	2,50	0,54	-0,11	-0,12
Only SHLCPTS	21	2,64	0,39	0,21	-1,18
Cash/in-kind only and no SHLCPTS	37	2,34	0,54	-0,96	1,24
Counseling only and no SHLCPTS	37	2,54	0,51	-0,13	-0,49
Both cash and counseling, no SHLCPTS	37	2,34	0,67	-1,02	0,77
No program	58	2,53	0,22	-0,08	-0,09
total	356				

When testing the differences on the avoidance subscale between the groups with an ANOVA (see Table 18-5), receiving cash/in-kind turned out to make a differences in group means in the sense that receiving cash/in-kind goes with lower scores on the avoidance scale.

Table 18-5. IES-R: Effect of programs on Avoidance

N (356)	F-value	p-value
Cash/in-kind	F(1,349) = 8,04	0,005
Counseling	F(1,349) =0,22	0,639
SHLCPTS	F(1,349) =0,97	0,325
Cash/in-kind*counseling	F(1,349) = 1,15	0,285
Cash/in-kind* SHLCPTS	F(1,349) =0,21	0,645
Counseling*SHLCPTS	F(1,349) =0,098	0,754

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, avoidance is still (negatively) affected by receiving cash (see also Table 18-6). Moreover, the analysis indicates that age, educational level, and occupation are not related to the avoidance scores.

Table 18-6. IES-R: Effect of programs on Avoidance when controlling for age educational level and occupation

N (351)	F-value	p-value
Cash/in-kind	F(1,337) = 7,73	0,006
Counseling	F(1,337) =0,58	0,448
SHLCPTS	F(1,337) =0,55	0,459
Cash/in-kind*counseling	F(1,337) = 0,74	0,390
Cash/in-kind* SHLCPTS	F(1,337) = 0,42	0,520
Counseling/in-kind* SHLCPTS	F(1,337) =0,02	0,891
Age	F(1,337) =0,08	0,784
Educational level	F(3,337) =0,43	0,729
Occupation	F(3,337) =1,19	0,315

18.3. **Intrusion**

Table 18-7 gives the statistics of the intrusion scores for each group of respondents. It shows that the average intrusion scores for the groups range from 2.2 to 2.7 (minimum 0 maximum 4, higher more trauma). The group cash/in-kind only that did not received the SHLCPTS program has the lowest score and the groups that received only the SHLCPTS program has the highest score.

Table 18-7. IES-R: Intrusion for each group of respondents (cash/in-kind transfer, trauma counselling, SHLCPTS program)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only and SHLCPTS	25	2,43	0,88	-0,89	-0,14
Counseling and SHLCPTS	56	2,65	0,61	-0,76	0,99
Cash/in-kind, counseling and SHLCPTS	85	2,60	0,66	-1,34	1,98
Only SHLCPTS	21	2,71	0,57	-1,65	2,91
Cash/in-kind only and no SHLCPTS	37	2,22	1,01	-0,40	-0,56
Counseling only and no SHLCPTS	37	2,67	0,77	-1,42	2,07
Both cash/in-kind and counseling, no SHLCPTS	37	2,32	0,81	-0,99	0,31
No program	58	2,64	0,89	-1,59	2,08
Total	356				

When testing the differences in the intrusion scores between the groups with an ANOVA (see Table 18-8), receiving cash/in-kind turned out to have a significant effect; those who receive cash have lower scores on intrusion.

Table 18-8. IES-R: Effect of programs on Intrusion

N (356)	F-value	p-value
Cash/in-kind	F(1,349) = 9,48	0,002
Counseling	F(1,349) =0,60	0,439
SHLCPTS	F(1,349) =2,31	0,129
Cash/in-kind*counseling	F(1,349) = 0,68	0,411
Cash/in-kind* SHLCPTS	F(1,349) =1,77	0,184
Counseling* SHLCPTS	F(1,349) =0,000	0,985

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, intrusion is still (negatively) affected by receiving cash (see also Table 18-9). Moreover, the analysis indicates that age, educational level, and occupation are not related to the intrusion scores.

Table 18-9. IES-R: Effect of programs on the Intrusion when controlling for age, educational level and occupation

N (351)	F-value	p-value
Cash/in-kind	F(1,337) =10,56	0,001
Counseling	F(1,337) =0,72	0,395
SHLCPTS	F(1,337) =1,65	0,200
Cash/in-kind*counseling	F(1,337) = 0,40	0,525
Cash/in-kind* SHLCPTS	F(1,337) = 2,25	0,135
Counseling* SHLCPTS	F(1,337) =0,08	0,781
Age	F(1,337) =0,79	0,375
Educational level	F(3,337) =0,19	0,901
Occupation	F(3,337) =78	0,504

18.4. **Hyperarousal**

Table 18-10 gives the statistics of hyperarousal scale for each group of respondents. It shows that the average hyperarousal scores for the groups range from 2.2 to 2.7 (minimum 0 maximum 4, higher more trauma). The group receiving cash only and not the SHLCPTS program has the lowest score and the groups that received only counseling has the highest score.

Table 18-10. IES-R: Hyperarousal for each group of respondents (cash/in-kind transfer, trauma counselling, SHLCPTS program)

	N	Average	SD	Skewness	Kurtosis
Cash/in-kind only and SHLCPTS	25	2,29	1,06	-0,62	-0,06
Counseling and SHLCPTS	56	2,63	0,81	-1,17	0,81
Cash/in-kind, counseling and SHLCPTS	85	2,57	0,84	-1,31	1,70
Only p SHLCPTS	21	2,60	0,66	-1,81	2,67
Cash only and no SHLCPTS	37	2,20	1,03	-0,46	-0,68
Counseling only and no SHLCPTS	37	2,69	0,78	-1,84	4,21
Both cash and counseling, NO SHLCPTS	37	2,34	0,87	-1,13	0,58
No program	58	2,50	0,89	-1,47	2,11
Total	356				

When testing the differences on the hyperarousal subscale between the groups with an ANOVA (see Table 18-11), receiving cash turned out make a differences in group. Receiving cash goes with lower scores on the hyperarousal scale. Counseling made a marginal difference ($p<0.10$) too: those who received counseling reported higher levels of hyperarousal.

Table 18-11. IES-R: Effect of programs on Hyperarousal

N (356)	F-value	p-value
Cash/in-kind	F(1,349) = 5,96	0,015
Counseling	F(1,349) =2,71	0,101
SHLCPTS	F(1,349) =0,82	0,366
Cash/in-kind*counseling	F(1,349) = 0,22	0,641
Cash/in-kind* SHLCPTS	F(1,349) =0,78	0,378
Counseling* SHLCPTS	F(1,349) =0,001	0,979

When the socio-economic background variables, age (as a covariate), educational level and employment are taken into account next to the programs, hyperarousal is still (negatively) affected by receiving cash and (marginally significant) positively by receiving counseling (see also Table 18-12). Moreover, the analysis indicates that age, educational level and occupation are not related to scores on the hyperarousal scale.

Table 18-12. IES-R: Effect of programs on Hyperarousal when controlling for age educational level and occupation

N (351)	F-value	p-value
Cash/in-kind	F(1,337) =6,57	0,011
Counseling	F(1,337) =2,81	0,094
SHLCPTS	F(1,337) =0,67	0,418
Cash/in-kind*counseling	F(1,337) = 0,11	0,741
Cash/in-kind* SHLCPTS	F(1,337) = 1,13	0,288
Counseling* SHLCPTS	F(1,337) =0,07	0,794
Age	F(1,337) =0,29	0,589
Educational level	F(3,337) =0,18	0,913
Occupation	F(3,337) =0,887	0,448

18.5. **Conclusion**

The main findings regarding the effectiveness of the programs in lowering trauma are:

- Cash/in-kind can reduce trauma at the overall level (total mean IES-R) as well as for each of the subscales. This suggests that cash/in-kind has a lagged effect on trauma.
- Counseling did not show an effect on the reported trauma. This suggest that counseling does not have a lagged effect on trauma
- The SHLCPTS program had no effect on the reported trauma. However, one should realize that the time between finishing the SHLCPTS program and this measurement was only a few months month.

PART IX: DISCUSSION

19. Discussion of Unexpected Findings and Validity

The construct of 'system' (experiencing rights) did not show an independent positive or negative effect in this study and the expected effect of this construct should be reconsidered.

Three unexpected effects were found in this research. The correlation with social resilience was negative with the SHLCPTS. This is explained by the decreased dependency on the family and the community of the participants in the SHLCPTS. The strong effect of the SHLCPTS and the possibility to not rely on group processes for the counseling can explain this finding. The interviews showed that women were seen as more socially active and capable, so the findings are interpreted as decreased negative reliance on social networks. This could be subject for further research in the future.

The second unexpected finding was that worry correlated negatively with social economic resilience and increase of income in the groups that received support for trauma relief. This is explained by the fact that women reported in the interviews to worry less about the pat but more about the present. So, the nightmares about traumatic events were replaced by in-the-present concerns about practical aspects of life, work and income. This findings explains exactly why women experience increased social economic resilience – and more worry, because they have moved from living in the past to living in the present, with an enhanced ability to manage the traumatic events. The increased worry is a sign that they have processed trauma and are able to make a more useful distinction between the past and the present.

The third unexpected result was that the groups that received different types of support (or none) did not differ in the trauma levels reported through the IES-R, although their level of worry was (negatively) increased. This finding needs further investigation. Several explanations can be offered, particularly the IES-R being insensitive to small changes with short time-lines and possibly requiring a higher degree of experience to conduct. A third data collection was implemented to investigate the possible impact of time (still to be reported) and a triangulation of results of a similar investigation carried out in Ethiopia may help reveal some of the reasons of this finding.

In order to identify whether the results of this study can be replicated elsewhere, a second study was undertaken in Ethiopia. The report of this research is forthcoming and confirms the findings of this investigation.

Appendix 1: Outline of SHLCPTS Intervention

1. Introduction to trauma

1.1 What is trauma and what are the risk factors that increase vulnerability to traumatic stress?

1.2 What is traumatic stress disorder and what are the symptoms?

1.3 What is complex post-traumatic stress disorder and what are its symptoms?

1.4 What is collective trauma and what are its impacts?

2. Introduction to PTSD and the brain and EMDR treatment

2.1 What does trauma do to the brain?

2.2 How can we heal the brain from the effects of trauma

3. Trauma healing techniques

3.1 Breathing exercises

3.2 A safe calm place

3.3 Finding and ranking touchstone memories

3.4 Bilateral stimulations and the butterfly hug

3.5 Four elements exercise (Earth-Air-Water-Fire)

4. Promoting Community wide healing

4.1 Community celebration events (‘graduation’)

4.2 T-shirts with trauma and healing messages as conversation starters

Appendix 2: Literature Review on Social Protection and Trauma

The literature reviewed for this study used a network approach to obtain literature, which was used as a first stage step (Bernard, 2006). As part of this approach, the research team approached researchers and practitioners who have written and those implementing social protection and psychosocial support to obtain recommended readings. A starting point for the search was the Ministry of Gender and Social Protection in Uganda.

A systematic review[1] was used based on the key-words: social protection, psychosocial support, trauma, cash transfers and women's empowerment. A second search was undertaken to capture the literature specifically on Northern Uganda, the study area for the research, and to extend the topics to look for potential overlap with other areas of research.

[1] A systematic review is defined as "a review in which there is a comprehensive search for relevant studies on a specific topic, and those identified are then appraised and synthesized according to a pre-determined explicit method" (Weed, 2005, para. 16).

Table 0-1. Literature review: Social Protection and Trauma in Uganda

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
Davidson et al. (2016)	No	None	Yes	Yes	Northern Uganda	-Psychological therapy can reduce depression. -Counselling and medication is valued by service users. Counselling improved depression, and increased empowerment and engagement in social activities.	-Limited literature on trauma counselling in Sub-Saharan Africa - There gaps in service provision, mental health policy and legislation -Compensation help to meet social needs and reduce feelings of shame and anger
Annan et al. (2011)	Yes	Yes	Yes	Yes	Northern Uganda	-Estimates the impacts of war on both genders -War leads to injuries, lost education and lost opportunities.	Little evidence of social exclusion or aggression in addressing effects of war

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
						-Ravages of war could lead to psychological trauma and aggression.	
Kirsten et al. (2012)	Yes	Yes	No	Yes	North eastern Uganda	-Providing access to basic services, social protection and support to livelihoods matters for the human welfare of people affected by conflict. -The current National Development Plan explicitly recognizes the need to integrate both Northern Uganda into the mainstream development of the country.	-Need for further research and assessment of livelihood promotion and basic services and social protection provision in Northern Uganda -Data exists on the problems facing the greater north, but little on what works to build resilient households and communities.
Alison et al. (2013)	Yes	Yes	No	Yes	Northern Uganda	-Depression and post-traumatic stress in post-conflict settings is public health concern worldwide.	There is need to standardize and test the efficacy of this intervention using randomized controlled trial.

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
						-Mental disorders before and after conflict indicate that depression may be more related to the persisting conditions of poverty and structural adversity than war related trauma.	
Logan Shelby (2016)	None	None	Yes	None	Northern Uganda	There is a need to focus on psychological needs first and then offer economic empowerment.	Trauma does not only affect individuals, but also entire families.
Ministry Of Gender, Labour And Social Development (2015)	Yes	None	None	None	Pioneer districts for SAGE	In Uganda there is growing numbers of people in need of social protection services.	Gap identified in the social protection policy—it does not focus on the psychological improvement of the beneficiaries and economic independence
Nakimuli-Mpungu, E. (2013)	No	No	Yes	No	Northern Uganda	Group counselling intervention offered in the trauma clinics is feasible and potentially	-Future studies should include randomized control trials with larger samples to evaluate the efficacy of

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
						effective in alleviating depression and post -traumatic stress symptoms.	locally-developed psychosocial interventions for individuals in post -conflict regions.
Harlacher T. (2009)	No	No	Yes	No	Northern Uganda	Although research on PTSD is biased towards the experience of western countries, it is a good starting point for investigating post traumatic stress reactions among the Acholi. -Despite existing local approaches to healing, the application of Western approaches to trauma therapy should not be categorically excluded.	There is need to investigate and support existing local capacities for healing.
Babatunde Omilola,	Yes	None	None	None	Africa	-African governments and development partners activities focus on the formulation,	-There is growing emphasis on social protection as a means of alleviating poverty and achieving the

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
Sheshangai Kaniki (2014)						adoption and implementation of social protection frameworks especially for women, youth and vulnerable groups.	Millennium Development Goals (MDGs) in Africa.
Joanna Santa Barbara, (1997)	No	No	Yes	No	Children	What has happened to children who witnessed war and the long and short-term psychological effects of war, which are manifested as a result of the trauma they were exposed to.	The psychological effect of the events of the wars on the parents and guardians of these children.
Gaithri A. Fernando, (2004)	None	None	Yes	No	Western communities	The study emphasizes the training of clinical psychologists as an intervention for traumatized victims.	The study ignores the rehabilitation of traumatized victims in terms of economic intervention.
Krishna Kumar (1997)	Yes	Yes	Yes	Yes	Selected countries	International interventions have helped traumatized	As much as the models that are used to treat traumatized victims in other parts of the world have worked,

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
					including Uganda	victims in countries where they have provided support.	chances are high they may not work in countries like Uganda given the nature of the conflict.
The World Bank (2011)	Yes	No	yes	yes	Latin America, Africa, South east Asia	Social safety nets are channels through which social protection can be dispensed.	- There is need to include cash transfers in social protection. - The study did not look at social protection giving economic independence to the socially vulnerable.
Babajan, B. (2013)	Yes	yes	yes	No	Mexico, Nicaragua, Malawi, Honduras, Brazil and Colombia	Social protection can be effective	The study does not address issues of gender and economic independence.
Ovuga E and Larroque C, (2012)	None	None	Yes, PTSD	None	Northern Uganda	It is necessary to understand the types of emotional difficulties children experience, as well as the degree to which	The outcome of post-traumatic stress disorder in Uganda is unknown. However clinical experience indicates that most individuals with the

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
						they are affected, in order to provide appropriate treatment interventions and resources that might prevent further psychological damage.	disorder recover after two to six sessions of counselling.
Bernstein E (2009)	None	None	Yes	None	Northern Uganda	Trauma can spread and negatively affect other aspects of daily life in the community.	Looking at existing programs that have successfully merged local and western approaches to healing.
ESID Briefing No 22 (2016)	Yes	Yes	None	None	Uganda	The progress of the social protection agenda in Uganda has been closely shaped by the extent to which the globalized policy coalition in support of social protection was able to align this agenda with the dominant and changing interests and ideas within Uganda's ruling coalition.	Certain key players within Uganda's government do not see social protection as an integral part of its overall development strategy.

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
Baingana F & Onyango Mangen P	None	None	Yes	None	Northern Uganda	-Combining medical/clinical activities with social activities leads to better outcomes for patients. -Formation and support of the patients' support group, who then provide peer-to-peer support to the patients and their carers, provide incomes to the patients and families of those with mental disorders.	It is important to develop guidelines for the training of village health teams, including how to form patient support groups, how to provide support for livelihood activities, and how sensitization and mobilization is carried out.

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
Christopher Blattman, Nathan Fiala & Sebastian Martinez (2013)	None	Yes	None	Yes	Uganda	-Cash transfers lead recipients to spend more on their basic needs (such as food) and may allow recipients to make investments with very high returns. -High returns on cash, even among poor, unemployed and relatively uneducated women	Important questions for future research are: the extent to which the framing and design of the intervention (an unenforced ;pre-commitment' to invest funds) and how the group nature of disbursements influences these high levels of investment.
Mawere, M., Mubaya, T. R., van Reisen, M., & van Stam, G. (2016)	None	None	None	None	Africa	He asserts that every person has a strong desire to realize his or her full potential, to reach a level of 'self-actualization'. His thinking has deeply influenced the paradigm of the development agenda, both in theory and in practice, and set the foundation for moral	As Graham and Messner (1998: 196) summarize, there are generally three major criticisms directed to Maslow's Theory of Motivation: (a) there is scant empirical data to support the theoretical model, (b) the studies assume human beings are similar and that the theory universally applies, and (c) applications or validation of the theory do not concern themselves with a theory of

Author & year	Social protection	Cash transfer	trauma/ PSTD	Gender/ women	Geographic location	Main findings	Research gaps/future study gaps
						thinking on individual entitlements.	motivation, but rather with theories of job satisfaction.

Appendix 3: Survey Descriptives

Questionnaire for Female Participants

Questionnaire No ----------Interviewee Name----------District---------- Sub County----------

Date----------Category ----------

Instructions

Explain the purpose of the interview and explain the participation is voluntary and read and have the consent form signed/thumb print by the respondent

A. Biographic data of the respondent

1) Age _____

2) Level of Education

a). Never been to school b). Attended Primary c). Attended Secondary d). Tertiary institution

3) Occupation/Employment

a). Farming b). Business c). Professional job c). None

4. Other sources of household income

a). Agriculture b). Poultry c). Market vending d). Produce trade e) Local brewing f) None

5) Marital status

a). Single b). Married c). Divorced d). Separated e). Widow

6) Headship of family

a). Female headed b). Male headed c). Child headed

7) Household size

a) One person b) 2-5 people c) 5-10 People

d) More than 10 people

8. Have you received any cash transfers from the government in the past one year?

a) Yes b) No

9) If yes, which type of cash transfers did you receive?

a) Hard Cash c) Cash vouchers

10) Did you receive any other form of transfers from the government other than cash?

a) Yes b) No

11) If yes, what other type of transfer did you receive from the government?

a) Food transfers b) Production asset c) Livestock

d) Seedlings

12) Have you received any other transfers from other sources other than the government?

a) Yes b) No

13. If yes what was the source of the transfer?

a) NGO b) Church/Mosque c) Neighbour/community

d) Family members

14) Which type of transfers did you receive from these other sources?

a) Cash transfer b) Food transfers c) Cash vouchers d) Production asset e) Food

15) Do you own land?

a) Yes b) No

16) What is your main source of information?

a) Radio b) Television c) Community

17) What is your main means of transportation?

a) Car b) Motorcycle c) Bicycle d) Walking

18) Which is your main gardening tool?

a) Hand hoe b) Sickle c) No garden d) Ox plough

19) What is your main source of lighting at home?

a) Electricity b) Solar c) Paraffin big lamp
d) Small candles (Tadoba) e) Torch

20). Do you belong to any community group?

a) Yes b) No

21) Have you received any counselling?

a) Yes b) No

22. Who provided this counselling?

a) Government b) NGO c) Friend
d) Church e) Radio

23. Did you Receive trauma management from EWP project a) Yes
b) No

Appendix 4: Impact of Events Scale- Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how stressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to…….. (event) that occurred on……(date). How much have you been distressed or bothered by these difficulties?

		Strongly disagree	Disa
1	Any reminder brought back feelings about it	1	2
2	I had trouble staying asleep	1	2
3	Other things kept making me think about it	1	2
4	I felt irritable and angry	1	2
5	I avoided letting myself get upset when I thought about it or was reminded of it	1	2
6	I thought about it when I didn't mean to.	1	2
7	I felt as if it hadn't happened or wasn't real	1	2
8	I stayed away from reminders of it	1	2
9	Pictures about it popped into my mind.	1	2
10	I was jumpy and easily startled	1	2
11	I tried not to think about it.	1	2
12	I was aware that I still had a lot of feelings about it	1	2
13	My feelings about it were kind of numb	1	2
14	I found myself acting/feeling like I was back at that time	1	2
15	I had trouble falling asleep	1	2
16	I had waves of strong feelings about it	1	2
17	I tried to remove it from my memory	1	2
18	I had trouble concentrating	1	2
19	Reminders of it caused me to have physical reactions such as sweating, trouble breathing, nausea or a pounding heart	1	2

20	I had dreams about it	1	2
21	I felt watchful and on-guard	1	2
22	I tried not to talk about it	1	2

Appendix 5: Social and Economic Resilience Scale (SER)

		Strongly disagree	Disagree
	Part 1: Subjective/social		
22	I feel I trust my community	1	2
23	I feel attached to my family	1	2
24	I feel my contact with the leadership in my community has improved?	1	2
25	I feel my relationship with the rest of the community has improved?	1	2
26	Part 2: Capability/ Human capital		
27	I feel my capacity to pay for medication has improved	1	2
28	I feel my capacity to pay school fees improved in the last 6 months	1	2
29	I feel I can get information about anything I want	1	2
30	I feel I have skills to enable me improve my life	1	2
31	I feel I have acquired new productive skills to improve on my life	1	2
32	I feel change in the amount of knowledge hold?	1	2
33	I feel I am able to handle misunderstandings in my household	1	2
34	My husband seeks my opinion on matters related to our household	1	2
35	I have been able to space my children		
	Part 3: Improvement of actual income/ Economic		
37	I am able to save money	1	2
38	I will be able to own a business in the next 6 month?	1	2
39	I will be able to improve production		
40	I will be able to find market for my produce	1	2
41	I am able to market my own produce	1	2
42	I am able to contribute to household income	1	2
43	My personal assets have improved	1	2

44	My access to household assets has improved	1	2
45	I am able to survive in hardship times	1	2
46	I am able to manage my own income	1	2
47	I am able to make decisions on income in your household?	1	2
	Part 4: Women empowerment		
48	I am able to take up new initiatives independently	1	2
49	I am able make decisions more independently	1	2
50	My hours of household work been able to reduce?	1	2
51	Have you been able to gain more time for productive activities?	1	2
52	Has your freedom of movement improved?	1	2
53	I feel improvement in my self-worth?	1	2
54	I feel there has been a change in my values	1	2
55	I feel I am in charge of my own body?	1	2
	Structural/System		
56	I feel I am able to exercise my rights?	1	2
57	I am able to access legal services much easier?	1	2
58	I am able to seek and access medical services?	1	2
59	I am able to access financial services?		
	Worry		
60	I am worried that conflict may happen again in my society	1	2
61	I am worried that I will fail to provide for my family	1	2
62	I am worried I may not find a job	1	2
63	I am worried of the hostility from members of my community	1	2
64	I am worried I may not get enough money	1	2
65	I am worried that my leaders will not address the needs of my community	1	2
66	I am worried that climate change will affect food production	1	2
67	I am worried that the government will not address my personal needs	1	2

Appendix 6: Value Scale (inspired by Barrett)

Instructions:

Read the values to the respondent and ask them to choose and rank their five important values ranking from their Very important to Not Important and then List the values that you think the local leader should have in your community

	Read the Values	List Personal Values	List values for leaders	(1) Not important	(2) Slightly Important	(3) Moderat Importar
68	Family					
69	Forgiving					
70	Acknowledgement					
71	Caring					
72	Careful					
73	Adaptability					
74	Friendship					
75	Respect					
76	Self-discipline					
77	Generosity					
78	able to handle insecurity					
79	Dialogue					
80	Perseverance					
81	Resolving conflicts					
82	sense of humour / fun					
83	Decisive					
84	Fair					
85	Empathy					
86	Wisdom					

87	Patience					

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