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# Gender Accessibility to Community-Based Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) By Communities Affected by The Post Lord's Resistance Army (LRA) War in Northern Uganda

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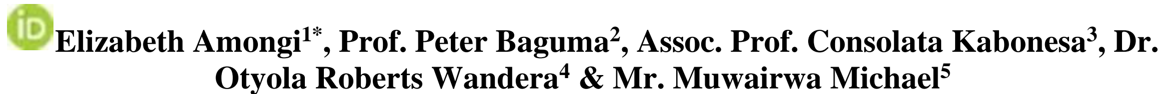
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## Abstract

**Purpose:** This paper sought to assess gender accessibility to Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) among communities which were affected by LRA insurgency for two decades in Northern Uganda. A pre study had found out that individuals who survived insurgency such as abduction, living in camps and death continuously displayed muted emotions and other symptoms of grief, loss and depression. This called for several interventions, TF-CBT being among them. The potential utilization of TF-CBT as an intervention to address post insurgency trauma requires equal access to the TF-CBT measures taking into account gender sensitivity. This called for assessment of its gender accessibility.

**Methodology:** The study design was qualitatively phenomenological. Purposive sample size of participants was 419. Data was got through the help of VHTs, TPO social workers, caregivers, health workers, clients and LCs. Interviews, questionnaires and Focus Group Discussions, (FGDs) with clients were tools that aided data collection and analyzed thematically. The Health Belief Model (HBM) was the guiding theory that helped in identifying that much as there was gender inequality, there were instances of equality in accessing TF-CBT with suggested cues to solving gender inequality.

**Findings:** This paper notes that causes of gender inequality in accessing TF-CBT are; alcoholism among men, limiting number of entrants, negative attitude towards enrolling for TF-CBT, lack of family support from wives, and self-trust among men. This paper proposes that gender inequality in accessing the intervention can be mitigated by both government and other stake holders through affirmative action, mobilizing all sexes, stopping restrictions in recruitment of beneficiaries, use various leaders for sensitization, extending services of TF-CBT in villages and employing more workers amongst others.

**Keywords:** *Gender*, *Accessibility*, *TF-CBT*.

## 1.0 INTRODUCTION

Gender means socially constructed differences between women and men with kin interest in sex roles and responsibilities. It is also useful in explaining a number of variations between men and women. It came as an alternative to the word sex (Lori, 2013). This paper looked at gender in line with how women and men access TF-CBT within communities that were affected by the LRA insurgency in Northern Uganda that resulted in the development Posttraumatic Stress Disorder (PTSD) among the survivors. PTSD is characterized by a person experiencing night mares, sleep and concentration problems, avoidance of reminders of trauma events. (Torre, 2019). Such traumatic experiences call for psychological support, among them being TF-CBT. Psychosocial Support (PSS) for years has been a recurrent component used in post -conflict areas to manage PTSD. Given the of PTSD occurrence of communities affected by the LRA atrocities in Northern Uganda, TF-CBT has been used to manage the condition in Acholi Sub-region. TF-CBT is a counselling model designed to enable patients to reinterpret complicated emotions and feelings that are associated with a traumatic event.

Dating back from the effects of Cold war, different ways of averting PTSD as a result of wars have been tested and registered success. TF-CBT as a similar intervention was based on humanitarian disaster model which pinpoints the existence of Humanitarian psychiatry that was used in Northern Armenia (Kienzler and Pedersen 2012) similar interventions have taken place in post-genocide Rwanda and post-war areas in the former Yugoslavia. In northern Uganda, after the civil war of LRA, PTSD has remained rampant among former survivors who require psychosocial attention (Torre, 2019). This paper notes that Cognitive Behavioral Therapy (CBT) was being offered to such survivors. These include counseling done by organizations such as AVSI, Health Net, Centre for Victims of Torture (CVT), Transcultural Psychosocial Organization (TPO) where they deal with the community (Pfeiffer and Elbert 2011 & Sonderegger, 2011). Despite this, Torre (2019) noted that the interventions so far done have little to do with Therapy. Torre, (2019:17) further notes that social exclusion is instead a widespread problem and that many former combatants - both men and women still lived in vulnerable conditions.

Out of this, the researcher set out to carry out a study on the effectiveness of TF-CBT in Northern Uganda. From that study, it was discovered that there were gender perceived inequalities in accessing TF-CBT. This continued posing challenges to clearly deal with PTSD. This proved to the case that there was need to look at causes of such inequality with an aim of averting them so as to boost the success of TF-CBT in dealing with PTSD.

### Gender Inequality in Accessing TF-CBT

Generally, reviewed literature put it that females somewhat are more likely to seek therapy when they are faced with PTSD as compared to males. Consequently, it points at a possibility of females and males responding differently if they are exposed to the same PTSD therapy. Out of this, suggestions are made that gender involvement and inclusion play a pivotal role towards the treatment of PTSD (Jingchu, H., Biao,F., Yonghui, Z., Wenqing, W., Jiawei, X. & Xifu. Z., 2017). Gender is an important yet an under -studied variable that may explain barriers to effective disease management (Christine, T., Milloy, M.J., Kerr, T., Zhang, R., Guillemi, S., Robert S Hogg, R.S., Montaner, J. & Wood, E., 2021). However, previous research has assessed factors associated with access and adherence to ART among IDU, there remains a paucity of research investigating differences in adherence to TF-CBT between male and female in Acholi Sub-region. This is

because most of the previous pilots indicated that there is gender disparity. A disparity pilot study on assessment was done in finding out the cause of gender disparity in accessing TF-CBT.

In the pilot study procedures, respondents were recruited using stratified systematic sampling by place and gender and were interviewed. The Gender-Equitable Men (GEM) Scale was included in the community survey to capture gender attitudes regarding norms, roles and equity that could have led to inequality in accessing TF-CBT. A mapping study was conducted by visiting Mental Health Unit (MHU) of Gulu Hospital, Peter C. Alderman Foundation and Children for Tomorrow, a project that was being hosted in Gulu hospital MHU, Victims Voice (ViVo) in Gulu, Center for Victims of Torture (CVT) and Transcultural Psychosocial Organization (TPO). By the time this phase was done, other than TPO that had its operations in Kitgum, Gulu and Omoro, the other organizations (CVT) were operating in Gulu only and the others were not implementing community-based TF-CB. The pilot study survey interviews to these organizations were administered orally where it was reported that there was unequal access to the therapy among men and women in Acholi sub region despite the ongoing interventions to combat the prevailing PTSD. Relatedly, the findings of the pilot study were that ViVo was implementing Narrative Exposure Therapy (NET) only to avert PTSD. CVT was implementing Cognitive Behavioral Therapy (CBT) but it was impossible to access their clients due to the organization restrictions. Peter C. Alderman Foundation was based in mental health unit (clinic setting) and Children for Tomorrow was handling only children's cases. TPO was implementing CBT for trauma at the grassroots; community level and operating in all three districts where the study took place. It is upon this that this paper zeroed on TPO much as other organizations such as CVT reported unequal gender access to TF-CBT.

## 2.0 METHODOLOGY

Most of the studies on PTSD have been involving samples with specific events that cause trauma irrespective of gender. This study involved residents of Acholi sub - region who had been exposed to traumatic events of LRA and other conflicts. The study investigated accessibility to TF-CBT by men and women in Acholi sub region. A purposive sample size of 419 participants who were presenting with PTSD symptoms. With the use of Village Health Teams (VHTs), Local Councils (LCs) and TPO social workers helped in identification and mobilization of people who were potentially suffering from PTSD. Men and women were mobilized from the three districts of Gulu, Kitgum and Omoro. VHTs and LCs were assisted by social workers and a Clinical Psychologist from TPO who helped in assessing the severity of potential PTSD cases. After identification and exposure to the therapy, we held group discussions and individual interviews with clients who were adult men and women. The clients were identified in areas presented in the table below:

**Table 1: Table Showing Areas Where the Study was Conducted**

| Districts | Sub-Counties | Villages |
|---|---|---|
| Gulu | Awac | Obokeber, Olel, Paromo, Laban and Payuta |
| Kitgum | Mucwini | Acutomer, Agwoko, Lagot, Lawogowogo, Ngweny East, Oryang Central and Pajong Central |
| | Namokora | Kakoo, Ladwogi, Lakokok, Mission Cell, Mulozi and Onyala |
| Omoro | Lakwana | Abura, Burkweyo, Labuje, Te-opok, Awoo and Teilwa |

*Source: Field 2018-2020*

The table above shows districts with specific village locations where data was collected from.

Data was collected using questionnaires, FGDs and interviews. All these tools were administered on men and women participants. With interviews, the study targeted Key Informants (KIs), study participants as is represented in table 2 below:

**Table 2: Data Collection Instruments and Respondent / Participant Categories**

| Instrument | Category of Respondents / Participants | Total |
|---|---|---|
| **Questionnaires (PTSD-8 for diagnosis) and PTSD-34 items by Emilio et al (2015)** | **Total sample size N=419** | 419 |
| | 120 men | |
| | 299 women | |
| **Focus Group Discussions** | **N = 56 participants** | 56 |
| | 8 FGDs | |
| | 6 women FGDs *7 participants = 42 | |
| | 2 men FGDs *7 participants = 14 | |
| **Interviews**<br>**KII**<br>**KII**<br>**I** | **Participants for individual interviews, N=25** | 25 |
| | 5 social workers | 5 |
| | | |
| | 1 clinical psychologist | |
| **Total** | | 87 |

*Source: Field 2018-2020*

Table 2 shows 56 participants who participated in FGD; six being for women and 2 for men. It also shows key informants where 4 are social workers and 1 is a clinical psychologist. Below in 1.3.1 is an explanation of how enrolment of beneficiaries was done.

**How Enrolment of Clients was Done**

TPO started with creating the sensitization and awareness campaign about the intension of implementing TF-CBT for PTSD management. Social workers could talk about the components of mental health; psycho-education in which we talked about mental illness and PTSD in particular and its signs and symptoms and management as well. Those who had a history of exposure to traumatic events, registered and TPO proceeded to use the tools such as the SRQ-20 to assess their general health condition be it physical or psychological, PHQ- 9 for depression and the PCL-5 trauma check list to assess for PTSD symptoms. These were for the enrolment in the group. These tools were being used twice; before exposure to CBT sessions and after completing the therapy. This would help to track their trend of recovery. The research team had another set of PTSD assessment tools namely:- PTSD-8 for diagnosis, PTSD-34 items for assessing the PTSD cluster characteristics and Exposure to Therapy tool for tracking participants' trend of recovery after exposure to the therapy.

From table 1 above, we see areas where the study was conducted. Data in respect to this study was got through FGDs with participants, TPO social workers and a Clinical psychologist interview. Identification of people with PTSD was done through the help of Mental Health officers in the upper level health centres (HC V) who would recommend clients to either enroll for the therapy or not. LCs, VHTs and community also helped in identifying people to enroll. Some family members also helped in identifying men and women who were recommended for enrolment. Strict adherence was observed in line with TF-CBT model which consists of 9 components summarized as PRACTICE. This is composed of 3 treatments that were done. Typically, the 10 sessions required under TF-CBT were adhered to with each phase taking an average of 3 sessions. For men and women participants who had multiple PSTD reactions, enhancement safety phase was administered to them. The first stabilization safety phases took longer than half of the sessions for treatment. For men and women who at some point required special attention it was given individually. Gender accessibility

Table 1.4 below is a representation of gender accessibility of TF-CBT:

**Table 3: Accessibility of TF-CBT by men and women**

| | Data Collection Spell | | |
|---|---|---|---|
| **Sex of Respondents** | **Baseline** | **Mid-Line** | **End-line** |
| Male | 120(28.6) | 90(26.1) | 90(26.3) |
| Female | 299(71.4) | 255(73.9) | 252(73.7) |
| Total | 419 | 345 | 342 |

*Source: Field Data 2018-2020*

As seen above, table 3 shows enrolment of participants with comparison between women and men from baseline, midline up to end line, where at baseline more females 299 (71.4%) were enrolled as compared to 120 (28.6%) men. This representation was maintained throughout where at midline 255 (73.9%) women were enrolled against 90 (26.1%) and at endline 252 (73.7%) women were enrolled against 90 (26.3%) men. This is a clear indication that access to TF-CBT against PTSD was unequal basing on numbers. Guided by the Health Belief Model (HBM), the study set out to assess the occurrence of unequal access to TF-CBT.

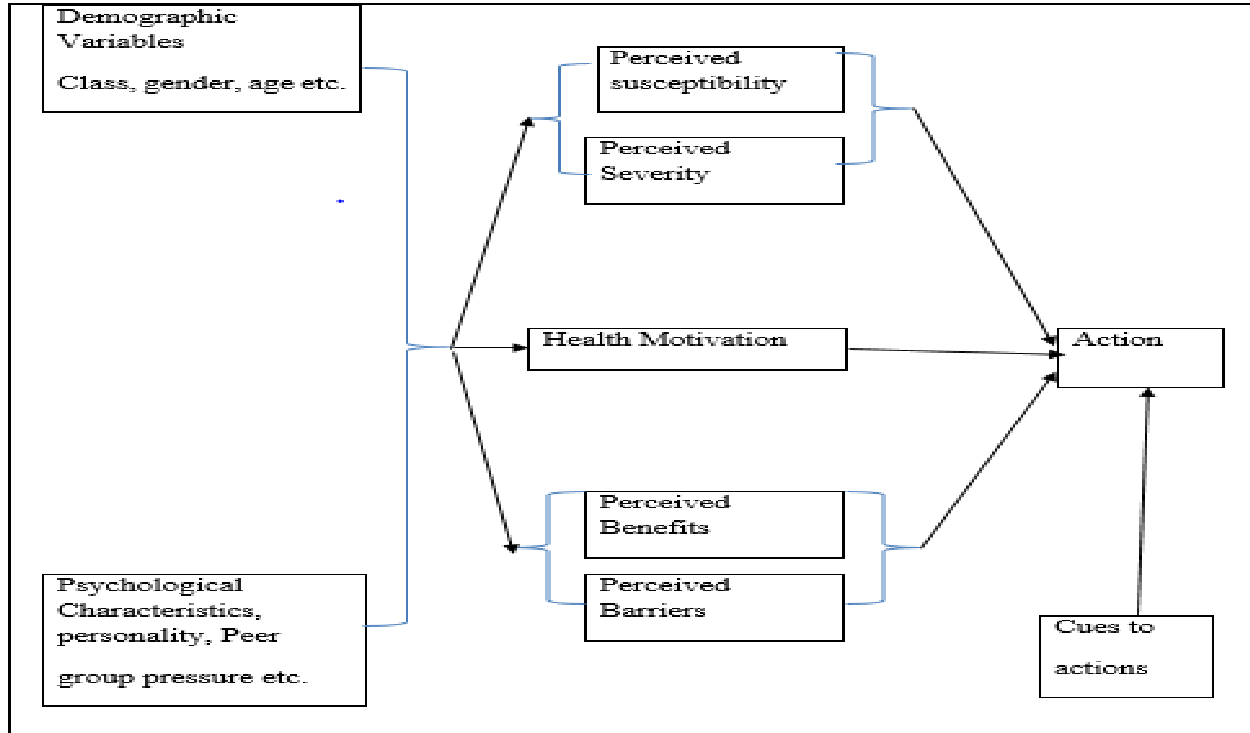
**Health Belief Model (HBM)**

This study was guided by the Health Belief Model (HBM) modified by Abraham and Sheeran (2015). In this study, HBM concentrated on two aspects of individuals' representations of health and health behavior in relation to presentation of PTSD that is to say; threat perception and behavioral evaluation. Threat perception was construed as two key beliefs: perceived susceptibility to illness or health problems and anticipated severity of the consequences of illnesses. Behavioral evaluation also consisted of two distinct sets of beliefs: those concerning the benefits or efficacy of a recommended health behavior and those concerning the costs of or barriers to, enacting the behavior. In addition, the model proposed that cues to action can activate health behavior when appropriate beliefs are held.

Threat perception and behavioral evaluation in this study was done in due consideration of severity of PTSD symptoms. This is hinged on beliefs of susceptibility to illness and severity of PTSD. This was done with the help of community; Local Councils (LCs), family members, Village Health Teams (VHTs) and members of Transcultural Psychosocial Organization [1](TPO). The assessment was based on consideration of both men and Women. Efficacy was looked at in consideration to how men and women have benefited from TF-CBT and how it is being hindered considering gender equality in accessing TF-CBT. Motivation was considered on what could trigger gender equality or inequality to access and recovery from PTSD. This involved taking action through helping the affected people who attended intervention in anticipation of recovery with due consideration to looking at gender inequality in accessing TF-CBT. This is represented in the diagram below:

[1]Transcultural Psychosocial Organization (TPO) deals with implementing programs on: Mental Health, Socioeconomic Empowerment, Peace Building, Land Conflict Mediation and Gender Based Violence etc

**Figure 1: Health Belief Model**




**Source**: Abraham and Sheeran (2015:32).

In line with the working model of HBM, it helped in assessing the severity of PTSD among men and women who enrolled for therapy. Health motivation was considered in line with what triggers gender equality in accessing therapy. The results are here by presented and discussed as follows:

## 3.0 FINDINGS AND DISCUSSIONS

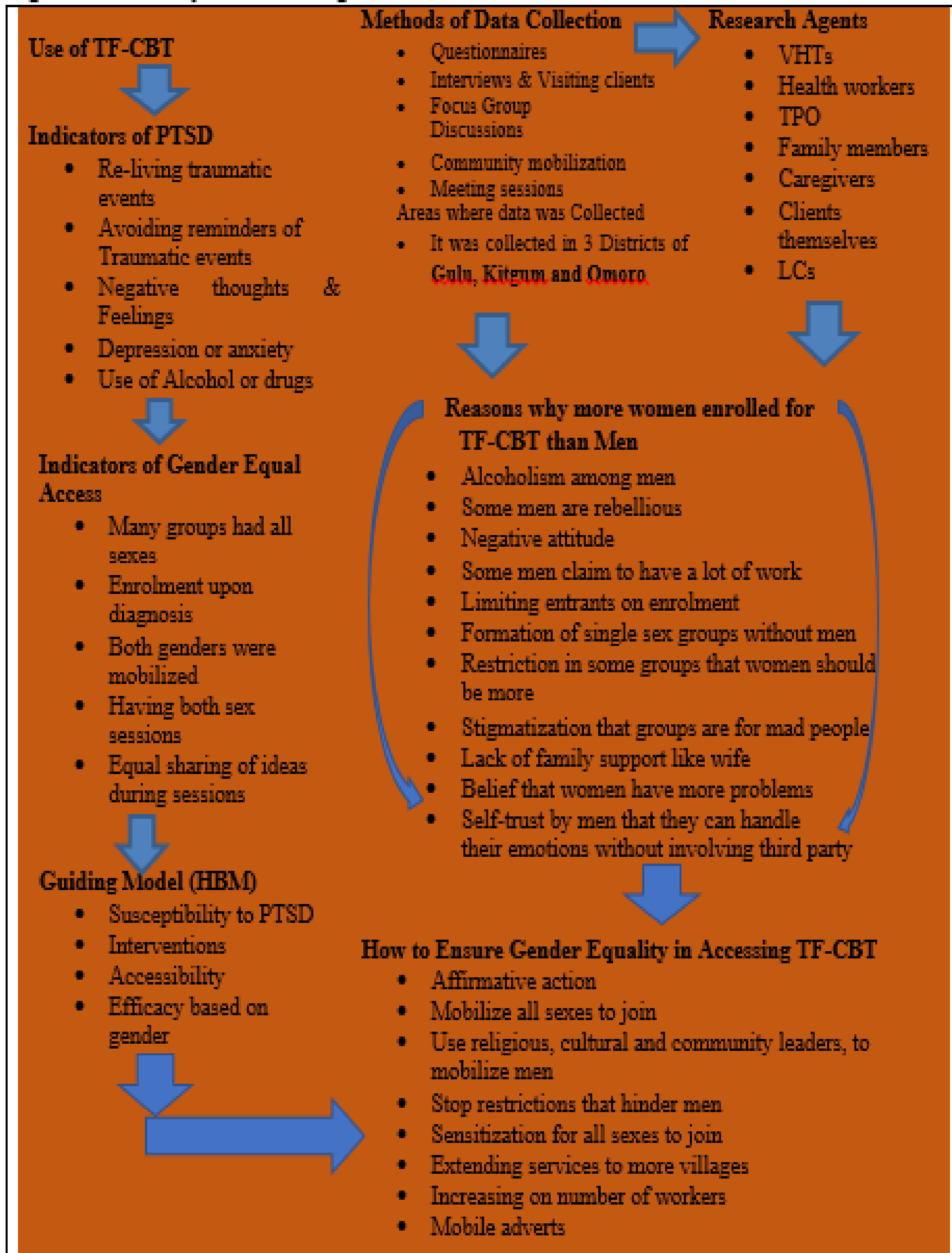
The findings were in line with addressing gender specific concerns in accessing and benefiting from TF-CBT in Acholi Sub region. Using questionnaires, focus group discussions and interviews that were administered to participants and social workers from TPO, the results of the findings addressed three fundamental questions majorly being:

(1) Whether Community Based TF-CBT is equally accessed by men and women suffering from PTSD in post-conflict Acholi Sub-region.

(2) Whether Community Based TF-CBT is beneficial in addressing PTSD among men and women in post-conflict Acholi sub-region. Arising from questions one and two above, the study found out that to a larger extent, there is inequality in accessibility to Community-Based TF-CBT by men and women suffering from PTSD in post-conflict Acholi sub region. This therefore called for a third question being:

(3) How can equal access be achieved in accessing Community Based TF-CBT among men and women with PTSD in post- conflict Acholi Sub region.

**Figure 2: Summary of the Findings**




*Primary Data Source: 2028-2020*

**Unequal Accessibility of TF-CBT By Men and Women Suffering from PTSD in Post-Conflict Acholi Sub-Region**

The findings in this regard revealed that accessibility was unbalanced. Referring to table 2, it was discovered that there were fewer men who accessed TF-CBT as compared to their counterparts. The research findings from respondents through FGD and interview with individual participants and KIs tell the reasons for this disparity as; alcoholism among men, some men are rebellious, some men claim to have a lot of work, limiting number of entrants during enrolment, formation of single sex groups without men, restriction in some groups that women should be more, stigmatization from the community that the therapy was for mad people, lack of family support like from wife, belief that women have more problems, and self-trust by men that they can handle their emotional challenges without involving third party.

Findings reveal that much as the intention of implementers was that there should be equal chance to access TF-CBT, the study found out that, to some extent men are a cause to the disparity because of spending much time taking alcohol. The study instituted that they do not only take it because of the trauma, but also due to addiction and they give it more time than anything else. One of the respondents is quoted to have said:

*"I think it is alcohol. The men in this community drink a lot and when they sit down to drink they do not think of anything else, from morning up to evening they will be drinking which really destroys them. So for me I think the biggest barrier would be alcohol because sometimes alcohol distracts people from their work."*

This was not only disclosed in one place but also in other places. One other respondent had this to say in regard to alcohol as a cause of unequal access to TF-CBT in regard to treatment of PTSD.

*"I think it is also because of alcohol, when they start coming here…, along the way they find their friends drinking and they branch there or they find where alcohol is being brewed and they want to branch there and in the end they don't appear for the training, some reach here while drunk, others remain in the bars but for us women we travel straight to our destination without branching anywhere"*

The study further revealed that CBT groups are formed with a limited number on account of first come first served irrespective of sex. The study revealed as:

"*We reached a certain number; they told us that we had reached the limit for the number allowed in a group and it happened that very few men had registered. There were many people who wanted to join but they were told we had reached the limit."*

The issue of limiting number of group members was further revealed through FGDs where it was said:

*"When we were forming the group there were no men, the men came when the group was now full and there was no space"*

This was not far different from the cause of implementers wanting more women than men in some groups. This was revealed through interview and FGD as:

*"They said in this group the number of females should be more than the number of males. They wanted only the females but they said there are also men who were affected by the war who should also be included in the group and even some elders."*

The reason for severity of presentation of PTSD was equally brought out as another factor. Respondents revealed that men reduced in number, not that there are no men with PTSD but also some were reluctant to disclose their status. This was after realizing that information was sent but response by men in enrolment still remained wanting. The study found out:

*"I do not know, it depends if you have mental illness then you come because they sent the information that they want people with mental illness then we came but men didn't come, may be there are no men with mental illness in this community."*

This was in line with a revelation that was reported through interviews and FDGs that more women have more challenges than men. One of the respondents was recorded saying:

*There is nothing that I can think of but one thing I can say is that we women have many challenges and so when called to attend such a thing, we usually come in droves thinking it may help them but most men just ignore and look at it as a waste of time. We women have so many challenges…and we look for ways to address them.*

The study revealed that sometimes men lack information. One of the respondents through FDG submitted that:

*"I was thinking that may be men did not get information that is why they did not turn up for the training. I think there are men who have mental health problems but they did not get information."*

This is similar to the reason on limited mobilization of men. The study acknowledged that there was mobilization yet it still remained limited. One among other responses in support of this argument was:

*"The main reason why there are no men in this group is because of misinformation, the information we got was that you needed only women in the group and that is why no men came to join the group"*

This point was made in refence to how TPO conducted mobilization.

However, some other respondents argue that even when they are mobilized, men have a tendency of dodging meetings. As one of them said:

"*Gin omio coo pe pol, pien pol kare tek olwongo cokere, coo pe maro bino tekki ojony pyer abedo ape…dong ikare ame olwongo cokere me rweyo jo,dwongere mon en aye te bino, icawa adong coo oero bino, mon dong onwongo otero kadebo duc"*

Literally translated, this means:

"*Why men are few is because most times when you call a meeting men don't come as long as there will be no sitting allowance, and so when the meeting was called, more women showed up and by the time the men came, most of the position was already taken by the women."*

Related to that, it was reported that some men pretend to be okay and others fear to admit that they have PTSD but in actual sense they have the symptoms. This was revealed through interview and FGDs as well. Concerning pretense, this is what was said:

*"Some men come here and pretend to be ok and that makes it very difficult to know whether he has recovered or not."*

About men fearing to admit that they have PTSD this is what was reported by one of the respondents:

*"Some people got embarrassed to admit that they have PTSD; they think that PTSD is for mad people. Like when the VHT of Lakwana-Omoro announced that the training was going to take place, some woman raised her hand for the husband to be registered but her husband shut her down and told her he does not want to see her near the training place."*

This is in line with self-denial and fear of reprimand from the community. This is what was revealed during the study about self-denial:

*"What prevented some people was self-denial that they have PTSD. There are many people in the community who will never accept that they have PTSD"*

Fear of reprimand by the community was reported as:

*"Some of them fear that they will be ridiculed by the community so sometimes they miss sessions. Some members can be there attending the training but keep thinking about what people in the community call them and it disturbs them"*

Relatedly the study revealed that some men have more responsibilities than women. This was reported as:

"*Men have a lot of work for example if he is a boda boda, he will first think of taking customers and get some money." Not only that, a FG in Mucwini -Kitgum reported that because some times the sessions last longer, they begin to feel the pressure to go back home to take care of the animals especially bringing them back home from the grazing places. Some times they end up not turning up for the sessions as they have to craze their animals*

Okello *et al.,* (2007), who compared formerly abducted to non-abducted adolescents in Gulu district with an aim of comparing how they were presenting with psychiatric disorders. In comparison to those who were abducted, the study revealed that more women presented with PTSD symptoms. However, in this study, findings revealed two elements; one, that it contributed to more women enrolling and secondly perceived unequal gender access. Kasujja (2012) reveals that during the war more women were affected than men. Whereas Abraham & Sheeran (2015) conform to the findings that revealed perceived unequal accessibility to TF-CBT between men and women existed, the reasons noted for the unequal accessibility agree with Kasujja and Abraham and Sheeran. Results show areas of data collection indicate that men who accessed TF-CBT were fewer than women. Whereas O'Callaghan et al (2022) in their study about a randomized controlled trial (RCT) of TF-CBT for sexually exploited war-affected Congolese girls, found out that girls benefited more. In the event that war in Northern Uganda affected men and women, they all had to be given equal chance of access to the intervention. On the contrary the study found out that less men attended. This was perceived gender inequality to accessibility since it was not intentional by design that less men should be enrolled. Both men and women were given equal chance to enroll for counseling, enrolment as not based on sex. Despite this, more women enrolled than men.

The idea that men were fewer than women was because men engage more in alcohol than women and so they did not have time to attend to TF-CBT. This is in agreement with Sadock & Sadock (2007) who point at alcohol as a hindrance to attending TF-CBT by men. In their study about psychiatry, behavioral science, they say that in a way of coping, flashbacks make them addicts and fail to attach value to important issues. While Carroll & Robinson (2000) suggest that when people become addicts they always concentrate on alcohol, the findings in relation to this reveal that men

could spend most of their time in bars than attending sessions. This accounted to increased attrition rate more at mid-line and somehow at end line.

Findings also revealed that the idea of first come first served contributed to a big extent, women out numbering men. While Cohen, Mannarino & Derblinger (2010) note that application of any form of intervention should involve men and women, they note that women respond more to any intervention than men. In fact, Cohen *et al.,* (2010) asserts that proper guidelines are laid down to ensure accessibility for intervention by officers. Contrary to this, the study revealed that TPO, VHTs and other support staff enrolled participants on first come first served basis. Many women, given their habit of being fast responders to intervention outnumbered men. The study notes that TPO and VHTs did not lay down a mechanism of ensuring equality on this.

Consequently, the findings revealed that at some point more women were needed than men. This coincides with O'Callaghan (2022) who says that TF-CBT is for women. However, the officers who were carrying out enrolment fell short of the realization that all people were presenting with PTSD symptoms. This also falls short of the theory by Jennings (2012) in the theory of Gender together with theory of HBM where Abraham & Sheeran, (2015) argue that both women and men should be involved in all matters of importance including health and any form of intervention. The study found out that during mobilization of clients, the mobilisers emphasized that they want women. Nonetheless, the study realized that their argument for more women coincides with the recommendations of Bila & Egrot (2022) in their study about gender asymmetry in healthcare-facility attendance of people living with HIV/AIDS in Burkina Faso. After realizing that more women were more prone to HIV and other health related issues, they came up with an affirmative action to have more women access any form of intervention. However, the study finds it contradicting the recommendations of the theory of CBT, Gender and HBM which advocates for inclusion of all sexes in any form of intervention.

Albizu-Garcia *et al* (2013) in their study about gender and health services, findings reveal that men and women receive health services in equal proportions. The argument was that they look at them being affected in the same way. Contrary to Albizu-Garcia et al (2013) findings, the findings of this study present a different perspective. Whereas the findings reveal that both men and women were supposed to access services of TF-CBT, the study found out that more women had access contrary to men. Reasons for this disparity were discovered to be lack of timely dispersing of information, need for sitting allowance, pretense by men to be okay, not admitting their PTSD status (self-denial), reprimand and stigma from the community and men claiming to be having a lot of work to do.

Despite realizing that there was unequal accessibility, the study revealed that there were some evidence that showed equal accessibility to TF-CBT by men and women suffering from PTSD in post-conflict Acholi Sub-region as discussed below"

**Equal Accessibility of TF-CBT by Men and Women Suffering from PTSD in Post-Conflict Acholi Sub-region**

The study found out that TF-CBT is meant for both sexes without being gender biased. This was revealed from both the respondents and the implementers of the therapy. One of the beneficiaries of Lawogowogo Mucwini-Kitgum when asked whether they had equal access, a man was quoted saying:

"*Everybody had an equal chance to join, it depended on the interest of the person because the information was given and the number of people in the group is the number that expressed interest in the training"*

This was confirmation that men had the same chance of joining the group as the women; there was no deliberate attempt to limit the number of men who wished to join the group. The only limitation was that they needed only 15 people in the group and number of men reduced on account of first come first served.

Relatedly, the study found out that gender was considered as long as someone was presenting with PTSD symptoms. It was revealed that any person who presented with PTSD symptoms was given equal opportunity and enrolled into TF-CBT irrespective of someone's gender. It depended on what the LRA did to that person or the kind of mental illness; it had nothing to do with gender this was reported by one of the respondents from Abura village Lakwana sub-county Omoro district who said:

*"... all men and women were given equal chance of being enrolled without biasness and when we were starting the CBT the counselor asked "where are the men?"*

In line with the above, the study revealed that equal access was based on condition severity. This was reported as:

"*Yes, both women and men had equal chances as long as the person had the conditions such as mental illness and if that person was abducted by the LRA in the past. The condition was for one to have had some traumatic past"*

From the interactions with one of the participants of Lawogowogo Mucwini-Kitgum when asked whether they had equal access, a man pointed out that all those who were enrolled on the intervention were given equal chance. This is in agreement with Pieh *et al.,* (2012), who advocates for equal access to intervention without any form of gender bias. Contrary to a limited number of 15 participants per group, the study found out that men and women who managed to report and enrolled before the limit was attained were treated equally. The only limitation was that they needed only 15 people in the group and number of men reduced on account of first come first served. But the ultimate goal was to ensure equal gender access.

Cohen, Mannarino & Deblinger (2012) in their work about the TF-CBT model suggests that clients who should access enrolment on TF-CBT should be people who present with symptoms of PTSD. Findings from respondents from Abura, Lakwana sub-county Omoro district revealed that people who were affected by LRA insurgency and presented with anxiety, emotions, and self-denial were enrolled on TF-CBT. Relatedly, the study found out that presentation of PTSD symptoms by a client meant giving priority to such a person to enroll for the intervention regardless of their sex. The consideration of giving priority depended on what the LRA did to that person or the severity of one's mental disorder; it had nothing to do with gender. Indeed, the study revealed that equal access was based on condition of having PTSD symptomatology. The study found out that those whose PTSD scores were high and had developed psychosis were referred to health facilities with mental health packages that included pharmacotherapy first and later joined psychotherapy, the other category was to benefit from combined management and this was done without gender biases. The other cases were also enrolled on TF-CBT without being gender-biased.

In consideration for severity, Koningstei (2013) acknowledges that people who were involved in war face a range of traumatic situations. The more the trauma exposure the more the severity of PTSD. Marquez (2016) concurs with Koningstei on the afore said notion "severe mental disorders are seen in people who have been over exposed to traumatic events", and he suggests they need attention. Out of this, the study found out that both men and women who were severely mentally sick but not very sick to get hospital care were enrolled for TF-CBT. Such a step was also taken indiscriminately.

As for psychotic cases, they were referred to health center IV that provide psychopharmacological treatment so that they could first get medication as they could not benefit from CBT at that point; one case was of a female participant who upon recommendation for hospital care insisted and came for CBT sessions but was rowdy, disorganized the session by coming loaded with her baggage of rubbish, insulting everyone including the counselor. She was forcefully taken to the Health Centre and retained there to undergo PTSD medical treatment . Nevertheless, several reasons have been advanced to explain why there is unequal gender access to TF-CBT as discussed below:

Through FGDs and interviews and KIIs, the following reasons were advanced; they observed that the war affected women more than men in that a good number of women had multiple exposure to psychological traumatic events during the LRA operations such as; being raped and the associated consequences of rape for example unwanted pregnancies, contracted diseases some which are incurable like Human Immune Viru (HIV) /AIDS and other Sexually transmitted Infections ( STIs-syphylis, gonorrhea) which claimed some of the abductees' lives and created a lasting negative impact for those who survived, there was also forceful marriage of the abducted women and girls to the LRA commanders, witnessing brutal killings or even being forced to kill, being beaten amongst others. On the other hand, their male counterparts mostly suffered being forced to become soldiers and having to fight against the UPDF and killing or witnessing killings, they were also ordered to command operations (abductions, burning homes and killing people) in the communities as testified by one of the participants who explained how he commanded an operation in Mucwini.-Kitgum Nevertheless, these male experiences are still not commensurate with the female traumatic experiences. Thus, this explains one possible reason for female accessing TF-CBT in greater number (299) as compared to men (120).

It was observed that all those who were affected needed attention as this is in line with HBM which particularly calls for action to be taken with due diligence to gender. Related to this, the study found out that several areas had been covered for TF-CBT implementation. Equal access was not only based on gender but also areas where those affected people come from. Districts that were hit by cases of people presenting with PTSD symptoms were considered in the study. Teddlie & Yu, (2007) observe that places where the problem is cited should be involved in the study equally so as to be able to handle the problem to its logical conclusion.

People who presented with PTSD symptoms were enrolled in places such as; Obokeber, Olel, Paromo, Laban and Payuta villages in Awac (Gulu district); in Kitgum district the study found out that in Lawogowogo, Agwoko, Acutomker, Ladwogi, Oryang Central, Pajong Central amongst others in Mucwini and Mission Cell, Lagot, Onyala, Ngweny East, Mulozi Kakoo, Lakokok, Ladwogi etc in Namokora Kitgum dsitrict were greatly affected. The study further found out that villages such as Abura, Burkweyo, Labuje, Te-opok, Teilwa and Awoo Obir all in Lakwana Sub County- Omoro district too had cases of people who presented with symptoms of PTSD though the researcher dropped Awoo -Obir after baseline assessment due to lack of exposure to the intervention; TPO decided to reserve it for another intervention cycle. Hence no analysis was done for this group.

Out of involving the affected areas equally, gender was put into consideration. Pieh et al (2012) opines that both female and male should participate in intervention. Whereas 419 participants were enrolled, 120 were men and 299 were women. This ratio presents unequal access between men and women. Through the use of FGD, the 56 participants involved both men and women. The study used 6 women FGD with 7 participants totaling to 42 while 2 groups only were for men with 7 participants totaling to 14 were involved in the study. This was on the context of male and female accessing TF-CBT. Through this alone the study found out that both men and women were given chance of accessing TF-CBT.

From this several reasons as to why there is unequal access to TF-CBT. Respondents through FGD and interviews were asked about solutions. Their responses are hereby presented in 1.5.3 below:

**Solutions to Causes of Gender Inequality in Accessing (TF-CBT) by Communities Affected by the LRA Insurgency in Northern Uganda**

Affirmative action and mobilization of both sexes were suggested by participants through FGDs and interviews so as to raise the number of men enrolling for TF-CBT. This can be achieved by putting in place a policy to ensure that a group is balanced, one member was quoted as saying:

*"Government needs to come up with a policy and make it mandatory for all men presenting with PTSD to enroll for TF-CBT. This will increase on the number of men. "*

*"Men should be brought on board by every woman in the group bringing along a man who has mental illness- PTSD"*

This was paired with a suggestion about mobilization that all sexes should be allowed to participate in TF-CBT. This was suggested by participants who expressed a concern of having sensitization program so that the people can feel they are stake holders. In an FGD, one member was quoted saying:

"As *long as men and women are taught and sensitized about the benefits of enrolling for TF-CBT, it will attract more people and as such, more men enroling will be achieved. Possibly this can be done through putting beneficiaries in groups in equal number."*

It was further suggested that there is need to increase the number of staff who can help in mobilization and make sure that the number of men and women is balanced. This was after it became clear that social workers are few, in the end, they end up limiting the number of participants leaving other people out. The same was reported about some staff who would prefer women to men. These participants attributed it to small numbers of men in the exercise. By so doing, participants suggested that religious leaders, elders, LCs and influential people such as 'Rwot Kweri'- chief of the hoe in the community can be facilitated so as to convince men to attend.

Some participants suggested use of many channels of communication to educate especially men. Things like banners which can even be put in bars where they take alcohol from will convince many men and possibly teach them that they are supposed to enroll. One person is reported saying:

*"Sincerely men are stubborn, even when they are presenting with PTSD they will still not want to enroll for therapy. We need to follow them up in their homes, bars, gardens; we should give leaflets to be supplied to families. Those leaflets should be written in many languages for anybody to understand why men should enroll for therapy as well as women."*

From this, it is evident that if put into action the number of men who enroll for TF-CBT will increase.

Furtada, Moreira & Mota (2021) in their study about gender, affirmative action and management, investigated a systematic literature review on how diversity and inclusion management affect gender equality in organizations. They opine that affirmative action is a way gender equality will be attained. In view of this the study findings reveal that both sexes need to be brought on board so that they can all enroll for TF-CBT. Through FGDs a policy on affirmative action was suggested… so that all men presenting with PTSD can enroll for TF-CBT. The study further suggests mobilization of both sexes with symptoms of PTSD to enroll for TF-CBT. The constitution of the republic of Uganda 1995 as amended 2018 together with UN Women on Global Gender Equality Constitutional Database states that "Without prejudice to clause (l) of this article, a person shall not be discriminated against on the ground of sex, race, colour, ethnic origin, tribe, birth, creed or religion, social or economic standing, political opinion or disability.

This suggests that both sexes have to be included in all programs be it mental health that this study looked at with a goal of streamlining the imbalance in gender accessibility to TF-CBT. While the feminist theory through Connelly et al, (2000:62-63) through GAD approach acknowledges gender equality and addressed unequal gender relations, which was said to prevent unequal development that usually hindered women from full participation. On the contrary, this study found out that instead more men have to be convinced to enroll for TF-CBT.

Church announcements were suggested as one way through which both sexes can be engaged. This is not a new method, it is always used to create awareness. In a study on Substance Abuse and Mental Health Services administration by Empowering America's Grass-roots (EAG) (2021), it states that faith-based community initiative led to successful strategies for recruiting, training and utilizing volunteers. This is not far from Ribbon (2021) in their study about fighting against breast cancer through the organization of Office of Women's Health, they acknowledge the idea of using religious institutions in creating community awareness. While EAG and Ribbon dealt with substance abuse and breast cancer, interviews and FDGs conducted revealed that churches and mosques are better places where people can be convinced (American Psychological Association, 2017).

The research team agreed with the participants on the suggestion of using religious institutions to convince both sexes to enroll for TF-CBT. This was also agreed after knowing from the participants that prayer places are one other key place where most people with PTSD run to, to seek help. Therefore, involving the church will not only aim at having the church convince men with symptoms of PTSD to enroll for TF-CBT but also spiritually helps them to handle PTSD symptoms.

Al-Dmour, Masa'deh, ASalman, & Abuhashesh (2022), in their study about the role of mass media interventions on promoting public health knowledge and behavior social change against COVID-19 pandemic in Jordan, they point at the use of social media. They say that using a social marketing campaign is a good strategy to raise public health knowledge about pandemic diseases. In the first half of 2020, the whole world was facing the rapid spread of the Corona Virus pandemic disease that has had a dramatic effect on people's daily lives and the world economy. The COVID-19 crisis is an example of a severe social problem where widespread awareness was crucial and social media played a big role. Like how successful it was, the suggestions by participants to have men who present with symptoms of PTSD increased, holds water. Abraham (2015) in HBM suggests that behavior is key in mental alignment.

The theory however does not deal with the idea of having both men and women brought on board. Yet this study ensures that men and women alike enroll for TF-CBT while social media has been used to raise public awareness. The study findings point out that using media platform like TVs, radios, WhatsApp groups, twitter among other media platforms, both sexes will access information and be able to enroll. Consequently, this paper notes that messages therein should target convincing men who present with PTSD to enroll for TF-CBT. This is not far different from the suggestion of Omoera & Aihevba (2022) who carried out research on Broadcast Media Intervention in Mental Health Challenge in Edo State, Nigeria. They point out that to avert mental health a broad campaign needs to be used. Whereas the studies done differ from our study, the study agrees with the suggestions of using social media.

Hasanica, Ramic-Catak, Mujezinovic, Begagic, Galijasevic, & Oruc (2020) in their study about, the effectiveness of leaflets and posters as a health education method advance that the distribution of health-educational posters is recommended in situations where it is necessary to reach a wide audience for a long period of time, if the site of the poster is protected. The wide audience in this study was the people who presented with PTSD. The participants' suggestions of use of posters in community centers, use of leaflets in this regard targeting PTSD symptomatic men so that they are convincing and coinciding with Hasanica et al (2020). Participants in the study suggested that these leaflets should be written in many languages and for area of interest, the local language is key in case it is targeting local communities, leaflet can be supported by bill boards. Kebede (2005) in his study about Effectiveness of Health Posters in Awareness Creation and Promoting behaviour Change. A Case Study of UNICEF's Billboards: points at use of billboards and leaflets as an effective method in fostering behaviour change. Our study deals with behaviour change. In this regard to the behaviour of men with PTSD symptoms to accept and enroll for TF-CBT. He insists on having well designed mobile posters or leaflets advertised on public open market days. The findings of the study team agreed to the suggestions concerning use of posters as suggested by some respondents. This paper agrees to it because posters have been used severally to create public awareness.

Banerjee (2022) in his study about, effectiveness of disease awareness advertising in emerging economy: also, like these participants, for him he attests to the fact that mobile advertisements help a lot on health awareness. The study suggests that mobile advertisements can be brought near market places on auction days, public gatherings and teach men and women on how best they can enroll for TF-CBT. While Banerjee looks at health awareness between drug manufacturers and its consumers this study looked at awareness in relation to identifying men with PTSD symptoms and convincing them to enroll for TF-CBT like their female counter parts and in equal numbers.

The study team agreed with the assertions of participants that mobile adverts indeed play a big role in information awareness. It is indeed prudent that such a challenge should be taken to the public. Men should be taught the importance of enrolling for TF-CBT if someone is showing symptoms of PTSD.

Bravo-Ortiz (2022) in his study about women and mental health observes that socially constructed gender roles make women the principal caregivers in many settings. While making reference to Schizophrenic patients he observes that married men were likely to be cared for and financially supported by their wives. Much as participants do not necessarily say women should make sure that women should bring husbands who present with PTSD yet suggest that women should bring all men who present with PTSD symptoms irrespective of the level of severity. The study found

out that this will not be the first time. This finds direction with Wibabara, Lukabwe, Kyamwine, Kwesiga, Ario, Nabitaka, Bulage, Harris & Mudiope (2021) in their study about the yield of HIV testing during pregnancy and postnatal period, Uganda. This study which was carried out between 2015–2018 data indicate that women play a big role in health assurance. The research team found this suggestion worth convincing that indeed the same way women have done it to take their husbands for HIV testing; they can still use the same convincing knowledge to ensure that men with PTSD come along with them for TF-CBT. The study however notes that any man in the community who presents with PTSD be brought for TF-CBT. This was also revealed by a Psychiatric nurse who was based in Awach health center IV who had already successfully adopted use of this model as reported by Amongi E., Baguma P.; & Nansubuga, F. (2022).

In line with the above, respondents suggested that women should share with men the benefits they have realized from TF-CBT. McRoberts (2021) in his study about possible benefits of dating someone who goes to therapy; in their idea of possible influence says partners who go for counseling tend to influence their couples to go for the same. In agreement with this argument the researcher agrees with his findings that women should ensure that they convince men, not only their husbands who present with PTSD symptoms to enroll for TF-CBT. Additionally, they should also be convinced to come along with them for sessions. The study team further agrees with the findings especially in cases where both the wife and the husband present with symptoms of PTSD.

In as far as involvement of community elders, the study found out that the chief of the Hoe locally referred to as "*rwot kweri*" observed that the Acholi respect their community leaders and that they are active in community mobilization. This paper notes that so for anything important for the community they can make arrangement. The participants' suggestion for use of community elders and political leaders can easily help in bringing men on board. Especially those who present with symptoms of PTSD. In a study that took place in Gambia carried out in 2017 by Dierickx, Sarah O'Neill, Charlotte Gryseels & Bannister-Tyrrell (2022) opine that community sensitization and decision-making for trial participation. Using a mixed method approach, community leaders were mobilized to make sure they mobilize local Gambians on how best they can control malaria. The leaders involved were, traditional healers, retired teachers, policemen, cultural leaders, village birth attendants among others. The study further concludes that after involving community leaders and they used few medical personnel's but were able to cover a very big area.

Basing on that, this paper concurs with participants' suggestion that if leaders are brought on board, they will convince men with ease and the disparity will be resolved. They further built on the fact that Acholi people believe in traditional healers and rituals. This affirms to the fact that sensitization of traditional healers and other community leaders and elders can help in identifying people with PTSD symptoms and will be able to encourage them to go for sessions keeping it I respect on the issue of gender.

In consistence with the above, some respondents pointed out the idea of using political leaders in convincing men to enroll for TF-CBT. This coincides with Clarke, Waring, Bishop, Hartley, Fulop Exworthy, Ramsay & Roe (2021) in their study about the contribution of political skill to the implementation of health services change. Using a systematic review and narrative synthesis revealed that political leaders help in convincing the community to respond to health solutions. The paper found out that political leaders hold the moral authority to mobilize their electorates. The paper notes that the same way they mobilize electorates; it is easy for them to mobilize them for this cause. Gonani & Muula (2015) had also echoed on the same in their study about the

importance of leadership towards universal health coverage in low-income countries. These leaders can access the community with ease in public places be it community local village to village meetings, community functions like weddings, burials where they can be given opportunity to talk. The research team was in agreement with the suggested response from participants. This is because given the fact that they are elected, people believe in them. They in fact have moral authority to speak to their electorate and advise them on crucial matters.

Using mental health clinic days for the health centers. This correlates with findings by Stein, Lee, Shi, Cook, Papajorgji-Taylor, Carson & Alegría (2014) in their study about characteristics of community mental health clinics associated with treatment engagement. They recommend the use of health clinic days as a way of attending to community health concerns. Participants recommended the involvement of health clinic days in identification of people who need health services. The paper agrees with this suggestion because it is free of charge, people get enrolled for free and medication if required is free. These days also the study learnt that they used pyscho education. These days normally attract big numbers of people. It is agreed that people with PTSD can be identified and emphasis should be put on men to enroll for TF-CBT. This coincides with the recommendations of WHO (2021) in their bid towards promotion of Hospital-based mental health services in promoting person centered and rights-based approaches, they recommend extension of services to the people and making them free. The HBM in its bid for action recommends for ensuring that men and women access mental health services.

It was further suggested that there is need to increase the number of staff who can help in mobilization and make sure that the number of men and women is balanced. This conforms to URS (2022) about their study capability statement community governance and mobilization on lessons learned about Community engagement in service improvement. It opines to the idea of increasing on the number of VHTs and engagement of peer educators. They point out that they used VHTs and Peer educators who move from house to house and find out the health challenges. It was tested in Acholi in 2019 during Covid 19 restrictions and many people were reached among those who had health related issues. Through these activities, the project reached 4,680 people with key integrated messages on HIV prevention, care and treatment, safe male circumcision, TB prevention, FP, ANC, teenage pregnancy GBV and COVID-19 prevention.

The same can be done incase staff number is increased to identify people with PTSD symptoms and bring both sexes on board. This is further in support by Morrison *et al* (2021) in their study about Community mobilization and health management committee strengthening to increase birth attendance by trained health workers in rural Makwanpur, Nepal. The idea here is that after increasing trained health workers birth related complications were reduced. This gives the research team confidence that increased number of staff to handle sessions and mobilization will reach out to even men with PTSD symptoms so that they enroll for sessions. This was after revealing that social workers are few, in the end they end up limiting the number of participants leaving other people out. The same was reported about some staff who preferred women to men. These participants attributed it to small numbers of men in the exercise. By so doing participants suggested that religious leaders, LCs and influential people in the community can be facilitated so as to convince men to attend.

## 4.0 CONCLUSIONS AND RECOMMENDATIONS

The paper has presented inequality in gender access to the intervention. The reasons for men being fewer have been put across and the possible solutions to those causes provided. However, this paper notes that overall, both men and women had opportunity to enroll for TF-CBT. This paper proposes that gender inequality in accessing the intervention can be mitigated by both government and other stake holders through affirmative action, mobilizing all sexes, stopping restrictions in recruitment of beneficiaries, use various leaders for sensitization, extending services of TF-CBT in villages and employing more workers amongst others.

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