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TRAUMA AND MENTAL HEALTH DIFFICULTIES AMONG ADULT REFUGEES IN KYAKA II SETTLEMENT IN UGANDA

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FIELD STUDY

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This report is a collaboration between DIGNITY-Danish Institute Against Torture, Christian Blind Mission (CBM), the School of Psychology at Makerere University, the African Centre for Rehabilitation of Torture Victims (ACTV), and the Transcultural Psychosocial Organization- Uganda (TPO-Uganda). The study is part of a pilot project financed by Danida, through the framework agreement with DIGNITY. However, the views herein should not be taken to reflect the official opinion of the Danish Ministry of Foreign Affairs.

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ABBREVIATIONS

ACTV	African Centre for Treatment and Rehabilitation of Torture Survivors
CBM	Christian Blind Mission
DRC	Democratic Republic of Congo
DDD	Digital Divide Data
KII	Key informant interviews
OPM	Office of the Prime Minister
MHPSS	Mental health and psychosocial support
TPO	Transcultural Psychosocial Organization

CONTENTS

EXCUTIVE SUMMARY

Uganda hosts more than 1.4 million refugees, making it the third largest refugee-hosting country in the world (UNHCR a, 2021). There are currently more than 426,000 Congolese refugees in Uganda, many of whom fled in the past decade due to episodes of ethnic and political conflict (ARC, 2019). Research with Congolese refugees in Uganda has shown that a high percentage have been exposed to conflict-related violence (Elbert et al., 2013).

The Kyaka II refugee settlement in southwestern Uganda is a primary site for hosting Congolese refugees. The population of the settlement has more than quadrupled since 2017, primarily due to Congolese fleeing ethnic and political violence in North Kivu and Ituri (UNHCR, 2019).

Several actors are collaborating on the mental health and psychosocial initiatives in Kyaka II, however, systematic data on trauma and mental health in the settlement, refugees' help-seeking behaviour, gendered vulnerabilities, and other risks and protective factors associated with well-being was lacking. The study was developed to determine the need for additional trauma-informed mental health and psychosocial support (MHPSS) for refugees in the Kyaka II and to provide knowledge to inform program development.

The initiation of the study was a joint effort between the African Centre for Treatment and Rehabilitation of Torture Survivors (ACTV), DIGNITY -the Danish Institute Against Torture, Christian Blind Mission (CBM), and faculty from the School of Psychology at Makerere University in Uganda. Prior to the data collection, the Transcultural Psychosocial Organization (TPO) Uganda also joined the collaboration.

Methodology

The study was carried out in Kyaka II settlement with ethical approval from Makerere University School of Social Sciences Research Ethics Committee and the Uganda National Council on Science and Technology. Permission was also obtained from the Uganda Office of the Prime Minister (OPM) to conduct the study. DIGNITY commissioned Digital Divide Data (DDD) to carry out the data collection. Five of the nine zones in Kyaka II settlement were randomly selected; each zone was sampled proportionately to the population of the zone. All participants provided informed consent and a total of 713 number of refugees (398 females, 315 males) were interviewed. Additionally, 11 semi-structured interviews were conducted with key actors working in the settlement.

Findings

The study's key findings are listed below:

- The study showed an exceptionally high rate of distress among adult refugees in the Kyaka II settlement. Approximately three-quarters of the sample had elevated symptoms of posttraumatic stress and depression, and nearly half reported symptoms to be so severe they were unable to successfully engage in tasks of daily life, including caring for family and taking part in community activities. Of particular concern is the percentage of refugees who reported suicidal ideation—more than 50% had thoughts of suicide in the past two weeks.

- Our results indicated that exposure to certain forms of interpersonal and other traumatic events, along with difficulties adjusting to the settlement and experiencing ongoing discrimination based on being a refugee, were significantly associated with more severe symptoms of PTSD and depression. The stress from living in conditions of extreme economic deprivation with limited opportunities for improvement also appears to be negatively impacting on the mental health of the population. Being a member of at least one social group was the only significant protective factor, with a negative association with symptoms of posttraumatic stress and depression.

- Participants were more likely to report frequent suicidal ideation if they had been abused as a child, imprisoned, or raped, and experienced ongoing discrimination. Being a member of at least one group, feeling a sense of connection to the community (i.e., cognitive social capital), and having at least one family member to confide in about their difficulties, were all factors associated with lower suicidal ideation.

- Findings of this study also highlighted gendered vulnerabilities; women reported higher rates of sexual violence which, in turn, was significantly associated with more severe posttraumatic stress, depression, and suicidal ideation. Women also had more functional impairment and significantly higher rates of nearly all acts of partner violence that were assessed.

- Cultural sensitivity was crucial when considering perceptions of mental health and well-being. Informants noted mental health issues were stigmatized and this created a barrier for help seeking. Nevertheless, more than 3/4 of the participants were willing to seek help from a mental health provider for an emotional problem.

- Lack of awareness of MHPSS of services in the settlement was also a barrier to seeking help. Despite multiple actors offering psychosocial support, only 15% of males and 18% of females were aware of any services, and few had accessed services.

- An additional barrier to help-seeking appears to be the dire economic situation in the settlement. Informants noted some refugees were reluctant to engage in MHPSS because their basic needs were not met. While this is understandable, the findings show mental health difficulties are interfering with tasks of daily life for a substantial percentage of the population. If not addressed, these difficulties can create a vicious circle whereby distress interferes with getting basic needs met, which in turn amplifies distress (Lund et al., 2011).

Recommendations

Results of the study highlight several potential action points for actors working in the settlement as well as recommendations for the implementation processes. Perhaps most urgent is the need for suicide prevention programming. Further, despite ongoing initiatives, there continues to be a need for mental health outreach and additional services that are trauma-informed and tailored to reach the most vulnerable. Our study and other research in the settlement (ACTED, 2019) identified survivors of torture and sexual violence, those affected by ongoing intimate partner violence, female-headed households, and people with disabilities as the most vulnerable groups. Initiatives aimed at improving the social cohesion of communities and social networks, particularly among refugees who are marginalized may be beneficial for promoting the mental health of the population. Regarding implementation, study findings highlight the importance of tailoring MHPSS interventions to be more culturally appropriate and gender sensitive as well as the need for enhanced multi-sector collaboration. Recommendations are further elaborated in the full report.

BACKGROUND

This study began as a joint effort between the African Centre for Treatment and Rehabilitation of Torture Survivors (ACTV), DIGNITY - Danish Institute Against Torture, Christian Blind Mission (CBM), and faculty from the Psychology Department at Makerere University in Uganda. Prior to beginning data collection, the Transcultural Psychosocial Organization (TPO) Uganda also joined the collaboration. The overall purpose of the study was to determine the need for additional trauma-informed mental health and psychosocial support (MHPSS) for refugees in the Kyaka II refugee settlement in southwestern Uganda, and to provide data to inform program development.

The Ugandan refugee population

As of February 2021, Uganda hosts more than 1.4 million refugees, making it the third largest refugee-hosting country in the world (UNHCR a, 2021). Refugees from South Sudan are the largest population 62%, followed by those from the Democratic Republic of Congo (DRC), with a smaller number from other countries in the region (UNHCR b, 2021). Only around 6 percent of the country's refugees live in urban centres, mainly Kampala, while the vast majority are spread across settlements in 11 refugee hosting districts. Less than 1% of refugees are resettled abroad, thus many remain in the humanitarian settlements for long periods of time.

Uganda's model of hosting refugees is unlike that of any other country. Refugees are permitted to work, cultivate land, move freely, and access government-provided healthcare and primary education. For all its hospitality to refugees, however, the country has struggled to manage the large inflow of people in need. Uganda ranks 163rd out of 188 countries on the Human Development Index, and much of the country's chronic poverty is concentrated in the West Nile refugee-hosting region. Resources and social services are strained in the country's numerous settlements, often leading to tensions between refugees and the host population, who also struggle with conditions of poverty. Problems have been amplified by the COVID-19 pandemic. A study by Danish Refugee Council (2020) found 96% of refugees sampled in six settlements reported an increase in difficulties meeting basic needs during the pandemic.

Congolese refugees in Uganda

According to UNHCR, there are currently more than 426,000 refugees from the DRC in Uganda, many of whom fled in the past decade due to episodes of ethnic and political conflict in the central and eastern part of the country (ARC, 2019).

The people of DRC have suffered from repeated cycles of war and conflict for more than 25 years. In 2017, a resurgence in violence led to more than 100,000 people fleeing the country, and the security conditions have continued to worsen. Currently, 15.6 million people need assistance in the country, and an estimated 5 million people are internally displaced, some repeatedly. The conflict is deeply rooted in enduring tension related to access to power, identity issues, and control of natural resources including mining and timber. More than 120 militias are active in the country together with numerous informal armed groups (UNHCR, 2020). The humanitarian situation has been further challenged by the Ebola outbreak in August 2018 as well as a measles epidemic. Thus, many recent refugees have endured years of adversity and instability prior to flight.

Research with Congolese refugees in Uganda has shown that a high percentage were exposed to conflict-related violence (Elbert et al., 2013). For example, in a recent study in the Nakivale refugee settlement, Ainamani et al. (2020) found 74.9% had witnesses someone being killed, 38.1% experienced sexual violence, and 29.1% had been kidnapped. Previous studies have found rates of PTSD from 20 to 89% among this population (Ainamani et al., 2020; Kolassa et al., 2010; Neuner et al., 2004; Onyut et al., 2009).

Kyaka II refugee settlement

Kyaka II refugee settlement in southwestern Uganda is one of the primary sites for hosting Congolese refugees. Kyaka II is, like others in Uganda, defined as a settlement rather than a refugee camp, as it is built on the national policy of self-reliance and freedom of movement for the refugees living there. The refugees are provided with land plots to build houses and to farm, with food rations decreasing over time (Danish Refugee Council, 2018).

Kyaka II was established in 2005 to host the remaining population when Kyaka I was closed after the mass repatriation of Rwandan refugees. The resurgence of violence in the DRC in 2017 led to an influx of new refugees to Uganda; in that year alone, there were more than 17,000 arrivals to Kyaka II. Since 2017, the population in Kyaka II has grown to more than 124,000, primarily because of the high numbers of Congolese fleeing violence in North Kivu and Ituru. Subsequently, Office of the Prime Minister (OPM) has indicated that Kyaka II settlement is reaching maximum capacity (UNHCR b, 2019).

The most recent arrivals to Kyaka II means refugees from DRC have joined refugees who have been displaced for decades. Tensions exist between long-term refugees and new arrivals as well as host communities, due to competition for the limited resources. The size of land plots assigned per household, for example, is decreasing and not considered sufficient to secure self-reliance and provide for the household without additional food rations (Danish Refugee Council & DDG, 2018). The ongoing stress from lack of basic needs being met can lead to and exacerbate existing trauma-related mental health difficulties.

Purpose

In this study we aimed to determine the need for additional trauma informed MHPSS in Kyaka II and better understand barriers to accessing services. Although there are several actors providing MHPSS in the Kyaka II settlement, according to a household survey by UNHCR (2018), 83% of households who reported having a family member with psychological distress were not able to access services and only 13% had been reached by awareness campaigns on available services.

Several studies (e.g., Ainamani et al., 2017; Bapolisi et al., 2020; Ssenyonga et al., 2013) have documented high rates of trauma exposure and PTSD among Congolese refugees; however, less is known about correlates of mental health. To inform mental health programming, we aimed to identify risk and protective factors associated with psychological distress. Hypothesized risk factors included past exposure to trauma (e.g., violence in home country) and present psychosocial stressors (e.g., lack of resources, discrimination). Protective factors were different social resources including relationships with friends and family and participation in groups in the settlement.

Refugees carrying water and supplies.

METHODOLOGY

Ethical considerations

Ethical approval was obtained from Makerere University School of Social Sciences Research Ethics Committee and the Uganda National Council on Science and Technology. Permission was granted from the Uganda OPM to conduct the study in Kyaka II settlement. All participants provided informed consent. Data were de-identified so that individual responses could not be connected to participants.

Research Tools

The survey questionnaire was composed of existing scales of the respective constructs. Those not already available in Congolese Kiswahili were back-translated by a professional translation company. The entire questionnaire was reviewed by two other translators for accuracy prior to beginning data collection. Additionally, five MHPSS providers working in the settlement reviewed questions to evaluate relevance. The final questionnaire was field tested and necessary adjustments were made to ensure items were understood.

Adversity was assessed with five items modified from the HESPER Scale (Semrau et al., 2012) that assessed the extent to which lack of basic resources (food, clean water, shelter), adjustment to life in the settlement, and discrimination for being a refugee were a problem in everyday life. Exposure to potentially traumatic events and functional impairment were assessed with scales developed in research with Congolese refugees in Uganda by Ainamani and colleagues (2017).

Exposure to emotional and physical violence from one´s partner was assessed using selected items from *World Health Organization Violence Against Women Instrument* (Garcia-Moreno et al., 2005). Items were modified to be gender neutral, so that both males and females were asked about acts of emotional and physical violence perpetrated by their partners.

Symptoms of posttraumatic stress disorder (PTSD) were assessed using the 20-item *PTSD Checklist for DSM-5* (Blevins, Weathers, Davis, Witte, & Domino, 2015). Symptoms of depression were assessed with the 15-item depression scale from *Hopkins Symptom Checklist* (Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974).

We used a modified General Help Seeking Questionnaire (GHQ; Wilson et al., 2005) to assess the likelihood that participants would seek help from a mental health provider, medical provider, and other community members (friend, family member, community health volunteer, religious leader) if they were experiencing an emotional problem. We also asked if they were aware of MHPSS services in the settlement and if they had utilized services.

A modified version of *Adapted Social Capital Assessment Tool* (De Silva et al., 2016) was used to assess social resources including membership and participation in groups in the settlement and a felt sense of belonging in the community. We also asked participants to report how many friends and family members whom they can confide in about a problem they are having.

In addition to the survey questionnaires, 11 semi-structured interviews were conducted with a convenience sample of key actors working in the settlement, both national and international organisations were included. Prior to data collection a list of all relevant actors was developed in collaboration with TPOUganda, participants were selected based on availability.

The interview guides were structured to include themes covering; work experience in refugee settlements; daily challenges and stressors in Kyaka; mental health difficulties and coping strategies among refugees; access barriers to mental health services; stakeholder collaboration; referral systems.

All informants were kept anonymous in the final report as well as the names of the organisations participating.

Data Collection

DIGNITY commissioned the Kenyan based organization Digital Divide Data (DDD) to carry out the data collection. Ten local enumerators (5 male, 5 female) and two field supervisors employed by DDD's Kampala office were trained for three days in the interview protocol and data collection for the study. Enumerators and supervisors were bilingual in English and Kiswahili.

Five of the nine zones in the settlement were randomly selected; each zone was sampled proportionately to the population of the zone (based on number of households in the zone reported by UNHCR September 2020). Because lists of residents could not be obtained to generate a random sample, systematic random sampling was used, wherein the enumerator started from a landmark in the zone, counted 5 dwellings and approached resident of the 6th to request participation. When multiple people were home, the enumerator asked for the head of household. If the head of household was not home, the spouse or other eligible adult was asked to participate.

After informed consent was obtained, the survey was administered verbally, and responses were recorded digitally on tablets.

As with the survey questionnaires, DDD was also responsible for qualitative data collection. One person (male) from DDS carried out all 11 interviews (9 male and 2 female) with the key actors present in settlement. KIIs were first provided with an overview of the purpose of the study provided informed consent to participate.

All interviews were conducted in English and recorded. Recordings were transcribed verbatim by DDD..

RESULTS FROM SURVEY DATA

Demographic information is shown in Table 1. The final sample consisted of 713 participants (398 females, 315 males). Most were from DRC, with fewer from Burundi, Rwanda, and Central African Republic. Approximately 78% had resided in the settlement for less than 5 years, the modal number of years was 2 (*N* = 268). A small percentage (9.7%) had lived in the settlement more than 10 years. Approximately 53% of males and 47% of females had close family members in Uganda.

Most participants were under the age of 40, married and living with their spouse. Most had little formal education; 62.1% of females and 42.5% of males reported being unable to read or write in any language. Few were engaged in any form of income generating activity, and on average of the participants had four children.

Table 1: Participant demographic information

AGE	MALE (N = 315) N (%)	FEMALE (N = 398) N (%)
18 – 25 YEARS OLD	38 (12.1)	103 (25.9)
26 – 34 YEARS OLD	91 (28.9)	111 (27.9)
35 – 41 YEARS OLD	77 (24.4)	73 (18.3)
42 – 49 YEARS OLD	46 (14.6)	51 (12.8)
50 – 65 YEARS OLD	48 (15.2)	44 (11.1)
ABOVE 65 YEARS OLD	15 (4.8)	16 (4)
LITERACY		
YES	181 (57.5)	151 (37.9)
NO	134 (42.5)	247 (62.1)
EMPLOYMENT		
YES	32 (10.2)	21 (5.3)
NO	283 (89.8)	377 (94.7)
HIGHEST LEVEL OF EDUCATION COMPLETED		
NONE	114 (36.2)	229 (57.5)
PRIMARY	141 (44.8)	132 (33.2)
SECONDARY	47 (14.9)	32 (8)
HIGHER	0 (0)	0 (0)
DO NOT KNOW	1 (0.3)	0 (0)
MISSING	12 (3.8)	5 (1.3)
HOME COUNTRY		
DEMOCRATIC REPUBLIC OF THE CONGO	297 (94.3)	370 (93)
BURUNDI	10 (3.2)	14 (3.5)
RWANDA	8 (2.5)	13 (3.3)
CENTRAL AFRICAN REPUBLIC	0	1 (0.3)
YEARS IN KYAKA II		
	MIN.-MAX. / MODE	MIN. -MAX. / MODE
	<1 TO 28 / 2	< 1 TO 37 / 2
NUMBER OF CHILDREN		
	MIN. -MAX. / MEAN (SD)	MIN.- MAX. / MEAN (SD)
	0-11 / 4.16 (2.5)	0-12 / 3.93 (2.42)

Exposure to Adversity and Potentially Traumatic Events

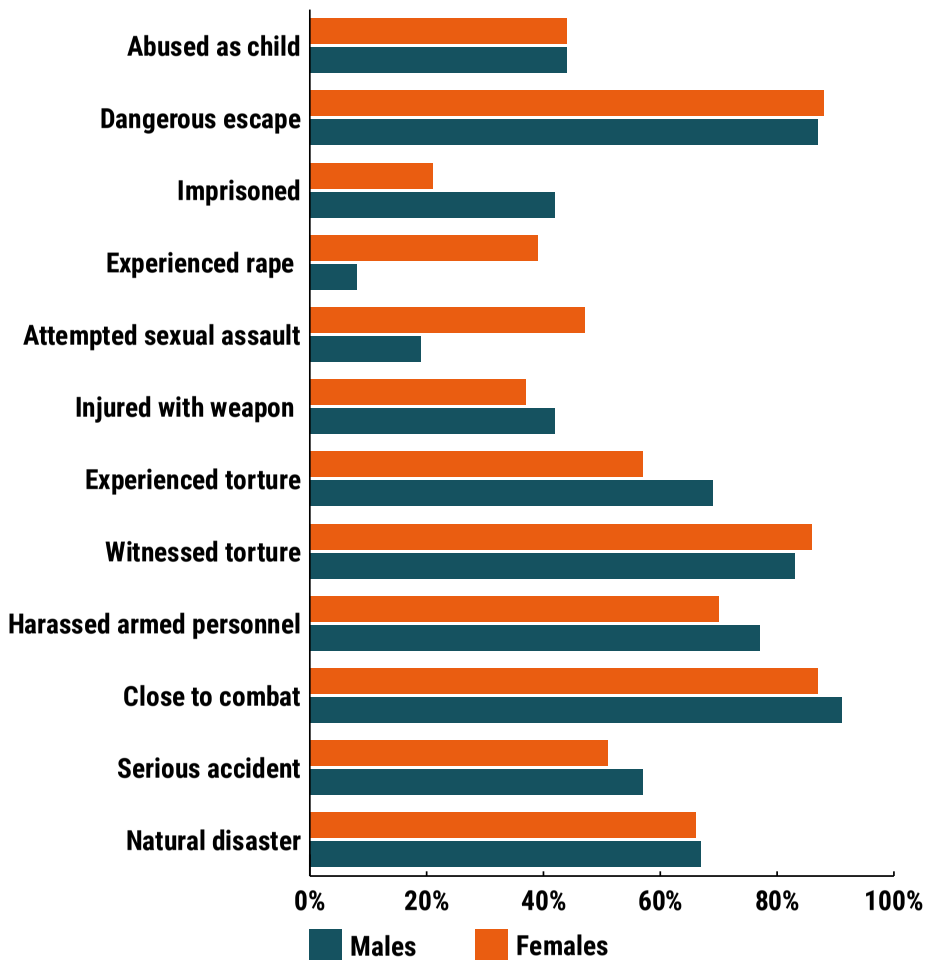
Participants reported high rates of ongoing adversity. Most reported 'a problem' or 'a very serious problem' accessing sufficient food (96.8% of males; 98.2% of females), clean water (95.9% of males, 92.5% of females), and adequate shelter (93.7% of

males, 93.7% of females). Approximately 37.5% of males and 42% of females stated discrimination for being a refugee was 'a problem' or 'a very serious problem', whereas 63.5% and 61.3% stated adjustment to life in the settlement was problem or serious problem, respectively.

Exposure to potentially traumatic events including witnessing or experiencing torture, being close to combat situations and other forms violence was also high as shown in Figure 1.

The traumatic events with the greatest gender difference were rape (39% of females, 8% of males), attempted sexual assault (47 % of females, 19 % of males) and imprisonment (21 % of females, 42% of males).

Figure 1: Exposure to potentially traumatic events (N = 713)



Intimate Partner Violence

Both males (*N* = 273) and females (*N* = 223) who were currently married or living with a partner were asked about emotional and physical violence from their partner. Approximately 72% of women reported at least one episode of emotional or physical violence from their husbands. Among men, approximately 52% reported at least one episode of violence from their partner. When interpreting this finding, it is important to note that the context in which the violence occurs was not assessed; it is not possible to determine if violence reported by the participant was in response to violence they perpetrated, or the severity of the physical acts. As shown in Table 2, females reported significantly higher rates of nearly all acts that were assessed.

Table 2. Percentage reporting acts of partner violence

	MALE *N* = 273		FEMALE *N*= 223	
HAS YOUR PARTNER EVER…	*N* (%)	*N* (%) MISSING	*N* (%)	*N* (%) MISSING
INSULTED YOU OR MADE YOU FEEL BAD ABOUT YOURSELF*	130 (48)	12 (4.4)	144 (64.6)	11 (4.9)
BELITTLED OR HUMILIATED YOU IN FRONT OF OTHER PEOPLE?*	96 (35.2)	13 (4.8)	100 (44.8)	11 (4.9)
DID THINGS TO SCARE OR INTIMIDATE YOU ON PURPOSE*	102 (37.4)	15 (5.5)	127 (57)	10 (4.5)
THREATEN TO HURT YOU OR SOMEONE YOU CARE ABOUT*	74 (27.1)	14 (5.1)	94 (42.2)	10 (4.5)
SLAPPED YOU OR THROWN SOMETHING AT YOU*	63 (23.1)	13 (4.8)	102 (45.7)	10 (4.5)
PUSHED YOU OR SHOVED YOU*	70 (25.6)	13 (4.8)	99 (44.4)	12 (5.4)
HIT WITH FIST*	43 (15.8)	14 (5.1)	80 (35.9)	11 (4.9)
KICKED, DRAGGED, BEATEN UP*	42 (15.4)	15 (5.5)	85 (38.1)	11 (4.9)
CHOKED OR BURNT	37 (13.6)	15 (5.5)	39 (17.5)	9 (4.0)
THREATENED WITH WEAPON	38 (13.9)	13 (4.8)	34 (15.2)	9 (4.0)
FORCED SEX*	46 (16.8)	15 (5.5)	56 (25.1)	14 (6.3)

Note. *Statistically significant difference between males and females in frequency, using a Chi-Square test. Missing indicates the participant refused to answer.

Social Resources

We conceptualized social resources as having a friend or family member to confide in, participation social and other types of groups within the settlement, and cognitive social capital (i.e., a felt sense of trust and belonging in the community). Most participants had at least one friend they could talk with about their difficulties (males = 86.1%, females = 79.3%). Of those who had family in Uganda, 81% of males (*N* =167), and 79.3% of females (*N* = 188) had at least one family member they could talk with about difficulties.

Table 3: Group Participation (N = 713)

GROUP	MALES N (%)	FEMALES N (%)
FARMING GROUP	49 (15.6)	38 (9.5)
REFUGEE WELFARE TEAM	21 (6.7)	12 (3.0)
RELIGIOUS OR SPIRITUAL GROUP	68 (21.6)	91(22.9)
CULTURAL GROUP	12 (3.8)	19 (4.8)
VILLAGE HEALTH TEAM	6 (1.9)	6 (1.5)
PEACE & RECONCILIATION GROUP	16 (5.1)	4 (1.0)
MUSIC OR DANCE	11 (3.5)	16 (4.0)
EDUCATION GROUP	5 (1.6)	3 (0.8)
WOMEN OR MEN'S GROUP	26 (8.3)	50 (12.6)
PSYCHOSOCIAL SUPPORT GROUP	7 (2.2)	10 (2.5)
CHILD PROTECTION TEAMS	9 (2.9)	6 (1.5)
YOUTH GROUP	10 (3.2)	4 (1.0)
SAVINGS GROUP	82 (26)	90 (22.6)
OTHER GROUP	10 (3.2)	8 (2.0)

Note. Other groups included sport, health-related, craft, & Red Cross

Participation in different groups and community organizations in the settlement is shown in Table 3. The most frequent type of group males and females participated in was a religious organization and a savings group. Approximately half of participants (49.9%) were a member of at least one group.

Psychological Distress and Functioning

Psychological distress among the participants was also high. The mean score for the full sample on the PCL-5 was 45.56 (*SD* = 18.5). Although scores were high for both, females reported significantly higher symptoms (*M* = 47.07, *SD* = 18.47) than male participants (*M* = 43.64, *SD* = 18.55), $t(714) = 2.46$, $p = .014$.

Depression scores on the HSCL were also elevated (*M* = 2.77, *SD* = .72), with females again scoring higher (*M* = 2.86, SD = .69) than males (*M* =2.66, *SD* = .74), $t(714) = 3.87$, $p = .001$. Of particular concern, a high percentage of participants reported having suicidal ideation in the past two weeks (see Table 4).

Table 4: Suicidal Ideation in the past two weeks (N = 713)

	MALE N (%)	FEMALE N (%)
NOT AT ALL	149 (47.3)	177 (44.5)
A LITTLE BIT	50 (15.9)	72 (18.1)
QUITE A BIT	49 (15.6)	64 (16.1)
EXTREMELY	67 (21.3)	85 (21.4)

Participants were asked to rate the degree to which posttraumatic stress and depression symptoms interfered with family relationships, social relationships, completion of daily tasks (housework, income generating activities etc.) and participation in community; percentages of participants who reported symptoms were interfering moderately to extremely are shown in Table 5. These figures suggest that although symptoms were high in the sample, less than half of participants reported symptoms interfering with each of these for aspects of life.

Table 5: Symptom Interference with daily functioning (N =713)

	MALE N (%)		FEMALE N (%)	
	YES	NO	YES	NO
DEPRESSION SYMPTOM INTERFERENCE WITH…				
FAMILY RELATIONSHIPS	218 (69.2)	97 (30.8)	315 (79.1)	83 (20.9)
SOCIAL RELATIONSHIPS	230 (73.0)	85 (27.0)	304 (76.4)	94 (23.6)
DAILY ACTIVITIES	246 (78.1)	69 (21.9)	327 (82.2)	71 (17.8)
COMMUNITY PARTICIPATION	194 (61.6)	121 (38.4)	258 (64.8)	140 (35.2)
POSTTRAUMATIC STRESS SYMPTOM INTERFERENCE WITH…				
FAMILY RELATIONSHIPS	139 (44.1)	176 (55.9)	199 (50)	199 (50)
SOCIAL RELATIONSHIPS	119 (37.8)	196 (62.2)	175 (44)	223 (56)
DAILY ACTIVITIES	133 (42.2)	182 (57.8)	219 (55)	179 (45)
COMMUNITY PARTICIPATION	103 (32.7)	212 (67.3)	142 (35.7)	256 (64.3)

However, Figures 3 and 4 show the percentage of people for whom symptoms were interfering with one or more aspects of their daily life. When examining the data in this way, it is clear, that most participants reported symptoms were interfering with at least one aspect of their daily lives. Depression symptoms were rated as problematic by a majority of participants, with 92% reporting symptoms interfered with at least one aspect of their daily life.

Figure 3: Depression Symptom Interference (N = 713)

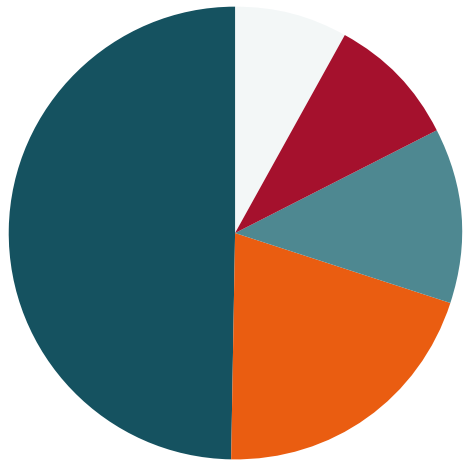


Figure 4: PTSD Symptom Interference (N = 713)

Four areas Three areas Two areas One area None

On the measure of functional impairment, participants were asked to rate the degree to which they have problems with specific tasks, regardless of the reason. As shown in Table 5, most participants reported being able to complete basic tasks like self-care, getting water, with relatively more difficulties with tasks requiring physical exertion or social engagement. Women overall reported more functional impairment then men, $t(711) = 4.01$, $p = .001$.

Help seeking behaviour

Participants were asked whether they were of any mental health or psychosocial support services (MHPSS) in the settlement, and if they had accessed services. Only 14.9% of males and 18.1% of females were aware of MHPSS services; 11.1% of males and 14.3% of females had used services at some point. Participants were also asked to rate how likely they would be to seek help from formal and informal sources. Results are shown in Table 6.

Table 6: Help seeking for an emotional problem

	MALE N (%)	FEMALE N (%)
	(N = 315)	(N = 398)
FRIEND	218 (69.2)	333 (83.7)
MENTAL HEALTH PROFESSIONAL	243 (77.1)	336 (84.4)
NURSE OR DOCTOR	243 (77.1)	298 (74.9)
COMMUNITY HEALTH WORKER	207 (65.7)	220 (52.3)
RELIGIOUS LEADER	280 (88.8)	345 (86.7)
	(N = 273)	(N = 223)
SPOUSE OR PARTNER[A)]	248 (90.0)	167 (74.8)
	(N = 167)	(N = 188)
OTHER FAMILY MEMBER[B)]	117 (70.0)	118 (62.8)

Note. Number who would be likely or extremely likely to seek help for an emotional problem
a)subsample who are partnered, b)subsample with extended family in Uganda.

Main Analyses

A series of multiple regression analyses were conducted to explain variability in symptoms of posttraumatic stress, depression, and suicidal ideation. Given the significant difference on distress measures for males and females, participant sex was included in the model. Hypothesized risk factors were exposure to trauma and ongoing adversity; hypothesized protective factors included social resources. Because of the number of traumatic events assessed, their overlap, and that a majority reported experiencing certain events (e.g., dangerous escape), not all variables are included in the model. Similarly, given nearly all participants reported problems with inadequate food and shelter, only adjustment to the settlement and discrimination for being a refugee were included in the analyses.

The full model for PTSD (see Table 7) was statistically significant F (15,697) = 29.429, $p < .001$, and explained approximately 39% of the variance in symptoms. Statistically significant risk factors, associated with higher symptoms of PTSD were being a female; having been harassed by armed personnel, imprisoned, raped, injured with a weapon, or tortured; having difficulties adjusting to the settlement and experiencing discrimination due to being a refugee. Participation in a group in the settlement was the only statistically significant protective factor; those who participated in at least one group had significantly lower symptoms.

The full model for depression (see Table 7) was also statistically significant F (15, 697) = 21.987, $p < .001$, and explained approximately 32% of the variance in depression symptoms. Statistically significant risk factors, associated with higher symptoms of depression, were being a female; having been harassed by armed personnel, imprisoned, or raped; having difficulties adjusting to the settlement and experiencing discrimination due to being a refugee. Participation in a group in the settlement was again the only statistically significant protective factor.

The full model for suicidal ideation (see Table 7) was also statistically significant F (15, 697) = 17.791, $p < .001$, and explained approximately 28% of the variance. Statistically significant risk factors, associated with more severe ideation were having been abused as child, imprisoned, or raped, and experiencing discrimination due to being a refugee. Participation in a group, cognitive social capital (i.e., a sense of belonging), and having at least one family member to confide in were statistically significant protective factors.

Table 7. Multiple regression analyses (N = 713)

	DEPENDENT VARIABLES					
	PTSD SYMPTOMS		DEPRESSION		SUICIDAL IDEATION	
PREDICTORS	*B* (*SE*)	P	*B* (*SE*)	P	B(SE)	P
SEX	3.868 (1.252)	.002	.204 (.051)	.001	.056 (.088)	.527
CHILDHOOD ABUSE	-.268 (1.263)	.832	.014 (.051)	.782	.209 (.089)	.019
IMPRISONED	3.007(1.328)	.024	.109 (.054)	.043	.532 (.094)	.001
RAPED	3.339 (1.476)	.024	.168 (.060)	.005	.335 (.104)	.001
INJURED WITH A WEAPON	2.879 (1.450)	.047	.069 (.059)	.243	.170 (.102)	.097
EXPERIENCED TORTURE	5.961(1.661)	.001	.087 (.067)	.195	-.040 (.117)	.734
HARASSED BY ARMED PERSONNEL	3.808 (1.667)	.023	.198 (.068)	.004	.050 (.118)	.672
SERIOUS ACCIDENT	3.558(1.258)	.005	.052(.051)	.306	-.012 (.089)	.893
NATURAL DISASTER	2.581(1.218)	.035	.066(.049)	.182	.142 (.086)	.098
ADJUSTMENT TO SETTLEMENT	3.854 (.678)	.001	.137 (.028)	.001	.044 (.048)	.362
DISCRIMINATION	2.342(.566)	.001	.097 (.023)	.001	.193 (.040)	.001
GROUP MEMBERSHIP	-3.596(1.184)	.002	-.195 (.048)	.000	-.360 (.084)	.000
COGNITIVE SC	.496(.529)	.349	-.009 (.021)	.666	-.091 (.037)	.015
FRIEND	-2.118(1.537)	.169	-.022 (.062)	.724	.058 (.108)	.590
FAMILY MEMBER	3.085(1.918)	.108	-.019 (.078)	.803	-.271 (.135)	.046

Note. Sex was coded 0 = Male, 1 = Female. Exposure to potentially traumatic events coded 0 = No, 1 = Yes. SC = Social capital. Friend = having at least one friend to confide in 0 = No, 1 = Yes. Family member = having at least one family member to confide in 0 = No, 1 = Yes. Values in bold are statistically significant.

Participant being interviewed

RESULTS FROM INTERVIEWS

Eleven semi-structured key informant interviews (KIIs) were conducted with actors working in the settlement. Content analysis confirmed the limited access to basic needs and economic opportunities and unpacked the compounded risks for mental health difficulties and functional impairment. Results also highlighted how knowledge and cultural perceptions of mental health impeded help seeking behaviour. Key themes are described below; to protect confidentiality of the informants, each was assigned a number, the type of organization they work in is shown in Table 8.

Table 8. Key Informants

NUMBER	SEX OF KI	ROLE OF KI	ORGANIZATION TYPE
#1	MALE	COMMUNITY FACILITATOR	NATIONAL NGO
#2	MALE	FIELD OPERATION MANAGER	INTERNATIONAL NGO
#3	FEMALE	CLINICAL PSYCHOLOGIST	NATIONAL NGO
#4	MALE	TEAM LEADER	INTERNATIONAL NGO
#5	MALE	DOCTOR, DEPUTY IN CHARGE AT THE FACILITY	INTERNATIONAL NGO
#6	MALE	PROGRAMME MANAGER, PROTECTION RULE OF LAW	INTERNATIONAL NGO
#7	MALE	PROJECT OFFICER, PSYCHOSOCIAL SUPPORT	INTERNATIONAL NGO
#8	FEMALE	FIELD COORDINATOR	INTERNATIONAL NGO
#9	MALE	TEAM LEADER	INTERNATIONAL NGO
#10	MALE	GENDER AND PROTECTION OFFICER	REGIONAL NGO
#11	MALE	PSYCHOSOCIAL COUNSELLOR	INTERNATIONAL NGO

Limited access to basic needs and economic opportunities

Informants considered access to basic needs and economic adversity to be most challenging stressors for the refugees living in the settlement. These issues appeared to influence uptake of MHPSS services, even for those individuals who are distressed, as illustrated by the following quote:

> *(…) for many, most services that is regarded as very important is the one that is addressing basic needs. That is food, shelter, and water. And that is the most cause of distress for people in the settlement. When they come to you, and they are expecting you to provide food, water and you're telling them that you are only providing mental health services, definitely, the attitude changes. (#8)*

KIIs also pointed out how the MHPSS services did not always these challenges, asking for interventions to be better adapted to the culture and context. One informant noted the challenging of implementing interventions from the global north:

> *Most of our interventions are more of western world. And so we need researched interventions that are going to suit the people within. Because, for the biggest part, you see that most of the intervention let's say in psychology are already working on assumption that someone has already gotten the basic need. (#9)*

Within the settlement there are limited interventions addressing the refugees' livelihood, and the present actors often only ensure support for specific groups. This leaves much of the settlement in need of initiatives focused on economic empowerment and force some refugees to seek opportunities within the host community. Neighbouring host community face similar challenges but receive far from the same support. The host communities often see the refugees as highly privileged which can lead to clashes and exploitation of the refugees working there. To avoid tension in the area, it was described in the KIIs how the district advocates for a third of the resources given to the settlement to be shared with the host community.

The economic situation has only worsened during the COVID-19 pandemic. Restrictions on movement have caused income and food rations for each household in the settlement to decrease, as the refugees have not been able to generate a supplementary income. Prior to the pandemic, the economic conditions in the settlement were already not stable and most refugees would only rely on small scale or subsistence agriculture.

Compounded risks for mental illness, suicidal ideation, and limited functioning

The alarming levels of mental health problems were also confirmed in the KIIs. Informants reported the refugees in the settlement experience a range of mental health issues including PTSD, anxiety, and depression because of the trauma they experienced before, during and after their flight to Uganda. The continued situation of adversity and lack of economic opportunities in the settlement were also clearly described to affect the refugees' mental health.

> *It is mainly [PTSD] because of the experiences they have gone through while before coming here. Because of the conflict they were exposed to in their country of origin. They come here may be some of them probably would be better now. They are in this kind gazetted places with limited resources just for survival. When they think of those [limited resources] plus the torture they underwent, people come here [to] tell you 'how I was beaten', 'gang raped'. All those have contributed to PTSD. (#5)*

It has been difficult for MHPSS actors in the area to properly address mental health needs due to the continued stressors, it was described that 'the symptoms surface again most especially when they lack the basics.' Therefore, the KIIs also highlighted the need for MHPSS services and livelihood initiatives to go hand in hand as well as for counselling services to have strong links to protection services.

The compounded effects on the mental well-being have persistent and long-term consequences affecting the residents' ability to function and take part in daily activities.

> *The manifestation we find that someone tells you, 'am not sleeping well, when I think of this', 'I get scared my heart beats a lot.' (…) they are actually losing interest in the little, which they can be able to do. So you may find they don't have interest to do like what they have been doing. Like I have said, some [refugees] do usually casual work, and even some have like businesses around. (#5)*

The KIIs also highlighted that in some cases, the refugees were affected by their mental health issues to such an extent that they completely withdrew from community life and some became suicidal. It was the limited ability to cope with the experienced trauma and distress, and the living conditions in the settlement that fuelled suicidal ideation.

> *Of course, when people are traumatized, depressed, the interactions amongst themselves become problematic. This is in such a way that you're going to have a number of people of that kind into violence. Some have abandoned their families, they feel overwhelmed. If you ran with 7 or 15 children to Uganda and there is nothing you can feed them on, you decide to abandon them. We have had of some cases of suicide or even those who have ideations. They want to kill themselves because of overwhelming burden they have to take care of themselves.*

> *Ideations these are thoughts, they feel it's better to die than to keep suffering, knowing that there is limited hope of going back home and even though they go back home, all that they had have been destroyed.*

> *It has also increased the burden on the medical aspect, where people are frequenting the health facilities because of sleeping difficult, lack of appetite, and stomach issues which are coming from the stress, depression, and so on. (#9)*

Other examples of negative coping mechanisms included committing crimes, substance abuse, violent behaviour, all reactions that affected the whole community. It was clear how mental health challenges transcend the community and have strong implications for the general health of the refugees.

Gendered needs and dynamics

The KIIs provided examples of the gendered-needs and risks that were apparent for the refugees in the settlement. In addressing the situation of economic adversity, it was described how early marriage of girls become a solution for some if their families do not provide for their basic needs.

Survivors of sexual and gender-based violence were highlighted as a specific group struggling with mental health issues. In Figure 1, it was clear how women disproportionately had experienced traumatic events of rape and attempted sexual assault when comparing to men. Moreover, many women and girls also face an increased risk of sexual and gender-based violence in the settlement and the host community while doing their daily chores e.g., collecting firewood or water. Female headed households and women living alone were particularly vulnerable.

A formal referral pathway has been established for the women and girls that are survivors of sexual and gender-based violence (SGBV) to receive the support they need. Furthermore, the KIIs suggested a coordinated effort of working with SGBV actors to identify cases. One informant stressed that when initiatives focused on women and girls only, it has created tensions within households thereby increasing the vulnerability of women and girls. The informant explained:

> *A lot of them [cases of family violence] is the GBV we are talking about. The main thing the women are being over-empowered by us the partners. So they [husbands/family members] think we are making the women big headed. And at some point, they even tell us that: 'You people are focusing on women, and they are becoming unruly in homes!' (#10)*

Thus, any work on this specific group needs to be done in a gender-sensitive and holistic approach that considers principles of doing no harm.

Knowledge, stigma, and cultural perceptions of mental health

Despite the prevalence and severity of problems, there is limited knowledge about mental health among the refugees. Often, they seek help from health centres because they experience somatic symptoms. For example, one informant stated:

> *We have gotten so many referrals from the health centres I think why they always seek services from the health centres in Kyaka II is because some of the symptoms of mental health problems come as somatic in nature that it is to do with one's body; the aching, having a headache, body ach, stomach each, body weaknesses. Only to find out actually there is not anything troubling them in terms of their body they are fine but actually it's in their mental state. So when they are referred here and may be assessments are done and you try to understand the person's history, you find out that it's actually to do with trauma that is causing all these symptoms. The body is reacting to the experiences they went through. (#3)*

The KIIs reported limited knowledge of where to seek help was also an issue:

> *Maybe finally there is knowledge gap. The knowledge gap in a sense that maybe people don't know where to go for mental health services. Additionally, some don't know that it is something that is treatable. (#10)*

In line with limited knowledge about mental health and symptoms, there are also a stigma tied to traditional beliefs about mental illness. The KIIs portrayed how many still perceive mental health problems as witchcraft, a curse and something contagious e.g. if you touch someone with epilepsy you will also become epileptic. This stigmatization also increases the vulnerability of these refugees with risks of violence and marginalisation within the community. One informant stated:

> *PTSD or other disorders, they may not be able to fit within their friends or society and are, thus vulnerable and prone to a lot of violence. For example, they may be stigmatized by fellow refugees, people around them, etc. and may also be prone to sexual violence especially rape. For instance, if someone like a single male/female is living alone without any family, they tend to be isolated. When someone is isolated is going through such incidents, they are vulnerable and prone to all protection risks. (#8)*

The stigma is so pervasive that it also affects help seeking behaviour of the refugees. While some refugees may have the knowledge to identify symptoms, they would still not seek help because it would label then of being "mad" or even psychotic.

> *(…) people don't know about mental well [being]. So like someone suffers all those things but they actually don't [know] that is mental illness. So, because when you [don't] know, you cannot act. So number one thing is failure to understand that they are having mental illness. The next thing if someone finds out, they get scared how will people hear, maybe am going to this place for such and such services. (…) Still, may be other factors now coming like stigma. Like how will they see me going to these mental people? (#5)*

Another said:

> *Yes, there is stigma because for many people seeking the service for mental health, they are already dubbed as mentally ill. So someone being asked where have you been, and you say I am from seeing a psychiatric or psychologist that means you're mentally ill, so they will call you 'mwenda wazimu', 'you're mad person!', 'you are throwing stones!' The person will be asked: 'why are you going there? Yet you haven't reached a stage of undressing?' This is already stigma. (#9)*

The KIIs also pointed out an existing notion of when someone could and should seek help, 'so because of stigma, somebody decides that they would rather stay home than going to the facility.'

The stigmatised perception of mental health was described as not only evident for the refugees in the settlement, but also seen among Ugandans in the broader community.

> *(…) also a lot of stigma and for people not just for the refugees, but even the nationals up to now we are struggling with the fact that people don't believe that mental health illness are actually there. People still attribute it to witchcraft. And because of that, they would rather keep quiet. Of course, people will still look at you in a funny way. But also they will stigmatize you. (#10)*

Perceptions and attitudes towards mental health, was not only about lack of knowledge and internal/external stigma. There is also a cultural element related to norms on the overall understanding of mental health and resilience that can serve as an access barrier.

> *Our understanding [of mental health] as professional has also caused a barrier. From the refugees also that understanding is not yet there, the importance of why they need to go and talk to someone about their issues (…)*
>
> *So that also is a barrier in a way that mental health services are seen as more of a Western culture thing than an African thing. We tend to think that we are strong enough; we have the capacity to be resilient. So the perception of mental health is a barrier itself. (#9)*

Increased awareness raising and sensitization of mental health were identified as a need and something crucial to go hand in hand with all initiatives in the settlement. Some organisations are already doing awareness raising in the settlement with promising results e.g., training community elders in identifying symptoms and referral to services. The KIIs stressed how the importance of continued awareness raising and training of senior members of the community was a key part of these initiatives. It also showed the important need for referrals between community representatives, and health care services and providers.

Outreach and access to services

Despite cultural and social barriers in seeking and accessing help, transportation to health facilities was a major access barrier being both costly in time and transport. For the refugees that make it to the clinic there are several additional access barriers, as illustrated by the following quote.

> *The refugees in this settlement do access mental health services although the support that is given is not enough, especially the medicine. You find that the medicine for those disorders is quite expensive. The government tries to provide the medicine but what is given is insufficient and unsustainable because the government is so constrained. (#8)*

Access to health care facilities and MHPSS services have also been affected by the COVID-19 restrictions confining all the settlements› refugees to their home. Restrictions have increased the vulnerability for some households. For example, one informant noted:

> *(…) [during] COVID-19 people did not access medication, did not get transport to take them to hospitals etc. so that means that someone who is supposed to be taking care of the family has to take care of these particular children or person who is at home with such kind of mental problem. This means that once a person is always at home there will be shortage of food within the family and this will lead to other problems like domestic violence, children dropping out of schools just to take care of the person who has got a mental problem. So we have tried to do our best because we move with [the refugees] to do counselling. #6*

A tollfree MHPSS helpline had also been established for the refugees to call with any mental health issues. Following the helpline service would ensure follow up with the individuals.

Cross-collaboration between actors in the settlement

The importance of cross-collaboration between actors in the settlement emerged as a key theme from the KII's. However, there were differing perspectives on the effectiveness of coordination. Within the settlement, there is already a strong hierarchy and consortium structure for actors collaborating under the regulation of UNHRC and OPM. Some informants noted significant cross-collaboration between organisations regarding MHPSS and protection services, in terms of the overall coordination, case conferences, referrals for services between the partners and communications. For example, one informant noted:

> *We have mental health psychosocial sub-working group which meets every month and discussing different health aspects. It is a mental health psycho-social sub working groups. Which has partners that provide mental health and also psycho-social services, so they meet every month deliberately on different aspects of their activities for the whole month. As they share work plans and even challenges. (#9)*

Another said:

> *(…) we have the coordination meeting on monthly basis whereby all the partners sit and share the challenges and achievements and look forward to see how they can harmonize and overcome such kind of challenges. That means we always share information as the whole team, and we normally have several meetings in the settlement that brings us together. (#7)*

To avoid duplication of work, a database has been created among the actors to share their work despite the partners working in different zones. This also include a shared form for referral while the working group is working towards formalizing a referral pathway among the MHPSS actors. Despite the already existing collaborations between actors in the settlement, other informants expressed a need for the overall collaboration to be strengthened and for a clear overview of referral pathways, actors to refer to and follow up after referral. One informant said:

> *The overwhelming numbers sometimes and the limited resources vis-à-vis the mental health experts, so when a client is referred, it doesn't mean that the person will be worked upon right away for it takes some time. Some conditions can be managed at its early stages, though some clients come out when the condition has aggravated. (#6)*

KIIs also highlighted the importance of working with and including refugee volunteers in initiatives, while building on existing community structures such as the Village Health Teams and ensure community dialogue to address the perception and use of available MHPSS services. Inclusion of refugee volunteers also have its ethical challenges that needs to be considered. Additionally, it was also described how churches played a significant role as many people would seek help there. This also pointed to the need for involving the churches in any formalised referral network.

DISCUSSION & KEY FINDINGS

Results of the study showed an exceptionally high rate of distress among adult refugees in the Kyaka II settlement. Approximately three-quarters of the sample had elevated symptoms of posttraumatic stress and depression, and nearly half reported symptoms to be so severe they were unable to successfully engage in tasks of daily life, including caring for family and taking part in community activities. Rates of distress were more than twice as high as those found on average among conflict affected populations (Charlson et al., 2019). Of particular concern is the percentage of refugees who reported suicidal ideation: 36.9% of males and 37.5% of females had frequent thoughts of suicide; more than half had suicidal thoughts at some point in the last two weeks.

Although higher than the global average, rates of distress are consistent with recent research of Congolese refugees in other settlements in Uganda (Ainamani et al., 2017; Bapolisi et al., 2020; Ssenyonga et al., 2013). Studies from representative and convenience samples have found between 65% (Bapolisi et al., 2020) and 89% (Ainamani et al., 2017) of participants, respectively, met criteria for PTSD. High rates of suicidal ideation have been documented among other populations of refugees in Uganda (UNHCR, 2020), and among Congolese refugees in Rwanda (Ingabire & Richters, 2020).

Our results indicated that exposure to certain forms of interpersonal and other traumatic events (see Table 7), along with difficulties adjusting to the settlement and experiencing ongoing discrimination based on being a refugee, were significantly associated with more severe symptoms of PTSD and depression. It was not possible to include variables assessing lack of basic needs in the main statistical analyses because nearly all refugees reported this as a serious problem. However, based on reports from key informants, the stress from living in conditions of extreme economic deprivation with limited opportunities for improvement is negatively impacting on the mental health of the population. Being a member of at least one social group was the only significant protective factor, with a negative association with symptoms of posttraumatic stress and depression.

Participants were more likely to report frequent suicidal ideation if they had been abused as a child, imprisoned, or raped, and experienced ongoing discrimination. Being a member of at least one group, feeing a sense of connection to the community (i.e., cognitive social capital), and having at least one family member to confide in about their difficulties, were each associated with lower suicidal ideation. The finding on the importance of family and social connection is consistent with a recent qualitative study of adult Congolese refugees in Rwanda that showed family conflict was a trigger of suicidal ideation (Ingabire & Richters, 2020). Ingabire and Richters (2020) also found that refugees with frequent suicidal ideation experienced loss of dignity by not being able to take care of their family and had a low sense of belonging to the community.

Findings of this study also highlighted the gendered vulnerabilities and needs among the refugee population in Kyaka II. Women reported higher rates of sexual violence, which in turn was significantly associated with more severe posttraumatic stress, depression, and suicidal ideation. Compared to men, women also had more functional impairment, and significantly higher rates of nearly all acts of partner violence that were assessed. When addressing the increased vulnerabilities, the KIIs highlighted how women-focused initiatives can influence and change gender dynamics, power and norms within households and cause tension. This finding is consistent with qualitative research of Congolese refugees in Rwanda that found changes in gender dynamics contributed conflict in many households (Ingabire & Richters, 2020). Future work needs to be culturally sensitive when addressing gendered issues.

Our KII's and findings from other studies in Kyaka II (ACTED, 2019) indicated that certain groups within the settlement are particularly vulnerable, including survivors of torture and sexual violence, those affected by ongoing intimate partner violence, female headed households, and people with disabilities. These individuals are more likely to experience higher levels of distress, experience extreme poverty, and be excluded from social networks. Other research has also shown people with disabilities are among the most marginalized in the settlement and have even more difficulties accessing healthcare (ACTED, 2019). These findings highlight the need for incorporating gender-sensitivity as well as intersectionality within frameworks addressing access to MHPSS to ensure inclusive and responsive interventions.

Cultural sensitivity also proved crucial when considering perceptions of mental health and well-being, as KIIs mentioned how understanding of mental problems stigmatized people, excluded them from community life and created a barrier for help seeking. A 2019 study in Kyaka II confirms this finding; 75% of refugees considered 'mental health' to be a negative term, implying illness, and 50% believed mental health difficulties were shameful (ARC, 2019). Other studies have also described how 'mental health' has negative connotations and associations to being "crazy", "lunacy" and "abnormality" (Colucci et al., 2015).

Despite reports from KII's of high levels of stigma around mental health, more than 77% of men and 84% of women in our study reported they were willing to seek help from a mental health provider for an emotional problem. The reason for this discrepancy is not clear from the data; however, intention to seek help does not always predict later behaviour. Help-seeking behaviour is also closely related to awareness and access to existing services. Despite multiple actors offering psychosocial support in the settlement, in our study, only 15% of males and 18% of females were aware of any services, and few had received help. Similarly, a household survey conducted by UNHCR in 2018, found 83% of people with psychological distress in Kyaka II were not able to access services and only 13% had been reached by MHPSS awareness campaigns. These results highlight the need for continued MHPSS awareness campaigns.

A key barrier to help-seeking appears to be the dire economic situation in the settlement. According to our KII's, when offered MHPSS, many refugees are reluctant to take part because their basic needs are not met. While this is understandable, the findings show mental health difficulties are interfering with tasks of daily life for a substantial percentage of the population. If not addressed, these difficulties can create a vicious cycle whereby distress interferes with getting basic needs met, which in turn amplifies distress (Lund et al., 2011). This cycle potentially contributes to suicidal ideation, particularly among those lacking family and social support (Ingabire & Richters, 2020).

Limitations

Results must be considered together with the study limitations. Collecting data during the daytime only could have resulted in a sample that is not representative of the population. It is possible, for example, that people who were more highly distressed were also more likely to be home during the daytime, whereas relatively more healthy individuals were out of the house engaging in work or other activities. This is reflected in the fact that only approximately 10% of males and 5% of females in our sample were engaged in an income generating activity whereas UNHCR (2020) estimated almost 28% of the population in Kyaka II are engaged in an income generating activity.

Data could also be biased due to the nature of self-reporting. It is possible some participants did not feel comfortable disclosing information about personal experiences. It is also possible that some participants overreported symptoms.

PTSD and depression are psychiatric concepts from the Global North. Although other research has confirmed their relevance among Congolese refugees, the measures used may not fully capture the emotional experiences of the population. Additional work is needed to identify culturally based expressions of distress.

There are other limitations related to the questionnaire used to assess refugees. We did not specifically ask about disability status which is a limitation given other research (ACTED, 2019) has shown people with disabilities are among the most marginalized in the Kyaka II settlement. Additionally, acts of partner violence were assessed but not frequency or context, so it was not possible to determine the severity of the problem.

RECOMMENDATIONS

Results of the study highlight several potential action points for actors working in the settlement as well as recommendations for the implementation processes. Perhaps most urgent is the need for suicide prevention programming. Further, despite ongoing initiatives, there continues to be a need for mental health outreach and additional services that are trauma-informed and tailored to reach the most vulnerable. Initiatives aimed at improving the social cohesion of communities and social networks, particularly among refugees who are marginalized may be beneficial for supporting mental health. Regarding implementation, study findings highlight the importance of tailoring MHPSS interventions to be more culturally appropriate and gender sensitive as well as the need for enhanced multi-sector collaboration. Each of the recommendations is elaborated below.

Adapt and implement suicide prevention programming

Results point to an urgent need for suicide prevention programming in the settlement. Suicidality has been recognized as a pervasive yet under-addressed problem in humanitarian contexts and little is known about effective preventive approaches in these settings (Haroz et al., 2020). Further research is needed to identify and adapt approaches that can be feasibly and effectively implemented in humanitarian settlements in Uganda. Our study demonstrated that having been exposed to certain types of traumatic events (i.e., physically abused as a child, imprisoned, raped) and experiencing ongoing discrimination for being a refugee were risk factors for frequent suicidal ideation. Being a member of at least one social group, feeling connected to the community, and having at least one family member to confide in were protective factors. Other research also highlighted the importance of social connection in relation to suicidality among Congolese refugees (Ingabire & Richters, 2020). It is recommended that both risk and protective factors be considered when developing programming in this context.

Enhance mental health outreach

Study findings indicate the need for additional MHPSS outreach and awareness raising. Despite multiple actors offering psychosocial support in the settlement, in our study, only 15% of males and 18% of females were aware of any services, and few had received help. This is only slightly better than findings of a 2018 study that found only 13% of the settlement had been reached by mental health awareness campaigns. Informants in this study indicated that many refugees were not aware of the mental health impacts of trauma and adversity and that stigma around mental health difficulties is pervasive, also affecting refugees' help-seeking behaviour. It is important that outreach and awareness raising activities are adapted to the cultural context with an emphasis on the reduction of stigma.

Improve access to traumainformed MHPSS, with an emphasis on reaching the most vulnerable

Specialized mental health services for people with PTSD or depression are still limited within the settlement. Given the high percentage of people suffering from trauma-related mental health difficulties, there is a clear need for additional trauma-informed MHPSS services.

As noted by KIIs, it is important for MHPSS interventions to be more relevant and accessible to the most vulnerable groups, identified by our study and other research in the settlement (ACTED, 2019) as survivors of torture and sexual violence, those affected by ongoing intimate partner violence, female-headed households, and people with disabilities. These individuals are more likely to experience higher levels of distress, experience extreme poverty, and be excluded from social networks. Therefore, it is important to consider how trauma history, gender and disability relate to access and benefit from MHPSS.

Strengthen community and social networks

Findings show the importance of social connection and cohesion within the settlement. Building on existing support systems in a humanitarian setting can help to ensure MHPSS interventions are relevant and that scarce resources are used for reaching populations who require formal interventions. Religious and spiritual leaders, for example, have a prominent role in many communities; in our study, nearly 90% of participants stated they would seek help from religious leaders for an emotional problem, and around half actively participated in spiritually oriented social groups. Key informants reported refugees often seek help first from the church when they are suffering. Religious leaders and other local community networks could play an important role in reducing stigma around mental health difficulties, improving awareness of MHPSS services, and providing support and referrals.

Adapt MHPSS approaches to be more culturally appropriate and gender-sensitive

In a priority-setting exercise over ten years ago (Tol et al., 2011), researchers, practitioners, and policymakers identified the importance of ensuring MHPSS interventions in humanitarian settings are culturally relevant and gender-sensitive; yet adaptation is still not common in practice. According to the KIIs, the existing MHPSS interventions may not be appropriately tailored to the cultural context. Evidence from other settings suggests that MHPSS is viewed more favourably (Sangraula, 2021) and is more effective (Benish et al., 2011) when local concepts of distress are integrated into interventions. In a study among Somali refugees in urban Kenya, for example, Im et al. (2017) found that people were discriminated against when they were labelled with psychiatric disorders, because mental illness was translated as "craziness (waali)." Adapting terminology to the local context, rather than only using psychiatric terms from the Global North, may help normalize distress and reduce stigma around seeking help for mental health difficulties (Sangraula, 2021).

Our findings also highlight the importance of gender sensitivity in MHPSS interventions. Women had higher levels of distress and more functional impairment compared to men. Women were also exposed to higher rates of sexual and partner violence, both of which are associated with elevated symptoms. According to KIIs, in the past, interventions that were perceived by the community as only focusing on the needs of women led to tensions within households. Therefore, although there is a clear need for interventions focused on the unique needs of the women in the settlement, it is important these are implemented with consideration of the cultural context to avoid worsening vulnerabilities.

Support multi-sector collaboration

Difficulties documented in this study are unfortunately not unique to refugee settlements in Uganda. Effectively addressing high rates of emotional distress among populations also suffering from lack of basic needs is a challenge in diverse humanitarian contexts around the world. Multisector collaboration and integration of MHPSS into other sectors (e.g., livelihood, protection) has been highlighted as the way forward to address the complex needs of populations in humanitarian settings, yet there are substantial knowledge gaps on how to best implement these approaches (Tol et al., 2020). It is important that future interventions take a collaborative approach with actors implementing livelihood or economic empowerment programmes to help ensure once mental health difficulties are addressed, refugees can better work toward having basic needs met.

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ACTV – African Centre for Victims and Torture Victims

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TPO - Transcultural Psychosocial Organisation

TPO was set up in 1994 primarily to provide mental health and psycho-social support services to refugee and post conflict communities. TPO is a rights-based NGO that works in partnership with communities, civil society, the private sector and government in Uganda, Somalia, South Sudan, Congo, and Liberia. TPO Uganda is working to improve the wellbeing and social functioning of persons affected by poor mental health and psychological distress as well as reducing vulnerabilities in humanitarian settings by supporting families and communities to cope better and reduce risks of exposure to further harm. TPO work is also covering children and women's rights and improvements of socioeconomic wellbeing of households.

CBM—Christian Blind Mission

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By Jessica E. Lambert & Elise Denis-Ramirez

Field Study prepared in collaboration between the authors, ACTV – African Centre for Victims and Torture Victims, TPO - Transcultural Psychosocial Organisation, CBM - Christian Blind Mission and other contributors stated in the acknowledgements

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