

**Current affairs**

# Addressing gender based violence and psychosocial support among South Sudanese refugee settlements in northern Uganda

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*This personal reflection describes how the nongovernmental organisation, TPO Uganda, tried to expand an existing programme providing psychosocial support to survivors of sexual gender based violence in refugee camps in Adjumani District to Bidibidi in Yumbe District, Uganda with an enormous group of new refugees from South Sudan. It describes the kind of (sexual) gender based violence the refugee girls and women experience, how staff try to find these women and provide support through using cognitive behavioural treatment therapy for trauma intervention. The author gives voice to the women who went through this intervention and shows the challenges staff experience in supporting new resettlements of more than 200,000 people since opening in August 2016.*

**Keywords:** cognitive behavioural therapy, refugees, sexual gender based violence, South Sudan, Uganda

## Introduction

### Background and context

Uganda has received waves of refugees from South Sudan since the crisis erupted in December 2013. At various times since then, the monthly refugee influx rates have reached an order of magnitude of tens of thousands. On 7 July 2016, heavy gunfire and military fighting broke out in Juba, the capital of South Sudan, between the government forces of President Salva Kiir and rebel forces loyal to (then) Vice President, Riek Machar. The clashes left over 300 dead and tens of thousands fleeing the capital. It

brought political instability throughout the country and challenged the transitional government of the August 2015 Peace Accords, bringing national unity into question. In Uganda, this outbreak of fighting in South Sudan triggered one of the worst refugee emergencies seen in the country since the initial influx of South Sudanese refugees in 2014, citing the fear of physical and sexual violence, persecution, political uncertainty, forced recruitment of children and looting as reasons for fleeing. As a result, the refugee influx into Uganda skyrocketed, from roughly 200 per day to a spike of more than 8,337 refugees crossing the border on 21 July 2016, with a daily average of 2,117, despite armed groups reportedly operating throughout the major corridors to border points into Uganda.

Alarmingly, women and children made up as much as 95% of new South Sudanese refugees entering Uganda during this period (United Nations High Commission for Refugees (UNHCR), 2016). However within the country, refugees are hosted by host communities that themselves have a high mental health disease burden, with very limited mental health services. (Kigozi, Ssebunnya, Kizza, Cooper, & Ndyanabangi, 2010). One of these refugee communities is Bidibidi.

### Refugee settlement in Bidibidi

Until August 2016, the small village of Bidibidi in northern Uganda was mainly grassland, houses and a few buildings. Now it is

third on the list of biggest refugee camps in the country. The Bidibidi Settlement officially opened 2 August 2016 and as of 28 November 2016, the population of Bidibidi stood at 239,570 individuals, with 91,359 households.

Refugees continue to arrive in Uganda, also via the Democratic Republic of Congo (DRC) due to blocked roads between Morobo and Kaya (Oraba). They report the lack of infrastructure, basic services and language barriers as reasons for not remaining in DRC. If they come directly from Sudan or through the Congo, all refugees report main roads remain blocked and fear of government forces and opposition groups impeding travel through the bush. Many refugees have spent several days walking with limited access to food, water and other needs. Women and girls are at high risk of attack by wild animals, or rape by militia and rogue government forces. UNHCR, the Office of the Prime Minister (OPM) and partners ensure that refugees arriving at border points are quickly transported to Bidibidi, where they have access to facilities such as water, food, shelter and medical attention/nutritional screening and where they receive Psychological First Aid (PFA). Refugees interviewed in Bidibidi mentioned the following reasons for fleeing as: 1) extreme violence and indiscriminate killings often based on ethnic origin; 2) extortion; 3) rape; 4) forced recruitment of boys and men; 5) burning of villages, property and livestock; 6) hunger and lack of adequate food, medication and basic services; 7) inflation and the soaring cost of living; and 8) ethnic discrimination by government forces.

The refugees presented with severe signs of emotional distress and acute stress reactions. For example, one refugee, reported that he needed rest because he felt like blood had accumulated in his brain. Other refugees shed tears during PFA provision and were restless. Refugees with symptoms of emotional and acute stress reactions require

adequate resources in terms of logistical support, technical human resources for consistent support and care to prevent development of more severe disorders, such as depression, posttraumatic stress disorder (PTSD), anxiety disorder or psychosis. All of these are more difficult and costly to manage, therefore, prevention is better than cure.

### **Survivors of sexual gender based violence among South Sudanese refugees**

The nongovernment organisation (NGO) TPO Uganda, where I have been working since 2015, partnered with UNWomen to provide advanced psychosocial support to (sexual) gender based violence ((S)GBV) survivors, specifically girls and women<sup>1</sup>. Initially, support was only available in the refugee settlements in Adjumani District, now it has also been scaled-up to include the Bidibidi settlement in the Yumbe District. Many agencies that provide (S)GBV services lack the capacity to carry out active outreach to find women and girls as survivors of (S)GBV, so therefore, mainly rely on self-reporting or obvious cases that have become a community concern. However, the majority of those exposed to (S)GBV suffer in silence.

There are two main sources of (S)GBV among women and girls from South Sudan: the acute threat of warfare and Sudanese cultural practices. Within war situations, women and girls are almost always targeted with sexual and other forms of violence. Sometimes warring parties will use humiliation of women and girls as a show of power and dominance. In refugee destinations, women and girls may also be at risk of violence due to conditions in reception centres, camps and settlements. Sometimes, early marriage is a way to fulfil their basic needs, such as shelter, food, security and secondary needs, such as clothing and cosmetics. However, most of the gender related challenges women and girls face are fuelled by

South Sudanese cultural practices, such as: wife inheritance and maltreatment of widows, forced and early marriages, bride price and dowry related violence, and the preference for sons. Some of the girls are in school, although a majority leave school early to do house hold chores and prepare meals for their siblings. Some of the girls are child mothers, and some are orphans. Some of the girls are unwilling to study, so they remain at home. According to one teacher in a refugee settlement, approximately 80% of girls are not in school, which is very alarming. This is also because there are no secondary schools nor vocational institutes in the settlements. As a result, most of these girls get married at an early age of about 14/15 years. This is also attributed to the fact that it's at this age that girls become more sexually active and are, therefore, under pressure from their families. Additionally, they face hardship in accessing basic needs, for example sanitary pads, towels and books within the settlements. Also noted within the refugee camp were instances where the parents of young girls forced them to get married for financial gain. Unfortunately, if the girls refuse to get married they often face physical abuse and exclusion from their families.

*As women, we play a big role in pushing our daughters into early marriages. We are expected to ensure that our girls learn how to manage a home early so they can bring a good dowry when they get married. You see, the dowry paid on the girls will help their brother to have dowry to pay for their own wives later. This makes it difficult for us to even encourage our girls to stay longer in school, because the blame is on us if we do not help them to be good wives and mothers.'*

(Refugee woman)

It is against this background of contributing factors of both war and culturally related (S)GBV that we provide advanced psychosocial social support to women and girls. A

necessity, in order to properly address main psychosocial issues for the more than 90% of the South Sudanese refugee population in Uganda, women and children.

### **Psychosocial support for survivors of sexual gender based violence**

The increasing numbers of refugees and the trauma that follows them as a result of violence has resulted in the need of psychosocial support and care for survivors. If not addressed, this may lead to significant mental health problems, as well as social and physical problems that are closely linked to (S)GBV they suffered. In order to address to such challenges, psycho-education about (S)GBV and its consequences has been one way to inform survivors about the nature of mental disorders and symptoms. This has also followed by provision of PFA and more structured therapeutic interventions, such as cognitive behavioural treatment therapy for trauma (CBTT), especially for persons with PTSD. We used a clinical and socio-economic model, which prompts the survivors to report cases of (S)GBV to responsible authorities (community support structures) and together develop preventive and responsive measures to (S)GBV and MHPSS problems within target communities.

### **The CBTT intervention**

The intervention addresses GBV related social and psychological morbidity by carrying out systematic assessment of the target group of women and girls. The approach employs a stepped screening for exposure to GBV, followed by a series of psychological assessments using standardised mental health assessment tools specifically those designed for stress related disorders (Beck's depression and anxiety inventories, the PCL-5) mental health inventories', a clinical guide to PTSD by Steven Taylor. Those who found to be have been exposed, or are exposed to GBV, and screen positive for

significant symptoms of stress related mental disorders such as depression, PTSDs and anxiety disorders are asked to join a group of 12 individuals and are taken through a 10 session CBT programme. After the sessions, they are assessed to determine remission of symptoms or improvement. The clinical psychiatric officer and a clinical psychologist are always on hand to offer extra support to those who may not have improved in the group. Social workers also work with the same groups to increase social support systems around them to enhance recovery. The finding of the screening indicated that GBV is common among the women and girls in the settlements and it is perpetrated by the spouses/husband. Also, the girls reported GBV against them by their own mothers or guardians/relatives due to acute difficulties within the families. The commonest form of GBV reported among the refugees was domestic violence, leading to psychological and emotional violence, and physical and sexual violence. The current situation, added to past traumatic experiences during the war, were noted to result in common mental health disorders, such as depression/suicidal thoughts, anxiety and PTSD. These were captured by Beck Depression Inventory (BDI), Beck Anxiety Inventory (BAI) and Post Traumatic Stress Disorder Checklist (PCLA) tools. Often beneficiaries presented with more than one type of common mental disorder. This co-morbidity was not taken as an independent/separate diagnostic group, but fused under the three main classes of the disorders mentioned above.

Beneficiaries were then zoned into the different diagnostic categories and taken through the 10 CBT sessions per group. The approach combines treatment with community psycho-education and awareness about GBV and its consequences.

We applied several types of interventions. Interventions focused on managing the daily settlement stressors, address GBV psychological and mental health consequences linked to displacement and the trauma

during flight. These daily stressors and other pre-existing conditions made women and girls highly susceptible to sexual exploitation and abuse. As they found their way to Uganda, women and teenage girls go through many ups and downs, like trekking long distances, lack of water and food, absence of shelter for privacy, separation and loss of loved ones. As a result, these women lost their agency and were disempowered as they embark on settling in to an unaccustomed environment. The enormous pressures of life, such as having to live in a closed settlement, also often lead to domestic violence.

Women suffered from effects of negative thoughts on feelings, behaviour and physical reactions, such as increased heartbeats and headaches. In order to reduce/alleviate such reactions, psycho-education has been one way to inform survivors about the nature of mental disorders and symptoms. All group members practiced psycho-education using metaphors. They were taught the cupboard metaphor, the wound metaphor, and the child and chicken metaphor, described in detail below.

The cupboard metaphor aims at explaining why people who have suffered trauma continue to relive the experience in an intrusive way. Meaning that when we go through traumatic experiences, these experiences continually come to mind, as if they are happening again. When this happens against your will, even when you ignore it or it comes to you in dreams, this can disturb normal functioning. It also gives the social worker the opportunity to inform the client methods of treatment required to overcome them. The wound metaphor is aimed at motivating the client to undertake treatment and to overcome avoidance. The chicken metaphor aims at giving a rationale for exposure therapies, such as helping a client construct a hierarchy of feared situations and encouraging them to confront them, starting with the least feared and working up to the highest. It also involves systematic, repeated and

prolonged exposure to a traumatic memory, including aftermath of the trauma. This reduces the distress associated with traumatic memories, reduces re-experiencing symptoms and teaches the patient that memories and associated emotions are not dangerous. Proper psycho-education reduces treatment dropout and improves outcome from treatment. Trainees were given a written script of group psycho-education.

Social workers support women and girls on how to identify unhelpful thinking, the link between thinking and feelings, between feelings and behaviour, and feelings and physiological reactions. Strategies for handling physiological reactions, behaviour and thoughts are discussed during the sessions, including stress management strategies and strategies for managing dissociation. Several stress management techniques are practiced, such as controlled breathing exercises as a tool for managing anxiety. Progressive muscle relaxation is also used, including a description of what progressive muscle relaxation is, and steps in doing this type of relaxation was discussed. Relaxation is a useful tool in managing anxiety and also in managing work related stress during debriefs and safe place exercise, including a description and rationale of using safe places was given. The social workers were given a calm place script, which requires that you imagine you're in the best place you can think of, such as a lovely place, or smell good food, or are on the beach, which was then explained to their interpreters so that they would be able to deliver it well to group members.

Grounding exercises used for clients in anxiety state to reassure them that, they are safe and keep them stable by reassurance that enables the person to build confidence, are used to targets dissociative experiences. Social workers discussed dissociative states commonly seen among people with PTSD. They practiced how to use grounding exercise to manage dissociations during the session.

Also, other behaviour strategies were used. Such as behaviour activation, where a social

worker educates clients about the link between feelings and behaviour. Thereafter, behavioural activation would be used to help client discover the link between behaviour and feelings. They were taught how to use it with depressed clients to increase activity levels and change how they feel. Another example is problem-solving where women and girls learn or re-learn problem solving skills.

This was also followed by provision of PFA and more structured therapeutic interventions, such as CBTT, especially for those with PTSD. TPO Uganda also maintains a referral pathway with other agencies offering support to GBV survivors, and only provides complementary services not offered by other agencies or beyond the capacity of other agencies.

Women expressed that after attending group interventions they started feeling better, their body pains, headaches, excessive thoughts about the past experiences began to diminish and their sleep improved significantly. Also, relationships with their children and husbands improved. As well as feeling better, their knowledge and skills have improved.

Other activities to complement services included:

1. Providing integrated protection services that enable refugee children to adapt to life as a refugee, including psychosocial support and trauma healing
2. Structured activities for children in child friendly spaces
3. Socio-economic strengthening interventions for vulnerable adolescents
4. Life skills development activities and parenting

### **The effect of the intervention described by a participant**

*If anyone could enter my brain and my heart, you would really know what is going through my mind. I despised myself, my children and the man I was forced to marry. Life is useless*

*and I regretted the day I was born. I beat my children endlessly even when they have not done anything wrong, I had sleepless nights because of too much thought and worries that keep on running in my mind? She cries loudly; 'You [her children] are the reason why am suffering, why he divorced me [referring to her husband]. One day you will not see me again as your mother, you will find me lying down in silence, you will wake me no more.'*

Tears continued rolling down her cheeks as she narrates her story to a social worker who had gone for home visit.

*'I attempted to commit suicide on two different occasions. One day when I was really very sick because of too much thinking and worries of who will support me to take care of my children and where am going to put my children, I went to the drug shop and bought medicine. Immediately thoughts started coming into my mind that, why can't you kill yourself with this medicine, indeed I took an overdose with the intention of dying, but fortunately enough I didn't die, the medicine only made me very weak.'*

*The second attempt was when my children were crying for food and I didn't have anything to cook for them, Immediately I recalled how their father divorced me because I have given birth only to girls. I felt all of my body shrinking and I could not understand what was happening, I even blacked out. The neighbours took me to hospital, as I was lying there without any help. I started coming back to my normal senses, fairly recovering, I was discharged to go home. Life didn't change for me at all, instead it became worse for me, until one day I was going back to health centre for more drugs. I saw people gathered around the church. I thought they were there for food relief, I also went there, then I heard this lady talking, and what caught my ears was; "we work with women who have undergone GBV problems and we find a way of dealing with such difficulties they went through together", she said. My heart leaped and I knew this lady has come as a saviour into my life.'*

## **The intervention**

*'As days went on, I continued coming to the church where the TPO lady used to come and sensitised the community on mental health, psychosocial support and GBV related issues. One thing which made me to start having hope was when she said: "I will ask women here one by one and talk and share with everyone. These questions I will ask [screening] will help me to support women much better in the problems they are going through". That was the day I tried to smile a bit because I knew someone will listen to me.'*

*On the third day, I came back, but there were very many women. I didn't give up, but instead I came back another day that was when she asked me those questions. Later she zoned me into a group of 12 members and I became very happy because she told us things I really feel about.'*

*There I started interacting with my fellow women who are almost the same age like me, this became interesting because we could really crack jokes and laugh a lot in our small group. This social worker didn't leave us alone, she continued coming to meet us in the group, she taught us on how to improve our sleep, how to manage stress, about body hygiene and how to relate well with our families and relatives. Above all, what really made me happy was one of the exercises, for relaxing muscles from toe to head [progressive muscle relaxation] and thinking about a very good place that you would really enjoy when you are there [safe place exercise] and this makes me happy, because every time when the bad thoughts starting coming into my mind, I just go straight to safe place and this has really worked out for me so much and my children.'*

## **The change or result of the intervention**

*'I really appreciate UNWomen and TPO who really supported me and changed my mind and attitude towards myself, my children and the'*

*relatives. I have stopped beating my children, punishing myself, now I love them so much. I always cook them food on a daily basis and when there is nothing, I endeavour to tell them that there is no food, and they would understand. I learnt how to manage my stress and I no longer off load it to my children, because I understood that, they are gift from God. I even sleep well at night, my children have also noticed the change in me because one said; "Mum you no longer beat and punish us, you prepare food and laugh with us, what has happened to you?" I smiled at her and said that I am sorry for all whatever I was doing to you, my children, I have realised that what I have been doing to you wasn't right, that's why I have stopped it and changed' (Agnes Foni<sup>2</sup>).*

## **The challenges of implementing the programme**

The massive number of new arrivals received following the 7 July 2016 crisis required a swift, programme implementation for immediate action by all partners and the government. The GBV project was an existing programme in other refugee camps when the Bidibidi settlement was opened. This created a challenge in terms of project outputs and outcomes, as the nine month project had components of data collection, structured therapeutic sessions and post therapy assessment, all of which are time specific in nature. We had to inform the donor as to why we were changing the content, which was due to the extreme refugee influx.

At the same time, the staff had to work as a team to step up sensitisation covering a wider area. They faced challenges on all levels, such as logistical challenges as the settlements are quite distant, more than 50 km from the field office where the staff reside. This also poses challenges of inadequate fuel and transport difficulties, for example, it is impossible to use motor bikes during the rainy season.

The staff was also hampered by the unexpected emergency, overwhelming numbers, human resource constraints, among logistical challenges and other factors. Regardless of these challenges, they were able to provide PFA and the CBBT programme.

Other challenges were that women can report (S)GBV to several service providers, but that this does not mean that they receive the necessary help. As one female refugee stated: *'although they go to report, they are never helped. They can even arrest those who reported, beat them today and tomorrow and release them without even going to court to solve the problem. Which means that they never solve the problems.'* The mistrust present among refugees and refugee community leaders at the settlements is reciprocal. Formal structures, like police representatives, rarely trust information provided by the refugees as the representatives often look for ulterior motives, or assume facts have been exaggerated. Many women also claimed that they were not getting sufficient medical care from service providers.

Poor network coverage and phone charging facilities in the settlement makes community mobilisation processes difficult for the implementation team. The staff also find it difficult to reach community facilitators who can help in translating and mobilising the community, thus affecting project implementation processes.

The stress on staff members was also worsened by high inflation rates against the merger of Ugandan currency. Considering this salary decrease, it was a tight personal financial challenge. This was addressed somehow by the staff having one meal per day, which exposes the staff to poor health. The suggestion is that it would be logical to give staff financial allowances as motivation to achieve project targets with minimised ill health. These challenges resulted into psychosocial problems for the staff members, which were expressed in terms of acute stress reactions/emotional distress and poor health related issues.

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<sup>1</sup> TPO Uganda has been partnering with UNwomen and UNICEF since 2013 to provide child protection and advanced psychosocial support to GBV survivors, specifically girls and women in the refugee settlements in Adjumani District and scaled-up to Bidibidi.

<sup>2</sup> This is not her real name.

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