"The unhealed wounds"

The effects of war trauma on the resettlement of internally displaced persons; a case of BUNDIBUGYO district

A study conducted by

KABAROLE RESEARCH AND RESOURCE CENTER©

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ABSTRACT

The Allied Democratic Forces (ADF) insurgence that took place in Western Uganda was one of the more than forty violent conflicts that concurrently decorated the world map at the turn of the century. The 180,000 people of Bundibugyo were part of a family of two million people world-wide who were displaced from their homes, but lived inside the borders of their homelands. The Bundibugyo Internally Displaced People (IDPs) that lived in camps during the ADF war were the subjects of this study.

In November, 2002, the Civil Peace Service Program of Kabarole Research and Resource Centre, in collaboration with Ghent University in Belgium initiated a study on the effect of the resettlement process of IDPs in Bundibugyo District. The study was carried out in two phases; the first phase in 2002 when displacement was at its apex, with 150,000 people living in camps. The second phase of the study conducted in 2003 was at a time when most of the people had left the camps and resettled in their homes.

The purpose of this study was to assess and describe the long-term impact of war trauma on the resettlement process of the IDPs. The researchers attempted to investigate the relative degree of the effects of war trauma. Although only 6% of the IDPs stated that they were unable to resettle due to war trauma, over 70% reported lasting effects related to war trauma on their lives even long after the war. An extensive multivariate investigation was launched to establish the prevalence of war related mental

disorders. Since no strong correlation was found between mental disorders and the resettlement process, this research report has been concentrated on describing the long-term psychosocial implications of war trauma on the already impoverished population.

As predicted, findings from this study confirm the presence of a burly effect on the resettlement process, and on the lives of the formerly Internally Displaced Peoples. The study also established a strong relationship between the individual inability to deal with psychological problems and the negative social environment in the camps, such as the decay of morals, the development of individualistic tendencies, indiscipline among children, and poor parenting. The second phase of the study in 2003 was able to identify some positive outcomes. Most remarkable was the empowerment of women (e.g. in doing business) and the growth in sustainable agriculture and cash crop growing. The later two are direct effects of the growth in trade within the District.

By way of conclusion the researchers cited the limitations of mainstream Western psychological interventions, and recommended a more culture-friendly, public health based, and community oriented approach to alleviating the negative effects of the ADF war trauma on the lives of people of Bundibugyo. This cultural specific recommendation is as essential as other forms of aid, and may still be needed long after material aid has been stopped.

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DEDICATION

United in mind and heart to all good willed people we dedicate this report to the millions of displaced people around the globe whose sufferings make them feel one with the people of Bundibugyo

ACRONYMS

ADF	Allied Democratic Forces/Army
AIDS	Acquired Immune Deficiency Syndrome
BUCOVOCA	Bundibugyo Community Volunteer Counsellors Association
CPS	Civil Peace Service
CSOs	Civil Society Organisations
CVCs	Community Volunteer Counsellors
DED	German Development Service
DFID	Department For International Development
FGDs	Focus Group Discussions
HIV	Human Immune-deficiency Virus
IDPs	Internally Displaced People
KRC	Kabarole Research and Resource Centre
LRA	Lords Resistance Army
MSF	Medecins Sans Frontieres
NGO	Non Governmental Organisation
PRA	Peoples Redemption Army
PTSD	Post Traumatic Stress Disorder
PWD	People With Disabilities
RTI	Respiratory Tract Infections
STI	Sexually Transmitted Infections
TPO	Trans-cultural Psychosocial Organisation
UPDF	Uganda Peoples Defence Forces
WFP	World Food Programme

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INTRODUCTION

General Overview

The Allied Democratic Forces (ADF) insurgence that took place in western Uganda between 1996 and 2002 was one of the more than forty violent conflicts that were concurrently going on in the world at the turn of the century. These conflicts combined created more than 40 million refugees, and over 2 million people displaced from their homes but living inside the borders of their own countries. The later category is the subject of this study.

The ADF conflict in western Uganda obtains its unique character from the nature of its effects on a population that was neither informed of the origins of the conflict nor capable of contributing towards its resolution. This situation rendered the people uniquely helpless. Unlike the conflict in Kosovo whose origins could be traced back to ethnic differences, the ADF conflict in western Uganda had little to do with the tribal differences between the rebels and the victimized population who were often targets of heinous activities of the ADF. Moreover the conflict did not attract the involvement of the local population through civilian support or direct combat. Although the conflict was between the government of Uganda and the ADF rebels, the innocent civilians were very often targets of the horrifying attacks of the rebels.

Although the ADF conflict was spread along the western border of Uganda, the current study was carried out on 10 Internally Displaced People's (IDP) Camps in Bundibugyo district. This district is bordered by the district of Kibaale in the north-east, and Kabarole in the East and South-East. It borders the democratic Republic of Congo (DRC) in the west. To the north it borders with Lake Albert.

Bundibugyo district covers an area of 2,338 square kilometers. One third of this area is covered by open waters, swamps and rivers; about half is covered by mountains, forests, national parks and forest reserves. Only one quarter is used for agriculture. This vast uninhabited land as will later be explained became home and sanctuary for thousands of ADF rebels that for many years terrorized and displaced a population of 180,000 people.

The local population is essentially Bamba, Babwisi, Bakonjo, Batuku and other minority tribes. Bundibugyo is basically an immigration zone because of its location on the border, and shores of Lake Albert. The literacy rate is about 53% for the age group above 10 years. Less than 1% of the population has obtained university degree education.

Bundibugyo's economy is dependent on agriculture with major cash crops being cocoa, oil palm trees, vanilla and coffee. There are also some small scale fishing activities on Lake Albert and river Semuliki. A few people carry out livestock farming for home consumption and very limited commercial value output.

Bundibugyo District is linked to the world by only two roads; the Fort-Portal Road that runs over the Rwenzori ranges, and the Bunia Road that links Bundibugyo to the most Eastern DRC town of Bunia. Bunia area with a population of about 340,000 people, with no road access to the rest of the DRC , depends on Bundibugyo for medical and other social services. The mountaineous terrain while posing a big challenge to the development of Bundibugyo, provided a sanctuary to the ADF whose sporadic attacks involved a kill – run – hide style.

Histo-Political Context of the ADF insurgence

Uganda's post-independence history is littered with the skeletons of successive rebel movements. While many of these were never capable of challenging the government, they have often wielded influence over civilians in their areas of operation and some have wreaked havoc and destruction. The National Resistance Movement (NRM), which itself came to power after a five-year guerrilla war, has had to face many rebellions.

Much of the fighting has taken place around the Sudan-Uganda border, but the groups and their aims have varied. Among those which are now defunct was the Uganda People's Democratic Movement/Army (UPDM), founded by former members of the Okello government and army which had briefly held power, having overthrown Obote's government in July 1985. In 1990, after the death in exile of General Bazilio Okello, the UPDA signed a peace accord with the Uganda National Resistance Movement (NRM) government. The West Nile Bank Front (WNBF) was formed by a former colonel from Idi Amin's army, Juma Oris, and became active in the northwest in 1995, but has not been very active in latter years. Another group, the Uganda National Rescue Front (UNRF), signed a deal with the NRM government, leading to the absorption of some of its members into the NRA, and of its top leaders including Brigadier Moses Ali, into the government. The UNRF II, a splinter from different groups, established a base in southern Sudan but soon signed a peace agreement with the NRM government. The most devastating and persistent war has been in the north against the Lord's Resistance Army and its earlier incarnations, Alice Lakwena's Holy Spirit Movement and the Uganda Democratic Christian Army

(UDCA). From time to time other areas have been afflicted by rebel activity. Moreover armed conflict in Uganda has not only been mounted against the state; in the north-east of the country, the Karamojong have long been involved in increasingly violent cattle raids affecting neighbouring districts.

The Beginning of the ADF insurgence

The ADF problem exploded in 1997 in an attempt to overthrow the current NRM government. Prior to that there had been sporadic attacks which did not appear to concern the government too much. The ADF launched a surprise attack on Ugandan soldiers at Mpondwe on the border with Congo in Kasese district. Attacks and atrocities escalated the following year with the army apparently unable to contain them, one of its problems being the lack of an adequate alpine force.

The roots of this collective are found within the Salaf Tabliq movement, an Islamic group that originated from India. This movement has always been a peaceful one. It was only after some discontentment with a government decision regarding the appointment of the new mufti of Uganda that a radical arm of the movement separated itself and took up weapons. Together with its leader Jamil Mukulu, this arm quickly shifted from Kampala to the Rwenzori Mountains, where they soon gained contact with former NALU rebels, with whom they formed the ADF. Other elements within the ADF were recruited out of leftovers from former rebel groups such as the Rwenzururu and the West Nile Bank Front (WNBF) and some volunteers who were promised jobs and money. The ADF also used to link up with Rwanda Hutu Interahamwe militias and ex-Forces Armees Rwandaises (Ex-Far) operating in

Eastern DRC. Last but not least, similar to the conflict in the North of Uganda where UPDF is fighting Joseph Kony and his Lord Resistance Army (LRA) lots of people were abducted and forced to fight with the rebels.

The ADF action radius was the former greater Kabarole District, including the present districts of Kabarole, Kasese, Bundibugyo, Kamwenge and Kyenjojo. Due to their location alongside the mountains, the first three districts were most hit whereas Kamwenge and Kyenjojo experienced less frequent attacks. Their modus operandi had a rather fixed pattern. Mostly at dusk a group of 5 to 10 fighters used to come down the mountains to carry out 'hit and run' attacks.

Escalation of the ADF rebellion and Government Interventions

Because of what was happening, the President of Uganda came to the area and camped there for some weeks in order to boost the morale of the fighters and to develop a strategy with his army. Since then, there was gradual improvement of security until the government declared to have ended the insurgence in 2001. The government started hunting down rebels; they killed them, captured them and took away their weapons and destroyed their hideouts. Those who surrendered were rehabilitated and reintegrated into society or the UPDF. The UPDF recruited local people in the form of home guards and local defence units (LDUs). The home guards are part of the community, where as the LDUs are part of the government defence force.

During the UPDF-ADF conflict, many people were killed, mutilated and abducted, often selected on the basis of vulnerability. This was done both to mark the

vulnerability of the local population and to gain food and materials needed for the survival of the rebels.

Due to some government interventions and the tanning support inside and outside the country the ADF slowly began to lose strength and by the end of 2001, the government didn't consider the ADF any longer a serious threat. However the wounds caused by this rebellion were far from healed.

The continued attacks by ADF rebels on the local communities of the Rwenzori region since 1996 caused the displacement of more than 150.000 people who resided in about 84 camps in the districts of Bundibugyo, Kabarole and Kasese. It was the district of Bundibugyo however that always endured the largest problem with internal displacement. This is mainly due to the key targeting of this District by the ADF during the insurgency, mountainous terrain, proximity to Congo and the ability to exploit existing ethnic conflict in the area. When the insurgency started to reach its endpoint in 2001, many people from camps outside the Bundibugyo district came back to Bundibugyo district to settle in camps nearer to their homesteads. Other districts like Kabarole and Kasese were more or less freed from IDPs at the beginning of 2002. As this research was conducted IDPs were only remaining in Bundibugyo district. Even in this district however most IDPs were contemplating to go back to their homesteads of origin.

Life in the camps

Because of the numerous attacks in the area, the security for civilians became a big issue. Besides, the ADF frequently followed up its ferocious assaults with a

demand that the local people leave the area. It therefore became imperative for the local people to leave their homesteads and join the camps where they felt relatively safer. This forced people to move from their own environment and left them helpless. The traumatic events they witnessed during the attacks "overwhelmed the ordinary systems of care that give people a sense of control, connection, and meaning" (Herman 1997, p.33).

Some of the serious concerns identified in the camps include; shortage of food, outbreak of diseases such as malaria, lack of transport, idleness, and the lack of clothing and beddings such as blankets, bed sheets etc. Shelters in the camp leaked terribly, especially during the rainy season. This made it even more uncomfortable for those with malaria and flu. There were no drugs in the camps and the education of pupils was adversely affected. There were no text books and other school supplies. Many camps were over crowded. In Mitandi camp alone there were over 4,000 people living there. In some camps you would find over 15 people living in a single room (African Rights Publication; Dec. 2001).

Social and cultural norms were eroded. There was a big increase in the number of school dropouts. As a result, child abuse in the camps was widespread. Girls were marrying soldiers at such an early age. Due to lack of privacy children were exposed to adult sexual behaviours in the camps. The cultural values of the society were destroyed. Traditional marriage rituals were abandoned. Official marriage no longer existed. Consequently, irresponsible sexual behaviour increased to a remarkable degree in the camps. This put girls and women at risk of acquiring sexually transmitted diseases such as AIDS, syphilis, gonorrhoea etc.

There were also changes in people's eating habits. People no longer had access to the staple food which they were accustomed to. For a Mukonzo, tapioca (Cassava flour) is the staple food, while a typical Mwamba Mubwizi considers gonja (plantain) as the best food. Camp life dictated that they depend on relief foods like maize floor, some of which tasted sour. Language was another cultural element that was affected by displacement. Life in the camp dictated the development of another language, "camp language." The proper dialects of Rukonjo, Rwamba/Lubwisi were no longer used without mixing them up with expressions from other languages. This enhanced their feelings of powerlessness and loss of identity.

Moral values shifted to fit situations. "Kill before you are killed" an acceptable life principle. This was a justification of killing as a means of self defence. Life in camps could best be described as miserable. Sexual immorality became rampant. Not only were children malnourished and dying at a higher rate in the camps, but there was also a rise in instances of "incest and defilement". Decline in morals was extremely damaging as it brought in its wake increases in HIV/AIDS infection, syphilis and gonorrhoea.

Another noticeable change was in the behaviour of student in schools, where discipline of students deteriorated to alarming levels. Life in school and outside was interwoven. War conditions resulted into many marital conflicts and break-up of marriages. Many women divorced their husbands who because of the war conditions could not afford to support them, and this affected the attitude of their children in schools. Most students came from broken homes. Students appeared to have no hope for the future since they lived in crowded homes in the camps.

Economic productivity came to a stand still. Uprooted from their homes people had nothing to occupy them. Several times in some camps there were out breaks of Cholera partly due to poor sanitation. The economy of the region dwindled and could no longer support the area's social services system.

Security concerns

Although displaced people were subjected to massive economic disruption, flight from their homes turned out to be more frustrating when on some occasions camps were attacked and government forces did not offer the expected protection. In the camps where people congregated they were exposed to risks of hunger, disease, and the threat of ADF surprise attacks. People settled near army bases for shelter and protection, but the ADF managed to invade camps repeatedly. People tended to move from camp to camp hoping to find better security. Such movements made needs assessments conducted by relief agencies extremely difficult.

Life after the camp (A Psychosocial impact)

Poverty, hunger and disease accompanied by on-going insecurity provoked strong feelings of hopelessness, fear, and acquiescence to an oppressing and dehumanizing situation. By the middle of 2000, some 175,000 people, mostly in Bundibugyo district, had been displaced. Most people were forced to abandon their homes and farms and lived in camps. Many took refuge with host families in the "safer" regions. Many people remained in the camps several months after the ADF activities had subsided. Their crops were not harvested and not attended. Once self-

sufficient, most families now depended on food aid brought in by government and aid agencies. Children could no longer attend school. The livelihood of the residents of western Uganda was placed in limbo and people struggled to survive on a daily basis. Life before the camp experience was bad enough; people worked hard and earned little, transport was poor or non-existent, social services were limited. Life after the camp experience was even worse. A displaced person in Mitandi camp said that the area desperately lacked roads, adding: "This place appears to be an island, isolated from the rest of the country" (African Rights Publication; Dec, 2001), "even the little we had before the war has been taken away" another one added.

There was abject poverty especially among the displaced people who were living in camps. They were denied education and development. There was also a breakdown of basic social services like medical care. Most schools in Bwamba county were severely affected. Furniture in these institutions was used as firewood, while textbooks, files, stationary was torched and used for lighting candles by both rebels and government forces. Rural primary schools have remained closed for several months, but learning centres were established in camps. IDPs interviewed by African Rights were quoted saying

> We once enjoyed a good income from growing passion fruits and potatoes but the war destroyed our plantations. We have now lost animals and food stuff, our beautiful farms and homes have been abandoned. There are no more economic activities in the area, hence no production. We're suffering from various diseases such as malaria, fever, scabies, worms and measles. There's now an outbreak of famine in the sub county" (African Rights Publication; Dec, 2001)

Government programmes were not possible to implement because they were supposed to be implemented in villages for the benefit of the rural people. Instead the

limited resources were spent on security and aid to the camp residents. Graduated tax, a major local government revenue collection was no longer available. This meant limited provision of social services. The district relied entirely on limited funds received funds from the poverty action fund in Kampala. But even then the money which was received was too little for the immense need. Moreover not all local government departments had access to that money.

Statement of the problem

The psychosocial effects of the ADF conflict in Bundibugyo district cannot be overemphasized. Even several months after the war many people had not returned to their homes. What is it about the ADF war that is hindering people, to resume their normal life? KRC/CPS picked interest in analysing and making an attempt to answer this question. A decision was made to conduct a study, 'the effects of war trauma on the resettlement process of IDPs in Bwamba County, Bundibugyo District'. The purpose of this study was to create an opportunity for a better understanding of personal and intra-personal war experiences of the IDPs and how that experience was affecting the resettlement process, which to the world looked a great opportunity, yet the people were slow to respond. The information obtained from this investigation would become useful in directing future resettlement interventions, and advocacy programs. Moreover such information would help us answer the sometimes bewildering questions: how long after the war should external aid be continued? What kind of help do people need as they return to their homes after the camp experience? This study attempts to answer these questions from a psychosocial perspective.

GLOBAL WAR TRAUMA LESSONS AND RESEARCH

General Overview

Any media house around the globe in the course of a single day finds itself investigating a war related story. Moreover war related topics have dominated psychosocial research and literature in the past forty years (Summerfield, 2000). The Bundibugyo ADF war is one of several conflict spots that decorated the globe at the turn of the century. Although each conflict claims its own uniqueness, the pain and injury inflicted on humanity cuts across continental and cultural boundaries. Therefore an experience from one conflict adds to our bulk of knowledge, enlightening us to work towards appropriate interventions.

Every conflict leaves behind some emotional and physical painful experiences. Let it be in Sarajevo, Angola, Rwanda or Iraq, it is universally true that terrifying experiences are disturbing and so overwhelming leading to a disrupted living and interrupted human development and progress. This is particularly true of the most vulnerable members of the population, the children. Most trauma researchers believe it is the repression of memories and feelings that is at the heart of trauma suffering (Herman, 1992). Psychological trauma caused by war like any other violence related traumas results into altered states of consciousness e.g., dissociation, freezing, trance etc. Although they serve a purpose, namely self protection from pain, these altered states deprive the person of his/her normal living. When these altered states disrupt the psychological and professional functioning of an individual they may be characterized as mental disorders.

The ability to recognize and if need be treat emotional trauma has rapidly changed in the last fifty years. Until recently psychological trauma was talked about in connection with war veterans, especially those from World War II, and the Vietnam War. This view appears to have been universally accepted until the 1960s when it was challenged by the women's movements in the United States. These social movements awoke professionals to a wider view of emotional trauma. The new view plea for the inclusion of non-combat related those distresses e.g. physical abuse, torture, sexual abuse etc. Discoveries during "the decade of the brain" (i.e 1990s) consolidated this view thus broadening the definition of psychological trauma to include those situations or events that may not have caused physical damage. War trauma is thus universally accepted as leading to possible dysfunctional living even if the victim has sustained no physical injury.

The attention of researchers, psychologists, and psychiatrists is at the moment turning towards the cultural differences that are beginning to emerge as to how different peoples respond differently to relatively similar experiences. Moreover, trauma professionals are beginning to question the once universally accepted interventions to war related trauma.

War Trauma and Research

Saa (2002) describes trauma as being "like a solid rock we swallow, and it is important that it will not simply melt in there". The western understanding of trauma based on the medical model sees trauma as an individual's problem and thus requiring individual-specific interventions. Current research on war trauma is

beginning to reveal a community face of war. This is particularly true of more cohesive societies like those in Africa. For instance the war in Acholi land in northern Uganda, or the ADF war western Uganda was not a private experience. Individuals suffered, but the community suffered through its members, and the members continue to suffer because the community carries the wounds of war.

Although the western biomedical approach to trauma continue to dominate academic houses, the third world events in the past forty years have opened many professional's minds to a new perspective. These experiences uncover the social aspect of war and reveal the social, religious, and tribal, meanings ascribed to the atrocities that people suffer (Bracken P, Giller J, Summerfield 1995). Bracken & others (1995) mention that the primary impact of war trauma is the witnessing of the destruction of one's social world.

War Trauma and Psychological Disorders

No research related to trauma has provided any indication towards a universal response to highly stressful events. This is true of war trauma. "Although some victims do develop significant psychiatric and social dysfunction, the relation between traumatic experiences and outcomes is not clear-cut" (Summerfield, 2000). There are however individuals who due to their pre-war psychological condition may be more vulnerable to stressful situations, and consequently predisposed to psychological disorders. An important finding from more recent research emphasizes the link between pathology and the secondary effects of war on the family, social, economic, and community life (Summerfield, 2000).

The absence of a universal response to war trauma while saving us from embracing some blanket predictions of disorders and packages of interventions, it leaves us with the flexibility to understand the effects of war on specific social-community settings. This does not rule out some common somatic complaints e.g., body pains, aches, decreased energy, decreased sleep, etc. Many of these physiological complaints are usually presented to medical facilities where they are treated using the traditional medical model, most of the time ignoring the emotional component. None the less with time healing takes place. Although a direct link between war trauma and long term emotional pathology may hard to establish with certainty, there is strong evidence that the primary impacts of war on community's resources predisposes members of that community to mental disorders (Herman, 1992).

War Trauma and Intervention Appropriateness

Although war trauma is characterized by some specific symptoms in any given population, researchers and other mental health professionals are slowly reaching a consensus that every culture has got its own way of dealing with war trauma experiences or any other psychological distress. Common to all cultures however, is the observation that a successful process of healing is affected or closely linked to the degree of cohesion in a given community or population that shares a distressing experience (Friedman, 1991).

Within the mental health professions is entrenched some well-established beliefs about trauma that would be very difficult to change. For instance, a diagnosis made by a

psychiatrist backed by a Diagnostic and Statistical Manual of Mental Disorders (DSM IV) criteria would require some critical thinking to challenge. Even then, without credible literature to back this critical thinking, there is likely to be a rift between public knowledge and specific intervention praxis.

Fortunately, most recent was trauma experiences in which people from different cultures get involved are beginning to open a forum for discussion that is to change our thinking about war trauma, the nature of pathology it causes, and intervention that would be most effective. Satel (2003) presents this need for change when he describes how the world reacted to the war in Iraq,

> The World Health Organization and other relief agencies worry that "half a million" Iraqi children are now mentally scarred for life -- damaged by the war in a way that calls for professional intervention. It is hard to predict exactly how many psychological casualties the recent war has caused, but one thing is fairly certain. We can expect to see a second army enter Iraq: the trauma therapists.

In the same article, Satel challenges the traditional models of intervention to war trauma by quoting the lessons learned from the recent war traumas in Bosnia and Rwanda. Although war victims met all the criteria for the DSMV Post Traumatic Stress Disorder (PTSD) diagnosis they displayed varying symptoms that could only be explained by factors other than those considered by the DSM IV e.g., cultural differences, resilience, and predisposing factors. One significant observation for instance was the Rwandan adults who witnessed their relatives being killed. Most of them reported symptoms that qualified them for the PTSD diagnosis. However, more than half of them sounded very optimistic about their future, most especially when they talked

about their extended families, and the urgency they experience to see to it that they provided for their children.

This increasing evidence that appears to challenge the traditional model diagnosing, and treating war related psychological distress has prompted relief agencies, mental health professionals and researchers to invest in studies that zero on one finding namely that "Most people are resilient and adapt well. They prefer to cope -- and can cope -- on their own. But the very idea that a potent stress could pose an ennobling challenge to the human spirit is the minority view among trauma professionals" (Satel 2003).

Global war trauma experiences in recent times, while well appreciated because of the existing traditional models of diagnosing and treating war related mental disorders, continue to provide us with information that challenges the traditional models of intervention especially the disorder-to-order based model of treatment. Many studies including this one pleads for cultural specific treatment models, most especially those that appreciate and utilize the existing resources.

RESEARCH METHODOLOGY

Subjects

The initial goal of this research was to observe and interview 10% of the adult population in each camp. Later this ambitious project proved to be unrealistic due to the constantly changing populations, in each camp. In order to minimize the rate of incomplete responses, 35 randomly selected adults in each of the ten camps of Bubukwanga, Hakitengya, Kanyamwirima, Busaaru, Bugombwa, Kayenje, Karindi, Karugutu, Kasitu, and Harugali were requested to participate in this study. The choice of the camps to be included in the study was greatly influenced by accessibility to research assistants.

Procedures and Measures

In order to obtain the most accurate and detailed information, we opted to use a multi method approach for data collection. The study was carried out in two phases. The first phase conducted during the zenith of camp life in 2002. During this phase a lot of data was collected mainly from the IDPs and other local leaders. At the beginning of the first phase a group of community volunteer counsellors (CVCs) belonging to Bundibugyo Community Volunteer Counsellors Association (BUCOVOCA) was recruited to work as research assistants. They were introduced to researchers and to the instruments to be used in the study. The CVCs were more educated than the average population and after orientation were considered competent to administer the questionnaires. Their acquaintance with geography of the area, the culture, and language of the people was later found to be an added value. The second phase of the research conducted in 2003 involved collection of data from a few camps and from people who lived in between resettlement and camp life.

Questionnaires

Questionnaires were used to obtain quantitative data and to guide the collection of valuable qualitative data from the participants. Close and open ended questions were used. The research staff interviewed 350 randomly selected adults. A number of questions targeted some general characteristics of life inside the camp, followed by questions regarding traumatic experiences and the impact they had on the respondent's life after the war. A few questions inquired about past and present support systems, coping methods, and attitudes about resettlement (see Appendix III). Respondents were randomly selected with a balanced distribution according to adult age and gender considerations.

Focus Group Discussion

Focus group discussions (FGDs) were initiated during the first days of the research. Participatory techniques were employed to build rapport and gather information which appeared to have been less forthcoming via one-on-one interviews. Discussion enabled the research team members to gather information rapidly, and to enhance the sharing of knowledge, to catalyse local action and to facilitate local capacity to analyse issues. Due to cultural considerations, FGDs were formed according to gender. Also the youth (aged 16 to 25) were assigned a special group. The topics for discussion were the same as those used with the key informants in the semi-structured interviews. As would be expected some of the FGDs took a positive direction of their own determined by needs of the group.

Interviews

Semi-structured interviews were conducted with two classes of respondents: key informants, and victims. The key informants were particular individuals with varied experience in dealing with trauma and/or IDPs. This involved members of BUCOVOCA (Bundibugyo Counsellors Volunteers Association) and members of CSO's (both who had knowledge of PTSD prior to our research due to training and experience on the field),

religious leaders, civil servants and local leaders (who had knowledge about the camps and its population). These interviews inquired about the nature of the ADF insurgency, natural disasters in the area, displacement and resettlement experiences, camp conditions and psychological distress resulting from the war.

In the first days of the research, we asked local Community Volunteers Counsellors (CVC's) to identify some people known to have been severely affected by one or more of the war events, which are believed to be responsible for the reported mental distress. Interviews with identified victims were carried out using the same semi structured interviews as used for the key informants. Each participant was encouraged to tell his or her story. Great care was observed not to push victims to talk about issues they were hesitant to discuss and/or that would trigger symptoms that would require specialized psychotherapy which was not accessible in the area.

Symptoms Check List

The Symptoms Check List (SCL) consisted of 33 questions 23 of which were focusing on the three symptoms clusters (i.e. intrusive memories, avoidance behaviour and hyper arousal) according to the DSMIV. The symptoms checklist (Appendix III) was to assess the prevalence Post Traumatic Stress Disorders (PTSD) within the selected camps. This checklist was developed for this purpose and its results may not be reliable for diagnostic purposes. However, it is a reliable tool sensitive to trauma experiences. Nine questions on the list targeted other PTSD related symptoms of depression, suicidal ideations, dissection, and feelings of revenge.

Document Analysis

Before, during and after the research, much value was placed upon available literature on war trauma and population displacement. Although, as already mentioned, the Bundiugyo war experience was a unique one, this research was greatly influenced by prior studies from other parts of the world. The literature reviewed in chapter two influenced the formulation of the research question for this study. The information obtained from other study reports guided this research to formulate conclusions and

recommendations that are grounded on a global experience of dealing with war trauma, while respecting the uniqueness of the Bundibugyo ADF insurgency.

Data collection Processing and Analysis

All quantitative data from the questionnaires were analysed using SPSS 11.0. Qualitative data was analysed by categorical aggregation which consisted of reading through transcribed interviews and field notes in order to identify issues relevant to the research question. Patterns were established by identifying some common themes from the different categories. Very useful themes were from the recorded data drawn from testimonies, interviews and Focus Group Discussions.

RESULTS

Introduction

As predicted, war trauma greatly influenced the resettlement process of the IDPs in Bundibugyo district. Although the findings from this study were very diverse, ranging from psychiatric complaints to social-economic and political concerns, relevant to this research report are those attempts to answer the research question: "What was the effect of war trauma on the resettlement process of the Internal Displaced People (IDPs) both during the initial stages of the resettlement and after the people's return to their homes?" Several months after people had returned to their homes, individuals and communities reported multiple war experiences tied to their social, economic, family, and individual emotional aspects of their lives (see table 1). Smooth resettlements require or would have required unique interventions that succeed in disentangling people from war experiences and enabling them to again "feel at home" in their homes.

Missing assistance formally provided by the deceased	30.2%
Having nightmares	7.6%
Having worries and being scared	13.8%
Feeling weak and lonely	9.8%
Strong memories	24.4%

Table 1: The ADF experiences are still causing problems

The ADF war: a Unique Experience

People of Bundibugyo District experienced the ADF war as a completely unique dehumanizing experience, incomparable to the natural disasters that they had ever experienced. The disasters considered to be common in Bundibugyo are floods, landslides, and/or epidemics. Less frequently experienced are storms and earthquakes. These natural disasters had affected 65.8% of the 330 respondents. However, none of the respondents remembered having had to suffer as much as during the ADF war.

The ADF insurgency had the most brutal impact upon the lives of the inhabitants of the Rwenzori region and appeared to be the only reason for displacement; it was found to be the main contributor to many traumatic experiences that were reported. Suspected cases of PTSD were related to war trauma. In general all those past (and sometimes continuing) traumatic experiences were still affecting the IDPs' and former IDPs' attempts to regain normal lives. These effects were to be found on two different levels. Firstly, most IDPs complained heavily about the prevailing poverty, secondly they complained about sleeping problems, bad memories, feeling unsafe, and being left alone without sufficient assistance after they had been resettled (see table 2).

No response	4.9
I still have memories	44.1
I feel weak	13.7
I am still facing the same problems	19.6
I get night mares	5.9
I feel suicidal sometimes	2.0
I am ever worried and scared	9.8

Table 2: How are these experiences affecting the daily life.

One 45 year old married male father of two from Bumadu camp described his war experience as follows:

> "Before the war started, we heard rumors about rebels in the Kakuka hills. When they drew nearer, killing whoever they came across, we fled our homes for the town. That is when I came to this camp. I have been here five years now (since 1997 when the war first broke out).When the rebels attacked area, they looted property, abducted people, killed others and even burnt houses. My brother was killed by the rebels when they attacked his village. People from his area told me about his death but it was very dangerous to go and fetch his body. The UPDF Commander gave me money and soldiers to escort me to the area where I got my brother's body and buried it. Only the two of us were left in my family, now I am the only one left. I have failed to sleep. I am always thinking about all we have gone through. I am only waiting for God's decision for my life. We are all hopeless. The rebels did not show mercy to even the children. They were also killed mercilessly. Because they are energetic, the youth were the target for abductions because they were being used to carry the rebels' loot. Many women died in their gardens where they had gone to fetch food for their families.The men were affected more by the war because when the rebels attacked an area, day or night, they went house to house calling out the heads of the houses, who are the men, under the pretext of wanting to tell them something. When a man came out of his house thinking they were going to tell him something, he was shot or hacked to death, even with his family watching. What would help me is to receive information about how far the war has gone. I also need building materials as my house has been destroyed by the heavy winds and rains."

A senior five student of Semuli high school described his experience of the war as follows:

> "It was a day full of rebel activities in my area when I had gone to school and we were kept there till late in the night due to rebel activities that day. The rebels were repelled to the mountains and my father's house is in the hills, so on their way to the mountains they passed by the home and knocked at the door and my father was in with two of my brothers at the time. They asked him many questions he couldn't answer as they spoke a different language. They hammered him on the head with a hammer and he died instantly. They then took my two brothers and one was killed on the way as he tried to fight them. The other was taken and later they chopped of his arm and later they released him. He came back and narrated the story and he is presently living in Kasese district."

A 60 year old female (Doloris) from Harugali with tear rolling down her face described her experience of the war:

> "One night, rebels came to my brothers' house which is next to mine and called a name (of someone else) we never knew about, while knocking on the house. My brother refused to open and they started banging till it opened. They grabbed him and beat him so badly and them went with him bleeding toward the mountains on their way to Fort Portal. As they reached the mountain they met a man and a woman who they also abducted and started beating them. Later the woman was released after 3 days and she was told to go back home and that she should not take the Fort Portal route, because that's where they were heading and she risked re-abduction. The woman then returned to the village and told us that my brother was still alive but was starving. We had no means of rescuing him so we left it to the almighty God to take over. Days later another person who had also been abducted along the way returned and told us that my brother had died along the way. He died of excessive bleeding and hunger. By the time of his death he was aged 50 years. This experience still haunts me, because I never buried him. I sometimes fail to eat each time I think about his death."

38 year old Moses a retired UPDF soldier described his experience as follows:

> "It was a Sunday and we got information that the rebels were in town. Bullets begun rocking the air and all soldiers were at the border. We begun running to the mountains and the rebels came and shot 11 people and 3 soldiers and slaughtered 2 men in the mountains. On their way they found a lady who was my neighbor and was pregnant at the time and about to deliver. She was being taken to Nyahuka health unit when she met them. She was being escorted by two other women and the rebels requested that they should have the lady and help her deliver if she had failed to do so naturally. They grabbed her and cut her stomach open, removed the baby and cut her to pieces, then chopped of her head and put it on a long stick which they had stuck in the ground. Then they later fled to the mountains and we feared to collect the body till the next day when we organized the burrier. The two ladies she was with were abducted and we have never seen them again."

These and similar stories that were told by people who participated in this study leave no doubts that the Bundibugyo war experience affected the people's existence right from the core of their "being" as individuals and as a community. While it is obvious that lives were lost, it may not be as obvious a year after to realize that lives were damaged by the

experience. As our research participants described their experiences one could tell there was an untold side of the story. The told side of the story included the content of what happened (for example, a relative was killed), and what have been the physical consequences (for example, I lost my business and I do not know where to begin). The untold side of the story is the emotional pain that cannot be adequately expressed in words. This is the side which if not properly dealt with can sometimes result into psychological distress a phenomenon which the people of Bundibugyo were not immune to.

Psychological Disorders

Although it is not within the scope of the purpose of this report, we cannot avoid making mention of the prevalence of psychological disorders that had a close link to the ADF war trauma. For instance the Symptoms check list results reveal high prevalence of hyper-arousal, intrusion and constriction, all linked to Post Traumatic Stress Disorder (PTSD). Using a low cut-off score, it was found that up to 71.4% of all our respondents are likely to be diagnosed as suffering from PTSD (see table 3). Most prevalent were symptoms related to re-experiencing trauma. Furthermore it was shown that the avoidance of stimuli related to the traumatic experiences was not so much present as were the symptoms of hyper arousal and re-experiencing of the trauma. This can be explained by the fact that most IDPs have no alternative than to face those stimuli. Avoiding such stimuli would interfere with their daily activities, especially going to the fields to cultivate crops. However if IDPs had a choice they would definitely avoid such stimuli.

Similar to other researches, few data suggests that there are differences in PTSD prevalence according to age or sex. PTSD is equally prevalent among men, women, and youth. The traumatic experiences and the causes of trauma however did vary. Women were seen to be suffering more from domestic violence and sexual abuse (both by the ADF, and within the camps by their family members).

Furthermore, contrasting to the men who were more likely to resign from their domestic duties and started to rely on alcoholic salvation, women got burdened by an overwhelming amount of responsibilities in the camps, making it even harder to cope with daily life. Consequently, women reported physical complaints more than mental ones. The men and male youth experienced more severe and brutal confrontations with the ADF. Mostly they got abducted in order to be recruited into rebel ranks or to carry the loot taken away from their villages. Many witnessed the killing and mutilation of other men and boys taken along by the ADF, which proved very traumatizing.

PTSD Symptoms	Prevalence (%)
Re-experiencing	
Intrusive and distressing recollections, thoughts	85.9%
Distressing dreams of the trauma	79.0%
Acting or feeling as if the trauma were recurring (flashbacks)	71.7%
Psychological distress at exposure to cues that symbolize trauma	86.2%
Physiologic distress at exposure to cues that symbolize trauma	74.5%
Avoidance and numbing	
Efforts to avoid thoughts, feelings associated with the trauma	71.4%
Efforts to avoid activities, places, people that arouse recollections of the trauma	84.5%
Amnesia for the trauma	21.7%
Diminished interest in activities	25.5%
Feeling of detachment from others	11.7%
Restricted range of affect	44.8%
Sense of foreshortened future	31.0%
Arousal	
Difficulty falling or staying asleep	70.0%
Irritability, outbursts of anger	62.8%
Difficulty concentrating	27.2%
Hypervigilance	90.3%
Exaggerated startle response	84.1%

Table 3: Prevalence of Posttraumatic Stress Disorder symptoms within respondents

When asked about how people traditionally dealt with such happenings as the death of a beloved one, the occurrence of a disaster, or a loss of some kind, people reported that their main healing strategy used to consist of community members offering social recognition of the problems and giving social support in order to help the victims to overcome the psychological disturbances. The main actors in this process used to be family and friends, village elders and local leaders. Also social gatherings used to prove very useful. The post camp experience however, was quite different. Every family was affected, thus tying it down to its own concerns living little or no emotional energy to reach out to others. Another aspect of the uniqueness of the ADF experience is that it

came at a time when traditional emotional support fibres have been traded in for "being modern".

Consequently the previous coping strategies have been nearly wiped out completely and people so far have found no ready answers to overcome their present mental problems in this new social environment. This inability to fall back on traditional coping mechanisms has probably contributed to the fact that the levels of PTSD are presently still very high.

Social Economic Impact

Living in the camps in itself prevented people to build new social structures. Reasons for that were twofold; firstly this was caused by the harsh living conditions, with their main focus mostly on their own and their family's survival. IDPs showed initial reluctance to trust and interact with their neighbours who were more often than not strangers to them. Secondly, and interrelated with the first reason, the psychological disturbances often formed a hindrance to formation of new social structures. This finding does not suggest that social interaction did not exist at all. What this means is that those ties never reached the same level as during the days before the displacement and that the strong social support as an effective form of coping strategy no longer existed. Moreover many people reported failure to recover due to devastating economic setbacks they suffered because of the war.

Twenty five year old male whose relative died of cholera described her feelings as follows:

> "I watched my aunt dying because there was no one near her; all the people feared to get cholera because the doctor had told them not to come near her, we didn't even prepare the body for burial. Prior to that, my friend and his wife both died of cholera, the experience made me lose 3 people in a week. I still fear to drink the water from the same well."

One opinion leader said that:

> "It is the necessities of life that are most important. But what also is very possible is that the people overlook their feelings, because they know that at least the economical needs will be clearly understood by the researchers and other social workers. People wish to have their basic needs first, and then they will attend to their feelings"

CONCLUSION AND RECOMMENDATIONS

That millions of people in many countries are suffering multiple effects of trauma arising from armed conflicts is a well-established fact. Nations and organizations are constantly mobilizing resources to assist affected people, very often referred to as victims. Most victims of violence by western standards would be encouraged to seek psychotherapy, individually or in groups. Eighty percent of the ADF insurgence victims would rightly seek therapy. Yet, if they did they would be disappointed. First, they would not find a therapist. Second, if one was found, he/she (the therapist), would be overwhelmed, not only by the complexity of the presenting problem, but also by the resilience of the victim who might display characteristics that contradict the already affirmed diagnostic criteria in the DSM VI. Findings from this study affirm the obvious, namely that the resettled former IDPs of Bundibugyo need some psychological help.

Psychological interventions

Psychological intervention would be the most obvious help to think of after incidents like those of the ADF war. As Brody (2002) comments "If the long-term psychological impact of the IDP/refugee experience is not addressed, then it will be all the more difficult for IDP/refugees to become effective citizens of the communities or countries to which they return"(p.57). Both our research findings on the high prevalence of PTSD (and comorbid diseases like depression and disassociative disorders), and the strong request for counselling by most of the respondents, stresses the need for PTSD therapeutic initiatives.

When confronted by such great need for psychological help the most obvious place to look for help is where material help usually is found, in the west. There, is found well

researched and scientifically validated modes of treatment. For instance, there are different existing approaches for PTSD treatment: one-to-one psycho-dynamically oriented programs, group-based programs and interventions focusing on community reconstruction. Unlike other forms of aid that can be imported without much question, some psychological treatment procedures will need to be examined for suitability.

Levin (2001) shows that whether the therapy is on an individual basis, a group basis or a community basis, the primary focus will always be on the following issues: to re-establish of feelings of basic safety, to work on affect management and affect processing, to solve cognitive distortions, and to integrate the traumatic experience into ones life. Generally within PTSD-therapy the focus lies within the fields of rebuilding the lives of traumatized people to a state as before the trauma. Therefore therapy will always try to reduce the consequence of the trauma, to maintain self-esteem within the individual and to prevent re-traumatisation. This global intervention outcome however need not be attained by using uniform procedures all over the world.

Beyond any doubt, most organisations and individuals working with psychosocial support programs with IDPs and refugees are favouring those interventions working on the community reconstruction. Although there are not many such treatment procedures that have been scientifically verified, there are enough testimonies testifying effectiveness (Levin 2001). There are also many good reasons why a purely western psychological intervention would not be as effective in Africa. Literature on the implementation of this classical approach to trauma in non-Western societies shows this would not work. For instance three main objections against classical PTSD purely western therapy are to be found; the financial limitations disposable within relief work, the issue of victimizing the victims, and finally the cultural specificity.

Classical Western Interventions to Trauma

In nearly each therapy within Western society the issues mentioned by Levin (2001) are tackled. However the way this happens still depends entirely on the kind of therapy used and the unique way each individual adapts towards his or her trauma experience.

Although similarities do exist among individuals in both the specific traumatic experience and the reactions, the combination between internal and external factors will always shape the individual's reaction in a very personal way. Consequently in Western society an individual therapy is mostly opted for, sometimes in combination with group sessions. This form of therapy however is very time consuming and has a low overturn in some cultures.

Psychosocial Aid as part of a Public Health Approach

As an alternative to the Western individual therapy approach, psychosocial aid programs that are integrated in what is known as a "public health approach" are favoured. This approach concurs with the WHO saying that mental health should be part of public health and social welfare programmes. This public health approach acknowledges the need for community-oriented interventions in all sectors and the existence of more individual and family-oriented interventions to address acute or chronic psychopathology. Also judged from an African cultural perspective general psychosocial interventions will have the widest impact when they are carried out on the community level.

Having psychosocial aid programs working on community level, especially rebuilding and strengthening of community ties is widely recognized. For example the UN acknowledges that the restoration of the community is a prime objective for trauma recovery within children. An ISTSS/UN text on this subject states that in responses to large-scale natural disasters or to populations affected by war, there is a need for rebuilding the full infrastructure of child support services at every level within a community.

Working at community level enables two effects. The overall aim of this approach is firstly to focus on the augmentation of protective factors and the diminishing of stressors in order to overcome all kinds of mental problems of all the community members,

including PTSD. Secondly, as a consequence of the first, the amount of healthy community members will raise steadily, which in turn will contribute to the community rebuilding process and will enable the reinstating of the previously used methods of coping with trauma or other stress evoking experiences.

The importance that we lay upon these community ties is not only a result from what we have found to be the traditional ways of dealing with trauma. It is something to be found in many other researches, e.g. "in situations where traditional methods of coping, which include family and community, remain intact and retain their natural capacity to support members and help them solve problems, people seem to adjust best" (Baron 2002, p.115). The same has been said to help war traumatized children in Rwanda.

As stressed before, it should never be forgotten that all forms of emergency responses could have direct impact on the psychosocial functioning and well-being of the IPDs. It is very important for all relief organisations to be aware of the fact that collective recovery over time is intrinsically linked to reconstruction of social and economic networks and of cultural identity. Relief organisations should moreover be aware that they can also negatively influence the recovery process of the IDP communities, e.g. by unequal distribution goods and materials, by creating dependency, or by imposing superficial cures.

Traditions Healing Practices and Rituals

Although undergoing a lot of transformation traditional healing practices in Africa remain a very important source of solace for many African communities. When appreciated and integrated into modern interventions, traditional practices can be very strong instruments of healing. It is being estimated that 70% of the African population use traditional medicine (Madu & others 1996). This percentage covers such practices as, the use of herbs, traditional midwifery, astrology and divination, and faith healing. Common to all these practices, and universal to many African cultures is the community aspect that is usually interwoven with intergenerational family ties that “communizes” the suffering of individuals, and individualizes the concerns of the community.

Common to most African traditional healing practices are rituals. Rituals provide structure and order for daily life. Rituals may also provide occasions for people to express their emotions which due to cultural inhibitions may have been bottled up. Since war trauma deprives people of their sense of belonging by uprooting them from their locality, any thing that reinstalls structure and order in people's lives is healing. Rituals carry this capacity to reinstate belongingness and ownership. Rituals cost little or nothing compared to the many of the western psychological interventions. Unfortunately little has been written about most of the healing rituals, and so western tailored intervention programs would have no space in which to insert these valuable practices.

Specific Recommendation

Ongoing mainstream counselling services

The prevalence of Post Traumatic Stress Disorder and other related mental distresses call for ongoing psychological support from trained personnel. The Bundibugyo Community Volunteer Counsellors Association (BUCOVOCA) is a very important resource that if reinforced and facilitated can become a stable provider of mainstream counselling services. Although these counsellors have received some kind of training, they have never received formal training, and as such they demonstrate a lot of limitations in their practice. These people need to be availed an opportunity to receive more training and supervision.

Sensitization of the population

Although the population has gone through the experiences of war, displacement, and loss, many fail to see the after effects of these experiences on their lives even now. Some of the past victims have developed attitudes that lead to their failure to adjust into "normal"

living. Sensitization seminars/workshops will help people to learn to appreciate their feelings, and tolerate other members of their community who may exhibit inappropriate behaviour related to war trauma. Such community appreciation is one way helping former victims to own their experiences and recover their connectedness to the community.

Traditional Healing Practices

One of the most helpful tools in the healing of memories is the capacity to remember and to be allowed to mourn. The telling of the story to caring individuals is a way to recovery, and enables a person to grieve with social support. There are many traditional practices; rituals, singing, dances, and story telling that are readily available as powerful channels of healing in Bundibugyo. Most of these have not been utilized by the intervention programs. Future programs would be more effective if they included a learning and utilization Component (learn the practices and utilize what they offer) in their schedule of activities.

Utilization of Available Resources

Reconnection with ordinary life is the goal of any after-the-war intervention program. For Bundibugyo this can be a very expensive goal to achieve due the limited resources available for the social services sector. Instead of setting up new systems and channels of intervention, it would be cheaper and easily acceptable if all the new intervention can be channelled through the existing social services systems. Such systems include schools, health units, places of worship etc. These are all congregating points at which specific interventions can be concentrated and then interwoven into the existing human service

resources. Healthcare workers, teachers, and religious leaders are all available human resource that if facilitated and empowered will become strong agents of healing.

Conclusion

What we are proposing here is an integrative approach that while allowing the in-flow of external aid (e.g. relief funds and goods, professional expertise etc), does not exclude utilization of available resources. The integration of new interventions into the existing systems will ensure their ownership and continuity long after external help has been stopped. Moreover given the poverty level of Bundibugyo any psychosocial intervention needs to be accompanied by material development schemes that enable people to care for their basic needs.

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APPENDICES

APPENDIX I

INTERVIEW GUIDE FOR KEY INFORMANTS

Personal data-who are you and what are you doing

Name

Function

How long have you been here?

Displacement

History of the camps

Are there differences between the camps (population, experiences, living conditions,…)

How have the women, men, youth and children been affected differently by displacement? What has been the impact?

ADF conflict

Did you notice any signs that this was likely to happen?

What was your immediate reaction to the war?

To what kind of violence was being inflicted on the people?

How has this war affected your community as a whole?

Natural disasters

What kind of natural disasters are common in this area?

When do they happen and how often?

What is the impact on the community?

How do people cope with the impacts of those disasters?

Did you expect any like this could happen?

Psychological problems and Trauma-interventions-strategies

Are there other circumstances/things that cause psychological problems/trauma?

How do/did people normally cope with negative experiences (death, disease, poverty,…)

Do people still recall the circumstances that led to displacement? How do they cope with these memories (different from the other negative experiences)?

Can you identify the most common psychological problems?

Are people willing to receive help in dealing with those problems, especially trauma?

What kind of psychological help is there provided and in what way do is it working?

Has the assistance helped in improving their situation?

What role have you played in helping the people in coping with their psychological problems, especially trauma?

Do children and adults come for help to you?

What kind of help do you provide?

How many children/adults do you helped/treated?

Which strategies can be used to overcome those psychological problems that the IDP's face?

Are the existing strategies and methods sufficient?

How do the IDP's look upon the assistance?

What traditional approaches to solving psychological problems do you know about?

Resettlement-related to security and trauma

How do people feel about going home?

Camp conditions- family and community breakdown-aggression-moral values Diseases-health situation

Domestic violence

New, early and broken marriages

Sexual harassment, prostitution

Diseases like HIV/AIDS, Malaria, STDs,…

Social and family breakdown

Finishing

What lessons did this teach you?

Do you have anything to add?

APPENDIX II

Former IDP'S QUESTIONNAIRE

Interviewer:

Date and Number: ……..

Interviewee:

Presently living:

Sub – County	Village

1. Personal Data

Age: 16 – 20 / 21 – 25 / 26 – 30 / 31 – 35 / 36 – 40 /
41 – 45 / 46 – 50 / 51 – 55 / 56 – 60 / 61 – 65 / 65 +

Sex: 1) Male 2) female

Marital Status: 1) Single 2) Married 3) Divorced/Separated 4) Widowed

Marital status before displacement: 1) Single 2) Married 3) Divorced/Separated 4) Widowed

Number of children …….

2. A) Were you displaced at all because of the war?

If yes, which camp he/she used to live in:

Sub – County	Village

B) What were the biggest problems you faced during resettlement?

1) Food-security 2) Security 3) Economic 4) Bad memories 5) no support 6) Others ….

C) Were the problems you faced the same as the ones you expected?

1) Yes 2) No

D) Did you resettle in the same village where you lived before the war?

1) Yes 2) No

if no, why not ……...…….

……

……

E) Did you resettle in your original home?

1) Yes 2) No

if no, why not ……

3. A) Is your community comparable to the state it was before the displacement?

1) Yes 2) No

Why?

……

……

……

……

B) Are there differences in the way people are leading their lives compared to the previous times?

……

……

……

……

C) Do you think the camp life has affected the way people live in the community

1) Yes 2) No

4. A) Do you feel secure in your village?

1) Yes 2) No

Why?……

……

……

B) Compare the security before the camps, in the camps and now

……

……

……

……

5. What is/are the biggest challenges you and your community are presently facing?

……

……

……

……

How do you think you can overcome these problems?

……

……

……

Do you find people more cooperative compared to the time before the camp or during camp life?

1) Yes 2) No

What are the causes for that?

……

……

……

……

6. Are there other events that happened in the past, that now still give you bad memories or make you sad?

1) Yes 2) No

If Yes,

a) Which events?

……

……

……

……

……

b) How do they affect your daily life?

……

……

……

7. Is there anything you want to add?

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…....

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