Addressing Mental Health Challenges due to

COVID-19 lockdown in Uganda

Activity Report

Group Therapy among Women Experiencing Depression

January 2021

P.O.BOX 196, Jinja
Old Kakira Road, Wairaka
Website:http://ccuginitiative.org

Executive Summary

Introduction: Depression is a prevalent and serious mood disorder characterized by persistent sadness. In Uganda, COVID-19 pandemic containment measures have resulted in the loss of livelihoods to women, causing loss of work and earnings. In addition, there has been an increase in cases of gender-based violence against women and girls. As a result, women's psychological well-being has been more affected due to a combination of financial and emotional stress, social restrictions, and violence among others. With support from AmplifyChange, CCUg undertook an intervention to address mental health issues caused by the COVID-19 pandemic.

Methodology: A mental health intervention employing the Interpersonal Therapy for Groups (IPT-G) techniques was used to assess depression status, and provide therapy to women from 5 villages in 5 sub-counties in Jinja and Mayuge districts.

Results: Out of the 169 people assessed for depression, 7 out of every 10 were experiencing moderate to severe depression. Also, 51.2% were thinking of, considering, or planning suicide where 65.6% had active suicide ideation and 34.3% had passive suicide thoughts. The majority of people assessed had Unipolar depression (71.2%), 19.2% had Perinatal/Postpartum depression, 8% had Chronic Depression while 1.6% had Psychotic depression.

Although 125 clients were eligible for group therapy for depression, only 112 were enrolled, and of these 98 finished therapy. All clients who attended therapy had mild or minimal depression by the 8th session.

Conclusion: The mental health intervention was not only successful at averting possible suicide among 42 beneficiaries but was also very instrumental in reducing depression symptoms among 98 beneficiaries in 5 villages. There is a need for continued monitoring of beneficiaries to assess relapse, and increased resource mobilization to provide therapy to more women and girls experiencing depression.

Table of Contents

Executive Summary i
Table of Contents i
List of Abbreviations iii
List of Figure iii
List of Tables iii
1.0 Introduction 1
1.1 Background 1
2.0 Objectives 2
2.1 General Objective 2
2.2 Specific Objectives 2

3.0 Methodology 2
3.1 Design, Setting, and Population 2
3.2 Sample Size and Sampling 3
3.2.1 Recruitment and Enrollment 3
3.3 Tool 3
3.4 Training, Screening and Therapy delivery 3
3.4.1 Training 3
3.4.2 Screening 4
3.4.3 Therapy Delivery 4
3.5 Ethical Issues 4
4.0 Results 5
4.1 Demographic data of beneficiaries 5
4.2 Depression and Suicide Ideation 6
4.3 Impact of the Therapy among beneficiaries 8
4.4.1 Achievements 9
4.5 Limitations and Lessons 9
4.5.1 Intervention Limitations 9
4.5.2 Selection and Recruitment Limitation 10
4.5.3 Adaptations made 10
4.5.3 Lessons Learnt 11
4.5.4 Monitoring 11
5.0 Conclusion and Recommendation 11
5.1 Appendices 12
5.1.1 Success Stories 12
5.1.2 Photographs 14

List of Abbreviations

CAO : Chief Administrative Officer

CCUg : Community Concerns Uganda Initiative

DALY : Delayed Adjusted Life Years

DHO : District Health Officer

DSM-IV : Diagnostic Statistical Manual IV

GBV : Gender-Based Violence

IPT-G : Interpersonal Therapy for Groups

IPT : Interpersonal Therapy

MHM : Menstrual Hygiene Management

OVC : Orphans and Vulnerable Children

PHQ-9 : Patient Health Questionnaire version scale 9

SRHR : Sexual Reproductive Health and Rights

SARS : Severe Acute Respiratory Syndrome

WHO : World Health Organization

WORI : Women Rights Initiative

List of Figure

Figure 1: Frequency of a household member being emotionally troubled in the past 3 months that they needed a counselor 6

Figure 2: Category of depression among assessed clients 7

Figure 3: Triggers of Depression among assessed clients 7

Figure 4: Pattern of beneficiaries' Depression Status from Screening to the 8th session 8

List of Tables

Table 1: Distribution of Depression Assessment 3

Table 2: Demographic characteristics of beneficiaries 5

Table 3: Severity of depression among people assessed 6

1.0 Introduction

Depression is a prevalent and serious mood disorder characterized by persistent sadness. In Africa, 1 in 23 people suffers from the disorder. According to WHO[1], Uganda is among the top six countries with the biggest number of people suffering from depression where about 3 in 10 people[2] suffer from the mood disorder.

Currently, psychological and pharmacological treatments exist for moderate and severe depression. However, in Uganda where access to basic mental health care is met with several barriers, depression—especially among the rural poor is characterized by delayed help-seeking and is a major source of Disability Adjusted Life Years (DALY).

In the past 10 months, global preliminary figures have shown that women are disproportionately affected by the COVID-19 pandemic. A review of previous epidemics such as SARS and Ebola[3] has shown that women are impacted differently by health crises. This is because they take on more caring responsibilities when schools close and when family members fall ill. In Uganda, current COVID-19 pandemic containment measures have resulted in known risk factors for mental health issues such as depression.

The institutionalized lockdown effected between April and July 2020 in Uganda led to the closure of enterprises that provide livelihoods to women causing short and long-term loss of work and earnings to women, driving many into poverty[4]. In addition, this also led to increased incidences of gender-based violence against women and girls. As a result, women's psychological well-being has been more affected due to a combination of financial and emotional stress, social restrictions, and violence among others. This has increased their susceptibility to mental health illnesses such as depression and anxiety disorders.

1.1 Background

Community Concerns Uganda Initiative (CCUg) is a Non-Government; not-for-profit organization operating in 5 districts in the Busoga Sub-Region (Jinja, Mayuge, Luuka, Kamuli, and Buyende). CCUg prioritizes providing grassroots-based integrated services to help vulnerable women, youths, and children through building their skills to enable them to reduce and escape household poverty.

On the 18th of March 2020, the government of Uganda announced a nationwide lockdown that lasted more than 45 days to curb the spread of the coronavirus. By around that time, CCUg was implementing a Menstrual Hygiene Management (MHM) Project in 20 schools and surrounding communities funded by AmplifyChange. The closure of primary and secondary schools coupled with movement restrictions led to the discontinuation of the implementation of the project. CCUg held discussions with its funder—AmplifyChange, to enable the

[1] WHO, (2017). Depression and Other Common Mental Disorders: Global Health Estimates. Licence: CC BY-NC-SA 3.0 IGO.
[2] Ovuga, E., Boardman, J. & Wasserman, D. (2005). The prevalence of depression in two districts of Uganda. *Social Psychiatry and Psychiatric Epidemiology 40, 439–445.*
[3] Bandiera, O., Buehren, N., Goldstein, M., Rasul, I & Smurra, A. (2018). The Economic Lives of Young Women in the Time of Ebola: Lessons from an Empowerment Programme (International Growth Centre; Working Paper F-39301-SLE-2).
[4] UNDP, (2020). Socio-economic Impact of COVID-19 in Uganda; Short, Medium and Long-term Impacts on poverty dynamics and SGD using Scenario Analysis and System Dynamics Modeling

organization to use unutilized funds to address challenges caused by the COVID-19 pandemic. One of the main agreed activities was undertaking a study on the effect of the COVID-19 lockdown on Sexual Reproductive Health and Rights (SRHR) and Gender-Based Violence (GBV) among women and girls. The qualitative study was conducted in 20 villages in 11 sub-counties in Jinja and Mayuge districts.

Due to the strong linkage between mental health and SRHR, CCUg included depression screening in the qualitative research it conducted between April and July 2020—when the country was under lockdown.

2.0 Objectives

2.1 General Objective

To address mental health issues associated with the COVID-19 pandemic with emphasis on depression among women and girls. We aimed to determine the severity and undertake treatment plans for women and girls found with depression in 5 villages in Jinja and Mayuge districts. The assessment was also aimed at averting possible suicide among beneficiaries who were experiencing suicidal thoughts and behavior.

2.2 Specific Objectives

1. To conduct depression screening among 200 women to assess the status and severity of depression.
2. To provide suicide prevention counseling to clients experiencing suicidal thoughts and behavior.
3. To provide Interpersonal Therapy for Groups (IPT-G) to women and girls experiencing depression.

3.0 Methodology

3.1 Design, Setting, and Population

This intervention was designed as a response to a qualitative study assessing the effect of the COVID-19 lockdown on SRHR and GBV. CCUg assessed 80 women and girls during this study and of these, 38 women and girls (47.5%) were experiencing moderate to severe depression. During the data collection exercise, local leaders reported facing challenges providing psychosocial support to women and girls who had depression-like symptoms. Also, a significant number of respondents suggested that the organization provides counseling as a way of addressing the emotional and psychological issues they were experiencing due to the COVID-19 pandemic.

"I have thought about dying and taking my own life. I am suffering with so much pain, please come and speak to us to reduce on these thoughts…" (Interview XIII: Pregnant woman—33 yeas)

"If there is any support for the women readily available, we welcome it, but right now, I think providing food handouts and counseling would be welcome…" (Interview I: Female Local Leader, Mayuge district)

In response to the above, we conducted depression screening and provided group therapy as a community-based response to address mental health issues triggered by the COVID-19 pandemic and containment measures. This intervention was conducted between August and November 2020 in 5 of the 20 selected villages where we were implementing a Menstrual Hygiene Management Project in Jinja and Mayuge districts. Three of the villages (Nalongo, Wanyange Hill, and Mutai Central) are situated in Jinja district while 2 villages (Bugodi and Nalubaale) are located in Mayuge district.

The primary beneficiaries of this mental health intervention were girls and women, and men were the secondary beneficiaries.

3.2 Sample Size and Sampling

CCUg had a target of 100 beneficiaries; 90 of whom were to be women and 10 were to be men. Based on an earlier assessment which showed depression rates of 47.5%, we hoped to assess 200 potential beneficiaries. However, 169 people were assessed and of these, 163 were women and girls while 6 were men. We discontinued the assessment because 74% (or 125) of those assessed were experiencing moderate to severe depression as presented in Table 1 below.

Table 1: Distribution of Depression Assessment

S/N	Village	Sub County	District	No. of women assessed	No. of men assessed	Women/men with depression
1.	Nalongo	Kakira Town Council	Jinja	57	-	42
2.	Wanyange Hill	Mafubira	Jinja	25	-	21
3.	Mutai Central	Kagoma	Jinja	19	-	13
4.	Bugodi	Baitambogwe	Mayuge	29	6	27
5.	Nalubaale	Wairasa	Mayuge	33	-	22
	Total			**163**	**6**	**125**

3.2.1 Recruitment and Enrollment

Enrollment of beneficiaries into this intervention was based on a participant location and female local leader identification and mobilization. Five female local leaders were tasked with identifying and mobilizing 40 community members per village, with depression-related symptoms. Upon mobilization of potential beneficiaries in their respective villages, CCUg staff explained to them the purpose of the depression screening, assured them of utmost confidentiality of the interviews, and sought their consent to voluntarily participate in the exercise.

3.3 Tool

We used a Patient Health Questionnaire version scale (PHQ-9) originally designed by Spitzer and colleagues[5]. The PHQ-9 is a validated, Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition (DSM-IV) criterion-based measure for diagnosing depression. The PHQ-9 assesses 9 depression symptoms and functional impairment to make a tentative depression diagnosis. The tool was translated into Lusoga and used for diagnosing depression, severity, and monitoring the progress of therapy among beneficiaries.

3.4 Training, Screening, and Therapy delivery

3.4.1 Training

Eight CCUg staff received training about psychotherapy for depression to strengthen their ability to assess, refer and provide group and individual therapy to women and girls experiencing depression. The training included the following;

[5] Kroenke, K., Spitzer, R.L., Williams, J.B. (2001). The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med. Sep 16(9):606-13*

a) Causes, predisposing factors, and impact of psychosocial problems including how the COVID-19 lockdown might affect the mental health of women and girls.
b) Concept of Psychosocial support and wellbeing
c) Basics of depression; Definition including local meaning, major symptoms, types, impact, and treatment.
d) Elements of Group Interpersonal Therapy (IPT); 4 problem areas, group IPT, delivery structure, and supervision.
e) Phases of IPT; Pre-group, Initial group phase, middle, and termination phases.
f) Strategies for dealing with IPT problem areas, common challenges faced when facilitating groups, and potential solutions.
g) Phases of the counseling process
h) Suicide Prevention Counseling
i) Depression screening while using the PHQ-9

Further training was provided to the staff on Problem Solving, Critical thinking, Conflict Resolution, Anger Management and the Act of Forgiveness, Communication Skills, Group Dynamics, and the Grieving Process.

3.4.2 Screening

Screening of participants was conducted using an interviewer-administered PHQ-9. The face-to-face interviews were conducted by trained CCUg staff who collected demographic and information about symptoms of depression. Upon confirmation that participants were experiencing depression, the staff made appointments for another assessment (pre-group) before enrolling potential beneficiaries into group therapy.

3.4.3 Therapy Delivery

CCUg selected and used Interpersonal Therapy for Groups (IPT-G) or Group Interpersonal Therapy (IPT) for depression to provide psychosocial support to beneficiaries. IPT is a type of therapy developed to manage clients with depression whose main goal is to improve interpersonal relationships and social function. The therapy can be used by both mental and non-mental health-trained individuals to provide therapy over 8 weeks[6]. CCUg trained staff formed groups according to villages where clients ranging from 6 to 18 members met for therapy sessions for 90 minutes once a week on appropriate days. The 8-weekly sessions per group were held in selected places in villages where beneficiaries lived.

3.5 Ethical Issues

CCUg obtained permission from the Chief Administrative Officers (CAO) and District Health Officers (DHO) of Jinja and Mayuge districts to conduct a study on the effect of the COVID-19 lockdown on SRHR and GBV and consequently address the reported effects. At the village level, CCUg had earlier permission from LC Is and female local leaders. At a personal level, verbal consent was sought from participants after they were informed

[6] Four CCUg staff have professional training related to mental health and at least 3 staff had ever utilized group therapy to support adult caregivers of Orphans and Vulnerable Children (OVC) heal from depression.

of the purpose and assessment, confidentiality of the information, and the voluntary nature of their participation.

4.0 Results

This section presents the key intervention Results organized according to demographic data, the severity of depression and suicide ideation, triggers, and the impact of the therapy among beneficiaries. The results are presented in figures and tables with corresponding narrations.

4.1 Demographic data of beneficiaries

Table 2: Demographic characteristics of beneficiaries[7]

Category	Frequency (N=98)	Percentage (%)
Age brackets		
Under 19 years	6	6.1
20-29 years	29	29.6
30-39 years	13	13.3
40-49 years	16	16.3
50-59 years	20	20.4
60-69 years	12	12.2
70-79 years	02	2.0
Gender		
Female	93	94.9
Male	05	5.1
Education level		
No formal education	44	44.9
Primary level	27	27.6
Secondary level	27	27.6
Marital Status		
Married	56	57.1
Single	06	6.1
Separated	17	17.3
Divorced	10	10.2
Widowed	09	9.2
Whether clients know how to read and write		
Yes	50	51.0
No	48	49.0
Availability of confidant		
Yes	53	54.1
No	45	45.9

Nearly 3 out of every 10 clients (29.6%) were in the age bracket 20-29 years while (2%) were in the age range of 70-79 years. The average age was 40.4 with a standard deviation of 15.7.

An overwhelming majority of clients (94.9%) were female while (5.1%) were male.

Less than half of the beneficiaries (44.9%) had not attained formal education.

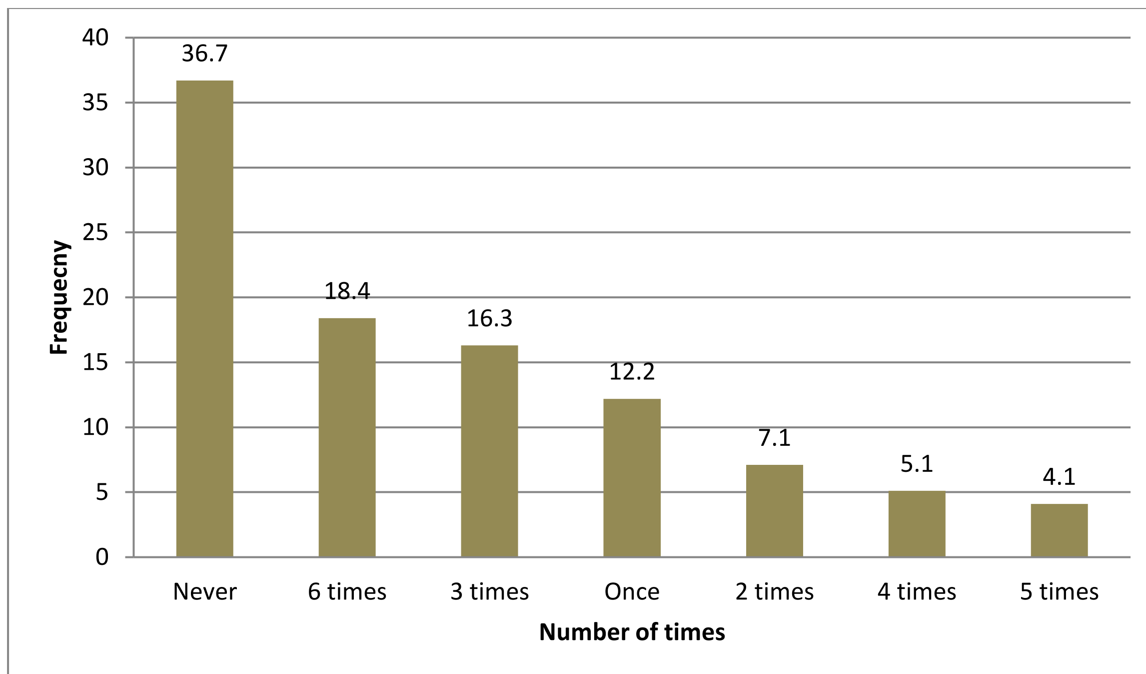
More than half of beneficiaries (57.1%) were married while (9.2%) were widowed.

Just over half of beneficiaries (51%) could read and write while (49%) could not read and write.

Most clients (54.1%) had a confidant while (45.9%) had no confidant. Besides, out of the 98 clients, 15 were pregnant women and 9 were postnatal mothers.

[7] These were the beneficiaries who completed the 8 sessions for Group Therapy.

Figure 1: Frequency of a household member being emotionally troubled in the past 3 months that they needed a counselor (N=98)



Slightly over half of beneficiaries (36.7%) did not have a household member who was emotionally troubled that they needed to consult a counselor while (4.1%) said it happened 5 times.

4.2 Depression and Suicide Ideation

According to information presented in Table 3 below, out of the 169 people assessed, 7 out of every 10 (73.9% or 125) were experiencing moderate to severe depression. Of these, slightly over half (51.2%) were experiencing moderate depression, 38.4% had moderately severe depression while 10.4% had severe depression.

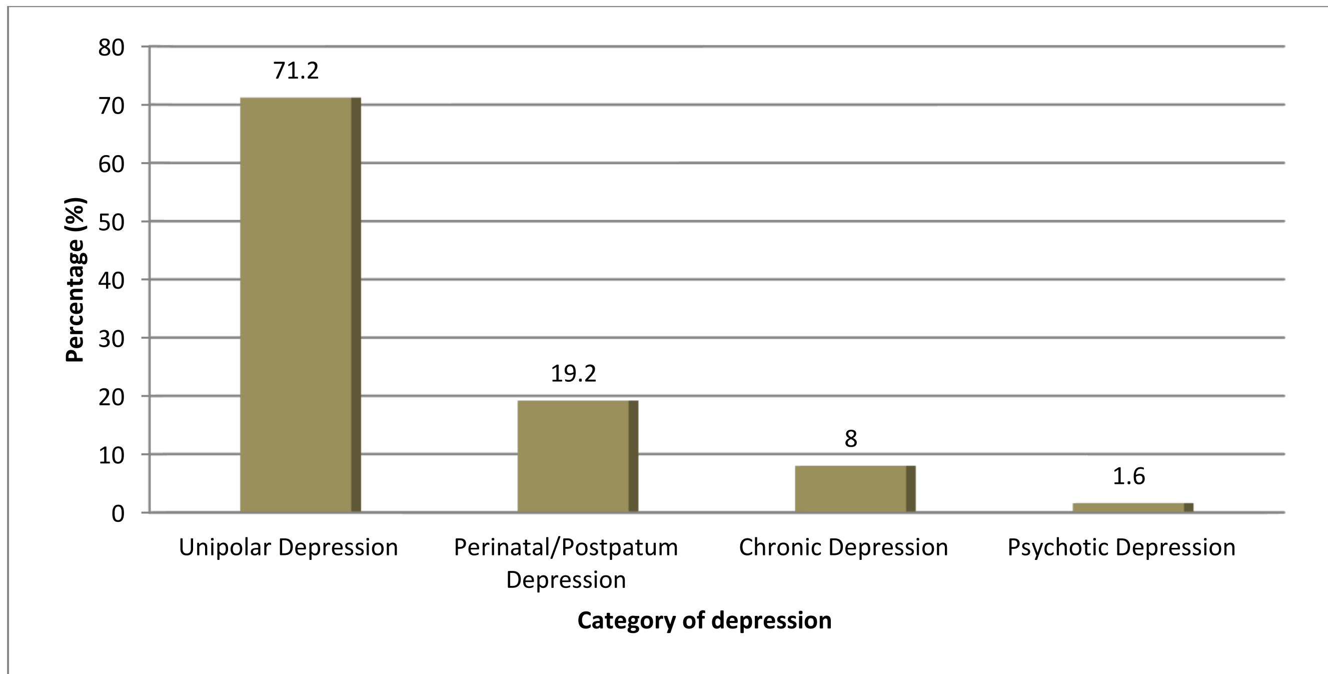
Table 3: Severity of depression among people assessed.

S/N	Village	No of people assessed	Severity of depression				Suicide Ideation		
			Moderate Depression	Moderately Severe Depression	Severe Depression	Total	Active Suicide Ideation	Passive Suicide Ideation	Total
1.	Nalongo Village	57	32	9	01	**42**	13	14	**27**
2.	Bugodi Village	35	05	15	07	**27**	04	02	**06**
3.	Wanyange Hill	25	08	12	01	**21**	10	02	**12**
4.	Mutai Central	19	08	03	02	**13**	06	01	**07**
5.	Nalubaale	33	11	09	02	**22**	09	03	**12**
	Total	**169**	**64**	**48**	**13**	**125**	**42**	**22**	**64**

Just over half of those who had depression (51.2% or 64) were thinking of, considering, or planning suicide; the majority (65.6% or 42) had active suicide ideation while (34.3% or 22) had passive suicide thoughts. Of these,

four out of every 10 clients (42.2% or 27) with suicide ideation were from Nalongo village, Kakira Town Council, Jinja district[8].

Figure 2: Category of depression among assessed clients (N=125[9])



Less than three-quarters of beneficiaries (71.2% or 89) had Unipolar depression, followed by pregnant and postnatal women with perinatal/postpartum depression (24 or 19.2%), then (8% or 10) had Chronic Depression while 1.6% (or 2 clients) had Psychotic Depression[10].

Figure 3: Triggers of Depression among assessed clients (N=125)

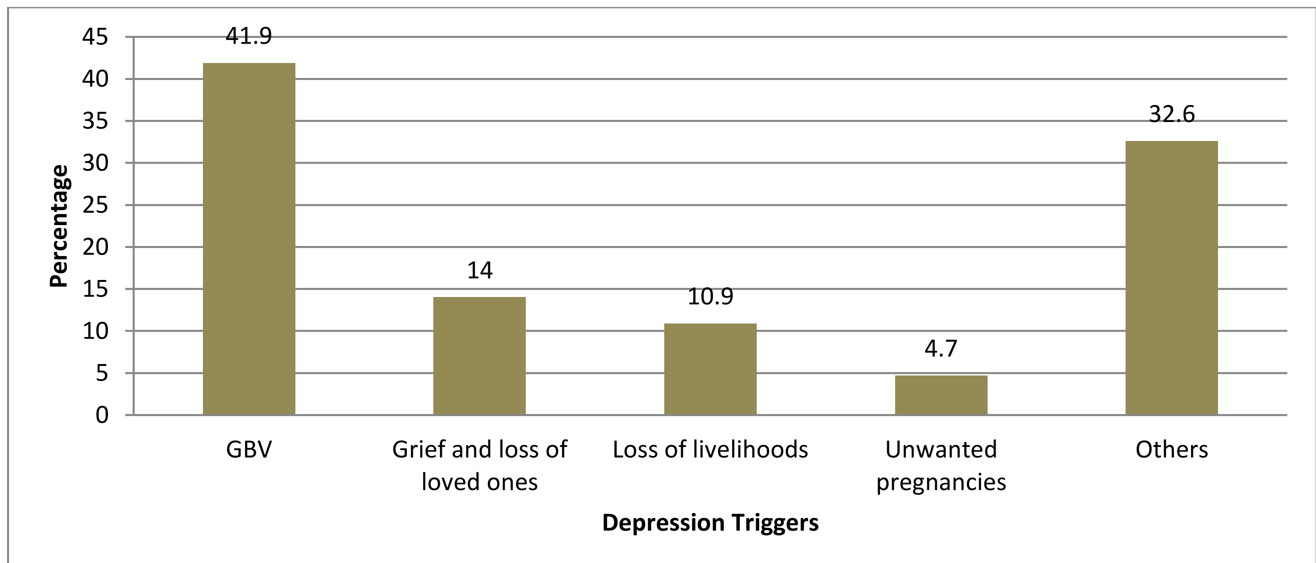


Figure 1 above shows that the single biggest trigger of depression among clients was gender-based violence (41.9% or 54) followed by grief and loss of loved ones (14% or 18), loss of livelihoods due to the COVID-19

---

[8] This village had the highest number of beneficiaries (30 women) due to the high rates of depression found among community members. This could have been because of high incidence of GBV among women in this village.
[9] This includes all the people who were eligible for therapy.
[10] These two clients were referred for further care and treatment.

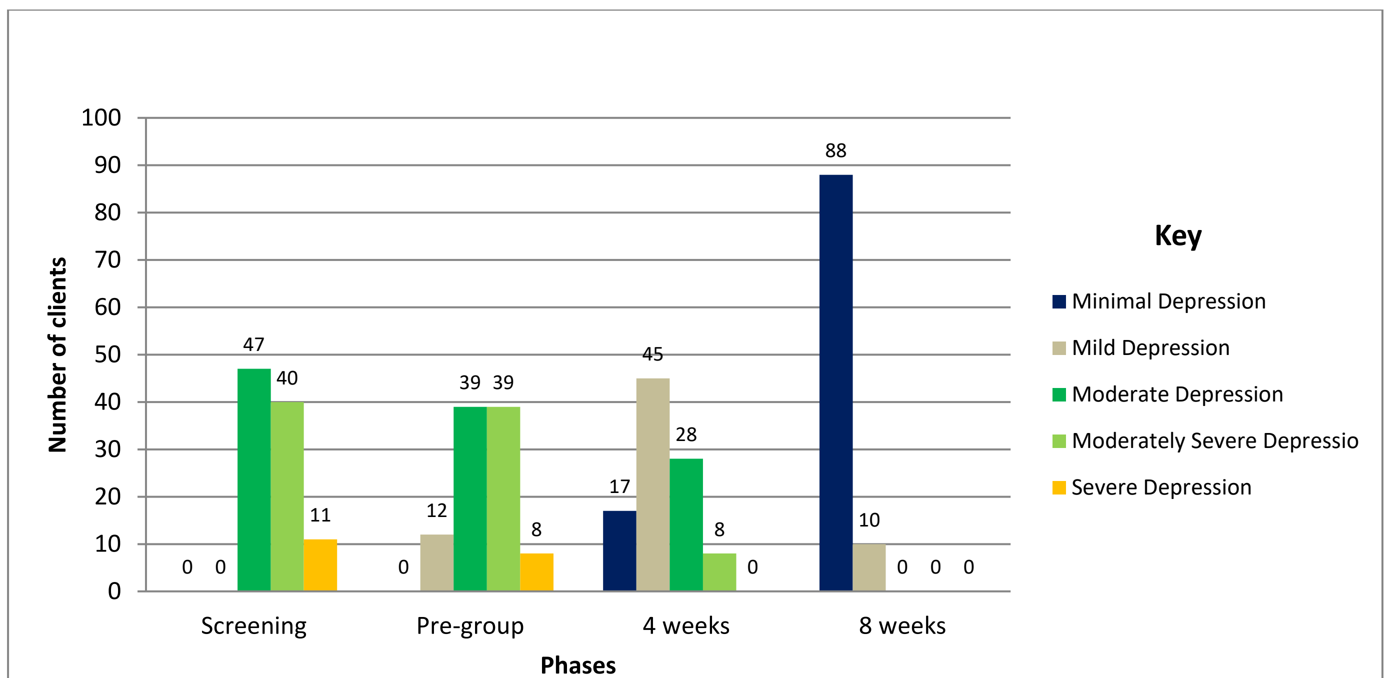
lockdown (10.9% or 14), unwanted pregnancies (4.7% or 6) among other triggers. (Most clients reported 2 or more triggers of depression)

4.3 Impact of the Therapy among beneficiaries

One hundred and twelve clients were enrolled into 7 IPT groups while 2 clients were referred to access further treatment and care. Before enrollment into groups, suicide prevention counseling—which started immediately after screening, was provided to 42 clients who had active suicide ideation.

Although 125 clients were assessed with moderate to severe depression, 13 clients were not enrolled in the groups. Of these, 2 clients were referred for further care, while 11 clients could not join the groups due to personal issues[11]. Altogether, 112 clients were enrolled for therapy in 7 groups and of these, 98 finished the 8 therapy sessions, a completion rate of 87.5%.

Figure 4: Pattern of beneficiaries' Depression Status from Screening to the 8th session (N=98).



Information in Figure 4 above shows that by the screening phase, almost half (47 or 47.9%) of the enrolled clients had moderate depression, 40 (or 40.8%) had moderately severe depression while 11 (or 11.2%) had severe depression. There were slight changes in the depression status of clients by pre-group; 39 (or 39.8%) had moderate and moderately severe depression respectively, 12 (or 12.2%) had mild depression while 8 (or 8.2%) had severe depression.

By the end of 4 sessions, the majority of clients had mild and minimal depression; 45 (or 45.9%) had mild and 17 (or 17.3%) had minimal depression. Additionally, 36 clients were still depressed with moderate (28 or 28.6%) and moderately severe depression (8 or 8.2%).

[11] Expecting financial support from the groups, confidentiality issues and having conflicts with some enrolled group members.

4.4.1 Achievements

- Provided Suicide Prevention Counseling and mobilized support to prevent suicide among 42 clients who had active suicidal thoughts.
- Provided IPT-G (pre-group and 8 group sessions) to 93 women and 5 men from 5 villages. Altogether, 7 IPT groups were formed; 6 for women and 1 for men. By the end of the 8th session, all the 98 clients had healed of depression; 89 (89.8%) had minimal depression while 10 (10.2%) had mild depression.
- Referred 2 clients with symptoms mirroring Psychotics Depression for further mental health care and treatment. We also referred a GBV survivor who needed safety to a women-rights organization—Women Rights Initiative (WORI).

4.5 Limitations and Lessons

4.5.1 Intervention Limitations

1. Some potential beneficiaries had mismatched expectations of the group therapy. When told that the intervention was psychosocial support, some of them refused to enroll in group therapy. Also, some women had past conflicts with enrolled members—which later led them to drop out. This hindered our ability to reach our planned target of 100 beneficiaries.

   Likewise, one female local leader from Nalubaale Village misunderstood the purpose of the group therapy and was not happy that women were sharing some problems in the groups, instead of first disclosing them to her.
2. The majority of enrolled clients faced food insecurity issues yet the organization was not providing food handouts to enrolled members then. Sometimes, this worsened the depression status of enrolled clients, delaying their healing. Additionally, a significant number of clients faced reproductive health issues without much financial resources to access care and treatment.
3. The prolonged rainy season frequently disrupted therapy sessions in Nalongo and Nalubaale villages. Due to a lack of a safe place to meet, many sessions were postponed which delayed the overall completion of the group therapy. In Nalubaale for example, it took 12 instead of 8 weeks to complete the therapy.
4. Mental Health facilitators faced language issues, especially in Nalongo village where the majority of the women come from diverse cultures. Facilitators used at least 4 languages (Lusoga, Luganda, English, and Kiswahili) although some enrolled clients could not understand any of these languages. Some mental health facilitators felt emotionally overwhelmed and stressed managing large numbers of clients with suicidal ideation and behavior. Moreover, some clients experienced suicide ideation during the lockdown with limited family support and mobility restrictions. This caused anxiety and self-doubt among some facilities, which negatively impacted their ability to provide suicide prevention counseling.
5. Some enrolled clients were delayed to disclose during group sessions due to shyness, and fear related to confidentiality of shared information.

4.5.2 Selection and Recruitment Limitation

1. Because CCUg tasked female local leaders to mobilize women and girls with depression-like symptoms, there might have been personal bias in the mobilization. For instance in Mauta Village, Mafubira Sub-County, where we had planned to provide therapy to women and girls, the female local leader mobilized mostly her relatives and close friends.
2. The project took on some of the most vulnerable community members for group therapy. For instance, although we had planned to assess 200 people to get the target number of 100, we only assessed 169. The majority of the beneficiaries had multiple triggers, from poor socioeconomic backgrounds and it is no wonder that many of them were suicidal.
3. In 4 of the villages where intervention was conducted (Nalongo, Bugodi, Mutai Central, and Nalubaale), local leaders requested CCUg to continue providing therapy to more women with depression-like symptoms. By the end of the sessions, some women in Nalubaale and Nalongo villages—having seen the impact of the therapy among enrolled women had mobilized themselves ready to begin therapy. Additionally, local leaders from Busalamu and Namulesa had also requested the organization to provide therapy to women and girls experiencing depression in their villages.

4.5.3 Adaptations made

1. **Mismatched expectation:** Mental Health facilitators clearly explained to local leaders the nature and purpose of the intervention, encouraging members to voluntarily attend therapy without monetary expectations.
2. **Disclosure Issues:** The mental health facilitator engaged the local leader explaining to her the nature of group therapy. Later, a consensus was reached where she was stopped from attending therapy.
3. **Food Insecurity and Illnesses:** Although CCUg provided food handouts, it was before the start of the therapy. However, facilitators engaged female local leaders encouraging them to work with related organizations that provided food handouts to some clients. In addition, we provided financial support to some clients to access medical care and treatment.
4. **Prolonged rains:** The facilitators postponed the sessions to another day or week in agreement with the enrolled clients.

6. **Language Barrier:** Facilitators used translators during therapy to reduce communication issues. However, this too slowed down therapy sessions including causing confidentiality issues.

5. **Emotional Stress:** We held weekly meetings among facilitators, discussing major challenges and potential solutions to ease the emotional stress experienced. In addition, all facilitators had earlier received training including ways of improving self-care in cases of emotional stress due to providing therapy. Furthermore, weekly supportive supervision was provided to all facilitators.

6. **Mobilization bias:** CCUg canceled out the village where there was heavy mobilization bias from the implementation of the group therapy. Furthermore, facilitators undertook additional assessments of clients to ascertain their depression status.

7. **Disclosure Delays:** Separate sessions were held with clients who had issues disclosing in groups, and role-plays were done to encourage and improve their disclosure in groups. Furthermore, at the start of each group, facilitators made strict rules regarding keeping the confidentiality of issues discussed in the groups.
8. **Most Vulnerable members:** After the end of therapy, the organization is piloting an additional intervention where selected women in 2 villages were assessed, trained in financial literacy including financial management of emergencies, and organized in saving and loaning groups where they are accessing credit to re-capitalize their livelihoods.
9. **Request for additional therapy intervention:** The organization is mobilizing resources to provide group therapy to more women and girls in and out of the intervention villages.

4.5.3 Lessons Learnt

1. IPT-G is a cost-effective intervention that can be used by non-mental health professionals to improve the mental health of rural poor women who are most likely not able to access it.
2. The purpose of the group therapy should be consistently communicated to clients to reduce unrelated expectations, which might affect their attendance and retention.
3. GBV against women and girls is a big contributor to poor mental health among survivors. A concerted effort by like-minded organizations is needed to ensure survivors receive needed care and safety.

4.5.4 Monitoring

CCUg conducted an assessment evaluating the economic status and spending, education, food security and nutrition, housing water, and sanitation on top of the depression screening. The organization plans to evaluate the beneficiaries 12 months later, to establish major changes experienced.

5.0 Conclusion and Recommendation

The psychosocial support in form of IPT-G was very instrumental in reducing depression symptoms and functionality among girls, women, and men in 5 villages in Jinja and Mayuge districts. There is a need for the organization to mobilize resources to provide more women and girls with therapy to address their mental health needs.

5.1 Appendices

5.1.1 Success Stories

Story I: Female Beneficiary, 30 years

"I had so much internalized anger, it cost me my job. One of the biggest issues I have had to face in my life is how to manage my anger. Then, a certain woman killed my son…she admitted to mixing pieces of broken bottles in his food. His intestines were perforated; he died in so much pain… I wanted to kill her… I swear I would have killed her; I did not care whether I went to prison or not, but the group restrained me. They gave me valuable advice.

When I joined the therapy group, I could not manage my anger outbursts. I was experiencing a lot of grief…I was very impulsive. But, the group was my restraint. They often calmed me down. During sessions, I cried a lot, it was very painful relieving the experiences that one day, I fainted. But, they were there for me through it all.

Before, I did not have friends to share with my problems but through the therapy, I gained a network of valuable friends. They have been very instrumental in helping me gain a hold of my life. I have learned to manage my anger…and though it was very hard, I forgave her… I let it go.

Our facilitator taught us that forgiveness benefits people like me more than the person who wronged me. And she was right. I now feel better and don't have those thoughts anymore. I am very glad that I joined the therapy group otherwise; I don't know where I would be now, maybe in prison.

After therapy, they trained us in Financial Literacy and Business Management. I am now working hard each day to see that I attain my long-term financial goals."

Story II: Female Beneficiary, 28 years

"My husband is a terrible drunkard and he was physically abusing me. Everybody including my parents advised me to leave him, yet there were issues with that decision that made me have suicidal thoughts. The man refused to change, but I did.

I chose to be happy, to continue with my life. I had lost hope, I could no longer eat, and I wanted to commit suicide. No one wanted to visit me because of what was going on. But now, there is a great change in my life. Though he still drinks, he stopped being abusive.

I was able to learn a lot in the therapy group, and I thank God that Community Concerns came at the right time…a time I need them the most. If they had come later, maybe I would be dead by now.

I have learned to love myself, and treasure my life…the stress I was experiencing reduced, my self-esteem has increased and I gained friends. I am now depression free and only focused on caring for my children.

Sometimes, they are ashamed of their father, but I know they understand why I chose to stay. It was hard to get what to eat because I was not productive at all but now I work hard every day. We started a saving group out of the therapy group; we started saving and I am flourishing…I even got some money to start a small business."

Story III: Female Beneficiary, 33 years)

"I had a horrible conflict with my immediate neighbor. They accused me of many bad things including linking me to the death of their son. We had a bad relationship and we were soon going violent. They threatened to cut me into pieces with a panga. I feared for my life and my esteem plummeted. I also had issues with my children, I had so many thoughts. I had developed so much anger and hatred for them…but I am grateful that we resolved it.

When I joined the therapy group, I shared with other women and they often advised me on what to do. Community Concerns facilitators reconciled me with my neighbor and I know how to manage my children better these days. I have learned how to manage conflicts and most importantly how to manage my anger. I am more happy and productive than before."

Story IV: Male Beneficiary—66 years

"I am a widower; I lost my partner in January 2020. Ever since that event, I had so many thoughts. My friends tried to console me until I joined this group. We had a young facilitator who has been supporting us. He is still very young but he has been very important in supporting us psychologically.

We have been with him for 8 weeks. But, every week, there is something small that changes in our lives.

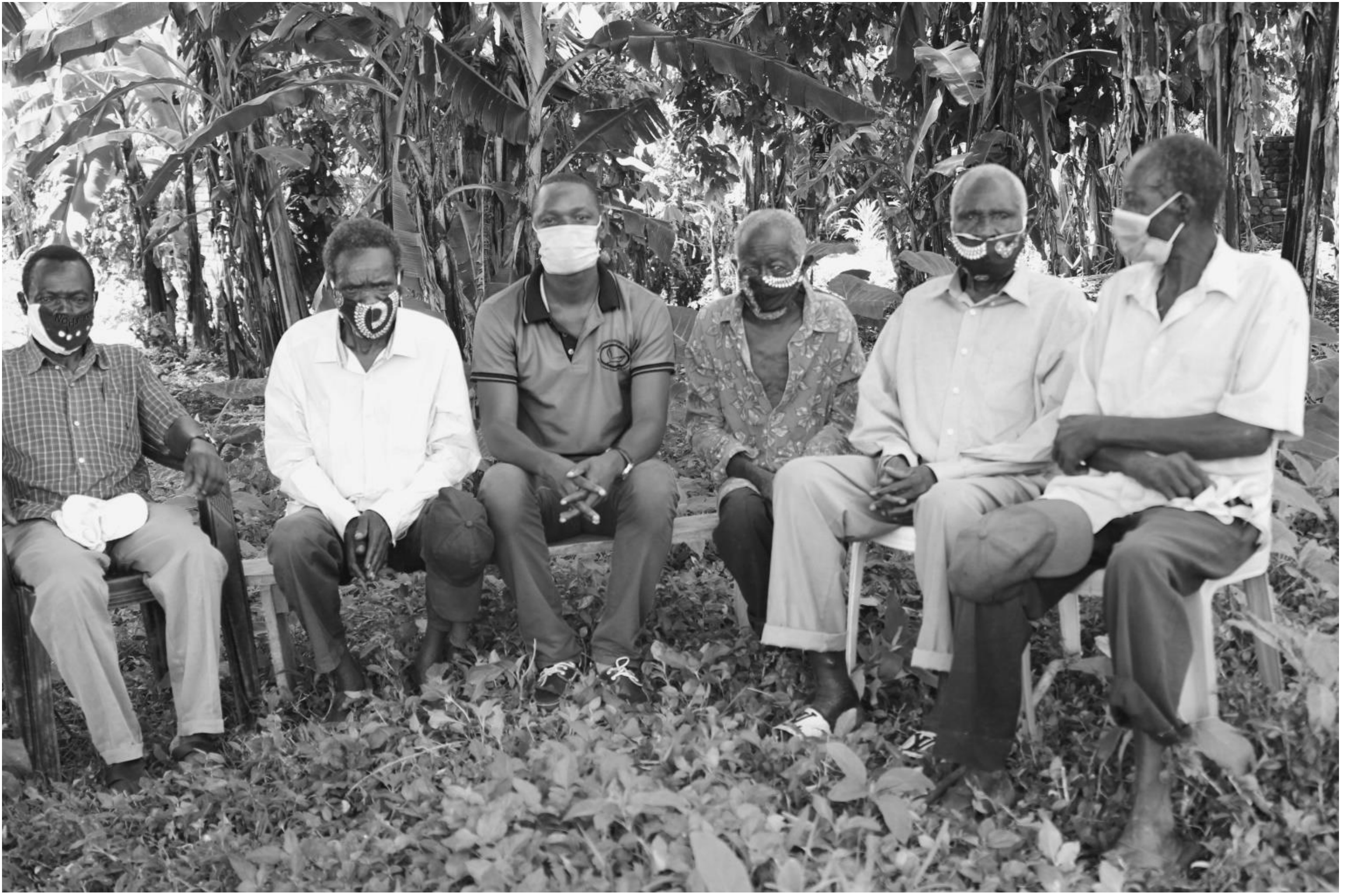
I had a lot of thoughts but they have gradually reduced. Sometimes, I did not have appetite, and even the food I ate felt tasteless because I was struggling with grief. When I came into the group, the members spoke with me and gave me valuable advice. I am not the same as I was before.

Generally, the loneliness is still there, I cannot deny that, but it does not affect me like before. I am thankful to God for bringing these people to work with us. They have been so caring and supportive."

5.1.2 Photographs

Members of Mutai Women's Therapy Group with their facilitator.

Members of the Wanyange Women's Therapy Group.



Members of the Bugodi Men's' Therapy Group