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ABOUT THE AFRICAN JOURNAL OF TRAUMATIC STRESS

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

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

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

All opinions and articles published in the AJTS will reflect views of the authors and not necessarily views of the Journal. Prejudicial and hate literature will not be allowed. The authors will have to accept the terms and conditions as outlined in the "Guide to Authors" page of the Journal. Papers submitted to the AJTS will not have been submitted for publication elsewhere. After acceptance for publication, the author(s) will transfer copyrights of the accepted articles to the AJTS unless if accepted by the copyright holders.

The AJTS is published by Makerere University College of Health Sciences in collaboration with the Peter C. Alderman Foundation (PCAF). There will be two issues per year. For more information please contact the AJTS website www.petercaldermanfoundation.org

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ABOUT THE PETER C. ALDERMAN FOUNDATION

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

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

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

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

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

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

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

PETER C. ALDERMAN FOUNDATION

Sowing the seeds that heal the sorrow

EDITORIAL

Many workers helping traumatized people in Africa (NGOs, FBOs, CBOs, health workers, lawyers, human rights activists, various government ministries etc) have long waited to have a medium through which they would share their collective knowledge, skills and experiences. The birth of the African Journal of Traumatic Stress (AJTS) is established in this need. The AJTS is a multidisciplinary non-sectarian journal with no ideological or philosophical underpinnings save for the belief in the universal respect to human rights, for the core values of caring and rehabilitation of traumatized victims and for the prevention of torture and organized violence.

In this inaugural issue, the AJTS features the original work of an African pioneer, the late Dr. James Walugembe, who documented war related Post Traumatic Stress Disorder in Uganda and then went on to dedicate his life to treating the poor and down trodden victims of political violence in Uganda. This issue also features various articles from the researches and experiences of various health workers treating traumatized victims of war and political violence in various parts of East Africa. The collective wisdom in those articles is that such mass trauma has had far reaching deleterious effects on the physical and mental health of Africans and it has retarded nearly all socio-economic development efforts thus creating mass poverty and contributing to the spread of epidemics including HIV/AIDS.

The AJTS intends to champion and bring to the forefront the heroic efforts of the often silenced and sidelined voices of the workers helping the masses of the traumatized victims in Africa.

The AJTS acknowledges and is very grateful to the Peter C. Alderman Foundation and to all the Alderman family who have generously sponsored the publication of this journal.

Long live African Journal of Traumatic Stress. We serve to heal.

A pioneer's look at psychotrauma in Uganda: "Post-traumatic stress disorder as seen in Mulago Hospital Mental Health Clinic (1992)"

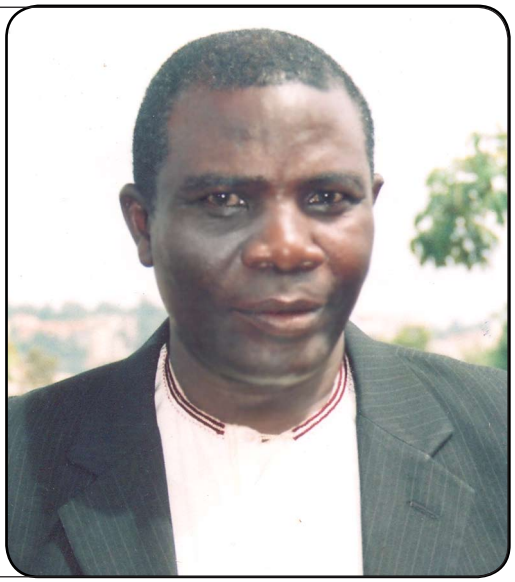
James Edward Walugembe (Post-humus)[1]

[1] Butabika National Psychiatric Referral Hospital

Abstract

Dr. Walugembe pioneered the investigation of the psychological effects of war trauma amongst patients in Uganda when the diagnosis of Post Traumatic Stress Disorder (PTSD) was not yet widely accepted. He did this at the Mental Health Clinic (MHC) at Old Mulago Hospital as part of his Master of Medicine degree (M.Med) in Psychiatry in 1992. He followed this work through with more research and treatment of war-related PTSD amongst the down-trodden survivors of Uganda's various wars till his death in 2009. The following paper summaries key results of his M.Med thesis as written in his own words and delivered by Prof. Seggane Musisi on the anniversary of the First PCAF – Dr. James Walugembe Memorial Lecture, at Butabika Hospital, Kampala, Uganda on July 20th 2009.

AJTS 2010: 1(1): 6-18



Introduction

Change and adjustment are part of life, and stresses affect everyone. However, stressful traumatic events can sometimes be overwhelming, shattering a person emotionally and leaving a feeling of total helplessness. When a person is faced with a threat to life, a risk of injury, or a loss of security, usual coping mechanisms can fail. Psychic trauma occurs when an individual is exposed to an overwhelming event that results in helplessness in the face of intolerable danger, anxiety and instinctual arousal[1]. The resulting psychological or physiological tension can lead to various emotional and physical symptoms and illnesses. Such traumatic events can bring on a specific constellation of severe, prolonged, disabling symptoms, an illness now known as Post Traumatic Stress Disorder (PTSD)[2]

Post traumatic stress disorder (PTSD) was first introduced into the official American psychiatric nomenclature in 1980 following its formal recognition as a clinical entity by the American Psychiatric Association and its inclusion in the DSM III[2]. However, the history of PTSD has been very much tied to the history of war.

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PTSD can occur following a traumatic event that is outside the range of normal human experience and would be distressing to almost anyone. The patient may have been the direct victim of the trauma, participated in the traumatic event or just witnessed it. The common traumas involve either a serious threat to one's life or physical integrity; a serious threat or harm to one's children, spouse, or other close relatives and friends, sudden destruction of one's home or community; or seeing another person who has already been, or is being seriously injured or killed as a result of an accident or physical assault. In some cases the trauma may involve learning about a serious threat or harm to a close friend or relative, e.g. that one's child has been kidnapped, tortured or killed.

Other stressors producing this disorder include natural disasters (e.g. floods, hurricanes, landslides, earthquakes), accidental disasters (e.g. car accidents with serious physical injury, airplane crashes, large fires, collapse of physical structures), or deliberately caused disasters (e.g. fires, bombing, torture, death camps). The trauma may be experienced alone (e.g. rape or assault) or in the company of other groups of people (e.g. military combat) or as mass trauma as when civilians are massively attacked in war.[2]
The fact that chronic psychiatric morbidity can develop from PTSD has been well described,

along with resulting impairment in employment, interpersonal relationships, attachment formation, poor impulse control, abuse of alcohol and other substances [3,4,5] and increased mortality from unnatural causes[6].

Helzer et al[7] found a 1.0% life time prevalence of the illness in an epidemiological study in a catchment area in St. Louis, USA. Numerous other studies of PTSD have been done on trauma victims, war veterans and residents of communities exposed to disaster. The "concentration camp syndrome" of 1947 and 1948 was described by Thygesen in 1954, among survivors of concentration camps who lived in Copenhagen between 1941 and 1945[8]. Askevold described similar symptoms among Norwegian convoy sailors during World War II and he called the condition "The war sailor syndrome". Komros[24] described it among veteran combatants in the Vietnam War. Burgess et al[11] described the "rape trauma syndrome" in American women who had been raped. The National Vietnam Veterans Readjustment study by Kulka et al[12] estimated that 479,000 Vietnam veterans suffered from PTSD and an additional 350,000 veterans had partial PTSD.

Symptoms of PTSD have been described in residents of cities in which racial riots had taken place in USA[13,14]. Similar symptoms have been described in people exposed to community disasters such as tornadoes, earthquakes and explosions[15, 16] or bombings during wars[17,24] and the urban and ethnic clashes in Belfast, Northern Ireland [18,19]. Systematic research studies have demonstrated the relationship between exposure to a traumatic event and the number and persistence of PTSD symptoms.

Shore et al[20] demonstrated PTSD symptoms which persisted in some patients among a population which was involved in the Mount St. Helens disaster, a volcano which erupted with a lot of disastrous consequences. Studies have examined psychiatric symptoms in groups of Southeast Asian refugees[21,25]. For example Mollica et al (1987) in a study of 52 Southeast Asian refugees found that 50% met DSM III criteria for PTSD[21].

Definition of PTSD

The DSM-III-R criteria necessary for diagnosis of PTSD are summarized below[2]:

Criterion A: Trauma Exposure

The person has experienced an event that is outside the range of usual human experience and would be markedly distressing to almost anyone, e.g., serious threat to one's life or physical integrity, harm to one's children; spouse, close relatives, or friends, sudden destruction of one's home or community, or seeing another person who has recently been, or is being seriously injured or killed.

Criterion B: Re-Experiencing

The traumatic event is persistently re-experienced in at least one of the following ways:

- recurrent and intrusive distressing recollections of the event,
- recurrent distressing dreams of the event
- sudden acting or feeling as if the traumatic event were recurring,
- Intense psychological distress at exposure to events that symbolize or resemble an aspect of the traumatic event including anniversaries of the trauma.

Criterion C: Avoidance

Persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness (not present before the trauma), as indicated by at least three of the following:

- efforts to avoid thoughts or feelings associated with the trauma,
- efforts to avoid activities or situations that arouse recollections of the trauma
- inability to recall an important aspect of the trauma (Psychogenic amnesia)
- markedly diminished interest in significant activities
- feeling of detachment or estrangement from others
- restricted range of affect
- sense of foreshortened future.

Criterion D: Hyperarousal

Persistent symptoms of increased arousal as indicated by at least two of the following:

- difficulty in falling or staying asleep
- irritability or outbursts of anger
- difficulty in concentrating
- hypervigilance
- exaggerated startle response
- physiologic reactivity upon exposure to events that symbolize or resemble an aspect of the traumatic event.

Criterion E: Duration

Duration of disturbance (symptoms in B, C and D) of at least one month and to specify delayed

onset if the onset of symptoms is at least six months after the trauma.

The DSM-III-R[2] definition of PTSD recognizes that not all victims of disasters are necessarily normal personalities, although the stressor must be of sufficient severity to invoke a syndrome in most people. Consequently the disorder may be diagnosed in people who had a prior psychiatric illness. The DSM-III-R definition also recognizes that people who develop symptoms of PTSD may at the same time develop another mental disorder. Finally the definition recognizes that PTSD can be chronic and some stressors can be chronic e.g. living in concentration camps.

PTSD Research in Uganda

Bracken et al[22] (unpublished) working with The Medical Foundation of Britain, under the auspices of the Ugandan Ministry of Health, studied some of the effects of torture and more generally the effects of war-time violence on individuals and communities in Uganda. In 1987 this London-based Medical Foundation for the care of victims of torture began a small project in Uganda to provide care specifically for victims of war-trauma and torture. The original plan was to use the available mental health facilities to collect patients. It was when few patients turned up that an idea was conceived to open up a specialized centre in the capital Kampala away from the stigma attached to the Mental Health Clinic (MHC), where referred patients could be assessed and treated. Referrals were encouraged from various sources such as hospitals, church groups and other aid organizations.

The first problem encountered was the scale of the problem. Many people in Uganda had experienced various degrees of personal suffering as a result of war thus defining who was a true 'client' became a problem, hence creating the problem of overdiagnosis resulting in too many patients who could not be assisted. Secondly the majority of patients were from rural areas, and the centre in Kampala was inaccessible to them because of poverty, poor roads and lack of transport.

The third problem was the danger of undermining local individual and community responses to trauma. In most African societies emphasis is placed on the maintenance of very strong family bonds as many of the effects of violence are dealt with within the extended family. In addition Uganda has an extensive network of traditional healers. As many forms of mental distress are perceived as having a supernatural causation in Uganda, they are dealt with by traditional healers. Western medicine is thought to be of no help to these disorders [36,37]. The fourth problem was the fear that the centre would undermine the concept of Primary Health care which encourages local communities and health workers to define and deal with their own health needs. Following a review of these problems the idea of a special centre was abandoned and it was decided to combine clinical work and research with teaching and training.

The conclusion by Bracken et al[22] was that there is no special knowledge necessary to deal with the effect of violence. To Bracken et al, what was required was a sympathetic ear and a genuine attempt to understand the person's suffering[22]. Such care, they concluded, could be provided by all levels of medical workers from primary level to consultant level.

It is only when there were severe physical or psychiatric problems that referral to a specialist was required.

No study had been carried out by any Ugandan researcher on PTSD despite more than 25 years of civil strife, wars, insurgences and urban violence ('panda gari'). This study sought to bridge this knowledge gap.

Research Question

Research done by Bracken et al[22] (unpublished) in Uganda among people in the war ravaged area of Luwero Triangle, (an area to the northwest of Kampala) indicated that some of the subjects investigated had symptoms compatible with a diagnosis of PTSD[2]. However hospital records at the Mental Health Clinic (MHC) in Old Mulago Hospital showed that the disorder was not being diagnosed by psychiatrists[23]. The research question then was therefore to find out whether the condition existed patients were registered in MHC during the study period, of these 180 were very psychotic and destructive and had to be transferred immediately to the National Mental Hospital Butabika. The remaining 380 patients were eligible for enrolment in the study. Every other patient was enrolled in the study making a total of 190 patients. Ninety patients were dropped out of the study (50 because they were review patients; 20 because they failed to comprehend questions asked during the interview; and 20 because they did not give consent).

at all as defined in DSM III among patients attending the MHC in Old Mulago Hospital; and if so, to what extent was PTSD being under diagnosed by practitioners working in the MHC clinic of Mulago Hospital.

General Objective of the study

To determine the prevalence of PTSD among new patients referred to the psychiatric out patient department of the MHC Old Mulago hospital during a three-month period from 1st February to 30th April 1992; and to assess the comorbidity of PTSD with other psychiatric illnesses found in the clinic.

Specific objectives

1. To describe the symptoms of PTSD as defined by DSM-III-R as existing among patients attending MHC Old Mulago hospital and to find out what kind of patients suffer from the disorder.
2. To determine the prevalence of PTSD among patients referred to the psychiatric out-patient department Old Mulago during a three-month period from 1st February to 30th April 1992.
3. To assess the comorbidity of PTSD with other psychiatric illnesses; in particular to find out with which other disorders it tends to appear.
4. To evaluate the common causative traumatic events of PTSD among patients referred to MHC Old Mulago.

Hypotheses

1. It was hypothesized that PTSD was common among MHC patients based on the history of exposure to very traumatic events as reported by patients referred for psychiatric treatment at the MHC Old Mulago.
2. Patients with PTSD frequently had another psychiatric disorder (comorbidity).

Methodology

Study site and study population

The study was carried out at the Mental Health Clinic (MHC) which is located at Old Mulago Hospital 3km from the capital city of Kampala. Old Mulago is part of the Mulago Hospital Complex (one of two national tertiary referral hospitals). The Mental Health Clinic is the referral psychiatric out patient clinic where patients thought to require psychiatric treatment are referred from the whole country. The clinic is run by a team of psychiatrists each one with a specific day of the week when he/she sees his/her patients. The MHC is open Monday to Friday but is closed on weekends and public holidays.

The clinic receives an average of 5 new patients every day, but this number fluctuates due to a number of reasons e.g. medication availability. When the supply of drugs is low as was the case when this study was carried out, the attendance at the clinic is very poor, some days may pass without registering a new patient. The psychiatrists are assisted by postgraduate students, medical officers and psychiatric clinical officers. The psychiatrist on duty:-

- sees all new patients referred to the clinic,
- old patients who are not improving on treatment and
- old patients who have relapsed or have developed new problems.

Patients seen in MHC are treated either as outpatients, or in case of severe illness, are admitted on ward 16 at Old Mulago a small teaching ward attached to MHC. Others are referred to the National Mental Hospital at Butabika. The MHC also serves as a review centre for outpatients and patients discharged from Butabika hospital and ward 16 as well as from the general wards of Mulago Hospital Complex.

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Study Design: This was a cross-sectional descriptive study.

Study Sample

The mode of referral of patients to MHC varied: some patients came to the MHC by themselves without being referred; others were referred by a relative, school teacher or employer who had

reasons to believe that the individual required psychiatric services; others were brought in by police, prisons or members of the Resistance Councils (the equivalent of local chiefs); yet another big group was referred by Health Workers from any of the health units around the country.

Sample Size

This was calculated to be 100 patients based on the Kish and Leslie formula for descriptive studies[9] and on prevalence of PTSD on other studies in war situations [21, 24, 25.]

The accessible population consisted of all new patients referred for the first time to MHC during the three-month period 1st February to 30th April 1992. A total of 560 patients were registered in MHC during the study period, of these 180 were very psychotic and destructive and had to be transferred immediately to the National Mental Hospital Butabika. The remaining 380 patients were eligible for enrolment in the study. Every other patient was enrolled in the study making a total of 190 patients. Ninety patients were dropped out of the study (50 because they were review patients; 20 because they failed to comprehend questions asked during the interview; and 20 because they did not give consent). This latter group consisted mainly of admitted private patients who despite adequate explanation were suspicious about the purpose of the study. The resulting sample was made up of 100 patients: 55 males and 45 females.

Criteria for inclusion/exclusion

All consecutive new patients referred to the MHC during the three-months period 1st February to 30th April 1992 provided they consented to participate in the study were eligible to be included in the study. Patients who were too psychotic to understand the questions and to give consent or appropriate answers were excluded from the study. There was no follow up of patients.

Ethical Considerations

Informed consent

All study participants were invited to sign/thumbprint an informed consent form after a careful explanation of the purpose of the study. Participation was voluntary and any patient who refused to participate in the study was not denied treatment facilities. Patients who agreed to participate had to abide by the study protocol.

Confidentiality

Since information obtained from the study was of a personal nature, every effort was made to ensure that the information was not divulged to anybody or made public without removing personal identities. Patients were assured of strict confidentiality. Personal identified were removed from the compiled data.

Potential benefit and risks

The study was free of physical risks since no invasive procedures were performed on the patient. However some subjects may have experienced increased PTSD symptoms in the interviews. Potential benefits included making the correct diagnosis (of an hitherto unsuspected psychiatric illness) and instituting the specific treatment i.e. specifically treating those who re-experienced the PTSD symptoms in the interviewing[3,4,5].

Instruments and Procedures

The Study Instruments were:

Socio demographic Questionnaire

Data was collected by means of a precoded, pretested structured questionnaire administered by the author. Information was gathered from respondents on demographic variables including; name, age, sex, tribe, marital status, educational background, occupation, religion, district of origin, district of present residence.

Trauma Events Checklist Questionnaire

Events accepted as fitting DSM-III-R definition of a traumatic event outside the range of usual human experience were grouped in nineteen checklist categories[2].

A twentieth category of "not anticipated" was also included. This was the trauma check list. The subjects were asked whether they had experienced an event that frightened them so much and was in their opinion outside the range of their usual experience. They were required to answer either "yes" or "no" to each of the trauma group category questions.

DSM III-R Diagnostic Criteria symptom checklist for PTSD Questionnaire

A PTSD symptom check list based on DSM-III-R diagnostic criteria for PTSD was used. For each symptom, subjects were asked to answer either "yes" or "no". Attempts were made to ascertain the period between the occurrence of the traumatic event and the appearance of the symptoms. Information regarding previous history of mental illness in the subject and family history of mental illness was elicited.

The Schedule For Affective Disorders and Schizophrenia (SADS)

Additional psychiatric diagnoses based on DSM-III-R criteria for diagnosis of psychiatric disorders were made by administering the schedule for Affective Disorders and Schizophrenia-Life time version (SDAS-L)[10] to all subjects.

Interview Procedure

The author was notified by the records clerk in the MHC whenever a new patient was registered. Then the author interviewed every consecutive patient in a face to face contact in the MHC on the first visit. The interview was conducted in English if the patient understood the language. For those who could speak and understand Luganda (the author's dialect) were interviewed in Luganda. In case of a patient who could speak neither of the two languages, the interview was conducted using an interpreter who understood the patient's language from among the medical students.

Data Management

Completed Questionnaires were checked for completeness and consistency prior to data entry into the computer using Epi-Info soft ware. The data were then edited by a statistician and data entry clerks and then subjected to analysis.

Study Limitations

This study had the following limitation: i) The study sample was small, making it difficult to make definitive conclusions of the statistical significances; ii) The study tools were developed for a west population, some of the questions may have had little local relevance; iii) The study sample may have been biased towards more affluence since the study clinic was not access the majority rural population; iv) Because of time and financial constraints, the interviews were carried out only once by the author on first contact with the patient.

Results and discussions

Sociodermographic characteristics of the sample

The study sample of 100 patients consisted of 55 males and 45 females. Slightly more males than females were referred to the MHC during the study period giving a male to female ratio of 1.2:1. The difference between the gender was not statistically significant, and its indeed similar to the ratio seen in records at the Mental Health Clinic as reported by Baingana (1988) in her study of the use of psychiatric services in Ward 16 and Butabika Hospital[26]. This sex ratio of almost 1:1 reflects the national sex distribution. Table 1 summarises the sociodemographic characteristics of the subjects.

Table 1: Sociodemographic Characteristics of Respondents

Variable	Percentage (N=100)
Sex:	
Males	55%
Females	45%
M:F Ratio	1.2:1
Residence:-	
Kampala	36%
Mpigi	25%
Luwero	10%
Mukono	8%
Soroti	5%
Other	16%
Age Range (Years):	11 – 72
Mean (SD):	29.5 (13.2)

The majority of patients were residents of Kampala (36%) and the surrounding districts of Mpigi (25%), Luwero (10%) and Mukono (8%). This is an expected result, the MHC is located in Kampala district and therefore people in Kampala and the surrounding districts of Mpigi, Luwero and Mukono have easy access to the clinic, and make use of the clinic more than people from other districts who would have to travel long distances to reach the clinic. The other factor which would be contributing is the fact that Kampala is an urban set up and more and more people are getting informed about the availability of psychiatric services.

As Baingana reported (1988) people in the rural areas tend to consult traditional healers in cases of mental illness and only use psychiatric services as a last resort[26].

The age range was 11-72 years with a mean age of 29.39years (SD =13.22 years). Both sexes were represented almost equally in all age groups.

Children below the age of 10 years were excluded from this sample as children's manifestation of PTSD differs from that of adults in being more behavioral than verbal[2] and therefore they could not be relied upon to answer questionnaires. However children would be an interesting group to study since children are reported to be very vulnerable to PTSD by virtue of their immature coping mechanisms. On the whole the study sample in terms of age was not much different from those studied by other researchers in Uganda or elsewhere e.g. Baingana in her study of MHC utilisation[26], Acuda and Ovuga (1985) in their study of hospital admissions in Kakamega Hospital (Psychiatry) unit in Kenya[27].

Trauma Events

Out of 100 new patients studied in the study population, 35 gave a positive history of exposure to a very traumatic event, which to them was outside the range of usual human experience sometime during their life time and 65 had not been exposed to trauma. The traumatic events reported included: serious physical threat to life (this was when a patient felt that his/her life was threatened and felt very helpless in the circumstances to defend him/herself). This was the commonest type of trauma reported by 14 of the 35 (40%) patients exposed to trauma. Table 2 summarises the trauma events elicited.

Most of the traumata reported by the patients were expected, considering that Uganda had been through a period of political turmoil and violence for almost twenty five years.

During this period a lot of people were killed, tortured, kidnapped or displaced. In fact all types of human rights abuses were common and no one was immune[28]. Natural disasters did not account for any of the traumas complained of, as these are very rare in Uganda. Those which occurred in the past could have been forgotten by the responds. Incidences of violence and armed robberies are also common basing on reports in the news media.

Table 2: Trauma Events Experienced by Respondents.

Event	Percentage
Experienced Direct Trauma	35%
Trauma with threat of death by the Army	14%
Trauma due to Natural Disaster	0%
Military (soldier) Trauma	3%
Civilian trauma (Torture)e.g. Gunshot, kidnap, displacement, rape, beatings, tying, 'Panda gari', arrests/ detention	97%

Posttraumatic Stress Disorder and risk factors

Table 3: PTSD and associated factors

Variable	Percentage%
Directly Experienced Trauma	35
Developed full blown PTSD	24
Family history of Mental illness	30
Associations of PTSD	**p- level**
Treatment	NS
Religion Tribe	NS
District of residence	NS
Mental status	NS
Employment status	NS
Level of Education	NS
Occupation	NS
Family history of Mental illness	NS

NS = Not Significant

Table 3 shows that out of 100 patients in the sample, 24% of the patients; (14 males and 10 females) met the DSM-III-R criteria for diagnosis of PTSD. However 35 (35%) patients had had a history of exposure to a very traumatic event, so 11 (11%) patients despite the history of exposure to a traumatic even did not develop PTSD. Among the 11 patients without the complete PTSD syndrome as defined in DSM III-R, some experienced some symptoms of PTSD following trauma, for example some had experienced only one or two of the DSM-III-R criteria for diagnosis. A similar result was found by Helzer et al, (1987) in his epidemiological study[7].

PTSD in this study was not significantly associated with: a history of previous treatment, religion, tribe, district of residence, marital status, employment status, level of education, occupation, and a family history of mental illness.

Previous studies in the west have however documented a positive association between PTSD and impairment in employment, interpersonal relationships and attachment formation, with the consequence that this has at times resulted in separation or divorce[3,4]. The lack of association between PTSD and these socio-demographic characteristics may have been as a result of the small sample size used in this study.

In this study 30% of the patients with PTSD had a positive history of mental illness in the family. The figure is lower than that of Davidson et al[32] who found that 66% of his study patients with PTSD had a positive family history of mental illness. The low figure in this study could be as a result of underreporting by the patients, or as a result of giving incorrect information since mental illness is still stigmatized in Uganda. The other explanation could be the difference in the sampled patients in this study and that of Davidson et al[32]. The study sample in this study consisted of new psychiatric patients whereas Davidson et al studied patients with chronic PTSD.

The question of why some of the patients exposed to trauma did not develop PTSD could not be answered by this study. The causes of PTSD are multifactorial depending on a number of variables. Pre-existing psychiatric disability, whether in the form of a personality disorder or a more serious condition may increase the impact of a particular stressor. By the nature and design of this study it was not possible to demonstrate the effect of premorbid personality to subsequent development of PTSD. Among the other variables are the nature and duration of trauma, the meaning of the trauma to the patient, and the availability of social support systems. A future detailed study comparing patients with history of exposure to trauma who subsequently develop PTSD and those who do not, in African circumstances, is recommended. Patients who had pure PTSD with no other diagnosis

Five patients had a diagnosis of pure PTSD with no other co-existing psychiatric disorders. Two examples are illustrated below:-

CASE 1: *"X" was a female patient referred from Kapchorwa, Northeastern Uganda. She was in her menopause and had had a long standing land row with her male neighbour. Then one evening her male neighbour ambushed her and raped her. After the rape he informed her that the land dispute was over since both of them were likely to die from AIDS in the near future, that he, the rapist, had AIDS.*

This was a lady who was raped by an AIDS victim on the village who was spreading the disease with impunity. The rapist was later arrested. For this patient, having taken precautions all her life and not having ever contracted an STD, but now getting raped and infected with HIV a "death sentence" was an extreme stressor. The pending court case made her to be more stressed and appeared to precipitate her PTSD symptoms as it seemed to drag on forever. Wilson et al[33] has concluded that some extreme stressors will produce symptoms in almost every one. The above patient was exposed to very extreme stressors.

She was menopausal and then raped. That alone was an extreme stressor. But then the knowledge that she was about to die from AIDS imposed on her by her rapist neighbour was even more stressful and the never ending court case worsened the situation.

CASE II: *"Y" was a male combatant from the Army. He was from Luwero district, the scene of extreme battles. During the insurgency, his entire family was wiped out. He felt no alternative but to join the army if he was to survive. He became exposed to a lot of combat, the details of which he was not willing to discuss (Avoidance). On one occasion, while traveling with fellow army men for battle, their vehicle was ambushed and most of his friends were killed but he survived and was captured. He joined the rebel side and was involved in a lot of more combat. Since then the rebel NRA has captured state power with the patient now integrated into the regular army.*

While he was involved in fighting in Soroti, their vehicle hit a landmine and he lost his leg. Since then, he gets frequent nightmares related to combat (Re-experiencing). He was referred from the military hospital to the MHC because he wanted to retire from the army.

This patient had been exposed to a lot of trauma, the loss of his entire family, being forced to join the rebel army through extreme circumstances of war and then exposure to a lot of combat and a loss of his leg.

This soldier begged to be given at least a 6 months leave to go and perform cleansing ritual to get rid of the spirits of the people he had killed, whom he believed were haunting him and keeping him tense and awake all the time (Hyperarousal). It was not very clear why he wanted to leave the army but this could have been due to avoidance symptoms. This patient also illustrated some of the cultural remedies recommended by Bracken et al (unpublished) who came across such beliefs where nightmares were taken to have a supernatural dimensions only remidable by "cultural healers".[22]

Comorbidity of PTSD with other psychiatric disorders

Table 4 shows that out of the 24 patients diagnosed as having PTSD, 19 (80%) had at least one other psychiatric disorder as follows: 6 (25%) patients with PTSD had affective disorder, 4 (17%) had grandmal epilepsy, 3 (13%) had generalized anxiety, 2 (8%) had schizophrenia and 1 (4%) each had alcoholic hallucinosis, delirium tremens, hysteria and somatoform disorder. Five (21%) patients with PTSD had no other associated psychiatric disorder. Using the SADS-L20 it was not possible to distinguish between unipolar and bipolar disorder because the schedule does not take this into account.

Table 4: Comorbidity of PTSD with other psychiatric diagnoses

Comorbid Diagnosis	Percentage (N=24)
Depression	25%
Epilepsy	17%
Generalised anxiety disorder	12.5%
Psychosis (schizophrenia)	8.5%
Alcohol dependancy	8.5%
Somatoform disorders	8.5%
No comorbidity	21%

Patients who are below 35 years might present with recurrent episodes of depression, and warrant a unipolar diagnosis only to get a manic episode later on in life, thus forcing/ changing the diagnosis to bipolar. So for this study the term affective disorder was used to denote unipolar and bipolar illness.

Comorbidity of PTSD with other psychiatric disorders was not unexpected. The DSM-III-R definition of PTSD[2] recognizes the fact that PTSD may be diagnosed in people who have had a prior psychiatric illness. In addition, DSM-III-R recognizes that people who develop symptoms of PTSD could at the same time develop another mental disorder [2,4]. Co-existence of PTSD with other psychiatric disorders particularly affective disorders, anxiety disorders, substance abuse and personality disorders has been demonstrated widely[3,34,35].

Comorbidity of PTSD with affective disorder

Six patients with PTSD (25%) in this study had existing affective disorder. This result is different when compared to other studies. Davidson et al[3] found 41% of patients with PTSD had depression, Sierles et al[34] had 75% of his subjects with PTSD suffering from depression and Beikherimer et al[29] in their study of a veteran population reported that 100% of the patients with PTSD had depression.

It is difficult to compare the findings of this study with other studies since unipolar depression and bipolar disorder were all put under the collective term "affective disorders". Also those authors did not use standard research diagnostic criteria (such as the SAD-L) to reach their diagnoses in their various studies. Indeed the symptoms of depression and those of PTSD overlap to some

extent. This makes it difficult in these patients to delineate the predominant psychiatric disorder.

Comorbidity of PTSD with generalized anxiety disorder

Three patients with PTSD (12.5%) had features of generalized anxiety. This result is slightly lower than that of Davidson et al of 19%[3]. Davidson et al[3] concluded from their study that there was a close genetic relationship between PTSD and generalised anxiety. The clinical features of generalised anxiety disorder are similar to those of PTSD and it was difficult to decide which psychiatric disorder had led to the referral. The reason for the low figure in this study could be the fact that patients with generalized anxiety disorder are usually treated by various medical workers other than psychiatrists and only occasionally or in severe cases are these patients referred to the MHC to see psychiatrists.

Comorbidity of PTSD with schizophrenia (psychosis)

Two patients (8.5%) had PTSD and schizophrenia. The figure is similar to that reported by Davisdon et al[3] of 6%. Whether the co-existing schizophrenia was triggered by unusual stress or whether a predisposition to schizophrenia rendered the patient more susceptible to PTSD is unclear. Patients with PTSD and schizophrenia were referred because of symptoms of schizophrenia and the finding of PTSD was incidental. It is therefore likely that these were old schizophrenic patients who were traumatised in "security operations".

Comorbidity of PTSD with alcohol related disabilities

Two patients with PTSD (8.5%) had alcohol related disabilities indicating abuse of alcohol. These patients had started taking alcohol before they were exposed to a traumatic event, and after exposure they increased the amount of alcohol consumed. It was not possible in both cases to establish how their drinking habit had started. One of the patients claimed that he was drinking to alleviate anxiety and treat insomnia which could have been as a result of PTSD. The other said he was drinking to avoid withdrawal symptoms. Nevertheless this result is lower than that found by Davidson et al[3] of 16% and Sieles et al[34] of 64%. Davidson et al[3] combined alcoholism and other substance of abuse as one group which would account for the higher figure. The sample in the study of Sieles et al was different from the sample in this study in that it consisted of Viet Nam combat veterans whose alcoholism predated the development of PTSD[34].

Comorbidity of PTSD with hysteria (conversion-dissociative disorder)

The co-existence of PTSD with hysteria is not commonly reported in the literature. However, one patient in this study had PTSD with hysteria. It is most likely that the patient had a conflict arising from the traumatic event and later developed conversion-dissociative symptoms to alleviate the anxiety. There have been reports of conversion-dissociation and multiple personality disorder in PTSD following early childhood abuse[2].

Comorbidity of PTSD with somatoform disorder

One patient had PTSD with somatoform disorder. Bracken et al (unpublished)[22] in his study in Luwero triangle came across a group of patients (48%) with psychological problems as a result of war, who presented with somatic complaints not responding to usual treatment. Bracken observed that it was usually through tactful inquiry that the patient talked about their exposure to trauma. The other explanation could be that either the patient had forgotten details about the trauma, or was unable to link the exposure to trauma with the presenting symptoms.

Some patients developed selective amnesia leaving out details about the trauma which were unpleasant. This symptom can be found in hysterical patients too and raised the issue of whether PTSD is another form of somatisation. Another possibility is the common occurrence of somatisation with depression reported among African patients presenting with depression.

Comorbidity of PTSD with epilepsy

Although epilepsy is a medical condition, in many developing country settings including in Uganda epilepsy is managed by mental health professionals. In this study 4 patients with PTSD had grand mal epilepsy. The association between epilepsy and PTSD could be that a number of the war traumatised patients suffered beatings on the head and this could predispose them to epilepsy consequent to brain injury. Literature on the co-existence between PTSD and grand mal epilepsy is not frequently encountered.

Most of the patients with PTSD in this study had co-existing psychiatric disorders. In the author's view the five patients who had PTSD and no other psychiatric diagnosis represented pure cases of PTSD. The other patients who had PTSD and co-existing psychiatric disorders had not been impaired seriously by the PTSD to seek treatment. They only came to hospital because of symptoms of the co-existing psychiatric disorder. However, such debate is not new to psychiatry. Indeed it still exists regarding anxiety and depression. There are many possible explanations for the low numbers of pure cases of PTSD. Firstly, this study was about patients who had experienced a variety of traumas as defined by DSM-III-R[2]. This was in line with the current concept of PTSD which is considered as a syndrome which can arise regardless of the type of trauma, provided the trauma is considered severe enough to be causing considerable stress. Secondly, patients with PTSD alone rarely come to hospital. Helzer et al[7] found the prevalence of a history of PTSD of 1% in the total population in USA but the majority of these patients were not attending hospital[7].

In this study only 20% of patients with PTSD had PTSD as the reason for attending hospital, with the other (80%) attending hospital because of another concurrent psychiatric disorder.

Thirdly, stigmatization of patients with mental disorders is still common in Uganda. Patients seek psychiatric services only when the psychiatric disorder is severe and advanced. Lastly, are the cultural beliefs. Many forms of psychological distress in Uganda are perceived as having supernatural causation for which people feel western medicine cannot treat adequately [36,37]. So, resort is very frequently made to traditional healers[26].

Factors associated with 'pure' PTSD

A comparison between patients who had PTSD only with those who had PTSD with another psychiatric diagnosis was made. Despite the small number of patients in the study sample, a statistically significant difference ($p = 0.017$) was observed on occupation between those who had PTSD only and those who had PTSD and another psychiatric diagnosis. Patients employed in armed security services were found to be particularly at risk of developing PTSD only with no other comorbid psychiatric illness.

This result is expected because of the nature of their work. Soldiers are constantly exposed to various types of trauma. In Uganda, a country which has had various wars for the last 25 years, virtually all soldiers have been in active combat at one time or another and therefore are at risk of developing PTSD. Most of the initial work on PTSD was done among combatants and Bracken et al in his study in Uganda (unpublished)[22] found that among his subjects soldiers were more vulnerable to develop PTSD.

There was a statistically significant difference between patients with PTSD only with those with PTSD andanother psychiatric diagnosis ($p = 0.001$). PTSD only was more likely to arise in cases of rape or combat. Other workers have found similar results. Martin et al[37,38] found victims of sexual assault to be particularly vulnerable to PTSD. Helzer et al[7] in his study of PTSD in the general population, found that only two types of traumatic events accounted for PTSD among his male patients: combat and seeing someone hurt or die.

The most common specific event accounting for cases among women was physical assault especially rape. Bracken et al (unpublished)[22] in their study found many of his patients (more than 90%) had been exposed to trauma and some had features of PTSD but did not require specialized treatments[105].

However they found a special sub-group of patients who required specialized treatment, and these included combatants and females who had been raped [22]. This finding, as well as that of this study is in keeping with established literature [7,37].

No statistically significant difference was observed between the two groups on: gender ($p = 0.66$), marital status ($p = 0.15$), religion ($p = 0.67$),education ($p = 0.85$), past psychiatric history ($p = 0.4$), and family history of mental illness ($p = 0.33$).

Conclusion

Post-Traumatic Stress Disorder, (PTSD) as defined by the DSM-IIIR classification of mental disorders was found to exist among 24% of consecutive new patients attending MHC Old Mulago Hospital. It was a common disorder and only second to schizophrenia with 26% in the MHC. This calls for systematic screening for PTSD in the MHC.

PTSD co-existed with other psychiatric disorders in 79.2% of the study patients. In most cases the co-existing psychiatric disorder and not PTSD was the reason for referral in those cases. Patients with PTSD did not differ from patients suffering from other psychiatric disorders in any of the studied demographic variables of sex, age, marital status, religion, ethnicity or place of residence.

'Pure' PTSD without comorbidity accounted for 20.8% of all the PTSD patients. Therefore it was uncommon to find PTSD existing alone, but more often it coexisted with psychiatric diagnoses e.g. affective disorder anxiety disorder etc.

This raised the question of whether it was a separate diagnostic entity.

PTSD in Uganda, as seen in the Mulago Mental Health Clinic followed man-made trauma especially war-related trauma and urban violence (Panda gari).

Recommendations

It would seem that many patients with a history of exposure to traumatic events can develop psychological symptoms of PTSD but did not attend specialized care until the condition was associated with another psychiatric disorder. This calls for research into the methods used by such patients to cope with trauma (resilience) and to explore these other methods for future application e.g. traditional healers, family supports, etc.

A special group of extremely traumatised patients always seemed to develop PTSD e.g. combat soldiers, rape victims. These very vulnerable patients for PTSD seemed to require specialized treatment thus calling for specialized PTSD clinics to be set up for these specific groups.

Given the common occurrence of PTSD in the MHC and the continued trauma in Uganda, this disorder should be routinely screened for by all health care providers. Lastly, there's need for research into culture-sensitive healing/treatment methods for PTSD as was evidenced that many of the patients in the Mental Health Clinic also went to traditional healers for one reason or another.

Addendum:

Lessons learnt from Dr. Walugembe's pioneering work

Dr. Walugembe was a noble clinician from a humble background, who scaled the heights of his profession to the level of Senior Consultant. However, he never forgot his calling and he dedicated his professional life and clinical acumen to caring for the down-trodden and traumatized.

Dr. Walugembe dared to ask and question his superiors (teachers and clinicians in Mulago Hospital) as to why PTSD was not being diagnosed in the Mental Health Clinic despite 25 years of armed insurgencies in Uganda and the associated urban violence in the form of Panda-gari and other quasi – military operations. Through this Dr. Walugembe demonstrated that rare courage and boldness to hold onto one's conviction and to foster an independent opinion and follow it through despite his quite junior status at that moment.

Dr. Walugembe's courage therefore is a humble lesson to all clinicians and teachers of medicine that they should always allow their students' curiosity to prevail and only serve to help to guide the students in their search for answers and knowledge.

Finally, issues surrounding PTSD which Dr. Walugembe raised almost 20 years ago still pertain today. They leave the following questions:-

1 What are the culturally bound symptoms of PTSD in Africa?
2 What Psychotherapeutic interventions work best for PTSD in Africa?
3 How can we prevent the repetitive various cycles of war trauma and political violence with the consequent tremendous mental health fall out for the masses of Africa?

IDP Camps & Children. From http://www.david-kilgour.com/Ugandan

http://www.david-kilgour.com/Ugandan IDP Camps & Children

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The sexual violence phenomenon in the Great Lakes Region of Africa

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Abstract

Sexual violence as a weapon of war is ancient but it is now being increasingly reported in Africa and other parts of the world during militarized conflicts. Though now condemned by the United Nations as one of the recognized "Crimes Against Humanity" no systematic study of this phenomenon has been carried out in Africa.

This paper is not a systematic study of this phenomenon. However, it is a chronicle of personal observations of this problem in the war-torn Democratic Republic of Congo. It is hoped, that systematic documentation of the problem and its sequalae to the people and their communities can be carried out and preventive measures taken

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Introduction

Since 1993-1994, the African Great Lakes region has hosted various groups of rebel movements which moved easily from one country to another causing devastating effects in the lives of the affected peoples resulting in much physical and psychological trauma amongst the local populations. Included in these groups have been those which came from Rwanda (Interahamwe, FPR, FDLR); from Burundi (FDD, FNL,) from DRC (RCD, Mayi Mayi, Mudundu 40,…); and from Uganda (LRA). Previous to these were other rebel movements which went on to succeed and form governments. Examples include the NRA from Uganda, the RPA from Rwanda and the SPLA from Southern Sudan. The consequences of these wars were often massive violations of human rights in general, killing people, sexual abuse, rapes, destructions of infrastructure, physical illnesses including epidemics and mass mental illness. The victims lose their dignity, honor, materials, family members, hope, lifestyle, human rights, and good governance.

Objective This paper aims to give a summary of my observations of the crimes of sexual violence meted out to women in the context of war. Since January 2008 to May 2009, I went frequently in the DRC to deliver services and build local capacities for the psychosocial care of victims of sexual violence in South Kivu province. The content of this article is the result of my observations focused on survivors of sexual violence, their families and the communities who experienced the sexual violence phenomenon.

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This paper is not a systematic study, but rather chronicles of my observations as I carried out my work in Kivu Province, DRC.

The observations

The most vulnerable group was women living in the conflict areas. I observe that over the years, the sexual abuse phenomenon has taken on different appearances from that which we knew before. Sex is a taboo subject of discussion in most African cultures. Yet sexual violence in the Great Lakes Region has become commonplace, amplified, diverse and widespread thus making it difficult to give its exact, complete and accurate description. The reasons for this are many and include, but are not limited to, the following:

1. ***Sexual violence is a taboo subject*** of discussion in the region and yet it causes serious consequences on all levels: physical, psychological, economic, social cultural, family, etc. Often it is not denounced and perpetrators do it with impunity.
2. ***The victims are not secure*** and may be punished for reporting it. Treatment is thus not given on time and often victims are left to themselves for a long time. This causes serious health consequences/ complications.
3. ***The impact of sexual violence is broad,*** to the individuals so affected and to society as a whole. For example, according to the Kivu Provincial Ministry of Health and the Provincial Synergy against sexual violence in the South-Kivu province: "In 2007, at least 180% of women in the eastern part of the DRC had been raped; 22% of the raped women were HIV positive; 10% had children born of rape; 60% were separated from their families; and 20% had severe gynecological injuries requiring surgery".

4. ***Rebel armies control whole territories*** yet have no central governing authority. They thus have ample time to continue committing their atrocities. There is often no or very remote intervention of the government (or UN MONUC) army. They, thus, violate individuals with disdain and cynicism both physically and psychologically, especially in the Eastern of DRC. Forced marriages to rebel soldiers and sex slaves are common. This un-censored sexual abuse of women is a new phenomenon of gender based violence and has very little factual documentation in the literature.
5. ***The exact numbers of women raped*** **is not known** because of the cultural silence in regard to rape. Talking about rape is a cultural taboo. However, when privately interviewed, most women of this region in the countryside or surrounding forests will say that all women of their region have been raped at one time or another by at least one rebel soldier belonging to an armed group. Repeat rapes and gang rapes are also common
6. ***Children also subjected to the social conflict*** 10% of women who were raped got pregnant and gave birth to children born of rape. In Eastern DRC, most often the perpetrators are Interahamwe or FDLR rebels. These children are often not wanted and suffer neglect and abuse. The often girl-mothers who had children from the rapes (of Interahamwe and FDLR) are often still children themselves and they experience social rejection. Moreover, the children born of rape are often not given national identity cards as they are considered foreign although the constitution of the DRC says that any child born on Congolese soil is of Congolese nationality. These children are thus subjected to social conflict and discrimination in their families, communities and on the national level.
7. ***The perpetrators who rape also commit other atrocities at the same time:*** Things have gone from bad to worse. Rapes are often accompanied by massacres of members of a family as often the rebels burst into the house at night. They start by tying up the male head of the family; they then rape his wife in his presence and order the members of the family to rape each other. The scene usually ends by killing the head of the family and taking the family property which is carried by women and girls who are taken hostage into the forest.
8. ***Sexual Slaves, Forced Marriages:*** In the forest, women and girls are taken into sexual slavery and may spend months or even years being subjected to all kinds of torture. Rape in the forest may take various forms: Dirty cloths and dirty water are used to clean the vagina after each sexual act. There may be gang rapes. Women are forced to marry the chiefs of rebels or to be wives for a group of rebels. Sadistic sexual acts may be performed on them including digital insertions, or pieces of wood or metal are introduced in the genitals areas. Victims are often tied to stop them from fleeing. Many other cruel acts are done them.
9. ***The pendulum rape*** This is probably the worst king of rape. It is a kind of rape where the woman is hanged on her arms and legs until her genital area is parallel to the penis of the rapist who is standing. The woman is then raped in a rocking back and forth movement on the pendulum and she can remain in this position till the rebels complete their swapping roles. Most women who have undergone this kind of torture have died.
10. ***To always be hunted: the woes of the raped*** For many kidnapped women, they often die on the road. For those who do not die on the road or during their stay in the forest, they can be hunted when they attempt to flee. Often they may manage to flee when sent on errands to fetch water, firewood or to look for food. Unfortunately when they escape and manage to arrive at their homes, they may face rejection by their family members. Husbands may reject their returned raped wives. Rebels may still continue to hunt them again. Members of their families may treat them as separate and outcasts because of fear of stigma, rejection or rebel reprisals.

    Since rapists are members of armed rebel groups they are still active and can easily move from country to country or from hiding to town and back again in the forest to return to the rebellion. No one controls them.

Conclusion

The governments of the African Great Lakes Region are challenged to act and to secure their populations. This often proves an impossible task. UN forces (MONUC), have attempted to help. However, these have not yet registered the expected success of demobilizing and disarming these marauding rebels. A new thinking on how to deal with these rebels is needed. On the other hand, demobilized soldiers from these rebel groups often annoy populations when they continue with some of the bad habits and practices they learned in the forest including rapes, armed robberies etc. It is important that Governments work hand in hand with International Peace keeping forces and NGOs to take the bull by the horns and stand as one to neutralize the rebels, to help victims, to prevent harmful behaviors among demobilized soldiers and rebel groups. It is important to avoid generalizing the harmful military-like practices of the rebels among civilian populations. More research is needed to find the best ways to curtail Human Rights abuses and Crimes Against Humanity meted out to civilian populations by warring factions in Africa. In such a way the crimes of sexual violence can be done away with and never to be used as weapons of war. Governments of the African Great Lakes Region need to determine which kind of intervention needs to be done by country and by region to stop the rampart sexual violence in this region. On the side of the victims, a multidisciplinary approach needs to be adapted to

deal with the massive physical and mental fallout of war in this Great Lakes Region in terms of caring and rehabilitation of the victims. This approach needs to be gender, age as well as culturally sensitive and research evidence-based with a commitment to observation of universal Human Rights for all and to democratic governance.

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MUSEMENTS

I. SELF ANALYSIS

THE JOHARI WINDOW PANE

FACTS:	KNOWN TO SELF	NOT KNOWN TO SELF
KNOWN TO OTHERS	PUBLIC SELF	BLIND SELF
NOT KNOWN TO OTHERS	PRIVATE SELF	UNKNOWN

Source: Mentors Workshop, Hotel Africana, Kampala, Uganda, 30th April 2010.

II. ON PREVENTING PSYCHOTRAUMA

What they hear, they understand
What they see, they believe
What they do, they learn and repeat

Conclusion: Prevent the vacious cycles of war and psychotrauma

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Source: Chinese Sayings of the Wise

Justice and health Provision for survivors of sexual violence in Kitgum, Northern Uganda

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Abstract

This report is based on a research programme that examined the governance of sexual violence in Northern Uganda using Kitgum as the case study. This paper presents results to inform stakeholders in the justice and health sector. The research was conducted in December 2009 with the assistance of Kitgum Women's Peace Initiative, KIWEPI, co-ordinated through Isis–Women's International Cross Cultural Exchange, an international women's non-government organization based in Kampala. It was funded by the UK's British Academy.
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Background

Little needs to be said to stakeholders in Uganda concerning the awful depredations carried out by the Lord's Resistance Army, LRA, over the last 23 years. Young people were abducted against their will by the LRA. Girls were forced to enter into 'marriages' with LRA commanders, as well as acting as soldiers. During their period of abduction, both girls and boys were forced to commit atrocities including killings, maiming, setting bombs and landmines, and torture of their communities. If they refused to engage in atrocities they were threatened with their lives or their family members or friends were killed in horrific ways. They were also made to carry heavy loads including military equipment, munitions and food supplies, walking for long periods without food, water or shoes. Girls were raped in forced marriages and most became pregnant. Boys were also forced to 'take girls' as wives to prove themselves as soldiers and some reported having been raped themselves.

These traumatic experiences of participants have caused untold physical, psychological/spiritual suffering and social/cultural effects. Briefly, the physical effects include: HIV/AIDS, gynaecological problems (such as sexually transmitted diseases, infertility, vasico-vaginal fistulae, etc), obstetric complications (such as complicated and delayed deliveries leading to birth trauma of babies and death of babies),

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surgical complications (such as chronic body pains, gunshot, bomb and landmine injuries as well as epilepsy secondary to head injury).

In terms of psychological effects: traumatic effects including anger, fear, stigma, shame, inability to communicate and homicidal urges; PTSD symptoms of loss of interest, avoidance, isolation, detachment, flashbacks and nightmares, intrusive bad thoughts and memories; depression; suicidal thoughts; and insomnia.

The effects of the ongoing sexual violence and torture on the community are serious and enduring. Participants frequently described the levels of alcohol and marijuana use in the community since their return from captivity and the increasing levels of crime including domestic violence and rape within their communities

The additional problems faced in the community by abductees included discrimination and harassment, particularly for those who returned with children.

This increased the levels of stigma and shame and in turn increased the lack of trust and negatively affected access to health and justice services. Participants described high levels of fear about reporting their experiences of sexual violence. This included fear of being tracked down and killed by the perpetrator and fear of lack of confidentiality amongst professionals.

The violence, torture and trauma inflicted on communities and the young abductees, both physical and mental, was impossible to measure. The physical and mental consequences of such suffering (let alone the economic, social and

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moral ones) may never be totally eradicated; but it is hoped it can, in some measure, be ameliorated. No recompense, let alone full justice, can be offered to the survivors at the hands of unknown or unidentifiable rebels, but again it is hoped that ways will be found to demonstrate a public acknowledgement that they have endured severe injustice through beneficial services to them now. A whole generation of Acholi people has been damaged by conflict; now, it must not be damaged by neglect. This paper gives some insight into what can be done to effect some justice, reconciliation and health care provision.

The ongoing crisis

Though the LRA has withdrawn from northern Uganda, sexual violence has not. The rape and defilement at the hands of the LRA, with cases of male rape as well according to our interviews, continued in crowded camps at the hands of fellow inhabitants and the UPDF. Survivors speak of the perpetrators of rape, child sexual abuse and physical assault as including the UPDF and police. Rape is even now perpetuated in eastern Kitgum by the Karamojong cattle raiders' parties; and continues according to women survivors at high levels in communities at the hands of husbands and community members. Male abductees, subject to trauma and anger and having lived much of their youth in a culture of LRA sexual violence, are also implicated.

Many argue that there has been demonstrable erosion of sexual morality and of social control among the traumatised abductees. It would hardly be surprising if this were so, though it is difficult to measure.

Even when the perpetrators (be they LRA, army, Karamajong raiders or community members) flee, there remains the ongoing consequences of damage to body and mind and, very often, the children of the rape. Such consequences live on after the hostilities have ceased and the international community has lessened its interest.

The point we wish to make here, therefore, is that to think of the north of Uganda as 'post-conflict' is problematic. Conflict has not stopped. There may be a military and political peace of a sort; but there has been no cessation of sexual violence.

There is no post-sexual conflict. Sexual violence lives on at very high rates in Kitgum.

Because of these high rates of past and present sexual violence, the numbers of those who seek health and justice service responses are very great. Yet in contrast to this scale of need, there exist very minimal health and justice services. Nor does there seem to be any likelihood in the near future of this situation being addressed either by the Uganda government or NGOs. In the case of government services there is what amounts to something close to system failure. The health and justice services of Kitgum are not only currently incapable of serving the needs of the population; but are, in our opinion, beyond being fixed by piecemeal training and equipment provision or even by the addition of further personnel. And the NGO response to the current crisis of health and justice services is small and getting smaller. Even as we carried out our research, some humanitarian agencies were finalising their plans to pull out of Kitgum as in their view the 'emergency' has now ceased.

Methodology

This research employed a qualitatiative methodology using Focus Group Discussions and Key Informant Indepth Interviews. The research considered the health and justice responses for survivors of sexual violence in Kitgum, both from the perspective of users and providers. To this end it has attached as much importance to asking communities, associations and individuals to share their experiences, as listening to state and non-state providers of health and justice services.

In collaboration with Kitgum Women's Peace Initiative, KIWEPI, as our local partners, we interviewed 51 men and 41 women survivors of conflict-related violence and torture, including sexual violence, in four parishes, Kiteny, Lolia, Lolwa and Katwotwo, in Orom sub-county; as well as 6 women survivors in Kitgum Town, as regards their experience of justice and health provision. Some of the interviews were conducted individually and others were held in focus groups. We also carried out 85 semi-structured interviews with police and health officials, and non-state providers that examined their training, facilities, interviewing techniques, use of women officials and success in bringing cases to a conclusion. We triangulated our findings by discussing the project's themes with key informants within the health and legal profession, human rights organisations, local and government leaders.

Overall we listened to over 200 people in individual interviews, focus groups and in three workshops.

The research was distinctive and unique in five ways. (1) It combined state and non-state policing and health in a single study, since the actual experience of survivors left them requiring both justice and health care. (2) It explored the theme of the quality of response rather than attitudes of survivors to peace, justice and reconciliation, which has been covered by others.[2] (3) It focused on Orom in the Eastern part of Chua County in Kitgum, as this was an area identified as having the highest number of affected citizens who have not benefited from the rehabilitation processes in northern Uganda and urgently in need of reproductive and mental health service provision.[3] (4) It examined resilience during war based on individual and collective experiences. (5) It investigated sexual violence not only against women but against men, an area currently neglected in the literature. Finally we made recommendations regarding what we felt needs to be done to give health justice to these women.

Findings

The Health System against this background of severe and widespread health needs is poorly resourced and struggling to respond. Participants gave the following reasons for this:

Low levels of access to health care

Most of the former abductees interviewed, for a variety of reasons, did not access health care. For those who did manage to access health provision they reported a lack of adequate treatment as the following women reported:

> "I was raped then I went back to my parents who took me to hospital but there was no clear result and I am still affected by what happened. (Woman's focus group, Orom)."

Both men and women survivors reported experiencing stigma and shame as a result of their experiences of sexual violence and were therefore reluctant to report them and lacked trust in the services to provide confidentiality and support. For those who attempted to access the local services in Orom, they reported that health staffs were often not available and when they were, they could not disclose what had happened to them. Some described completing a medical form but most did not receive treatment at the clinic and were referred to Kitgum Hospital, about two hours drive away.

However, the majority of participants lacked money for transport and treatment and failed to follow this up. A woman in Orom explained:

> *"We were raped and tortured yet when I went to the health centre there was no money to help me with transport and accommodation or transport to the main hospital for treatment."*

Poor health facilities and infrastructure

The health service facilities were reported by interviewees as being inadequate and unable to respond to their needs. Within the District, half of the health clinics were not open since during the insurgency health care was transferred to the Internally Displaced Person's camps. Hence in Kitgum, the Ministry of Health's minimum requirement of one health clinic per parish is not met. When participants walk to their nearest health centres they usually do not find any treatment and are normally referred to Kitgum Hospital. Unable to afford transport they usually return home without any treatment. A woman Director of a non-government organization in Kitgum explained:

> *"The 23 year war destroyed the health centres and we are still reconstructing the health units. There are so many sicknesses that resulted from the atrocities. There is a lack of medical personnel and funding for hospitals. Hospitals and clinics lack examination facilities …The facilities are inadequate".*

The participants who attempted to access health services described only receiving basic treatment at the local clinic and the majority failed to access comprehensive screening, assessment and treatment following sexual violence. For those few participants who did manage to access health care it usually comprised of very basic treatment with Pep (Post-Exposure Prophylaxis, as a preventative for HIV infection) and/or Paracetamol for pain. The local clinic in Orom lacks staffing, drugs and facilities as this woman described:

> *"You can be at the health centre for one week and not see any staff there. It opens at 10am and closes by 5.30pm. At night it is closed and at the weekends. Often you find people dead in front of the health centre. The structures, facilities and personnel should be improved."*

A male local councillor also described the local situation in Orom as follows:

> *"There are no facilities as well as resources being accessed by the victims of rape in particular. That is why rape cases in Orom were reported and immediately referred to the main hospital in town for the purpose of investigation. This leaves us in a dilemma in the situation where the person is brought from Akuromo for example, and should again wait for transport to move up to the government hospital in town. And there is not a thing that can be done to speed up the investigation within 72 hours."*

There are no medical doctors at the clinic in Orom, whilst Kitgum Hospital, the main District Hospital, had only one doctor who is also the Medical superintendent at the time of writing this report. There are no specialist doctors such as a gynaecologist or surgeon. There is a private facility at St. Joseph's Hospital, Kitgum, but this only has a visiting gynaecologist and the services require payment, which is out of reach for most of the war affected population. All of the participants interviewed described their needs for urgent and proper health care in terms of physical and psychological support and treatment. For instance a woman former abductee in Orom said:

> *"We would like trauma counseling including advice and support so we can forget what happened. We would also like to be given training and advice regularly so we can forget about those experiences."*

The additional factor which affects access to health care is the need for quick treatment within 48-72 hours to prevent HIV infection and pregnancy. This time period is rarely met as the current procedure of reporting delays access. This requires the Police Form 3 to be completed following an incident of sexual violence and this form needs to be taken to Kitgum Hospital, where it has to be signed by the medical superintendent, before emergency treatment is given. In most cases, even if the survivor manages to complete this form (which usually entails bribes to the police) the health treatment is delayed. Hence, many survivors are being infected with the HIV virus and becoming pregnant through the rapes they endured due to the lack of timely access to emergency health care.

In terms of support some of the participants reported a little 'psychosocial' support provided by non-government organizations following their return from captivity e.g. undertaken by the International Rescue Committee, Concerned Parents Association and World Vision for example. However, this involved mainly practical assistance in the form of soap, blanket, mattress and a saucepan with limited counselling for a maximum period of six months. The majority of participants described ongoing psychological and emotional effects related to their experiences and required ongoing trauma counselling and support, which was not available.

Lack of support and training for health care staff

During interviews with health care staff at the main hospital in Kitgum, staff described their own experiences of sexual violence and torture during and since the insurgency. They described a lack of support, staff shortages, having to work long hours without breaks, and poor salaries and working conditions. They spoke of feeling exhausted and requested psychosocial support including trauma counselling for their own experiences. They described their frustrations and difficulties in dealing with survivors of sexual violence. This was exacerbated by the restricted resources for assisting them but also due to the overwhelming effects of hearing their traumatic stories which activated reminders of staff's own experiences. This was made worse by the lack of support and opportunity to discuss these feelings.

Several respondents described a lack of knowledge at all levels within the health services in terms of providing effective responses for survivors of sexual violence. Participants in the research suggested continuous training programme in assessment and treatment of survivors of sexual violence, confidentiality and trauma counselling. They stressed the need for there to be continuous follow-up and increased liaison between justice and health services to assist with this process.

II The Criminal Justice System

The reasons for the severe weakness of the criminal justice system to provide for the survivors of sexual violence in Kitgum are multiple. Below we give a summary of some of the explanations we heard from both survivors, criminal justice professionals and key informants.

Low level of reporting

A culture of responding to sexual violence through local negotiation between the families of the accused and the survivor undermines the deterrent effect of the law. The law regards aggravated rape as a capital offence; and less serious cases as liable to life imprisonment. Yet offenders know that most cases do not face such formal court penalties, but will be settled locally. Any failure of negotiation that does lead a case towards the criminal justice system, however, stimulates the offer of bribes (to the police; police doctor; and magistrate) to ensure that a case with such severe sanctions quickly falters.

There is then a situation where cases are rarely reported and where they are, they are very often dropped. This by-passing of the criminal justice system is further aggravated by the survivor's own shame and fear (e.g. of the husband divorcing her); the distance and expenses of getting to the police, police doctor and court; and by the deep suspicion of and lack of trust in the police. Hence though women interviewed reported high levels of sexual violence, the police and medical centres record very few cases. Orom police station reported that they had recorded about 10 cases in the previous 6 months; and Orom clinic estimated they saw about 15 cases per year.

Understaffed, under-trained and under-resourced police

Even if cases are reported, there are very few police and even fewer women police officers to respond to the survivors. Kitgum district has just 67 fully trained police (plus 450 'special constables'; and 58 Local Authority police, now integrated with the police; both have very little education or training). In Orom there are 22 police officers with a special constable in charge of the Family and Children's Protection Unit (FCPU).

The police are very short of transport. This impairs their ability to take survivors and the accused to the central police station, police doctor and court. As a result, cases fail to obtain a doctor's report within the crucial post-rape 48 hours; or because witnesses and survivors fail to appear in court. The inadequate transport (just one motor cycle at Orom) also delays the arrival of the police at the scene of the crime and their investigations.

There is a near total lack of special facilities for interviewing survivors in police stations and posts. There is a tent at Kitgum, but no private space at Orom and apparently at all other police posts in Kitgum. To be interviewed as a rape survivor or to conduct an interview with a rape survivor in a public space is unsatisfactory, both in terms of privacy and the likelihood of full disclosure.

Few police officers have had training in handling cases of sexual violence; and that which has been received has been minimal. There appears to be no available training manual and no knowledge among officers of written procedures. It is not surprising; therefore, that as a result a universal legal misapprehension with serious consequences holds sway in the police.

This is the assumption that the only evidence that rape has occurred that the courts will allow is that of a police doctor, of which there is just 1 in Kitgum (the Medical superintendent) though 3 other doctors at the private St Joseph's hospital have also been used.

In fact the interpretation of the law regarding expert witnesses, according to the local judiciary, is that the testimony of anyone who can demonstrate experience in this field is acceptable. In a recent case in Kitgum itself, the court allowed the testimony of a nursing assistant. That understanding alone would ensure more cases proceeded with the necessary expert witness evidence in place.

The police are poor at gathering evidence of crimes of sexual violence. Both delays (mentioned earlier) and lack of skills are to blame. The poor evidence collection by the 36 CID in Kitgum is compounded by poor presentation of the evidence in the prosecution. Many cases fail for this reason alone.

Failure of court cases and the court system

Of those cases reported to the police, few end up with successful prosecution. Some fail as the case is prolonged and survivors and their families give up; others are alleged to be dropped due to bribery of the police, police doctor or magistrate. Even those that make it to court often fail according to the admission of the police and local journalists, as files are lost, witnesses fail to appear and evidence offered by the police is inadequate.

The courts like the police suffer from understaffing. There is just one probation officer for the whole district. She alone has to offer counselling to all rape victims under 18 years of age and represent their interests in the court. Further, there is only one senior magistrate to hear 'simple' cases of rape (the one other magistrate in Kitgum is not allowed to by law) and one visiting judge who alone can hear cases of aggravated rape (where the survivor is immature and/or has received a sexually transmitted disease as a result).

A system failure

What has been described above is a criminal justice system that cannot offer justice to all those who are survivors of sexual violence. It cannot even offer it to the very few that even go to it for redress. It offers little to survivors of current sexual violence; and in practice virtually nothing for the tens of thousands of survivors of sexual violence from the LRA rebellion. Such a tragic situation is almost inevitable given the limited financial resources available to the Uganda state; the high corruption levels among actors within the system; the poor educational standards of those recruited to the police; and the very limited penetration of the state beyond the main towns.

In other words, this is a situation that cannot easily be remedied even with the 'enhancement' of police and justice services spoken of by the Uganda government's Peace, Recovery and Development Plan for Northern Uganda (PRDP). Nor will donor aid for training and equipment do the task. The problem is structural. There are structural deficiencies within the economic life, educational system and social values of the country as a whole that are not readily changed overnight.

Recommendations

Realistic policies

Many have made recommendations concerning specific policies to improve health and justice services (e.g. Isis-WICCE, Redefining Peace and Development: women's recommendations for the peace, recovery and development plan for the north and north eastern Uganda, 2009). They call for specific polices of legislative change; capacity building through training; institutional innovation; and sensitization regarding women's rights. These all have their place, but for the most part involve executive decisions regarding government policy, legislative programmes and revisions to existing programmes for northern Uganda. These decisions made in Kampala can be preceded by lobbying on behalf of the people and concerned organisations of Kitgum, but it largely lies beyond their reach to ensure implementation single-handedly. For our part, we have chosen to deliberately focus on low cost and achievable (in the short term) solutions for the people of Kitgum. Some of these solutions and recommendations are less than the ideal that many would want, but they mark, in our opinion, valuable transitional steps towards a better health and justice provision for the survivors of sexual violence in the District. Hopefully here are solutions that local actors and communities can immediately implement by themselves or with minimal assistance.

I. Health policy issues to be considered

Recruitment of Health Specialists

Kitgum has a District Hospital without any specialists. Although the District has recently requested to be upgraded to a Regional Referral Hospital, Gulu has been ungraded so it is unlikely Kitgum will be upgraded as well in the near future. We therefore suggest that the Ministry of Health approves the appointment of further medical specialists to Kitgum District, particularly a gynaecologist and a general surgeon as a matter of priority. We also recommend that considerable effort is made to employ health care staff to bring the District up to at least the minimum health care requirements as stated in the strategic health document for Uganda (MOH, 2005-2010).

Awareness raising and Training on Sexual and Gender-Based Violence

A focus group of male local councillors in Orom argued:

> *To end sexual and gender-based violence there is need to form teams or groups that are empowered to sensitise the community on sexual and gender-based violence.*

And a medical professional working with an NGO in Kitgum said:

> *There needs to be training for police and justice and health as well as technical staff. They should all come together for the training.*

In our opinion there would be benefit from a programme of awareness raising at the community level as well as within health and justice services regarding supporting and responding to survivors of sexual violence. This would increase the local capacity within the District to handle the responses speedily and more effectively. It was proposed by several respondents that this training should include all those involved in responding to survivors of sexual violence so as to promote collaboration and working. Not only would such programmes assist communities to realise that these issues are everyone's responsibility, but it would also improve the health and justice responses. This is particularly important with respect to emergency health treatment, particularly Prep and pregnancy prevention, which has to be provided within 48 hours and 72 hours respectively to be effective.

Psychosocial and support programme for abductees and health care staff

> *Survivors have not been given psychosocial support, medication or training. After training they need further empowerment activities as well as group support to develop their community resilience. (Counsellor, Kitgum)*

> *There needs to be counselling services, trauma counselling and people should be followed up. (Medical Doctor, NGO, Kitgum)*

The recovery programme for northern Uganda does not include any psychological support programme for war survivors or other vulnerable groups (Isis-WICCE, 2009). This is a serious omission from the rehabilitation programme as the levels of trauma, shame, stigma, fear and distress amongst the survivors is high, contributing towards escalating levels of alcohol use and resultant crime including domestic and sexual violence.

As well as the ongoing suffering of the population, if these difficulties are not addressed, it is likely to result in serious trans-generational effects with the greater likelihood of further violence and political instabilities (see Liebling-Kalifani et al. 2008). Of real benefit would be a psychological support programme in Kitgum District, using a mobile clinic. This might initially be funded by donors. It could include gynaecological treatment, trauma support and counselling, utilising the village health care teams, support groups of former abductees and awareness-raising amongst community members. Initially this programme could involve the Peter C Alderman Foundation (PCAF) Trauma Centre staff in Kitgum and external expertise with the aim of awareness-raising regarding supporting and counselling survivors of sexual violence and capacity building at the local level. The idea is that these skills are built within the community involving survivors themselves, who form confidential support groups. These programmes should include local leaders and community members and address the issues relevant to the successful re-integration of former abductees back into their communities where possible and protection and resettlement into alternative locations, where not.

Although the population is now starting to return from the IDP camps the ideal standards recommended in our previous article on northern Uganda are still a goal to aim at for Kitgum (Liebling-Kalifani et al. 2008:187):

> *A holistic gender-sensitive public health intervention approach to address the physical and mental health needs of women war-survivors in IDP camps in Uganda. This should include provision of free treatment services for women including HIV/AIDS testing and treatment, specialist gynecologist and obstetrician services and women counsellors using a holistic approach and involving women war survivors in all aspects of decision-making.*

It is also important that the issues of shame and fear are addressed by these programmes, as one of the former abductees in Kitgum said:

> *The other issues we face are fear. For me I can't stay in my village as I am afraid and frightened until Kony has been caught I have to stay somewhere else in the town. If I go to the village I am scared I would be found and abducted again. I only visit the village as I am so scared. The rebels might come back and pick me.*
> *We should also be helped to form groups and support each other rather than being left as individuals.*

> *We all require training in trauma counseling. We would benefit from in-house training as well as external training. (Counselor, Kitgum)*

Ideally, the psychosocial support programme should include specialist and sensitive trauma counselling for both men and women former abductees. But initially local support groups could be facilitated through counsellors from the PCAF Trauma Centre and Kitgum District.

Through running regular confidential local support groups trust can be developed whereby survivors will be able to discuss their experiences and difficulties faced. This, in conjunction with awareness-raising of the community of their problems, will assist them to deal with the feelings of shame and stigma.

There would also be great benefit from free education and support for the mothers with children from forced marriages. As one of the former young woman abductees' stated during a focus group in Kitgum:

> *We would like education of our children from the forced marriages, assistance with our health and the health of our children, economic support and income-generating schemes for instance assistance to be market vendors. The trauma continues and we would like support from the trauma centre.*

In order for any psychosocial programme to be successful it also needs to include support and counselling for staff providing services for survivors of sexual violence. This would help staff to manage their feelings of being overwhelmed and to deal with their trauma more effectively, as this member of the nursing staff at Kitgum Hospital described:

> *We as staff have had no support since the war to deal with all our trauma. I have discussed this with our medical superintendent as we are dealing with very difficult situations so we need ongoing support for this. We really need trauma support, practical assistance as well as training to deal with stress and trauma management. Many of our staff deal with stress by taking Waragi [Ugandan spirit].*

This staff support could be initiated by an external facilitator from the Trauma Centre in Kitgum and carried out in confidential groups. Subsequently health care staff would continue to share their experiences and provide support for each other on a regular basis. There are also many widows whose husbands were killed during the insurgency and this has left women facing a large burden of responsibilities. Psychosocial and justice programmes should consider their particular needs.

II. Justice Policy Issues to be Considered

Below we consider policy that might be directed to the village/community; to the police; to abductees; and a general point about data collection.

Village dialogue

The culture of sexual violence needs to be broken by continuous awareness campaigns at the village level. Nothing less can break the apparent degeneration of sexual morality and the increase in sexual violence, both of which are reported by many. We envisage local dialogue and debate that covers the dignity of women, the respect due to them, their value, their equality with men and the tragic consequences on them and their communities when they are subjected to sexual violence. This is a debate that is not to be conducted only amongst women; rather it should include men and boys so that they too are part of the solution. Our research made clear that many men did not view forced marriages (whether to LRA commanders or to rapists following inter-family negotiations) as rape. The nature of sexual violence is therefore another topic that should be the subject of local debate and review.

Communities and their leaders (LC1-3) should be made aware of the need for their own speedy health and justice responses following rape in their localities. They should be acquainted with the nature and quality of the evidence required by courts for a successful identification and prosecution of the perpetrator. Such evidence will include preserving/recording data gathered from the scene of crime; full witness statements; medical examination of survivors within 48 hours and the like. This ensures the evidence is gathered should the police be slow to respond.

More controversially, we would accept that in the short to medium term negotiations between the family of the perpetrator and the family of the survivor, mediated by the local leader, will continue. We imagine that families will continue to consider that small compensation is better than the high risk of no compensation from the formal courts. This being so there is a case to be made for seeking to improve the quality of these negotiated settlements rather than simply calling in vain for every case to be taken to the police in cases of sexual violence. For us the intolerable aspect is where the settlement involves forced marriage of the survivor of the rape to the rapist. Leaders should be persuaded that that is unacceptable in every circumstance. We would also like to insist that when leaders consider compensation that they ensure that it more evidently reflects the serious nature of the offence. Both minimal requirements should be part of a consultation process with local leaders and their communities urging radical review of their practices. In addition, there is value in calling for any such agreements to be ratified by the community and also the LC3 and a local women's leader in joint session, to ensure transparency and conformity to the minimum requirements.

Communities and their leaders also need to be made aware that to offer bribes to the police, doctors and magistrates to pervert the course of justice is a serious criminal offence with serious penalties.
The above recommendations envisage dialogue and debate as the key process, rather than directives from above on rights and laws, with threats for disobedience.

This is a contentious position, but our case is that an argument won (even only in part) by persuasion, is preferable and likely to be adhered to more than a rule decreed from above and from outside.

Police improvements

The police should be made aware of the law as regards (i) what constitutes expert medical witness in court that a rape has occurred (see above) (ii) the serious offence of receiving bribes to pervert the course of justice.
The misapprehension concerning expert witnesses highlights the need not only for the continuation of the criminal justice liaison committee to clarify such confusions between police and magistrates, but for expanding it whenever the issue of sexual violence is to be discussed to include health professionals. It is not clear at present that the police fully understand what medical practitioners require of them; or that medical practitioners understand what the police require of them. The outcomes of such liaison committees should be clearly communicated to all local junior staff in the health and justice sector.

Gender training and women's rights should indeed be incorporated into police training curricula, but even the immediate availability to local personnel of a specific training manual and police procedures in responding to survivors of sexual violence would be helpful. Training in these procedures of those officers in Kitgum CID and CFPU should be an immediate priority.
The serious shortage of female officers in Kitgum, despite it being an area of particularly high rates of crimes of sexual violence, is detrimental to a police response that is sensitive and effective. The diversion of more women officers to the District would be a short term solution, even though the long term one has to be the recruitment of more female officers into the Uganda police.

A more survivor-friendly service would be achieved by the provision of exclusively designated interview rooms at police posts and stations. A permanent building programme might be out of reach of the finances at present, but others could follow the example of Kitgum town police station that has used (and now has had donated) a tent.
Such is a cheap resource that donors and/or women's groups might consider sponsoring.

Dealing with police corruption is notoriously difficult. Possibly all examples of cases of sexual violence where (i) files are lost (ii) charges are dropped (iii) cases are abandoned (iv) and cases are thrown out by the courts, could be reviewed by a local users committee, consisting of the station CO and Head of CID, a paralegal and two women's representatives. Their conclusions would not be grounds in themselves for the prosecution of a legal officer, but nonetheless they might act as a warning and could have a positive disciplinary effect provided that the hearing and findings are published locally.
Simply to find that 'there is a serious suspicion of corruption but not proof' might have a salutary effect on the officer at the centre of the inquiry.

Justice for abductees

Full justice in the case of crimes of sexual violence carried out in the course of the LRA rebellion, where the evidence and the perpetrators are difficult to establish, is virtually impossible in practice in northern Uganda. Nor is there a strong likelihood that the Special War Crimes Division of the High Court, will, when it is established, be able to successfully prosecute large numbers of the perpetrators. Nevertheless, there could be, where there is a prime facie case of sexual violence (e.g. a child; genital mutilation; damage to the reproductive organs etc) be (i) a District formal acknowledgement to such that they have indeed been wronged (ii) a provision of reparation in the form of free schooling for the child of rape (iii) a gynaecological examination and appropriate surgery for those in need of it (iv) and if necessary, in the case of severe stigmatization by the local community, resettlement outside the District. It would also require a new registration scheme to catch people unable to register for amnesty initially.

Conclusions

Combined Health and Justice Approaches

Although we have examined health and justice separately in this consideration of policy issues, the research itself looked at them together because sexual violence was experienced simultaneously as a violation of the survivor's body and rights. It left the survivor in need of both a health and a justice response. As the two are connected in the experience of the survivor so they go hand in hand in terms of service responses required.

We therefore argue that there is real value in promoting increased collaboration between local health and justice services:

> *'We need to strengthen the links between health and justice as the health professionals fear the police. There are tensions between health and justice and there needs to be more flexibility in the justice system to accept evidence from less senior staff. We should engage health, justice, and police and understand their different perspectives. (Medical professional, NGO, Kitgum).'*

Participants described the need for increased collaboration between health and justice services. They suggested that this could involve combined training on supporting survivors of sexual violence as well as joint meetings and discussions. Likewise the judge, police and medical superintendent would benefit from a meeting to agree on other health personnel who would be acceptable as expert witnesses, e.g. senior clinical officers. This would hopefully expand the number of expert witnesses and therefore assist the court processes. In addition it would facilitate more efficient and successful urgent health treatment.

For the long term, improvements to the quality of data collection and its dissemination between justice and health providers would offer real gains. Ideally there could be the establishment of a combined health-justice sector data collection and analysis. It could cover prevalence of sexual violence by age/sex/location; medical and justice services offered; medical and justice outcomes etc. It would identify vulnerable groups; service bottlenecks; obstacles to successful case management; successful strategies; and the relationship to other variables e.g. alcohol/drug abuse. It is the sort of project that a university with medical research funding might like to undertake for the District.

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Mental health problems among Kenyan refugees in a transit refugee settlement in eastern Uganda.

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Abstract

Objective: This study was undertaken to estimate prevalence of mental health problems among Kenyan refugees resident in a transit refugee settlement in eastern Uganda.

Method: The Hopkins Symptom Checklist, Harvard Trauma Questionnaire and MINI International Neuro-psychiatric Interview were used to assess for psychological distress, trauma experiences and mental disorders respectively.

Results: Of the 51 refugees interviewed, 90.7% reported symptoms of psychological distress and 25.6% reported substance use. Further evaluations showed that the commonest mental health problem was depression (22.8%) followed by posttraumatic stress disorder (21%) and substance abuse (14%). The most common trauma experiences were physical trauma from gunshot wounds and witnessing the burning of their homes and churches.

Conclusion: These findings affirm that high levels of psychological distress and mental disorders were prevalent among this sample of Kenyan refugees. Therefore, specific mental health interventions should be a component of psychosocial programs for post-conflict refugee populations.

Keywords: Posttraumatic Stress Disorder; Depression; substance abuse; Trauma;

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Introduction

The number of refugees and internally displaced persons (IDPs) in need of protection and assistance has increased from 30 million in 1990 to more than 43 million today as a consequence of war and civil strife (Toole & Waldman, 1993). Thus, there has been a substantial growth in psychosocial interventions to alleviate and prevent human suffering following conflicts and natural disasters (Batniji et al., 2006). However, few of these interventions have included mental health evaluations and interventions particularly for refugees migrating from one developing country to another. Refugee populations have an increased risk for mental health problems for a variety of reasons including traumatic experiences, difficult camp or transit experiences, culture of conflict, adjustment problems in the country of resettlement, multiple losses of family members as well as loss of country and a familiar way of life (Lipson, 1993).

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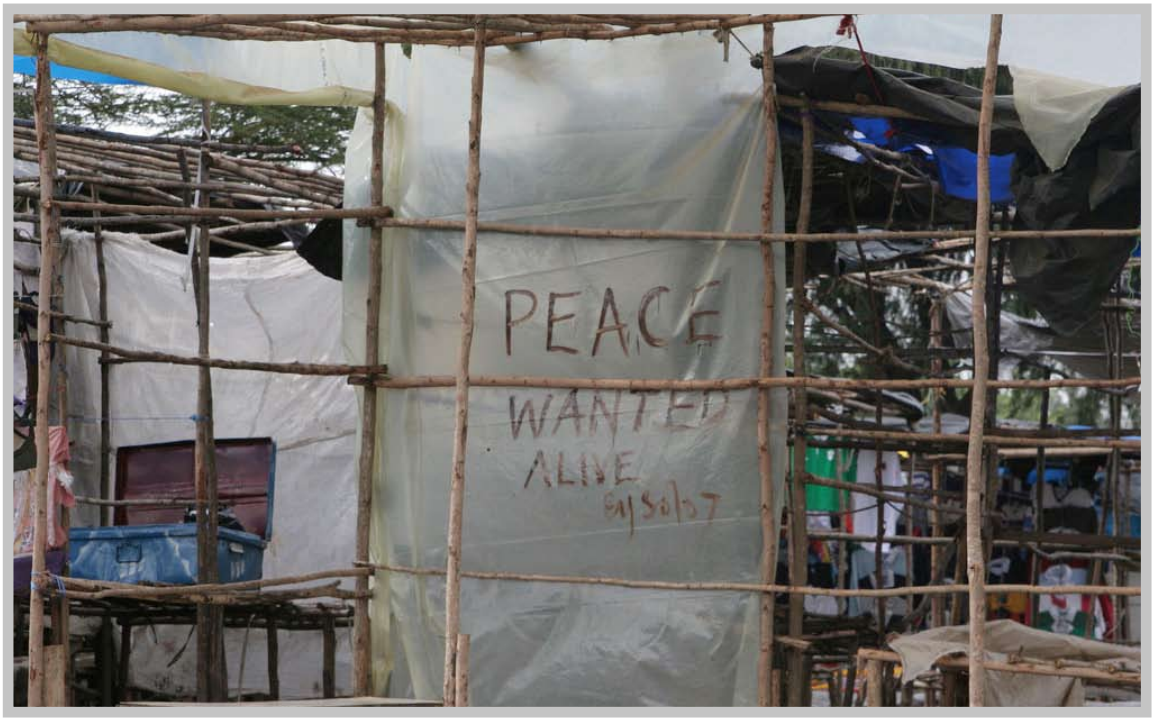
Previous researchers have reported high levels of somatization, depression, and post traumatic stress disorder (PTSD) among refugees with relatively high levels of physical and psychological dysfunction during their first two years of resettlement. (Chung & Kagawa-Singer, 1993). The majority of these studies have focused on refugee populations from developing countries who have migrated to developed countries(Kinzie et al.,1990; Marshall et al.,2005). Recently, a few studies investigating mental health of refugees in eastern Africa have emerged. These studies have mainly focused on depression and PTSD.

In December 2007, when over 2000 refugees, fleeing from political violence in Kenya crossed into Uganda, the newly established Peter C. Alderman trauma clinic at St. Anthony's hospital in Tororo, provided early psychosocial interventions to alleviate immediate sufferings and to mediate long-term psychological problems of the Kenyan refugees who were temporarily settled at Mulanda transit center. During this intervention, the clinic staff evaluated a sample of the refugees for a variety of mental health problems.

This paper describes demographic characteristics, trauma experiences and provides estimates of prevalence rates of a wide range of mental health problems and/ or mental disorders among these Kenyan refugees. The goal of this study was to provide information that may be used to update strategies and policies governing refugee's health.



Peace Wanted Alive from http://www.flickr.com/kenya elections 2008

Methods

Study setting and population

Over a 2 month period, we performed a cross-sectional study of Kenyan refugees living in Mulanda Transit center(MTC) - a temporary refugee settlement situated in Mulanda sub-county about 23km Northwest of Tororo town. At the time of the study, MTC had a total population of 1977 refugees with 1014 males and 963 females. There were 353 children under fives years, 656 were between 6-17 years and 930 were between 18-59 years and those over 60 years were 38. The refugees were split up into six blocks from A-E. Block A had 350 refugees, block B had 358, block C had 395, block D had 279, block E had 270 and block F had 323; (UNHCR data bank , 2008). Fifty-one refugees were consecutively enrolled into the study as they came in for psychological and other physical interventions. All refugees who were requested to participate in the study gave informed consent and none refused to participate. Permission to carry out the intervention study was sought from the co-ordinator of the United Nations High Commission for Refugees (UNHCR).

Measures

Demographic and general psychiatric history measures

A standardized questionnaire was locally developed and assessed subject age, marital status, education, income, and employment, self-reported general psychiatric history with respect to family psychiatric history, diagnosis, suicide attempts and present substance use.

Trauma exposure measure

The Harvard Trauma Questionnaire (HTQ) was used to assess traumatic events experienced when political violence erupted in Kenya. The HTQ inquires about a variety of trauma events, as well as the emotional symptoms considered to be uniquely associated with trauma. This instrument was specifically developed such that it could be adapted for use in local settings throughout the world.

Psychological distress (depression symptoms)

The Hopkins Symptom Checklist was used to assess symptoms of depression. It is a well-known and widely used screening instrument whose history dates from the 1950s and has been validated among Somali and Ethiopian refugees in Uganda (Onyut et al., 2009). Individuals who scored above 1.75 on the depression sub-scale were evaluated further for DSM-IV Axis 1 mental disorders using the Mini International Neuropsychiatric Interveiw (MINI)

Statistical Analysis

Statistical analysis will be performed by using Stata 10.0 (Stata Corp., College Station, Texas). Frequencies of demographic variables, substance use, social problems and mental disorders were computed.

Table 1: Socio-demographic characteristics of Kenyan refugees at Mulanda Transit Center

Characteristic	Frequency (N=51)	Percentage (%)
Sex		
Male	25	49
Female	26	51
Age (Years)		
0-20	17	33.4
21-40	25	49.0
>40	9	17.6
Marital Status		
Single	25	56.5
Married	15	40.5
Divorced/Separated	3	7.14
Widow	5	11.9
Religion		
Christian	41	83.6
Moslem	4	8.2
Others	4	8.2
Level of Education		
No formal education	8	16.3
Primary level	18	36.7
Secondary level	21	47.0
Tertiary level	2	4.1
Tribe		
Kikuyu	13	26.5
Luyas	5	10.2
Bukusu	19	38.8
Others	12	24.4
Employment		
Peasant	8	16.7
Professional	7	14.6
Trades person	16	33.4
Artisan	4	8.3
Un-employed	4	8.3
Others (student)	9	18.6

Results

Social demographic characteristics

Table 1 summarizes the demographic characteristics of our sample. . The majority (49%) were in the age range of 21-40 years. The male to female ratio was 1:1. Almost half of the respondents had achieved secondary school level education. Majority of the respondents were Babukusu 19(38.8%) and Kikuyu 13(26.5%) tribes. The other tribes included Luyas 5(10.2%), Arabs 3(6.1%), Meru 1(2.0%) and others 5(10.2%).

Information on employment status of the study participants before the conflict reflected that majority 16(33.4%) were traders, shopkeepers or operated small-scale businesses.

However, they sadly noted that they lost everything during the riots. Next to that were peasants i.e. 16.7% most of whom were women and most had no formal education 16.3%.

Traumatic Events Experienced by Respondents:

Most people who participated in the study experienced some form of violence. The commonly mentioned ones included; gunshots, burning of houses and churches. Many people lost their loved ones, homes, property and livestock. During the interview, respondents were observed shading tears as they narrated their trauma histories.

Mental health problems among the Kenyan refugees at Mulanda Transit refugee camp:

Most of the respondents 39(90.7%) had general psychological distress and scored 4 or more positive items on the Hopkins Symptoms Checklist (HSCL-25).

Those respondents who scored > 4 positive items according to the HSCL-25 under went further evaluation with the MINI to specifically diagnose their mental disorders. Table 2 summarizes the mental health problems of our sample.

Table 2: Frequency of Mental health problems among Kenyan refugees at Mulanda Transit Center.

Psychiatric disorder/problem	Frequency (N=51)	Percentage (%)
Lifetime suicide	14	24.5
Depression	13	22.8
PTSD	12	21.0
Substance Abuse	8	14.0
Generalized Anxiety disorder	5	8.8
Conversion Disorder	4	7.0
Adjustment disorder	4	7.0
Epilepsy	4	7.0
Psychotic disorder	3	5.3
Deliberate self harm	3	5.3
Panic disorder	1	1.8

Substance use among Kenyan refugees at Mulanda Transit Center:

This study revealed a high degree of substance abuse and dependence to drugs in the camp.

The commonest substance abused was alcohol with about 70% of the respondents having problem drinking (CAGE > 2. Table 3 shows the substances of abuse within the Mulanda Transit Camp.

Table 3: Substance use among Kenyan refugees at Mulanda Transit Center.

Variable	Frequency (N=51)	Percentage (%)
Use of any substance drug		
Yes	11	25.6%
No	32	74.4%
Types of Substance Used * (N=11)		
Alcohol	10	90.0
Cigarettes	7	63.6
Marijuana	3	27.3
Mairunji (Khat)		
CAGE Score		
<2	3	30%
>2	7	70%

*** Some respondents abused more than one substance.**

Social Problems among the Refugees:

Social problems observed among the study participants included family disintegration, marital problems, fighting, defilement and theft. Table 4 shows the frequency of these social problems.

Table 4: Social problems among Kenyan refugees at Mulanda Transit Center.

Social Problem*	Frequency(N=51)	Percentage (%)
Family disintegration	59	84.3
Marital problem	3	4.3
Fighting	3	4.3
Defilement cases	2	2.8
Thefts	3	4.3

*** Some respondents had more than one social problem.**

Discussion

These findings affirm that high levels of psychological distress and mental disorders, particularly depression, posttraumatic stress disorder and alcohol abuse were prevalent among this sample of Kenyan refugees. The rates of these mental disorders within this refugee population are consistent with findings from other post-conflict populations (Onyut et al.,2004).Previous research in other war affected areas particularly in Uganda, documented various experiences of violence that included sexual and gender based violence (SGBV) including rape, sexual slavery, forced marriages, killing of loved ones, displacement into IDP camps, destruction and stealing property, burning of houses, etc (Isis WICCE, 1999; 2000; 2001). Further studies have documented a significant number of psychiatric problems as a result of this violence which included Post Traumatic Stress Disorder (PTSD), Depression, psychosis, alcohol and substance abuse, suicidal behavior (Musisi et al, 1999, Kinyanda & Musisi, 2001; Kinyanda et al, 2002).

The high rates of psychological distress with suicidal ideation observed in this study point to a need for early mental health screening and initiation of early interventions to prevent the occurrence of full blown mental disorders. The experience of violence impacted negatively on the refugee's psychological well-being. During clinical interviews, most of the respondents presented with extreme distress symptoms including panic attacks, anger, tiredness, sleep problems poor appetite, feeling sad, lonely & hopeless about the future

Consistent with other reports in the literature (Fazel et al.,2005; Mollica et al.,1999), there were high rates of substance abuse in this sample of Kenyan refugees. Most respondents who reported excessive drinking of alcohol attributed it to idleness and lack of sleep as the major reason why they were drinking so much. Furthermore, the insecurity of refugee life, lack of employment and poor access to social services aggravated the drinking among the refugees.

Although this study has a number of limitations such as small sample size, a lack of validation of study instruments, the data documented is valuable because conflicts continue to proliferate in Africa and even more people are migrating from one African country to another. For example, Uganda is receiving an influx of thousands of new refugees from the Congo. Such information is vital for planning emergency and other services in the host countries.

Thus we recommend that humanitarian agencies that work in refugee settings, should include mental health evaluation as one of the major intervention components for the refugees among other needs. Also efforts should always be made to stop the brewing and sale of alcohol in refugee camps.

Conclusion

A variety of mental health problems were highly prevalent in this Kenyan refugee population. Given that mental ill health also contributes to poor physical health, reduces functioning thus interfering with capacity to uptake developmental activities, allocations for mental health provision are just as urgent as any emergency material provisions made for refugee populations. The identification and treatment of not only posttraumatic stress disorder and depression but also substance abuse among post-conflict populations is of paramount importance.

Acknowledgements

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The human validation process model in loss and psycho-trauma healing: A proposed approach to helping traumatized commmunities

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Abstract

Mass trauma often in the form of politically engineered militarized conflict, affects a large number of African peoples creating refuges, exiles, internally displaced peoples, driving epidemics and poverty and fueling ethnic tensions that go from generation to generation. Often, African governments don't have the resources or the political will to address the tremendous mental health fall out of these war-related mass traumata. There's no documented literature on evidence-based African specific mass therapies to address this huge problem. This paper discusses a proposed intervention model that could be used to helping the massively traumatized communities in Africa by taking the recent Kenyan political violence as the case study in point.
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Introduction

When people go through major loss with subsequent psychological trauma, they, in most cases, prefer to push the painful events out of their minds. Consequently, these painful events intrude in their thoughts, feelings and behaviors thus making their lives difficult. This is marked with a sense of unworthiness, stagnation and hopelessness. These people apply defense mechanisms to cope but unfortunately these distorted ways of coping are limited and if not checked might lead to adverse systemic issues in the lives of the affected individuals or their families. They develop long term psychological conflicts which, on a mass scale, may result in sick and poorly motivated underdeveloped communities with lack of vision and sense of purpose in their future. Often these communities become non-productive, marginalized and engulfed in self destruction as is seen in the chronic alcoholism of many native Indian communities in North America or the Aboriginal communities in Australia.

Objective

This paper discusses a possible approach to helping communities which have been affected by chronic and vicious cycles of mass violence as have been seen for generations in the Eastern African region, e.g. Rwanda, Somalia, Sudan, Uganda, Kenya etc. The proposed intervention model is 'The Human Validation Process Model'

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which was developed by Virginia Satir in 1983 – a systemic/family therapist - to treat families that had lost direction and lived confused, incongruent and hopeless lives. Her approach emphasizes clear open communication and emotional experiencing through art (e.g. family sculpting), exploring past dysfunctional relationship patterns, reframing, establishing functional rules and roles, using available and untapped resources and mapping the way forward to self-actualization and fulfillment.

Background

Mass trauma has been endemic in Africa for generations. There were the raids of the slave trade, religious wars, tribal wars to control territory, colonial wars of independence and then the current post-independence wars which seem to be driven by global ideological hegemonies, fundamentalisms and control of resources (oil and minerals) or strategic routes to these resourcese e.g. Somalia (Musisi, 2005). The consequent loss and psycho-trauma in Sub Saharan Africa has to some extent been due to past flawed thinking manifested in ethnic, international, racial biases and prejudices, rigid rules, unclear incongruent communication systems or sometimes pure ignorance of the globalised forces which drive these wars e.g. the international trade in arms.

The Human Validation Process Model can be applied in the reconstruction and reframing of broken systems and families in otherwise massively traumatized communities for a better productive future for all. It fits the African

Background Information: The Kenay Post Election Violence

The effect of Post-election conflict in Kenya from http://www.warshooter.com

approach to issues through a sense of community and using the community leaders.

All human beings need validation in a hopeless situation. Loss and subsequent psychological trauma leaves many a people hopeless and depressed in their states. This model can be applied to help reframe a system's painful past, develop a sense of worth and purpose, unearth hidden potentials and resources and enhance self actualization to a fulfilling future. Kenya will be taken as a case study to describe how this model can be applied to help traumatized communities of the 2007 Post Election Violence, PEV.

Background Information: The Kenya Post Election Violence

The recent post-election violence in Kenya has had adverse effects that have disrupted the normal functioning of individuals and families as well as the entire society. Some people suffered direct injuries, bereavement, displacement (650,000 people were displaced) or loss of property while others witnessed the suffering of loved ones (1133 people died) and others are still being haunted by disturbing images in the media (Daily Nation Newspaper, Tuesday, November 10, 2009). The result has been a collective trauma that left many Kenyans angry, bitter, frustrated, confused, insecure, suspicious of one another and very anxious about the future. If these feelings and issues are not addressed, relationships, teamwork, performance, productivity and general social harmony are likely to be negatively affected for generations and may lead to repetition of the violence. Following the post election violence in 2007, many families were displaced and pushed to seek refuge in churches and public grounds like stadiums and show grounds. The largest Internally Displaced Persons (IDP) camp in Nakuru housed 740 IDP families who were subsequently relocated in Nyandarua on 19th November 2009 and thus re-traumatization (Sunday Nation October 18, 2009).

About 600 people were killed in the North Rift Valley province following the post election violence. These deaths touched many people especially those who were related to the dead and indeed the manner of their deaths was very traumatic (Waki, 2007). There seemed to be a hurry to resettle those IDP's due to the threats posed by El-nino rains which begun with heavy downpours beginning in the month of August 2009. There was also the urgency to meet Kofi Annan's (United Nation's Secretary General and Chief Mediator, PEV 2007) reforms and ultimatum of IDP resettlement. There were demonstrations in the IDP camps for all sorts of reasons including lack of basic needs – food, clothing, shelter, health care not to mention political interference, raids by criminals.

The general insecurity led to mass exodus back into big towns thus swelling slum populations and increasing the scramble for the already scarce resources. Many vulnerable women were lured into commercial sex for survival among others. Families broke up and many children were abandoned hence resulting in much family disintegration (Daily Nation, Tuesday, 10 2009).

The issues and concerns faced by the IDP's likely made them behave irrationally, suscipious,mistrusting and paranoid about their present and future situation. This state of affairs persisted even in their resettlement schemes. There was fear of mass intrapersonal and interpersonal conflicts in addition to the trauma they suffered. All this was likely lead to mental distress. Literature show that even major psychiatric illness, psychosis, including schizophrenia, could be triggered by stressful changes in the otherwise normal lives of individuals after severely traumatizing events (Sadock and Sadock, 2003).

The Proposition

Reconstruction Intervention for Trauma in Kenya

The IDPs were very traumatized by the 2007 Post Election Violence (PEV) ordeal. Their continued fear was characterized by the avoidance of going back to where they were displaced from. They had also been relocated to new areas with smaller land despite the fact that the majority of them were dependent on farming large pieces of land hence leading to relocations. They had fears that their original land would be taken for ever. The PEV 2007 was an explosion of long term ethnic differences and stereotyped perceptions that dated back to colonial Kenya (Citizen TV, Media Focus on Africa Foundation Production,12/11/09).

The Problem

There is a clear indication of intergenerational trauma and violence in Kenya dating back to pre- and post-colonial eras. That trauma was never addressed in care. Traumatized peoples require specialized care and treatment to deal with their pain, pick up their broken lives, put them together and move on with life like the rest of the normal population in society. Healing, in most cases, means not just alleviating individual symptoms, but also addressing the healing of both personal and communal systems – i.e. a holistic approach through the use of body- mind-spirit interventions to heal and renew the energy of the person and the community (Cane, 2000). Unfortunately in Kenya today, like in many African countries, there is a general lack of awareness, recognition and involvement of the role of community leaders in the healing and reconciliation process, yet they are very instrumental in local harmony and development.

Justifying the Community Based Reconstruction Trauma for Kenya

Human beings are emotional beings. Emotions are sensitive in decision making. Negative emotions have been known to cause negative actions. Negative emotions are often a result of negative thoughts. The Human Validation Process Model as promulgated by Virginia Satir is a systematic approach to counseling families holistically. This model can be extended to communities in crisis to reconstruct their thinking, emotional well being and subsequent behaviors (actions). This model emphasizes the collaborative efforts of the community, therapist and family members to achieve family wellness by releasing the pent up emotions, breaking rigid rules like tribal stereotypes, hopelessness and fear of success, through genuine emotional and behavioral expressions and positive interventions (Goldenberg & Goldenberg, 2004).

Traditional African socio-political leadership often comprises of councils of elders whose roles mainly include promotion of peace, culture and morality of a society. In today's Africa, the elderly are often sidelined and their opinions ignored. Yet, these elderly leaders would be conduits to peace building and reconciliation not just within displaced/resettled IDP's but among communities to avert future conflicts (Kenyatta, 2004, Chopra, 2005 & Nkanata, 2009). Modern African communities today also comprise of all kinds of educated professionals who could be used to pool resources and join hands with the community elders, community members and significant stakeholders to heal, and reconcile resettled IDP's (Hollander, 1998)

Theoretical Approach to the Community Intervention

Virginia Satir is a systemic therapist who worked not only with families in conflicts but also with larger systems like churches and communities in her Human Validation Process Model. She facilitated sessions that reviewed causes of conflicts, people's experiences in those conflicts, genuine expression of the pains suffered and conflicts as well as mapping a joint healing process for the participants (Golden berg & Goldenberg, 2004). Satir's model is supported by Brief Dynamic Psychotherapy suitable for crisis intervention. This is both cost effective and community friendly. It emphasizes joint community understanding with a therapist, places responsibility on the participants for their healing and together they develop a treatment plan.

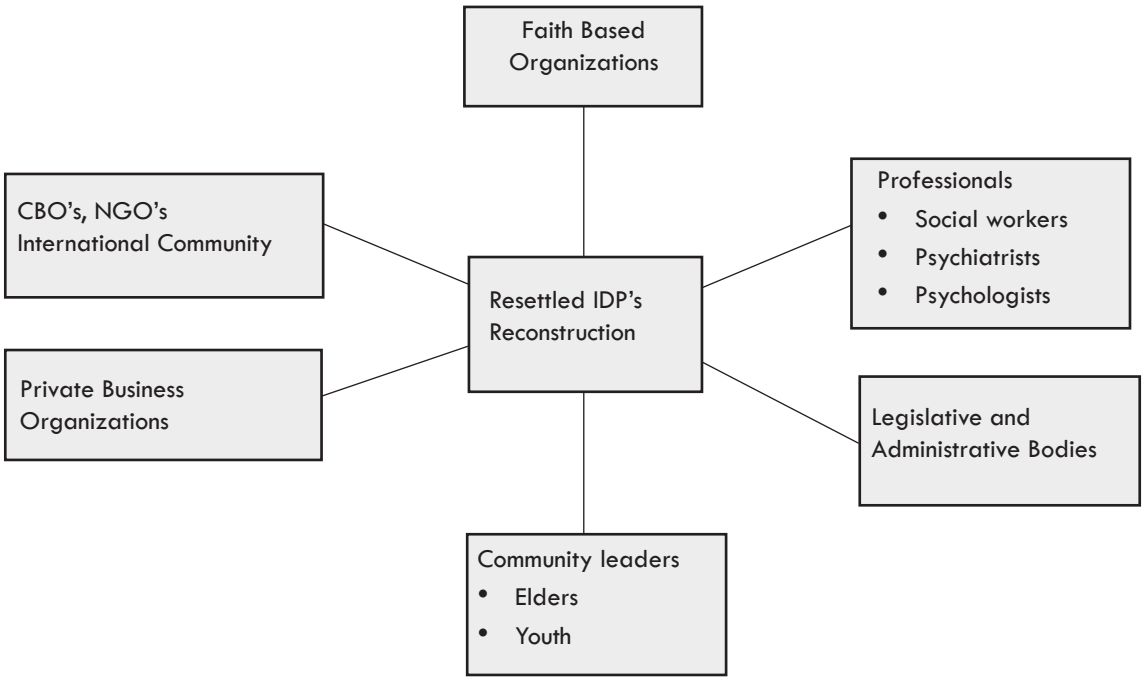
The techniques include; reassurance, suggestion, environmental/community manipulation, brief hospitalization and psychotropic medication if necessary (Sadock & Sadock 2003). In Kenya, the survivors of the 2007 PEV had stories to tell before, during and after the ethnic conflicts and were burdened with a responsibility to move on with the life after trauma. A genuine expression of their feelings, thoughts and actions and fears for their present and future needs was thus paramount for the holistic healing and reconstruction of their lives. Virginia Satir's model aims at taking the participants through a genuine process of recovery while validating all their experiences and successfully healing them in the present and preparing them for future eventualities.

The PEV in 2007 in Kenya was, to some great extent, fueled by past flawed thinking manifested in ethnic biases and prejudices, rigid rules, unclear incongruent communication systems and this model could be applied in reconstruction and reframing of these systems for a better productive future for all. Community based treatment is favored by many a mental health practitioner as it pools community resources for effective interventions for community rooted and related problems (WHO, 2008). This is still evident even after resettlement efforts in North Rift Valley province where suspicion remains high with some IDPs in transit camps despite the launch of the resettlement program called "Operation Rudi Nyumbani" translated as "Operation Return Home" (Sunday Nation, November, 2009).

Theoretical Conceptualization Of The Intervention Model

Human beings need help to achieve self-validation when in hopeless situations. Hope is necessary in a crisis. It is one of the chief ways that peoples' minds are protected (Chopra, 2005). Loss and the subsequent psychological trauma leaves many people feeling hopeless and depressed. Most resettled persons in post conflict regions suffer from disorientation from their normal routines which get disrupted during the conflict and post conflict period. Going back to their displaced homes or being resettled to different areas is a big challenge emotionally, socially, spiritually and psychologically. It is the concern of every community member to facilitate a smooth resettlement of those wounded people. A community based approach is the ideal and holistically effective approach in reconstructing the lives of traumatized persons. Figure 1 below shows how such an approach can be integrated in an effective multi disciplinary community based trauma intervention model (Kombo and Tromp, 2006, http://www.conceptsystems.com).

Fig 1: Community Based Human Validation Process Model for Resettling IDP's in Kenya



The various stakeholders can be of use depending on the different roles they play and how they could be strategically positioned in the intervention chain. The affected peoples can be referred to a central trauma healing and reconciliation focal point, the Psychotrauma Clinic. Through health centres, local administration, community based organization, NGOs or others using community based systems, the psychotrauma services are organized from the top most leadership to the grass roots level.

Conclusion: Outcome

After the resettled IDPs are taken through the community based trauma intervention, they become part of the whole community. They pick up the community spirit, develop a sense of care for others, interact with the different stakeholders and thus boost their sense of belonging to and in the community. The narrative part of healing, through psychological intervention helps them to get in touch with the reality of events despite experienced pain and loss. Cognitive Behavior Therapy (CBT) is the most favored psychotherapeutic technique by many trauma therapists. Eventually, most IDPs are helped to see and accept their direct and indirect role(s) in the conflict through open sharing and personal discussions. They will desire to belong to the same community within which they suffered, reconstruct their systems and develop a joint approach to permanent solutions to present and future conflicts.

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Demon attack disease: a case report of mass hysteria after mass trauma in a primary school in Uganda

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Introduction: *Mass hysteria is the spontaneous en mass development of identical symptoms among a group of otherwise healthy people who share common attributes and believe they have been made ill by external factors. It is often preceded by mass psychic trauma*
Objective: *This paper describes the management of a case of mass hysteria in a primary school in Uganda and review of related literature.*
Case Report: *Layamo is a remote village Primary school in war affected Northern Uganda. The school was paralyzed when massive numbers of students started running around hysterically and fearfully, biting each other in a frenzy of "demonic possession". The school was ordered closed and re-opened after ritual of prayers, traditional cleansing, cutting down a "demonic tree" and psychiatric intervention of isolating and treatment of two index cases with symptoms of PTSD, depression and panic and recognition of two unmarked mass graves and ordering of construction of the memorial "to rest the spirits in peace".*
Conclusion: *This case illustrated mass hysteria following mass trauma in keeping with the Literature and how traditional and modern healing methods were combined to deal with the problem.*
AJTS 2010; 1(1): 43-48

Background:

Mass hysteria refers to a spontaneous, en masse development of identical physical and/or emotional symptoms among a group of people, who usually share a common attribute e.g. a school, church or village. Modern scholars refer to it today as mass psychogenic illness, defined as a 'collective occurrence of physical symptoms and related beliefs among two or more persons in the absence of an identifiable pathogen' (Colligan & Murphy, 1982). It is a social phenomenon often occurring among otherwise healthy people who suddenly believe that they have been made ill by some external factor. (Jones et al, 2000). Mass hysteria is usually preceded by mass psychic trauma.

Historical precedents: Hysteria as a human behavioral phenomenon goes as far back as the beginning of man's psychosocial development. In the middle ages, epidemics of dancing manias occurred in Mertz, Cologne and Aix-La-Chapelle.

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In 1374, many towns along the valley of the Rhine River were gripped by a strange affliction in which hundreds of people were seized by a compulsion to dance for days, even weeks, without pausing to eat or sleep. This epidemic spread like wild fire and consumed large areas of North Eastern France and the Netherlands(Waller, 2009) In 1518, another explosive case was reported in the city of Strasbourg that affected about 400 men, women and children (Waller, 2008). Another sensational report is made of a nun, Mother superior Jeanne De Anges who fell into a dissociative state in which she accused a local priest Father Grandier of plotting with the devil to make her lust for him. Within days, several of her sisters had followed suit, all pointing the finger at the priest, who was consequently charged and burnt alive (Waller, 2009). The index victim later confessed to having felt a burning desire for the priest, followed feelings of worthlessness and guilt, finally precipitating her hysterical breakdown. This episode, and several others in nunneries from Rome to Paris, was marked by frantic activity, delirium, foaming, convulsions, and behavior generally counter characteristic of nuns such as sexually propositioning priests and exorcists, and confessions to having sexual relations with devils, or Christ.(Waller, 2009) Mass hysteria episodes of this nature have reduced in the West but they have increasingly been reported in Africa.

A SCHOOL AMIDST NO WHERE.

Mass hysteria in Africa: Literature suggests that mass hysteria episodes have frequently occurred in Africa. In February 2000, about 1430 learners, particularly girls, at schools in Mangaung and Heidedal, in the Free State Province of South Africa presented with mass itching of unknown origin. At the first school to be affected in the Mangaung area, itching begun as soon as the learners entered the school premises; very few reported itching or scratching at home. The affected learners were taken to the principal's office and those who came to observe what was happening, experienced an onset of itching.

The epidemic affected students; a few teachers, mainly female, reported some itching as well. No organic cause was found for the itching and finally, a diagnosis of anxiety mass hysteria was given for this outbreak (Rataemane & Mohlahle, 2002).

Kaggwa, (1964) describes yet another case of "mass madness; early in 1963, the Ministry of Health in Uganda received alarming reports from the Eastern Region of the country where over 300 people were affected by an illness of sudden onset that caused them to run around aimlessly and sleep out of doors. They all complained of 'headaches' and 'pain in the heart. The affected stated that they could see the faces, and hear the voices of their dead 'elders'. Almost all caught a white chicken, or wore white chicken feathers on the head. Local exorcists attempted to alleviate the problem by visiting the burial grounds of the victims' clans. White chickens were slaughtered and their blood was used to anoint the tombs. Pieces of chicken, baked plantains and calabashes of wine were placed at the tombs as gifts to the spirits of the dead clan elders. (Kaggwa, 1964)

In East Africa many schools have from time to time been closed due to peculiar epidemics of frenzied, aimless running of unknown origin. In early 1962 to late 1963, three major out breaks occurred in schools around Lake Victoria and Tanganyika (now Tanzania). In his report on the epidemics, Ebrahim (1968) described a form of 'running mania' and two cases of violent "running manias'. The first case appeared in a thickly populated area of Mbale in Eastern Uganda and quickly spread to the school population.
Common characteristics included a sudden onset of agitation, talkativeness and attempted assault. The people believed these symptoms to be in response to commands from spirits of dead relatives. At the height of the outbreak, about 300 people were affected, mainly between the ages of ten and forty years. It is interesting to note that not one authority figure; no teacher, policeman or tribal chief was affected. (Ebrahim, 1968).

Recent Mass hysteria in Uganda: In the past ten or so years, a series of mass hysteria cases have been reported in Uganda. In the 1980's, boarding secondary school girls in Ndejje Secondary School were attacked by mass abnormal dancing gaits whose cause was never established. This school lies in the path that soldiers of the ousted dictator, Idi Amin Dada took as they fled. Destruction of lives and property, fear and total mayhem was wrought throughout the countryside as these soldiers fled.

Between 1988-2002 many boarding school girls in Mityana Secondary School were attacked by "demons and spirits" and ran amok. These episodes followed the Liberation war by the National Liberation Army, (Walugembe, 2002). As in all wars, the hallmarks of that war were mass fear, suffering, uncertainty and loss, both at the hands of errant rebel armies and what was then viewed as liberation forces. More recently, the New Vision Newspaper, on 4th February 2008 carried a report that, over 100 pupils went out of control in Sir Tito Winyi Primary School, located in Hoima district, Western Uganda. The school's head teacher told 'New Vision', "The situation is bad. The pupils are totally mad; they are chasing everybody including teachers and fellow pupils, throwing stones, banging doors and windows…" The authorities termed the incident as "demonic attacks" and invited a church leader to conduct special prayers for the pupils. The head teacher admitted that this was the second attack of its nature on the school. In the previous year, 210 pupils had been similarly attacked. Following the episode, four suspects had been charged in court with casting a spell on the school, due to a land dispute.

The case was never resolved however because the witnesses (students) became hysterical again upon seeing the suspects. The prosecutors fled in fear, forcing court to adjourn. It is in this atmosphere of fear and anxiety that school opened again the following year and crashed headlong into the February 2008 episode.

All these Mass hysteria episodes which have been increasingly reported in the Ugandan Media in the past ten or so years resulted in school closures but with no definitive management or policy strategies. This paper describes the definitive management of a case of mass hysteria in a primary school in Uganda.

The Case Report

Layamo Agwata is a remote village Primary school located in Pawena Subcounty, Kitgum District in war affected Northern Uganda.

In 1991, the National Resistance Army(NRA), under the government of Uganda; launched an operation against the Lord's Resistance Army (LRA) rebels. The rebel group opened their camp around the school and the school was ordered closed down. Later the NRA over-ran the LRA camp and also established a base there. In all this process, it is reported that a number of people were Killed and buried in 2 mass graves near the school. The school buildings were completely destroyed.

In 1997, the school was re-built, re-opened and studies resumed. On 9th February, 2009, at the beginning of Term 2, a strange disease attacked the pupils of the school. Pupils were reported running wildly, shouting, fighting each other, biting and beating each other with sticks. The Headmistress of the school recorded the sequence of the attacks. She said…

> *… On Monday 9th February 2009, during the 2nd week of term one, one girl in P.5 was attacked with demons and began shouting, running amok, fighting, biting, crying and impossible to restrain...*
> *…After three minutes another pupil in P.4 was similarly attacked. By lunch time 3 girls had been attacked and by 3:00 p.m, 3 more were attacked. 7 cases were reported on that first day."…*
> *…Friday 6th March 2009 was the worst day of my life. I appealed to the LC III Chairman (chief) for help…*
> *…The strength of the demon attacks went so high that the school management and the parents were all afraid and failed to intervene…*
> *…The DEO came from town to see what the problem was. He asked the girls what was happening. They were attacked in his presence and the whole school was in chaos. He ordered the school closed and he ran for his life…*

The learners who were attacked reported…

> *'… The demons descended from a tree and approached in the form of human beings but then turned into skeletons. …*
> *… The demons would order you to bite a fellow pupil, that pupil would then receive a mark; he/she would then be protected and would not be bitten again. That pupil would then bite another person and so on and so on…*

The vicious cycle of attacks, biting, and demon possession then continued with running, shouting and crying. At the height of the episode there were a total of 54 cases; 47 girls and 7 boys. The worst affected learner was the Head girl of the school. The second worst affected was the cleverest and most cheerful and charismatic girl in the school. Both of these were still in treatment several weeks after the attacks receded

Intervention

Intervention I

The school was closed by the District Education Officer and traditional cleansing rituals were done by elders in the community. These included slaughtering of animals like goats and the blood sprinkled over the school grounds in an effort to appease the spirits. Prayers were carried out by CARITAS International, a Christian Non Governmental Organization operating in Northern Uganda. The headmistress of the school, in spite of her own fear and ominous warnings from community members, cut down and burnt the "demonic tree" from which pupils believed that the demons descended to attack them.

Intervention II

A Psychiatric Clinical Assistant at the local hospital was consulted. She isolated and treated the two index cases that had symptoms of Post Traumatic Stress Disorder, depression, anxiety and panic.

These were the Head-girl and the cleverest girl. A consultant psychiatrist who visited the school noted two unmarked mass graves from the previous massacres of village people by marauding armies. He also noted that many in the graves were actually relatives of the pupils; or were a representation of the people that had died or disappeared during the turbulent years of the war. He recommended construction of a memorial over the site of the mass graves to rest the spirits of those buried therein in peace. He also recommended that an annual vigil be held, which would give the local people and the pupils an opportunity to mourn the loss of their loved ones, and to pray for their souls. No more cases of demon possession were reported after that.

Discussion

Among the victims of mass hysteria, there is always a mass dissociation of content of consciousness from the overt manifest grotesque symptoms, (Kaggwa, 1964). Several descriptions of the victims have carried terms like "frenzied, wild, seeing visions and totally mad". (Kagwa, 1964, Ebrahim, 1968, Waller, 2009, et al,). It is therefore difficult for the lay witness or the affected to make a connection between the overt symptoms of the hysterical victims, and the possible cause of the episode.

Literature on mass hysteria points to a number of related attributes to the outbreaks. Mass hysteria is characterized by prevailing intense mass affect, anxiety and fear (Folieux en masse). The type of symptoms displayed in the Layamo school episode, and other episodes of mass hysteria in East Africa and Uganda are comparable to mass motor hysteria as described by Wessely (1987). Mass motor Hysteria typically requires a prolonged build-up of psychological tension which then manifests itself in dissociative states and other psychomotor abnormalities, (Waller, 2009). All these also characterized the Tanganyika Dancing manias, the Mityana, Ndejje, Sir Tito Winyi and Layamo schools episodes described earlier.

Waller (2009), in his paper on Dancing plagues and mass hysteria cites 'fear and loathing' as precedents to the outbreaks. The following is an excerpt from his paper

The years preceding the dancing epidemics were exceptional in their harshness. The 1374 outbreak maps onto the areas most severely affected, earlier in the same year by one of the worst floods of the century.

Chronicles tell of the waters of the Rhine rising 34 feet, of flood waters pouring over town walls, of homes and market places submerged, and of decomposing horses bobbing along watery streets. In the decade before the dancing plague of 1518, famine, sickness and terrible cold caused widespread despair in Strasbourg and its environs …

The Ndejje and Mityana schools episodes were preceded by prevailing mass fear and trauma, after the political unrest caused by fleeing Amin Soldiers and clashes with the liberation armies

respectively. As far as the rest of the world was concerned, the guns of the Kony Rebel group and government forces had quieted by early 2008. For the pupils of Layamo however, this was far from the truth. The children remembered the actions of the marauding armies, and they were afraid. They also had the constant reminder of mass graves just outside their school compound. The atmosphere was pregnant with anxiety, and at some point, something had to give.

The anxiety caused by the political insurgence, and the pain and horror associated with the war had another insidious bedmate. Although it may be easily ignored or made light of by an outsider, the essentially African belief in the spirit world was a powerful and overriding factor in the Layamo hysteria episode. Acholi tradition dictates that a grave is dug as soon as a person has died, and a brief ceremony is held prior to burial. All procedures are conducted with care, in an attempt to ensure that the spirit of the departed does not become angry (Acholi religion and Expressive culture, 2009). For Layamo, no ceremonies were performed for the dead in these particular mass graves. Needless to say, their spirits still roamed the area. It is therefore not surprising that the pupils insisted that they were compelled by spirits to bite each other.

The belief of people in Uganda, and indeed Africa in the spirit world is not a new concept. It is a deeply ingrained belief that even today directs the day to day activities of many African communities. The influence of this belief is seen in the account by Kaggwa (1964). He writes...

> *… Without exception, all complained of pain in the heart… when asked to explain where the heart was however, they pointed at the sternum. It is interesting to note that their word for heart, 'mwoyo' also means 'spirit'…All this (talkativeness, compulsive smoking and attempted assault and robberies) was said to be done in response to the orders of the spirits of the dead family elders…*

The same precipitant could also be inferred from the hysteria episodes in Sir Tito Winyi primary school. It was believed that a spell had been cast on the school (probably involving spirits that had been sent to haunt the school) due to a land dispute with the school authorities.

This case had not been resolved due to the disruption of the court proceedings. None the less, the school had reopened but the anxiety over the said "spell" had not been diffused. It therefore took very little to spark off another episode of hysteria among the pupils.

The identification of and dealing with the source of conflict, isolation and treatment of the index case and dispersal of the affected others usually dissipates the mass anxiety, resolves the problem and prevents relapses. The Strasbourg city authorities did not help matters when they collected all the affected and left them to dance in some of the most public places in the city (Waller, 2008). "Infection" during the mass hysteria episode appears to be related to proximity. In the Mangaung and Hiededel Schools episodes, it was by line of sight, where those that came to watch the affected, had their own turn at the itching, (Rataemane & Mohlahle, (2002).

In Layamo Agwata primary school, each pupil that ventured close enough to be bitten by another possessed pupil, carried on the possession in turn. The attacks did not subside until the courageous headmistress cut down the 'demonic tree' (source of conflict), the psychiatric assistant isolated the two index cases and the District Education Officer ordered the school closed; thus effectively dispersing the affected others. The intervention by the visiting psychiatrist to construct an appeasing memorial for the spirits, and a vigil to ease the hearts of the surviving descendants put paid to the issue.

This case also illustrated how traditional and modern healing systems were combined to effectively deal with mass hysteria. For the Mbale manias of 1964, religious leaders slaughtered white chickens and left gifts for the spirits, but the event also attracted the professional medical attention of the Ministry of health at the time. In Layamo, the local leaders performed traditional rituals and the religious organizations held prayers to ease the anxiety of the people. The attacks reduced, but did not die out completely. The consultant psychiatrist worked with the very beliefs of the people when he recommended the memorial and the vigil to achieve the same end and prevent further relapse

LAYAMO SCHOOL TODAY

Conclusion

Mass hysteria, wherever it has occurred and for whatever reasons, has led to escalation of mass fear and anxiety, and caused a lot of destruction of property. Episodes are characterized by stampeding, crushing, crowding and trampling which may in some cases cause injuries that may result in death in Uganda. These cases mentioned here were not followed by strategies to prevent mass hysteria. Mass Hysteria can effectively be prevented by preventing psychic mass trauma such as through peaceful conflict resolution and not war, with all its torturous and traumatic results

In the meantime, the conditions that have preceded episodes of mass hysteria in history are still in place in present day northern Ugandan. The fear is still real in the hearts of many. Northern Uganda is also in conflict caused by transition from one era of war to another era of peace, there is friction between the practices associated with both eras. Societies in flux, in which people continue to practice the old in face of the new, seem particularly prone to hysteria epidemics. (Faigel, 1968). The backdrop for the Tanganyika laughing manias was a time of rapid social economic change. The children were caught between the traditional practices they were involved in at home, and the modern and foreign Christian lessons thrust upon them at them at the mission schools that they attended. (Ebrahim, 1964). The people of northern Uganda are coming out of a time of war, of uncertainty, of life in internally displaced peoples' camp and coming home to an uncertain future. At the same time, the traditions of the Acholi co-exist in a fragile peace with the foreign practices of the religious churches and organizations that have come onto the scene to help alleviate the pain of the people with the message of Christianity. In this kaleidoscope of practices, ideas, fears and beliefs, it is not far fetched to expect that northern Uganda may indeed be faced with yet another episode of mass hysteria in the near future.

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General instructions:
Submit original and two copies of the manuscript to: Editorial Secretariat , African Journal of Traumatic Stress, Department of Psychiatry, School of Medicine, College of Health Sciences, Makerere University P.O. Box 7072 Kampala, Uganda Email: ajts@gmail.com. The AJTS has no charges for papers accepted for publication. Papers published in the Journal should be evidence based and should have relevance to trauma. They can be research papers, reports, reviews, personal stories short communications or news worthy briefs. Manuscripts should be typewritten on white A4 paper using font size 12, double spaced and should not be more than 15 pages excluding references, tables, graphs, pictures or charts with wide margins (2 cm) and line numbered where possible.

Title: Should be brief and reflect the main theme of the paper. It should be less or equal to 15 words.

Authors: Names should appear below the title and below which the address should be typed.

Abstract: An Abstract in English should, if possible, be accompanied by French translation and Vice Versa. It should include key words, arranged alphabetically with one the first letter of the first key word capitalized. Key words should be separated by commas. Abstracts should be limited to a maximum of 250 words and should contain salient features of the study, briefly indicating Title, Introduction, Objectives/aim, Methods, Results and main Conclusions. Single solid lines should separate the by-line material from the Abstract and the Abstract from the main text.

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If there are more than 3 authors quote only 3 and put et al and leave out the rest. Within the text, references should be given as; Lin and Liu (2000) and if many citations cite as Okello (1981), Otim (1993).

For books list as: Smiths G. (1987). Changes in composition of pathogen populations caused by resistance to fungicides. In Population of plant pathogens, their dynamics and genetics. Cook M.S and Cohen, C.E (Eds), pp 227-237. Blackwell Scientific Publications, Oxford.

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For websites: Kariuki

T. (1997). Report on the Joint JSPRS Commission III/IV Workshop '3D Reconstruction and Modelin gof Topographic Objects, Stuttgart, Germany. http://www.radig.informatic.tu-muenchen.de/ISPRS/WG-114-1V2-Report.html (accessed 28 March 2005).

Tables and figures: Tables and figures should be self explanatory, without reference to the text or other tables and figures. Captions should be brief but adequately describe contents. The word Table should be in Upper case letters and should be numbered with arabic numerals. Figure captions should be typed on a separate sheet of paper. In the text spell out the word Table but abbreviate Figure to Fig. Capitalize the first letter of table column and row headings. Footnotes are designated with supersript lowercase letters.

Graphs should be boxed and cordinates and abscissions marked with index lines. Pictures and illutrastraions may be in black and white or colour and of a size that allows reduction of up to 50%.

Paper revision: An author receiving editorial recommendations for revision should submit the revised manuscript within 4 weeks otherwise longer intervals will be treated as new manuscripts.

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