RETROSPECTIVE EVALUATION OF INTERVENTIONS FOR HANDLING PSYCHOLOGICAL TRAUMA IN FAMILIES AFFECTED BY THE JULY 11, 2010 TERROR ATTACKS IN KAMPALA

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DECLARATION

This study is original and has not been submitted for any other degree award to any other university before.

Signed:

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Jacob Waiswa

Date:

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APPROVAL

This dissertation entitled, *"Retrospective Evaluation of Interventions for Handling Psychological Trauma in Families Affected by the July 11, 2010 Terror Attacks in Kampala"* by JACOB WAISWA was submitted to the directorate of research and graduate training for examinations with my approval as the academic supervisor for the award of a Masters of Arts Degree in Peace and Conflict Studies.

Signed:

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Prof. Peter Baguma

Academic Supervisor

DEDICATION

I dedicate this book to my mother, Daisy Namulemo, for the relentless support she offered me; and my sisters, Rachael Babirye and Regina Kiiza, whose life conditions drove me to consider a mental health study on top of the fact that I came from the same academic background (mental health).

Together we shall win.

ACKNOWLEDGEMENT

I salute all victims of the July 11th, 2010 terror attacks for accepting to open up to me and for their time during the research data collection. To some, it was challenging to speak to me as it always came with terrifying memories, sadness, and tears, more so, me being a stranger to them.

My former undergraduate lecturer, Makerere University School of Psychology, Makerere University, Simon Nantamu (PhD Candidate; Trinity College, Dublin), who provided intelligent advice on how best to develop my research idea; Prof. Peter Baguma (Dean, Makerere University School of Psychology), who did all he could to direct my research to more feasible and meaningful approaches every time I put myself in a very difficult situation; Dr. Musana Paddy (Head of Department – Religion and Peace Studies) for the constant encouragement to finish my research project when I felt burnt out and needed to relax away; Mutebi Eddie, Executive Director, Union of Community Development Volunteers (UCDV-UG) for contributing partly to data collection fund; and friends: Asif Kigenyi, Obang Hannington, Grace Kibuuka, Francis Mugyenyi, the 2010 MA Peace and Conflict Studies class, and the Dag Hammarskjold Hall Community provided me with a home away from home. Similarly, I appreciate the golden time from some service providers –in the area of mental health, including Uganda Counselling Association (UCA) and Basic Needs (Uganda).

May this book serve the needs of survivors, the rest of the country, and the global community that may fall victims of devastating terrorist attacks, and may the souls of the dead victims rest in eternal peace.

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AAR	:	Africa Air Rescue
ACP	:	Accelerated Cure Project
APA	:	American Psychological Association
AMISON	:	African Union Mission in Somalia
AMRF	:	African Medical Research Foundation
ARC	:	American Red Cross
ARCDC	:	American Red Cross Disaster Service
7/11	:	July 11th of 2010
9/11	:	September 11th of 2001
CBT	:	Cognitive-Based Therapy
CHHRD	:	Center for Health Human Rights and Development
DSM IV	:	Diagnostic and Statistical Manual of Mental Disorders
DMHI	:	Disaster Mental Health Institute
DoF	:	Department of Health
DREF	:	Disaster Relief and Emergency Fund
DRN	:	Disaster Response Network
ERU	:	Emergency Response Unit
Exp	:	Experience
FAO	:	Food and Agriculture Organisation
GIEWS	:	Global Information and Early Warning System
FBI	:	Federal Bureau of Investigations
FEMA	:	Federal Emergency Management Agency
FHRI	:	Foundation for Human Rights Initiative
FM	:	Frequent Medium
ICU	:	Intensive Care Unit
IGADD	:	Intergovernmental Authority on Drought and Development
IHK	:	International Hospital Kampala
KHHSZ	:	Knowledge Hub for HIV Surveillance and Zagreb

NASMHPD	:	National Association of State Mental Health Program Directors
NCDPT	:	National Center on Disaster Psychology and Terrorism
n.d.	:	no date
NHS	:	National Health Services
NTV	:	National Television
PRO	:	Public Relations Officer
PTSD	:	Post Traumatic Stress Disorder
Re-exp.	:	Re-experiencing
Sig.	:	Significant
RLP	:	Refugee Law Project
SPSS	:	Statistical Package for Social Scientists
St	:	Saint
UK	:	United Kingdom
WHOCC	:	WHO Collaborating Centre

ABSTRACT

Between 1968 and 2006, global terrorism between was responsible for 35,000 deaths. These deaths seemed senseless and arbitrary, and victims experienced a sense of lack of control (Summit Report, 2008). From this study, the medical reports comfirmed 76 people killed when terrorists struck Kampala City on July 11th 2010. This study explored the nature of psychological trauma, levels of preparedness of service providers, forms of psychological trauma interventions, appropriateness of psychological trauma interventions, and efficacy of psychological trauma interventions. The study was cross sectional descriptive. It employed both qualitative and quantitative approaches. It also applied non-probability sampling techniques: snowball rolling and purposive sampling, to obtain a sample size of 160, including 150 affected individuals within families and 10 key informants, respectively. DSM IV items were used to measure PTSD; 11 items for the forms of interventions, and 5 items for efficacy of interventions, and 5 items for efficacy of interventions. Data was quantitatively and qualitatively analyzed. 1) Nature of psychological trauma suffered: mean for psychological trauma was 95.3%, respectively. 2) mean for levels of preparedness of service providers (81%); 3) observations for forms of psychological trauma interventions: medical (90.7%), psychological (55.3%), compensation (83.3%), culture-related (50%), religious (96%), family (97.3%), group (94%), community (82.7%), security (83.3%), international assistance and legal aid (79.3%); 4) mean for appropriateness of psychological trauma interventions (49.5%); and 5) mean for efficacy of psychological trauma interventions (20.1%). The psychological trauma interventions involved traditional and non-traditional approaches, and primary (medical) and secondary interventions (psychological support services). There were strong linkages between primary and secondary interventions in as far as achievement of efficacy was concerned. Family and religious support were most predominant. Due to high cost of long-term treatment and operational costs, interventions and treatment regimes got shortened by both the service providers and victims; thus, leading to low efficacy (20.1%). On the other hand, the informal interventions lacked expert coordination of efforts towards recovery. Soon both the formal and informal interventions lost efficacy as experiences of uncertainty persisted. There is need to protect citizens from terror-related trauma, to focus more on trauma prevention rather than remedy, to integrate tradition and non-tradition approaches to care, and to make access to care affordable to all. Further research is needed to evaluate interventions made to handle secondary psychological trauma in service providers.

CHAPTER ONE:

INTRODUCTION

1.1 Background

Of the 15 global challenges, attainment of peace was inclusive (The Millenium Project, 2009). Terrorism was a major threat to peace, security and development. Terrorism was a tactic used by fighting groups to control the population on either side (Goodhand and Lewer, 1999). Between 1968 and 2006, global terrorism between was responsible for 35,000 deaths. These deaths seemed senseless and arbitrary, and victims experienced a sense of lack of control (Summit Report, 2008). Schuster and colleagues found that stress reactions to the attacks were felt across the country after the September 11, 2001 (9/11), with 44% of adults and 35% of children showing what they called 'substantial' symptoms (upsetting reminders, disturbing memories, difficulty concentrating, trouble sleeping, feeling irritable or angry). A nation-wide survey of Americans after 9/11 found that the most common coping strategies (interventions) among Americans on that day and several days after were talking with others (98%), religious thoughts or actions (90%), participating in group activities (60%), and making donations to 36% relief services (Schuster Et al., 2001). The Oklahoma City bombing represented a major loss of life and property, with much causality. Both direct victims (survivors) and indirect observers (residents of Oklahoma) of the attack reported significant levels of Post-traumatic Stress Disorder (PTSD). Similar data was reported following the 9/11 attacks, showing symptoms of PTSD being higher for those closest to the actual site of attack. In the United Kingdom (UK), 75% of those seeking help following the Lockerbie disaster (mostly individuals who knew a victim) reported symptoms of PTSD (Mansdorf, 2008). These experiences and responses provided lessons and became benchmarks for future interventions –respectively.

As such, terrorism was understood to cause a 'crisis by observation', affecting people not directly involved. It had massive impact on the collective consciousness and global media. The ideological extremes had strong influences on terrorism (Coleman and Bartoli, 2002). The extreme tendencies between two or more parties did not provide room for reasoning before taking actions during conflict situations, which culminated into physical violence –including acts of terrorism. Psychological trauma was a prominent mental health issue over the years due to

mass violence –including acts of terrorism. Mental health was a right reflection of peaceful states. A person who had peace was mentally healthy (Quadri, n.d.). Globally, 1 in 4 (25%), suffered from mental disorders in both developed and developing countries (National Alliance on Mental Illness of Greater Chicago, 2013). And, incidentally, terrorism was one of the world health organisation's target areas under the mental health and psychosocial support in emergencies (World Health Organisation, 2014). Trauma-associated mental disorders were increasingly prevalent in developing countries, the consequence of persistent poverty-driven conditions, the demographic transition, conflicts in fragile states and natural disasters. At the same time, more than 50% of developing countries did not provide any care for persons with mental disorders in the community. The disorders brought significant hardships not only to those who suffered but also to their caregivers –often the family, given the lack of mental health resources in developing countries. Reports indicated shortage of care for mental health patients, particularly, the schizophrenic and psychotic ones. A few sufferers got recommended levels of care. This necessitated a radical overhaul of the health care system, effective use of funding, and investment in prevention and community support (World Health Organization, 2007).

Generally, mental conditions had its sources and healing effect from within families. Families offered environments for outbreak and make-up of conflicts and mental illnesses. The freedictionary.com (*retrieved* October 7, 2010) defined family as a family a fundamental social group in society typically consisting of one or two parents and their children. In a classical family, members got bonded spiritually, psychologically, emotionally, culturally, socially, economically, and politically –where any deviation in the values by one member affected others. The implication was same when the quality of life too changed. The values served for the good or for the worse –depending on the family mental states. However, the mentally well families showed overall states of well-being for their members that went on to impact neighborhoods, sub-regions, nations, and even the world. Fancher (2010) explained that, because what other people thought determined what opportunities someone else was going to have in life, and other people already had that power –whether the client and the psychotherapist recognized it or not.

Since 1999 Uganda has experienced intermitted terror attacks, most serious event being the 7/11 bomb blasts in Kampala. Its closeness to the unstable countries in or being part of the Inter

Governmental Authority on Drought and Development (IGADD) region rendered it vulnerable to terrorism. Crisis interventions were a social responsibility: it was not tied only to government, or to the mainstream health personnel. The communal element was huge and provided most prompt responses in times of need. Social capital provided the value to do things for each other in case disasters destroyed family orderliness and cohesion (Putnam, 2000). On July 11, 2010 (7/11), Uganda was exposed to international terrorism, when local terrorism agents detonated three explosives at Kyadondo Rugby Club and Ethiopian Village Bar and Restaurant in Kampala City. According to media reports estimated 84 people died were killed on the fateful night (Ssenkabirwa, 2010).

The dreadful experience provided, in many ways, grounds for rethinking safety of life and property, preparedness of service providers, appropriateness of interventions, efficacy issues, as a base –to comprehensively provide measures for future readiness and actions. The interventions were instituted by wide range of actors, making unique contributions to the cause. Most of them acted outside professional institutional arrangements to provide support to victims and brought relief to them much as their contributions were hardly documented, and who could have otherwise been acknowledged and evaluated alongside the formal and specialized institutional service deliveries. While institutions were monetarily motivated, traditional aspects of interventions were rather voluntary –involving individuals, groups, families, churches, and community. The International Federation's Disaster Relief Emergency Fund (DREF) was a source of un-earmarked money sourced by the Uganda Red Cross (DREF Operation Final Report, 2011). Voluntarism was enduring and most reliable. It was a true reflection of *Ubuntuism* (human spirit).

After the 7/11 attacks, volunteer individual (including survivors), corporate bodies, police, local and international organizations, and the media responded, accordingly (Ntulo, 2010). On the aftermath of several contributions were made by them towards the wellbeing of families that suffered the shock. However, the study focused on victims of the 7/11 terror attacks in the context families. It established evidence of psychological trauma prevalence, preparedness of actors, comprehensively revisited the different forms of interventions and assessed them in respect to psychological trauma found, and measured their appropriateness and efficacy in order

to get data relevant in redesigning safety mindsets, and institutional efficacies in transformation of the victims' lives –who found themselves in similar situations in future.

1.2 Statement of the Problem

Terrorism was a global threat bound to spread to all countries that shared conditions and history of discrimination, oppression, foreign dominance and social alienation, which turned victims into killers (Mamdani, 2004). In Uganda, reports showed 84 people –either blown out of being by 7/11 explosions or dead but with some body parts missing. This was masterminded by the Somali terrorist group called the Al-Shabaab, allied to the Al-Qaeda Network (Ssenkabirwa, 2010a). These events occurred with concerns of possible psychological trauma suffered by survivors, rescuers, families, neighborhoods, and concerned members of the public, whether present at the bomb scene or not. It had a contagious effect (Greig, 2006). The experiences showed that events as the 7/11 may have caused wide range of emotional and behavioral problems (Tanielian and Stein, 2006). This prompted interventions to enable coping, well-adjustment, and sustainable psychological healing for families from well-prepared and equipped service providers. Indeed, following the 7/11, a handful of service providers rushed to the scene to attend to the victims (Ntulo, Mugherera and Ndyanabangi, 2010). Proactive responses were made at various fronts to deal with the adverse impact it caused: at the military, medical, psychological, family, individual, group, religious, and media levels –within the country, regionally, and globally to support families of the dead, injured, and survivors –without injuries.

The incidence was so tragic and historical –without experience on interventions and guidelines. Since the threats of terrorism were still ripe and the status of the lives of affected families 2 years later was not known.

1.3 Purpose of the Study

The purpose of the study was to establish evidence of prevalence of psychological trauma suffered by families of the victims of the 7/11, forms of interventions done, and to retrospectively evaluate the appropriateness and efficacy of interventions, and make recommendations.

1.3.1 Specific Objectives of the Study

The study will undertake the following specific objectives:

1. To establish the nature of psychological trauma suffered.
2. To establish the levels of preparedness of service providers to handle psychological trauma.
3. To identify the forms of psychological interventions applied.
4. To assess appropriateness of psychological trauma interventions.
5. To assess efficacy of psychological trauma interventions.

1.3.2 Questions

The study had the following questions:

1. What was the nature of psychological trauma suffered?
2. What were the levels of preparedness of service providers to handle psychological trauma?
3. What were the forms of psychological trauma interventions?
4. How appropriate were the psychological trauma interventions?
5. How efficacious were the psychological trauma interventions?

1.4 Scope of the Study

The study scope regulated research activities to be done in specific ways, elicit certain information, and results, with respect to the topic under study, and was divided into the geographical, content and time scopes. Establishing context was vital element in evaluation studies. The context included stakeholders, who were potential players in the interventions and their outcomes (Suvedi, Heinze, and Ruonavaara, 1999).

1.4.1 Geographical Scope:

The study was limited to Kampala City, where the 7/11 terror attacks and tragedy occurred.

1.4.2 Content scope:

The study measured the extent of trauma, and retrospectively evaluated interventions conducted by different bodies (both local and international) to manage psychological trauma trauma, understanding nature its nature, levels of preparedness of service providers to handle psychological trauma, forms of psychological trauma interventions, appropriateness of psychological trauma interventions, and their efficacy from the perspective of the families and, where applicable, engaged service providers (for example –whilst looking at preparedness of service providers).

1.4.3 Time scope:

The study applied to a period between 11th July, 2010 and July 11th, 2012 within which the attack and interventions happened.

1.5 Definition of Key Terms

The key words used and that had an influence on the study were explained hereunder to build and ease understanding of the research script.

1.5.1. Retrospective Evaluation

This was used to mean systematic determination of merit, worth, and significance of something or someone using criteria against a set of standards (Wikipedia, 2011b).

1.5.2 Trauma

Psychological trauma was used to mean negative and painful life experiences faced when exposed to major events such as wars, rape, kidnapping, or surviving a natural disaster. In their article, Jaffe, Segal, and Dumke (2005:1) further wrote:

> The emotional aftermath of such events, recognized by the medical and psychological communities, and increasingly by the general public, is known as Post-Traumatic Stress Disorder (PTSD).

1.5.3 Levels of Preparedness of Service Providers

LoPSP was used to mean the readiness of agencies to provide support services.

1.5.4 Forms of Psychological Trauma Interventions

These were major activities done to reduce damage incurred.

1.5.5 Appropriateness of Psychological Trauma Interventions

AoIs implied the application of the right action to a given cause to achieve measurable outcomes.

1.5.6 Efficacy of Psychological Trauma Interventions

EoIs was used to mean the relationship between the level of resources invested and the level of results or improvements in health (Madore, 1993).

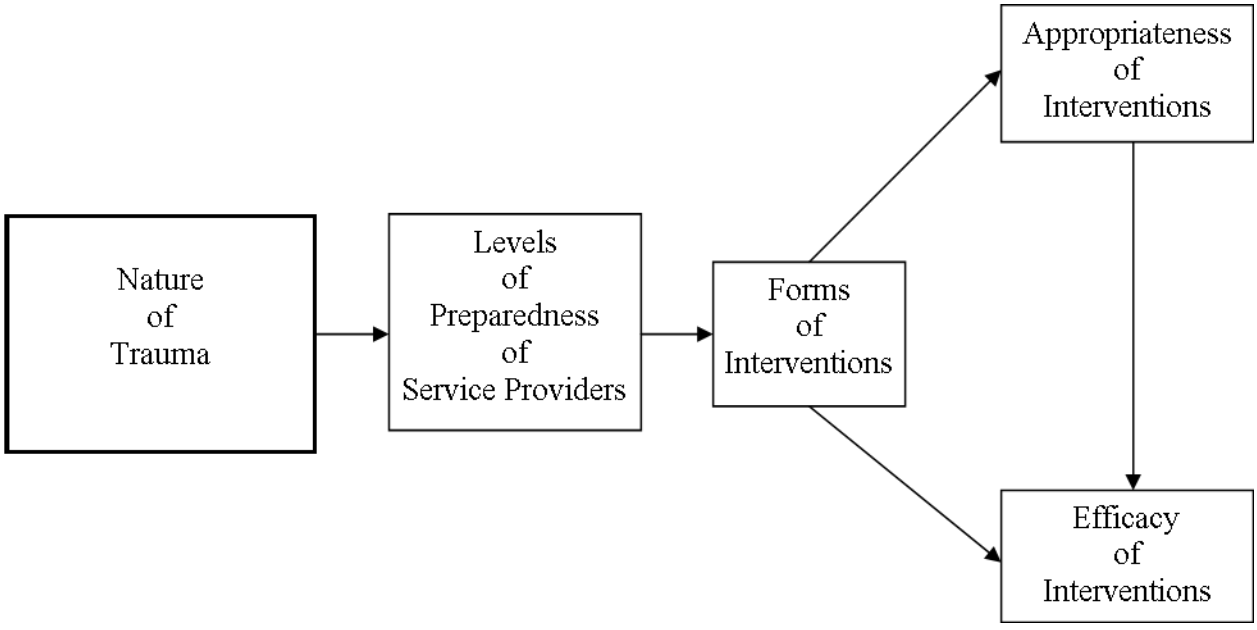
1.5.7 Family

Family implied basic unit of the bigger societies where human characters, social norms, and expected behavior were shaped.

1.6 Significance of the Study

The study provided knowledge on interventions necessary to proactively manage trauma as first aid package to individuals; to mental health workers who time and again face trauma cases; and to institutions and organizations with interest in the subject of trauma interventions. The project helped to strengthen the mental health infrastructure to support sustained healing of traumatized families. It recognised and catered for the diverse approaches employed to manage trauma with a special emphasis on terrorism; both professionally or institutionally structuralised and unprofessionally or non-institutionalised. Their overall outputs and outcomes got highlighted. The study served as referral point for researchers and the general readers, and went a long way to guide them in the management of both natural and artificial disasters. While this study limited itself to affected families, it inspired researchers to cover psychological trauma and interventions among members of the security forces, medical personnel, and other service providers such as the media fraternity and general community, who were vulnerable to psychological trauma. Thereafter, appropriate interventions were designed to effectively and efficiently manage the different contexts it (trauma) occurred.

1.7 Concept Framework of the Study



Source: Brønna and Olsona (1999).

The figure above was adopted from the conceptual framework of interventions suggested by Brønna and Olsona (1999) and modified to support the objectives of this study. It illustrated the interplay of the study path of researcher, beginning with identification of psychological trauma, preparedness of service providers, associated interventions, their appropriateness, and efficacy. The occurrence of psychological trauma provoked questions over stake-holders responsible for preventing trauma-causation incidents and its management, and proceeded on to evaluate the appropriateness and efficacy of the respective interventions.

CHAPTER TWO:

LITERATURE REVIEW

2.1 Introduction

In this chapter, the study elements as portrayed in the works of other authors were located and highlighted –reflecting research objectives. The objectives were: to establish the nature of psychological trauma suffered, to establish the levels of preparedness of service providers, to identify the forms of psychological trauma interventions applied, to assess appropriateness of psychological trauma interventions, and to assess the efficacy of psychological trauma interventions. And literature synthesis involved location of gaps and asserting researcher action towards filling them with respect to trauma experience of families in Uganda. Below was the literature the researcher located and reviewed.

2.2 Nature of Trauma Psychological Trauma Suffered

World Health Organisation (2013) showed that significant proportions of disabilities were caused by injuries and violence. The injury-related impairments involved physical or cognitive limitations due to neuro-trauma and paralysis from spinal cord trauma, partial or complete amputation of limbs, physical limb deformation resulting from mobility impairments, psychological trauma, and sensory disability such as blindness and deafness. After a traumatic event, physical trauma eventually subsided, leaving behind psychological trauma. When left unchecked, the person yielded serious psychological issues (Theravive, 2011). Assessing extent of trauma suffered helped mental health workers to know what to do and by how much to do about it (Brock, 1999). Understanding the nature of trauma was important part of planning interventions. However, from the general trauma manifestations, psychological trauma had to be revealed more pronouncedly. The trauma information taken was based on guidelines developed from many other trauma experiences elsewhere in the world but clear data about the tragedy – with regard to a given situation and context was most helpful in trauma data gathering and analysis processes. In this study, the researcher established nature of trauma as priority action and how it implied psychological trauma experiences of families affected by the 7/11 terror attacks.

Two factors were critical in appraisal of person's stressful life event: that was the level of perceived threat to a valued goal and the level of the person's-perceived control over the event. Often the less severe events resulted in diagnosis of psychological trauma and further caused psychological problems such as depression, anxiety, and somatic pain. That persisted until the event and its aftermath got resolved. When affected-person's sense of security faced disruption, it was generally more distressing, more so when any given person identified himself or herself with the victim or situation. And because the episodic memory was not processed, a relevant semantic memory was not be stored and the traumatized persons had difficulty at using knowledge of traumatic experience to guide future actions (Accelerated Cure Project, 2007). But it called for measurable patience and time to monitor experiences that were psychological in nature while the physical ones called for urgency since addressing physical trauma also implied tackling psychological trauma. This study determined the nature of trauma suffered –with respect to psychological trauma experiences of families affected by the 7/11 terror attacks.

The victims who experienced PTSD and a psychiatric disorder had persistent flashbacks and nightmares, extreme irritability and jumpiness, and emotional numbing or avoidance of reminders of trauma while the long-term consequences of terrorism were anxiety, grief, depression, and anger (Tanielian and Stein, 2006). And because traumatic experiences were terrifying, survivors avoided thinking and talking about them. This avoidance prevented processing of the information. Psychological trauma altered physiology and gave rise to images, feelings, sensations, and beliefs that persisted throughout life. Stimuli-triggered traumatic memories associated with the traumatic event. The victims subsequently re-experienced in their original intensity. Survivors soon felt the terror and lost their sense of time and place (Eldra and Heide, 2005). There were greater risks for females than males for developing psychological disorders following a traumatic event. However, some studies have associated lower intelligence (lower IQ) with an increased conditional risk for post traumatic stress disorder (PTSD). While the strength and impact experiences varied from one person to another, the unique experiences provided wealth of information to guide future decisions on the specific cases. This study summed up experiences of victims following the 7/11 in Uganda and revealed the magnitude of the impact of trauma suffered –irrespective of their variations whilst singling out how extent of psychological trauma suffered.

The diagnostic and statistical manual for mental disorders (DSM IV-TR) was one of the criterions for diagnosing stress disorders based on 4 major items: 1) exposure to a traumatic event: a) loss of 'physical integrity' or risk of serious injury or death, to self or others, and (b) response to events that involved intense fear, horror; 2) persistent re-experiencing –involving: a) flashback memories, recurring distressing dreams, and b) subjective re-experiencing of the traumatic event (s); 3) persistent avoidance and emotional numbing, and included: a) avoidance of stimuli associated with trauma –including certain thoughts or feelings or talks about the event (s), b) avoidance of behaviors, places, or people that might lead to distressing memories, c) inability to recall major parts of the trauma(s) or decreased involvement in significant life activities; d) decreased capacity (down to complete inability) to feel certain feelings, and e) an expectation that one's future was somehow constrained in ways not normal to other people; 4) duration of symptoms for more than 1 month characterizing significant impairment, a stage at which the symptoms reported led to "clinically significant distress or impairment" of major domains of life activity, such as social relations, occupational activities, or other "important areas of functioning" (Wikipedia, 2011). Guiding tools as these were helpful at attaining right understanding of trauma experiences observed in a given context. All the same, it was necessary to capture other experiences that occurred beyond what this tool described so that, even more refined ones emerged for application in trauma care and new tools for successful care developed. This study applied the DSM IV which proved easier to understand and use –to illustrate and describe the nature of psychological trauma suffered with reflections from the physical nature of trauma and how the two accelerated pain of another form.

2.3 Levels of Preparedness of Service Providers to Handle Psychological Trauma Suffered

According to the Directorate of Service Policy and Planning (2004), the reinvigorating factor of positive outcomes from health interventions included: joint management, joint governance, human resources considerations of training, training and implementation of frameworks. The guidance noted that information from local partners was important. There was great emphasis on practical steps to meeting the immediate physical needs –such as provision of supplies and equipment. Often, however, a tragedy was followed by well-meaning but poorly prepared volunteers seeking to provide psychological assistance (Mansdorf, 2008). On the aftermath of the

1995 Oklahoma bombing, counterterrorism measures were stepped up, through the Federal Bureau of Investigation (FBI), and Criminal Investigation Agency (CIA), and were asked to work more closely (Clinton, 2005). And how well preparations were done elsewhere varied with levels of technological advancement. They were to be done with the consideration of available resources, which a country like Uganda was considerably less at an advantage. In this study, various attributes that amounted to preparedness of local service providers on the aftermath of the 7/11 in Uganda were explored.

The American Psychologist Association (APA) played a leading role during emergency missions alongside relief workers. Under the auspices of the National Association of State Mental Health Program Directors (NASMHPD), fifteen state departments of mental health initiated formal efforts to better address the needs of persons exposed to trauma –with state-wide trauma initiatives and resources. Subsequently, "tool kits" were developed to better help trauma victims. Further, it revealed that educational opportunities existed for students to learn how to serve their communities in times of disaster helped to expand the programmes and capacity to run them. The undergraduate program included working with the American Red Cross Disaster (American Psychology Association, 2004). On the other hand, the necessities to have such preparatory arrangements for a tragedy arose from lessons learned from earlier traumatic experiences – without which such preparations advanced preparatory levels remained a dream for the majority nationals. Without long history of management of traumatic events, existing organizations were rendered weak and ineffective. Good training had to be made relevant with real life experiences of trauma handling and the different contexts they occurred. This study determined how preparations helped to enhance readiness to handle psychological trauma and its inducements – without experience at managing large scale traumatic events in cities of the magnitude that claims over 76 people and many that were either injured, psychologically scarred or both –and where families were the focus.

The APA developed a Disaster Response Network (DRN) to respond to the need for mental health professionals to be on site with emergency workers to assist with psychological care of trauma victims. In case of a disaster, over 1,500 psychologist volunteers were standby to provide free, onsite mental health services to survivors and the relief workers who assisted them. The

APA worked with the American Red Cross (ARC), the Federal Emergency Management Agency (FEMA), state emergency management teams, and other relief groups on every major disaster smaller disasters since 1992. Besides the Pacific Graduate College and Stanford University created the National Center on Disaster Psychology and Terrorism (renamed National Center on the Psychology of Terrorism). It trained doctoral students to help victims of catastrophic events. The Disaster Mental Health Institute was set up in 1993 by psychologist, Gerad Jacobs –to bring together practice and research in disaster mental health, and help to prepare psychologists to deliver mental health services during emergencies and their aftermath. Perceptually, though, psychological trauma care was mostly concerned with secondary to physical trauma care, thus; one needed more urgent attentions than the other to accelerate healing processes. Besides, psychosocial challenges had to be catered for –for example unemployment, poverty, lack of social support as they too impended healing processes and worsened mental health situation of families affected by 7/11 terror attacks. Successful preparations to offer psychological trauma care were unlikely to happen in Isolation. Much of the cases describing preparedness pointed to collaborative form of preparedness, which narrowed scope of service providers' preparation system. This study developed wider scope of disaster preparation mechanisms and extents to which they implied wholesomely well to the victims.

The drive towards efficacy was reinforced by quality of services readied. Preparedness of service providers was qualitatively measured and had to be guaranteed through aspects of management sufficient, adequate supply and training, strong performance monitoring systems, and empowered patients and families (Counte, 2007). These qualifications were formulated before hand for readiness to intervene in a tragic situations and their management. Still, preparedness of service providers was made stronger with experiences of previous interventions of the kind – such as determining specific services and programmes for the victims and their families as well as community-based ones, and specific trainings and updates service providers had to equip themselves with –every other time and again. Therefore, strong systems of monitoring and evaluations had to be developed and updated annually that this study was all about.

2.4 Forms of Psychological Trauma Interventions

In the preliminary stages of interventions, it was essential to bring disaster victims to safe places that were free of threats to life and re-exposure or re-trigger of horror until all were

professionally handled. Quickly returning patients to the community after acute states of illnesses, chronic disabilities were encouraged. The move was climaxed with preparing them for employment (Barham, 1992). It was critical to supervise relationships clients found themselves in, and to secure a reliable support system. Family members, lovers and close friends played immense roles to full recovery. Indeed, recovery took place in the context of relationships (Herman, 1992). The interventions were processes of different kinds aimed at leading clients to full recovery from the tragic event. Nevertheless, the baseline elements that sustained health relationships were essential foundations for post-trauma recovery –including socioeconomic, legal and political environment, in which families lived. This study found various forms of interventions and categorizing them in major categories that were easily identifiable by a third party from both actual instinctive yet transformative actions done on the event of the 7/11 terror attacks and the previous interventions conducted in other countries.

In the wake of Oklahoma bombing, the United States of America (USA) leadership comforted and encouraged families, which lost their loved ones, and the country at large. The Federal Emergency Management Agency (FEMA) was dispatched to the scene, and security and emergency briefs made to the nation (Johnston, 2010). There was further investment in preparedness to prevent future terrorist damage to lives and property, new security designs were integrated in the building technology and design to affect 8,300 buildings (Ungar, 1998). Leadership was critical component in formulating intervention strategies based on experiences of tragic events elsewhere and prioritising them (strategies) –with respect to the local setting. The lack of oversight on potential terror and trauma incident was an issue to consider while formulating interventions so that the leadership in position gained capacity to deal with traumatic event. Even so, how that was an issue during the interventions to handle psychological trauma and in the management of all other conditions that predisposed victims and families to it, had to be established in this study.

Psychosocial interventions conducted by multitask-based teams were most popular during soon after the tragedy. Services were meant to target the bereaved, injured, those found at the two sites uninjured, police, health workers, journalists, and the general public. On the aftermath of 7/11, for instance; services centres were set up at St. Francis hospital, Nsambya, Mulago

National Referral Hospital, International Hospital Kampala, and Africa Air Rescue (AAR) clinic on Parliament Avenue. Home visits were conducted, and the police from the Emergency Response Unit received psychosocial support. One radio programme was held on Star FM to educate the general public on the effects of psycho-trauma on normal functioning of the body, and how adverse effects could be addressed. National Television (NTV), on its part, held programs on the same matter, and run daily announcements on the available counseling services and stations to find them while the new vision and vision voice ran similar announcements (Ntulo, 2010). While the contributions of each service providers was crucial under the circumstances that the country found itself with, how harmonious those multidisciplinary teams worked and their general contribution to families affected by the 7/11 terror attacks were of much importance to this study.

The administration of treatment following a traumatic event reduced the occurrence and severity of emotional disorders in trauma survivors. It was individualised to meet the unique treatment needs of clients. Although, a combination of group therapy, cognitive behavioral therapy (CBT), disensitisation and reprocessing were important intervention strategies used to handle cases of psychological trauma (Cohen, 2013). Stories from survivors were encouraged and expressed about the tragedy, and how they survived (Davies and Boyle, 2011). The calming techniques were applied in panic prevention and treatment that featured when psycho-physiological and neurobiological reactions activated by extreme stress –the fight, flight or freeze reactions deeply embedded in the brain, could not be easily switched off (Heir, Hussain, and Weisæth, 2008). There were a lot of approaches –both convention and non-conventional, however, much of what can be found was the conventional (and western-type of interventions) –without regard and appreciation of indigenous forms –all of which this study attempted to amalgamate.

The Church exorcised evil thoughts (resulting trauma or trauma experience) as part of patients' betterment, especially in populations that were so spiritual. Affected people were encouraged not to bother about the evil thoughts, and used prolonged prayers and fasting, until a point of temporary debilitation was reached, when a priest or holy man could be in position to alter the behavior patterns in the patient's mind. The process involved arousing discomfort of the patients, regulation of their breathing, inducement of panic and fear, causing weird or vigorous lighting

and incense, discloser of awesome mysteries, and coupled by drumming, dancing, and singing. Intoxicant drugs were given as ways to modify normal brain functioning for religious purposes. There was focus on direct stirring of emotions as a means of affecting higher nervous system, and implantation of saner beliefs and attitudes. There was higher likelihood to achieve success if higher nervous tensions were reached (Sargant, 1957). This form of interventions was challenged by a fact that different religious worship differently –some were noisier than others. If being noisier was an indicator of successful spiritual-religious and overall healing, many other elements of worship could have lost significance in the lives of families affected by the 7/11 terror attacks. The outcomes of each form of worship along with analysed processes were not yielded. The study sought various religious engagements with respect to fostering healing and, subsequently, measured their role to facilitate comparison with other forms of interventions.

2.5 Appropriateness of Psychological Trauma Interventions

Experiences of the 1995 Oklahoma bombing necessitated to need to form a counter-terrorism centre under the direction of the Federal Bureau of Investigations (FBI) to coordinate efforts against terrorism, involving chemical, biological, and nuclear weapons. The media was sensitised on the need to weigh words spoken so that violence would not be encouraged in the minds of the people. The media often assumed that governments had the sole responsibility over crises and that should be made accountable (An and Gower, 2009). The FBI had similar obligation in Uganda after the 7/11 (Butagira and Okello, 2010). This was the basis of starting war on terror in Somalia under the African Mission in Somalia (AMISOM) which was extensively funded by the United States of America (USA) and the United Nations Organisation (UNO) (Olupot, 2010). While ascertaining security level and civilian safety from further terrorist attacks were crucial, more resources were channeled to supporting the war more than on recovery of families affected by 7/11 and reconciliation to resolve both old and new conflict situations. In this study affected families were central to that.

The successes of the 9/11 psychological trauma interventions were attributed to the ability to construct social support and fostering personal coping skills. From the American Red Cross (ARC) experience, lessons were: the need to assign a big section of its human resources to keeping contact with the families whose presence after the tragedy was always remarkable. And the clients' needs were rather put into perspective by those providing and managing

interventions. Mostly multifaceted approaches were most desired. They involved social support, provision of brief information sessions and the subsequent provision of some sort of behavioral-based interventions (Mansdorf, 2008). Whether multifaceted approach was good or not remained an important question verses the ones on contents and duration of interventions, which this study wholesomely analysed.

Early diagnosis and interventions remained the best at predicting recovery and timely referral be followed to bring out the usually besieged complications of psychological trauma by physical trauma interventions (Weis and Grunert, 2004). Some interventions had to consider only age, religious or cultural appropriateness or any other patient inclination found during diagnosis. Establishing comorbidity was crucial part of interventions in order to understand that the genetic factors may contribute to post-traumatic stress disorder (PTSD). Earliest diagnosis and consideration of specific cases requiring special attention hardly found space and time during interventions. For example; the physical and psychological trauma cases necessitated different amount of time –much as the interventions of one accelerated healing from another – respectively, which this study went on to ascertain.

The protection of patients from further risks was a very critical care aspect. Knowledge of pre-existing psychological disorders provided reliable insights about trauma manifestations and a guide to interventions. Specialized tools, procedures, and clinics were necessary to address the multitudes of those manifestations while routine checks got periodically done overtime by mental-health service providers, and a coordination unit set up by the ministry of health to oversee their administration (Walugembe, 1992). Efficacy was matched with expert knowledge and experience about trauma and modes of intervention. In spite of that, routine checks were made possible by willingness of clients to seek further support and care as well as continued funding, which were hardly viewed as an issue to tackle as well. And while coordinating various operation units during interventions very meaningful, it was not certain whether too many 'cooks did not spoil the broth.' In this study each of those aspects constituted forms of interventions, got measured and compared to yield results to the concerns.

Studies appreciated enormously the role of high professional qualities of health workers in influencing positive treatment outcomes. The strong quality during interventions was avoidance of the blame-games exhibited before the victim or acts in other ways that were unsupportive. These rather increased the risk of developing PTSD or other outcomes. The same guidance could be provided to families or associated caregivers. Giving mental client freedom to say anything on his or her mind, and have them rewarded (or approved, disapproved, or punished), avoiding criticism (or calmness), sympathetic interest and understanding, reassurance, questioning and interpretation were useful approaches during interventions (Dollard and Miller, 1950). Knowledge of responsible and helpful persons enormously helped non-professionals to connect to care providers when a need arose. In such rapidly changing and expansive field of mental health, psychologist and other care-givers needed to update themselves about new assessment and interventions models, to enable proficiency (Weis and Grunert, 2004). Unfortunately, professionalism suffered greatly due to prior motivation package and the poor working environments. How that affected interventions remained an interesting area to this study.

Community System Strengthening (CSS), which was born out of on-going processes of monitoring and evaluation of existing community-based psychosocial interventions, proved very useful as it borrowed lessons directly learned from preceding projects. It emphasized community mobilization rather than assistance; empowered people to restore social cohesion and trust; built community capacity to take care of their health and general wellbeing; and community resilience was enhanced through inviting people to participate in interventions from the very beginning of the exercise, ensuring that the community felt responsible for the changes made, providing information, creating capacity, coordinating structures of organizations, groups and individuals, involving a broad range of community actors, providing space to them to contribute as equal partners, and other activities supportive at community level –including enabling of a responsive environment in order to sustain the benefits. CSS framework consisted of 1) mapping of communities, 2) building networks of support at different levels, 3) development of an action plan based on identified resources and needs, 4) capacity-building of local stakeholders, and 5) specific community activities and service delivery (HealthNet TPO, 2012). On the contrary, a stronger community that was willing to respond to challenges affecting it emerged over time with strong and responsive governance structures, which were defective in many countries. In

this study, management of the different elements within the social system that made it possible to response to traumatic events as the 7/11 was an issue of study.

2.6 Efficacy of Psychological Trauma Interventions

The general acknowledgement was the experience of difficulty involved in measuring efficiency. Cost-enabling was critical way of achieving efficacy (Appleby and Thomas, 2000). Setting of performance indicators is most renowned way of achieving efficacy of interventions; they are set depending on the dire need of affected communities or families. While the United Nations developed its eight millennium development goals, the Afghanistan government demanded more of such goals, inclusive of security improvement (Browne, Fane, and Brown, 2011). The National Framework for Assessing Performance has six simultaneous, very connected aspects to consider in determining performance in health systems work, which included health improvement, fair access (cost), effective delivery of appropriate care, efficiency, patience and care experience, and health outcomes of care. Efficacy delivery measure elements derived from these performance measurements, give considerably reliable elicited information as findings or results (1998). But paper work did not always equal the outcomes, which called for monitoring and evaluation studies as was the aim of this study in its attempt to track and learn from interventions conducted to handle psychological trauma following the 7/11 terror attacks.

The potential benefits of interventions had to exceed the risks involved (Boyce, Et al., 1997). The psychological first aid package was developed to replace debriefing therapeutic options; it involving contact and engagement, safety and comfort, stabilizing (to reduce stress), information gathering (to assess the immediate needs of survivors), practical assistance (to create a situation, in which survivor was in position to solve own problems): connection with social support, coping information (to offer verbal and written information on coping), and linkages and collaborative services (to inform survivors of the services available elsewhere for them) (Uhernik and Husson, 2009). The common aspects of most intervention approaches involved multifaceted models that fostered social support, a preparatory phase, a phase of ‘psychological first aid,’ and a referral arrangement for more severe cases. But while individuals possessed natural abilities to deal with any degree of stress and challenge, they still face problems in functioning normally (Bonano, 2004). The long term support to affected families until they recovered was not a subject of concern for the service providers and managers because of conditions that were

beyond their ability to contain. This study measured the efficacy of interventions to gain proper understanding of the outcomes of the service providers and the client relationships for the period of time support services were given.

In respect to trauma healing process, the victims had to face the pain. Elizabeth Kubler-Ross observed the following supervised realities, and healthy adjustments during the healing process in respect to bereavement or loss: denial and isolation, anger, bargaining with God (so as to live longer), depression (person recognized that he could not recover, felt futile, exhausted, and deeply depressed, and separated from friends and loved ones), acceptance (reached a state, during which they calmly accept death, neither sad nor happy but at peace). Grief began with shock and numbness, yearning for dead person, weeks or months of apathy, dejection and depression, loss of meaning for life, insomnia, loss of energy, appetite, depression, and memories of the dead remained painful, where suppressing them only led to later expressions (Coon, 1985). With respect to that, it was not always easy to control the time and continue be available before clients as the conditions they went through easily caught up with service providers in what emerged as secondary trauma. They (service providers) too required help which was rarely in reach as some guidelines reflected. This study paid its greatest attention on the wellbeing of affected families regardless of what their caregivers went through.

Propranolol and hydrocortisone have been used in the acute phases to prevent posttraumatic stress reactions without conclusions on the preventative effect of medical intervention. Knowledge about natural attenuations was used to foster hope after the quick and effective disaster rescue, relief and reconstructions to counter pessimism and *catastrophising* effect. Collective efficacy and the belief in one's group yielded positive outcomes. People found strength in numbers and the positive expectancy of recovery. Early CBT interventions counteracted negative thoughts; restored self-efficacy, and installed positive action-orientated expectations about the future. Exposure was important to desensitize the nervous system. Many have stated that the visit back to the disaster area had given them a better perspective of events (Heir, Hussain, and Weisæth, 2008). Regardless, there existed diverse knowledge of care and support of families with trauma experiences. Such knowledge was managed by unique experts who were often challenging to coordinate along the clients preferred source of treatment that too

was unlikely to be the cure. In this study, collaboration and teamwork was examined and measured in relation to efficacy of trauma intervention.

Biologically Informed Therapy (BIT) was found to be effective. It focused on processing traumatic experience. Episodic memories were processed and information transferred from the limbic system to the neocortex, and filed away along with other narrative memories. It involved bottom-up processing, which focused on what was going on in the body. This approach helped clients connect with their bodies and with their feelings. It facilitated their learning to tolerate intense feelings, and to release emotion appropriately. Survivors learnt to calm their physiology (Eldra and Heide, 2005). Having the framework for interventions could not be used mean that formal psychological treatments had been carried out, at all. Rather, it was critical that over-treatment did not take place. Research showed that brief, specialized interventions were most ideal. For example; while repeated exposures, alleviated avoidance, it does not happen to all other features of PTSD (Taylor, Et al., 2003). Often issues of physiology predicated much psychological wellbeing yet hardly was multi-tasking an option for consideration as a means of accelerating efficacy of interventions. In this study, changes in the lives of families traumatised by the 7/11 event were identified and measured.

Evidence showed that interventions done in a fertile social context decreased the association between individuals' emotional response and posttraumatic stress –and individuals with high social capital, negative events could become less demanding for individuals' psychosocial resources (HealthNet TPO, 2012). As an outcome of close collaboration between security agencies charged with overseeing new counterterrorism measures meant to deter further terrorist attacks on Americans, several terrorists were brought tried in courts of laws –with aid of extradition treaties among states despite some human rights aspects about them (Wouters and Naert, 2004). These constituted professional knowledge and its application, which yield much desired outcomes. Since human needs were holistic, sustained healing was possible with the provision of both immediate and development needs overtime –alongside physical and psychological trauma support for psychological trauma healing to take greater effect. In this study whatever effort considered in achieving wellness of families affected by the 7/11 was subjected to efficacy measurements to yield to yield validity and reliability of them.

2.7 Conclusion

The five study themes shows sequence of steps taken on the aftermath of traumatic event, reflected in the conceptual framework, using local and international experiences recorded in various texts. However, experiences gained from earlier interventions were the basis of future actions while facing a new tragedy. New experiences had their unique knowledge to offer in addition to what was learned from earlier trauma interventions. And different contexts offered different challenges, which necessitated openness to learn quickly and apply immediately as a matter of urgently –under circumstances were old experiences did not apply. This chapter thus provided strong foundation for researcher to pursue research objectives from informed view point.

CHAPTER THREE:

RESEARCH METHODOLOGY

3.1 Introduction

In chapter three, the researcher provided appropriate procedures about how empirical information would be obtained and managed to yield valid results of the study. With a good research methodology, a decent piece of research would be expected. Decent means resulted in research that was useful in organisational practice and, potentially, met academic standards (Jonker and Pennink, 2003). This study evaluated psychological interventions used to handle psychological trauma after the 7/11 terror attacks. It aimed at establishing whether the participants (affected families) received the benefits they were intended to receive (Weiss, 1998).

3.2 Location of the Study

The study was conducted in Kampala City. It attained district status in 1979. It had a total coverage of 189 kilometres squared, in southern region of the country, and on the northern shores of Lake Victoria. It was administratively divided into 5 divisions, namely; Rubaga Division, Nakawa Division, Makindye Division, and Central Division. Night population was 774,241 in 1991 (Statistical Abstract 1997 in Ministry of Finance, Planning, and Economic Development, 2000). A number of neighbourhoods are curved out of Makindye Division, which included: Kibuye, Kabowa, Lukuli, Luwafu, Nsambya, Kansanga, Muyenga, Ggaba, Munyonyo, and Kabalagala, a centre for Kampala nightlife. Ethiopian Bar and Restaurant where one of the terrorists activities occurred, is located in Kabalagala while the victims of the 7/11 terror attacks are spread in all the sub-divisions (Wikipedia, 2012).

The population was composed of mainly young people (40.3%) above 15 years and 67% under 24 years (The 1991 population and housing census cited in Ministry of Finance, Planning, and Economic Development, 2000). Kampala's population was estimated to be 1,660,000 (mid-year 2010 projections; with a total health units 873; government (26), NGO (22), and private (825), nearest distance to health centres (5 kilometres); and total number of hospital beds (2153), according to the 2010 statistical abstract and the Kampala District Development Plan Financial Year 2006/07-2008/09 cited in Atukunda (2011). The Uganda Demographic and Health Survey

(2006) cited in Ministry of Finance, Planning, and Economic Development (2000), revealed that fertility rate was still high over the last 3 decades: at 6.7 children per woman.

Indeed, according to Ssekabirwa (2010), most of the dead were in the prime of their years. They were a youthful category of Ugandans living independently living in and around the Kampala City. The city was mainly a business, administrative, and entertainment centre, whose elite lived close-by, and the rest of the population either in the slummy areas or in fast developing districts around it such as Mukono, Wakiso, Mpigi, and Luwero, where mostly middle class indigenous families established permanent homes. Some residential areas like Naguru, Muyenga, and Kololo, hitherto, were referred to as "rich man's areas" (Mutabazi, 2012). Families went to the Kampala City to work, shop, and for entertainment purposes. The Districts such as Wakiso, Mpigi, and Mukono shared greater sections of it (Kampala District).

The 7/11 bombs were detonated at Kyandondo rugby facility and the Ethiopian village bar and restaurant. The rugby facility was situated on approximately 7 acres (2.8 hectares) of greenbelt-designated, sports-specific land, just 5 minutes drive from the centre of Kampala, the Club boasts the only internationally-approved size, double pitch ground in the country, and the whole region (Kyadondo Rugby Ground, 2012). Ethiopian Village Bar and Restaurant was predominantly visited by foreign nationals (Eritreans, Ethiopians, and Americans), and only a handful of their Ugandan friends and staff. For the last 17 Years Ethiopian Village provided quality Ethiopian and international cuisine to our discerning customers (Ethiopian Village Bar and Restaurant, 2012).

3.3 Study Design

It was a descriptive exploratory study design that employed both quantitative and qualitative methods to measure, identify, analyze, and explain nature of variables. Descriptive exploratory study aimed at seeking the nature of variability with a group for a given trait (Black, 2002). Descriptive statistics were recommendable, when describing and discussing data, more generally and conveniently (Texas State Auditor's Office, 2012). Good descriptive research was capable of answering 5 basic 'W' questions such as who, what, why, when, and where—and an implicit sixth question, so what? Descriptive statistics aimed at describing the state of affairs as at the present while explanatory research went beyond description to explain the reasons of the

phenomena that descriptive research observed (Eisten College, 2012). Qualitative research was very important at spelling how humans arranged themselves in their natural settings (Berg, 2000). The quantitative and qualitative methods validated study outcomes of each other (United Nations World Food Programme, n.d.).

3.4 Study Population (N)

An estimated 1640 people occupied Ethiopian Village Bar and Restaurant (140 seat counts) and the back space of Kyadondo Rugby Club (1500) when terrorists struck Kampala City on July 11th 2010. Revelers came from different places around the country. Cochran (1977) cited in Bartlett, Kortrik, and Higgins (2001) suggested estimation of the population size assisted by some logical mathematic results and use results from previous studies. The 15.84% of the population size (1640) represented the estimated Kampala City population size that this study was intended for. The Kampala City population size of 7/11 victims was 266. Thus, N = 266.

3.5 Sample Size Estimate (n)

The researcher used a sample size estimate (n = 160) as the representative sample of 266 population size. But considering the Kampala Population alone, a simplified formula for proportions proposed by Yamane (1967:886) cited in Glenn (2012) was used.

$$n = \frac{N}{1 + N(e)^2}$$

$$\frac{266}{1+266\ (0.05)^2}$$

$$=159.7598$$

Ine sho $= 160$ (Rounded off)

3.6 Sampling Method

Sampling methods entailed possible yet suitable ways, through which participants were selected to take part in the study. These were purposive sampling and snowball sampling. Purposive sampling method for all participants was used to select research participants (not less than 14 years). Kerlinger (1986) explained purposive sampling method as one type of non-probability sampling, which involved deliberate effort to obtain samples by including typical areas or groups

of samples. Snowball rolling was applicable to all participants in the circumstances, where victims of the 7/11 did not have defined locations or residences, from among the vast city population. Under it, existing subjects volunteered to recruit future subjects (Kerman Knowledge Hub for HIV Surveillance and Zagreb WHO Collaborating Center, 2009). The study employed participants no more than 5 per family.

3.7 Data Collection Methods, Sources, and Research Instruments

In respect of the quantitative and qualitative data collection methods, interviews and interpretative observations were made. Data sources sought were both primary and secondary data, allied to the study, and suited for the specific study themes. Research instruments employed were personal interview, key informant interviews, and secondary literature reviews. Personal interview researcher-guided, structured questions –with semi structured section were used to seek responses on the following themes: nature of trauma, using the DSM-IV-TR (Wikipedia, 2010) and (World Health Organisation, 2013); levels of preparedness of service providers; forms of interventions; their appropriateness, using the views of (Neil, 2011). The efficacy of interventions applied to handle psychological trauma used aspects of the NHS Performance Assessment Framework (Department of Health, 2009). Qualitative notes were taken for analysis, interpretation, and presentation of findings. A total 150 participants participated in this study.

Service providers, relevant to the subject of study, were sought to answer questions under the theme: preparedness of service providers. Interviews involved asking semi-structured questions, to elicit quantifiable data; and were reinforced through probing, prompting to collect deeper information, and active listening to make sense of what was being said (Kafeero, 2011). Any additional information, of interest to the study, was written down for future considerations during data management. Researcher considered 10 key informants for the study. Below are agencies from which key informants were picked.

Document reviews and analysis as a qualitative instrument was employed to collect information regarding the 7/11 terror attacks. Archives such as newspapers, books, videotapes, drawn comics, maps, and so forth, were credible sources of data (Berg, 2001). And visual ethnographers suggested the importance of photographs as means for providing contextual information, and significant got attached to them (Musello, 1980; Schwartz ,1989 cited in Berg,

2001). The researcher used thematically relevant materials to compliment and validate quantitative results.

3.8 Data Control

Ensuring data quality was an integral part of the research process. It not only presented the means, through which to obtain valid and reliable data, but eventually helped to meet that objective. Pre-testing of research instrument (questions) was done on potential respondents to enhance validity and reliability of the research instrument. Researcher piloted 5 families, and anomalies found were subsequently corrected –including the vague and ambiguous questions. Instruments were shown to the would-be respondents and to the supervisors. The feedback from them was analysed so that clear and consistent questions remained for consideration into the final research instruments (Punch, 2000). Ensuring quality data required planning clear goals, objectives and questions, pre-testing methodologies, quality data checks, complete forms, clear writing, consistent answers, correct tallying, covering of all elements of interest, completing of all sets of data for each element, testing of instruments to ensure validity and reliability, and time management (Kafeero, 2011). Also, pilot studies (or pretesting) played pivotal roles of improving research data collection routines, trying scoring techniques, revising locally developed measures, checking for appropriateness of standard measures, and providing additional knowledge that led to improved research (Borg and Gall, 1989). The researcher sought descriptive validity, or an accurate accounting of events that most people including participants similarly observed and would find accurate. It was possible that qualitative approaches could have a feel of other approaches. Particularly descriptive statistics provided an accurate and valid representation of variables, relevant to the research questions (Van Wyk, 2012). The outputs were revised and peer reviewed to reduce as much calculation errors as possible, and to ensure consistence with the study objectives.

3.9 Procedure

An introduction letter was sought from the department identifying with the researcher, stipulating his motive, and calling for participant cooperation. The in-charge of organizations and household heads, under-which respondents worked and lived were met first, issued with a letter of introduction or identity card and, complimentarily, verbally requested for their permission to speak to respondents.

A sampling frame was obtained from relevant organizations and agencies concerned with interventions on the aftermath of 7/11 terror attacks in Kampala. For this particular study, the Uganda Police Force (UPF), Uganda Red Cross (URC), hospitals, Refugee Law Project (RLP), Interaid Uganda, media houses, and referrals by key community persons were sought for clues about the identity and location of victims and their families. The frame included all persons and places that qualified or were seen fit to participate or be included in the study. The sample was selected from the listed, eligible population on the sample flame. Using purposive and snowball rolling selection strategy established sample size (150) was obtained, and interviewees, one at a time, got interviewed. The researcher conducted face-to-face interviews. The interview commenced with brief introduction led by researcher, indicating the purpose of the study. And thereafter sought interviewee consent and assured them of confidentiality. From here, the researcher proceeded to read the questions clearly to elicit responses from given list of options to every sub-unit question.

3.10 Data Processing and Analysis

Data processing involved clarity-seeking, creating of sub-categories to be critically examined, editing, coding of series of responses under sub-categories, data entry, and revision of data-sets to rid them of errors and non-representation. Data analysis was quantitatively and qualitatively done. The quantitative approach was used find out levels of prevalence of cases, and to examine differences and homogeneity among categories. Qualitative analysis was used to provide non-numerical incidences and explanations of unit cases under study, in most simple and understandable manner.

Quantitative row data was coded and entered into the statistical package for social scientists (SPSS) using a 1 to 4 scale (1. Yes; 2. No; 3. Don't Know; and 4. Not Applicable) for questions under the 1 and 3 study objectives; and 2-scale (1. High; 2. Low; 3 Neither High Nor Low; 4. Not Applicable) for objective 2. The scale for objective 4 (the nature of trauma), the coding was: 1. Appropriateness; 2. Inappropriateness; 3. Neither Appropriate nor Inappropriate; and 4. Not Applicable. While for objective 5, was: 1. Efficacy; 2. Inefficacy; 3. Neither Efficacy nor Inefficacy; and 4. Not Applicable. A combination of SPSS and Microsoft Office Excel were used to generate statistical graphs, by having frequencies of sub-itemed tables of the major categories

developed in SPSS in Excel. Tabulation with the help of computers saved time and made it easy to study large number of variables affecting the problem systematically (Kothari, 2004). It involved summing up the frequencies, dividing each unit frequency by the sum, and multiplying it (each unit) by 100%, to all the 5 questions, in order to obtain percent distributions.

Field notes were summarized along with relevant photographs, opinions, and case studies. The data that proved excellent at providing information comprehensively consistent to the 5 objectives or categories got sorted out and were subsequently presented as findings, where it was absolutely necessary. The vital information matched to the categories had to have the highest intensity of providing a consistently 'yes' meaning and answer to the research questions in order to be included.

3.11 Ethical Considerations

An authorization letter from the research unit coordinator of the MA Peace and Conflict Studies Programme, in the Department of Religion and Peace Studies, was obtained seeking agreement with organizations and agencies associated with the study to embrace it.

Basically, informed consent was seen as a major determinant of the ethicality of research (Blanche, Durrheim, and Painter, 2006). Respondents were considered to participate in the study after seeking their due consent from to participate in the study while children below 18 years were only allowed to get involved after seeking permission from their parents. Participants who declined to participate in the study after consenting to doing so were allowed to withdrawal from it.

The costs and benefits were communicated to participants before conducting the interviews, indicating the burden and safety concerns that could result from the study, and how the study would benefit participants over a given period of the time.

The researcher indicated commitment to use information provided by respondents for research purposes only, and their identity was not revealed or shared with any other person other than the respondent. The interview guide made it optional for respondents to provide their names to the interviewer. This helped to reduce their fears of reprisal by security agencies.

The findings were disseminated at the end of the study before an academic supervisor, a vetting panel at an international conference, and published to help better decisions at national regional and global levels for sustainable peace.

3.12 Merits and Demerits of the Study

The main advantage of this form of study was the personal enriching experience with 7/11 victims, survivors, and their families. The victims and survivors were so scattered all over the central region of the country, across the country and globe that locating them caused a lot of uncertainty and time wastage. Besides, accessing information from affected families was very challenging. The research used past records to find the names and locations of victims and survivors of the 7/11 bomb attacks, exploited face book system, and referral system from peers and agencies that worked closely under them while those who refused to answer were left out of the study as an ethical consideration. And by limiting the study to Kampala District, research process was made easier.

CHAPTER FOUR:

PRESENTATION OF FINDINGS

4.1 Introduction

In chapter four, analyses of data were affected, presented and, respectively, interpreted in follow-up of the questions, using quantitatively-generated descriptive statistics, qualitative findings relevant to the study themes, and categorically-linked information from document analysis, applicable and with consistent to the personal interview results to the themes, were selected and applied. The study's aim was to establish the nature of trauma suffered, to establish the levels of preparedness of service providers, to identify the forms of interventions applied, to assess appropriateness of interventions, and to assess the efficacy of interventions.

4.2 Background Data about the Sample

The background data about the sample provides contextual information about the study, from which study findings were eventually obtained. It consists of both affected families and service providers. Data was collected using interviews (See Tables 1-8 below).

Table 1 Age of Respondents:

Age groups	Frequency	Percent
14-23	46	30.7
24-33	81	54.0
34-43	11	7.3
44-53	6	4.0
64+	6	4.0
Total	150	100.0

According to the table above, the youthful age was 84.7%. Most of the victims were 24- 33 years (54%) fairly more than other age categories, indicated by 14 – 23 (30.7%); 34- 43 (7.3%), 44 – 53 and 64^{+} (4%).

Table 2 Sex of Respondents:

Gender	Frequency	Percent
Male	86	57.3
Female	64	42.7
Total	150	100.0

In the table above, quite more males (57.3%) than females (42.7%) participated in the study.

Table 3 Religious Affiliation of Respondents:

Religious Affiliation	Frequency	Percent
Muslim	32	21.3
Christian	117	78.0
Other	1	.7
Total	150	100.0

The illustration in the table above showed the majority of respondents being Christians (77.3%); Muslims (21.3%); and other (0.7%).

Table 4 Nationality of Respondents:

Nationality	Frequency	Percent
Ugandan	121	80.7
Ethiopian	8	5.3
Eritrean	17	11.3
American	3	2.0
Other	1	0.7
Total	150	100.0

The majority of the respondents were Ugandans (80.7%), indicated by a constituency of victims having: Ugandans (80.7%); Eritreans (11.3%); and Ethiopians (5.3%); Americans (2%); and Other (0.7%). That was indicated in the table above.

Table 5 Levels of Education of Respondents:

Level of education	Frequency	Percent
Degree	66	44.0
Diploma	13	8.7
UACE	25	16.7
Vocation	21	14.0
UCE and below	25	16.7
Total	150	100.0

From the table above, the degree honors-level education (44%); diploma (8.7%); Uganda Advanced Certificate of Education [UACE] and Uganda Certificate of Education [UCE] and below (16.7%); and vocation studies (14%). From these, the degree holders were majority (44%).

Table 6 Occupation Levels of Family Heads:

Occupation	Frequency	Percent
Self-employed	68	45.3
Junior Staff	35	23.3
Senior Staff	16	10.7
Unemployed	31	20.7
Total	150	100.0

Over all the working class were 79.3%, showed by respondent composition of: self-employed (45.3%), junior staff (23.3%); senior staff (10.7%); unemployed (20.7%). That was indicated in the table above.

Table 7 Family Size of Respondents:

Family size	Frequency	Percent
0-3	87	58.0
4-6	50	33.3
7-9	10	6.7
10+	3	2.0
Total	150	100.0

The family size of the respondents indicated smaller sized families of affected families (58%). The family sizes of respondents constituted the following: 0-3 (58%); 4-6 (33.3%); 7-9 (6.7%); and 10^{+} (2%). That was indicated in the table above.

Table 8 Marital States of Respondents:

Marital Status	Frequency	Percent
Married	9	6.0
Single	126	84.0
Cohabiting	4	2.7
Divorced	9	6.0
Widow	2	1.3
Total	150	100.0

There were 84% of the respondents were single; married and divorced (6%); cohabiting (2.7%), and widowed (1.3%). The single stature unit was highest (84%). That was indicated in the table above.

4.2.1 Background Data from Service Providers

Background data hereunder was obtained from key informant interviews (See Table 9-16) below:

Table 9 Ages of Service Providers:

Age	Frequency	Percent
24-33	5	50.0
34-43	3	30.0
44-53	2	20.0
Total	10	100.0

From the table above, 50% were between 24-33 years more than the year's category above: 34-43 (30%) and 44-53 (20%).

Table 10 Sex of Service Providers

Gender	Frequency	Percent
Male	5	50.0
Female	5	50.0
Total	10	100.0

According to the table above, service provider males (50%) were equal to females (50%).

Table 11 Religious Affiliation of Service Providers:

Religion	Frequency	Percent
Muslim	1	10.0
Christian	9	90.0
Others	0	00.0
Total	10	100.0

From the table above, Christians were majority (90.9%) more than Muslims (9.1%).

Table 12 Nationality of Service Providers:

Nationality	Frequency	Percent
Ugandan	10	100.0
Ethiopian	0	00.0
Eritrean	0	00.0
American	0	00.0
Other	0	00.0
Total	10	100.0

From the table below, all service providers were Ugandan nationals (100%).

Table 13 Level of Education of Service Providers:

Education	Frequency	Percent
Degree	8	80.0
Diploma	0	00.0
UACE	1	10.0
Vocation	10	10.0
UCE and Below	0	00.0
Total	10	100.0

From the table above, 80% of the service providers were degree holder and above; UACE and Vocational Studies Certificates Level shared the remainder 10% each.

Table 14 Occupation Levels of Service Providers:

Occupation	Frequency	Percent
Self-employed	0	00.0
Junior Staff	5	50.0
Senior Staff	5	50.0
Unemployed	0	00.0
Total	10	100.0

From the table above, 50% of the service providers were senior staff, and 50% junior.

Table 15 Family Size of Service Providers:

Family Size	Frequency	Percent
0-3	4	40.0
4-6	5	50.0
7-9	1	10.0
Total	10	100.0

Slighted more service providers had larger family sizes 4-6 (50%) than 0-3 (40%), and 7-9 (10%).

Table 16 Marital States of Respondents

Marriage Status	Frequency	Percent
Married	9	90.0
Single	1	10.0
Cohabiting	0	00.0
Divorced	0	00.0
Widow	0	00.0
Total	10	100.0

From the table above, 90% of the respondents were married; only 10% not.

4.3 Establishing Nature of Trauma Suffered

4 items (exposure to traumatic event, re-experiencing traumatic event, avoidant of situations similar to the traumatic event, and significant impairment) constituted psychological trauma category of the nature of trauma theme, while 3 items (Dead, Injured, and No Injuries) represented physical trauma category of the same theme. These got analysed and findings were presented as follows:

Table 17 Nature of Psychological Trauma

Psychological Trauma: DSM IV Items	Responses	Frequencies	Percentages
1. Exposure to Psychological Trauma	1. Yes	149	99.3
	2. No	1	0.7
2. Re-experiencing Psychological Trauma	1. Yes	142	94.7
	2. No	8	5.3
3. Avoidant Behaviour	1. Yes	141	94.0
	2. No	9	6.0
4. Significant Impairment	1. Yes	140	93.3
	2. No	10	6.7

Scores on DSM Items 1-4:

Exposure to traumatic events was yes (99.3%) and no (0.7%), henceforth, very high. That was indicated in the table above. Re-experiencing of the traumatic event was yes (94.7) and no (5.3%). Avoidant-type characters were yes (94%) and no (6%). Respondents who showed structured dysfunctional aspects (significant impairment) were yes (93.3%) while those who did not: no (6.7%).

Qualitative Findings: Nature of Psychological Trauma Suffered

1. Exposure to Traumatic Event:

The injuries ranged from very severe, severe, to minor injuries. The incident was very tragic, had to imagine, and to tell by affected families as an unidentified survivor responded below.

> *"The International Hospital Kampala (IHK) was filled with bloodied bodies; my brother was severely injured. ...I was coughing blood. I realized later on that I had been hit by fragments in my groin areas, and felt pain only after 30 minutes. My brother asked to know where I was. He was able to locate me right next to him. He held my arm firmly. But suddenly his hand slipped off. I felt he had died, but the medics kept it a secret. My other brother was killed while running away by the second bomb."*–Survivor: Naguru, Kampala.

The immediate reaction was confusion, emotionless; in a long run was failure to speak about it and getting irritated by noise and crowds. It prompted families to move homes to avoid bad memories, and foreigners to subsequently leave the 'troublesome' country while some Ugandans were forced to change residences from the experiences as narrated by a survivor below:

> *"I sustained injuries on the head and leg, skull got cracked and nervous system damaged, and I could not walk for 5 months. I felt bad like for the first 3 months. Sounds and noise cause flashbacks and discomfort. I remember a girl lying on the floor with open tummy asking me for help. I avoid using Nakawa route to town; it reminds me about the horror". –* Survivor: Ntinda, Kampala.

4.4 Establishing Levels of Preparedness of Service Providers to Handle Psychological Trauma

The ten (10) items, including: availability of paid and unpaid staff, setting up of functions and services, trained and prepared institutional staff, availability of multiple communication tools, training staff and stakeholders, identification of partners to share resources, documentation and accessibility of information, emergency payment options, early warning, and observance of ethical issues; were measured, analysed and presented below, dominantly constituting 2-levels scale (1.High Preparedness, 2. Low preparedness):

Table 18 Levels of Preparedness of Service Providers

Items for Levels of Preparedness	Responses	Frequencies	Percentages
1. Readiness of Staff: Paid and Unpaid Staff	1. High 2. Low	9 1	90.0 10.0
2. Readiness of Essential Functions	1. High 2. Low	9 1	90.0 10.0
3. Availability of Trained and Prepared Institutional Staff	1. High 2. Low	7 3	70.0 30.0
4. Multiple Communication Tools	1. High 2. Low	9 1	90.0 10.0
5. Training for Staff and Stakeholders on Preparedness	1. High 2. Low	8 2	80.0 20.0
6. Existence of Multiple Communication Tools (Media)	1. High 2. Low	9 1	90.0 10.0
7. Collaborative training of staff and stakeholders	1. High 2. Low	8 2	80.0 20.0
8. Identifying of Partners for Resources Sharing before Hand	1. High 2. Low	8 2	80.0 20.0
9. Documentation and Accessibility of Vital Information	1. High 2. Low	10 0	100.0 00.0
10. Knowledge of Emergency Payment Options	1. High 2. Low	6 4	60.0 40.0

From the table above, paid and unpaid staffs were readily available, indicated by high preparedness (90%); only 10% indicated: low preparedness. There was a greater indication of essential functions (tools) and services set on high preparedness (90%) against low preparedness (10%). The existence of trained and prepared staff indicated: high preparedness (70%) against low preparedness (30%). The item of conducting of collaborative training of staff and stakeholders indicated: high preparedness (80%) against low preparedness (20%). The identification of partners, with whom to share resources indicated: high preparedness (80%)

against low preparedness (20%). Documentation and accessibility of vital information was excellent and indicated: high preparedness (100%) against none.

Qualitative Findings: Levels of Preparedness of Service Providers

1. High Preparedness:

High preparedness was depicted in many other aspects such as security. Security units showed high preparedness. In light of that, a survivor cop recalled:

> *"…As security personnel at the scene, I called for police vehicles to remove the dead. The exercise of removing dead bodies ended at 2am. The police and the UPDF were the first at the scene. There is extra security at the borders and screen whoever enters. Security is not represented by the visible men and women in uniform only. Police came after 20-30 minutes. The police was the first on the scene. …Police shoved off the bomb scene to open ground for investigations."*

Different institutions had specialized workforce to meet special needs of victims, among which were international non-government organizations. A psychosocial worker from Interaid Uganda revealed that: *"refugees were attended to by relevant non-government organisation namely UNFCR, Interaid, and refugee law society. Refugees complained of social exclusion and threats from public because of the resemblance with Somali people."*

Some of the media personalities were victims. This made it easily to swiftly share information and prompt public engagement in interventions and safety issues. Equally a journalistic action of writing own stories were mentally redeeming (desensitising): *"I took several of the photos and wrote a report, which was desensitizing enough."*–Service provider: Kampala.

There was community readiness, involvement, and willingness to support victims. Mami Mengashi, Survivor and Proprietor: Ethiopian Village Bar and Restaurant, Kabalagala, Kampala, was quoted: *"management rang International Hospital Kampala, who rushed in to help. The public was very good to us; they came to participate in the rescue process…"* The individual survivors, who before rescue workers arrived, did the evacuation of the injured and phone-called service providers for superior support, a reveler and a member of the Uganda Police Force confirmed: *"those who survived started helping.*

2. Low Preparedness

The service providers' performance left a lot to be desired, in order to be prepared. The extent of the tragedy was so overwhelming that facilities got overstretched. But within the limited resources service providers gave everything within their means to help victims, as indicated by a senior representative of a private medical facility (IHK), M/s. Hellen Mbabazi, below:

> "*…we did not have volunteers. We were inadequate in responding to the tragedy. New protocols had to be devised to cope with such an overwhelming response. Medical facility was not well equipped as the only equipment to use was the MRI scan, which was only at the Kampala Imaging Center. …we treat all the 45, apart from a case of aggravated head injury."*

Low preparedness was indicated by service providers in regards to readiness of essential functions and services: "*Services were provided to those who needed them. It was impossible for all people to receive what they needed."* –A service provider and survivor in Kampala.

Service providers were overwhelmed by the high cases of emergences cases and having to work extraordinarily hard to save lives, and seeing some of the victims die in their hands. Their experience too was very traumatic. A collaborative engagement with mental health professionals to support health care providers distressed by the nature of work was not adequate to help quell aftershocks of interventions such as psychological distress and mental exhaustion, as indicated by Mayanja Bryan, a medical worker in 2011 below:

> When I got to ICU, it was full to capacity; it had never been that full. It normally accommodates about 11 people. We already had patients and when they brought the 17 bomb victims we had 24 patients in ICU. There was blood everywhere. We had to bring in beds from other floors and stretchers were stationed in Casualty and ICU to work as beds. …we kept on changing the life-support machines from time to time; ensuring the most critical were given utmost attention [http://www.monitor.co.ug/SpecialReports/-/688342/1198430/-/uvsq0q/-/index.html *accessed on* September 12th, 2011].

Low preparedness: the 7/11 event yielded more questions than answers. The traditional value systems pertaining to every victim were not considered as bases of interventions. There was not space and time to do so, as service provider revealed: *"…because of the emergences nature of the cases, most technical and ethical issues needed for effective interventions were omitted. Service providers were challenged by the extent of the tragedy."*

4.5 Identifying Forms of Psychological Interventions

Eleven forms of interventions were identified, measured, analysed and presented as follows:

Table 19 Forms of Psychological Trauma Interventions

Items for Forms of Intervention	Responses	Frequencies	Percentages
1. Medical Intervention	Yes	136	90.7
	No	9	60.0
	Don't Know	2	1.3
	Not Applicable	3	2.0
2. Psychological care and support Intervention	Yes	83	55.3
	No	67	44.7
3. Financial aid / Compensation	Yes	125	83.3
	No	24	16.0
	Don't Know	1	0.7
4. Cultural Aspects of Interventions	Yes	75	50.0
	No	72	48.0
	Don't Know	2	1.3
	Not Applicable	1	0.7
5. Religio-spiritual Forms of Intervention	Yes	144	96.0
	No	6	4.0
6. Family-level Forms of Intervention	Yes	146	97.3
	No	4	2.7
7. Group (of significant others)-level Form of Intervention	Yes	141	94.0
	No	8	5.3
	Don't Know	1	0.7
8. Community-level Form of Intervention	Yes	124	82.7
	No	24	16.0
	Don't Know	2	1.3
9. Security and Peace Form of Intervention	Yes	125	83.3
	No	22	14.7
	Don't Know	3	2.0
10. International-level Interventions	Yes	119	79.3
	No	19	12.7
	Don't Know	12	8.0
11. Legal forms of Interventions	Yes	82	54.7
	No	47	31.3
	Don't Know	21	14.0

From the table above, the scores for psychological form of intervention were: yes (55.3%) and no (44.7%). Only 55.3% received the psychological care and support form of intervention. The financial form of intervention had the following scores: yes (83.3%); no (16%); and not applicable (7%). Financial form of intervention was highest at 83.3%. The scores for cultural forms of interventions were: yes (50%); no (48%); don't know (1.3%); and not applicable (7%). Barely 50% of the respondents received culturally-tailored forms of intervention. The scores for religious forms of intervention were as follows: yes (96%) and no (4%). A religious effort to comfort bereaved families and to secure survivors was very high (96%). The family-level forms of interventions were popular indicated by yes (97.3%) in contrast to no (2.7%). Group-based form of interventions indicated yes (94%) for group-level support provided; no (5.3%); and don't know (0.7%). Community-level form of intervention indicated: yes (82.7%); no (16%); and don't know (1.3%). Community effort to save lives and support victims was high (82.7%). Security and peace provided was rated as follows: yes (83.3%); no (17.7%). The international-level interventions scores were: yes (79.3); no (12.7); and don't know (8%). And the expressions of the law having taken its course were: yes (54.7%); no (31.3%); and don't know (14%).

Qualitative Findings: Forms of Psychological Trauma Interventions

1. Yes: Positive Response (s) for the Forms of Psychological Trauma Interventions

Multi-stakeholder involvement) of mainly psychosocial workers, medical, police, and media was indicated yes, quoted from the findings by Ntulo, Mugherera, and Ndyanabangi (2010) that:

> Psychosocial services [were made available] at BasicNeeds premises, St Francis Hospital at Nsambya, and Mulago Hospital - Bossa Mental Health Unit, the ICU, wards and the Accident and Emergency Department. Other agreed upon sites included the New Vision newspaper offices (for the media staff), AAR, IHK (staff and in patients), Butabika Hospital Psycho-trauma Unit and at the ERU for the police [p.87].

The International Hospital Kampala was one of the referral hospitals where victims were sent for critical trauma support without being monetarily charged. Mami Mengashi, Survivor and Proprietor of Ethiopian Village Bar and Restaurant noted: *"Management rang International Hospital Kampala rushed in to help. The public was very good to us; they came to participate in the rescue process."*

There was high security involvement. The government relentlessly prevented further terrorism against its already vulnerable population despite difficulties in guaranteeing 100% security as an

outcome of the provocation from terrorists. Asuman Mugenyi, police spokesperson in an article posted by Birungi (2012), Uganda Picks (http://www.ugandapicks.com/2012/07/july-11th-kyadondo-bombings-road-down-memory-lane-76925.html) was quoted below:

> [Terrorism] threat is still a major security concern to our country and it is a growing problem which is affecting the world not only Uganda. It destroys life and property. The Uganda Police supported by other sister security agencies have increased visibility not only in Kampala Capital City but the country at large in form of foot, motorized patrols and general vigilance to prevent any possible terrorist attack.

2. No: Negative Response (s) for Provision of Psychosocial Services

There was limited influence of psychosocial support. The relevancy of psycho-therapy is unknown to most Ugandans. Unconventional therapies were most powerful because of non recognition of psychological forms of intervention by government as told by Mwebaze Crescent: Administrative Assistant, Uganda Counseling Association (UCA) that: *"Government does not recognize psychological interventions."*

Poor health-seeking behavior was very characteristic of victims, without physical injury. They felt no need and importance for seeking psychosocial support, despite their maladaptive states as was told by an Ethiopian survivor: *"…sometimes I feel depressed and bad about what happened, but what could I do. I could not waste time to see psychologist because they would not change anything."*–Survivor, Kabalagala, Kampala.

4.6 Assessing Appropriateness of Psychological Trauma Interventions

A constituency of 10 items under this theme were analysed (See Table 20) below.

Table 20 Appropriateness of Psychological Trauma Interventions

Items for Appropriateness of Interventions	Responses	Frequencies	Percentages
1. Service Delivery System	Appropriateness	99	66.0
	Inappropriateness	42	28.0
	Neither	6	4.0
	Not Applicable	3	2.0
2. Handling of Emotional and Psychological Pain	Appropriateness	68	45.3
	Inappropriateness	81	54.0
	Neither	1	0.7
3. Dealing with Physical Damage (injury) and Pain	Appropriateness	92	61.3
	Inappropriateness	28	18.7
	Neither	13	8.7
	Not Applicable	17	11.3
4. Cultural Appropriateness	Appropriateness	68	45.3
	Inappropriateness	76	50.7
	Neither	1	0.7
	Not Applicable	5	3.3
5. Religious Appropriateness	Appropriateness	126	84.0
	Inappropriateness	22	14.7
	Neither	2	1.3
6. Follow-up of Cases after Discharge from Care	Appropriateness	31	20.7
	Inappropriateness	91	60.7
	Neither	5	3.3
	Not Applicable	23	15.3
7. Compensating Victims for the Losses Incurred	Appropriateness	101	67.3
	Inappropriateness	42	28.0
	Neither	1	0.7
	Not Applicable	6	4.0
8. Sufficiency of the Compensation Package	Appropriateness	38	25.3
	Inappropriateness	81	54.0
	Neither	1	0.7
	Not Applicable	30	20.0
9. Administration of Justice	Appropriateness	29	19.3
	Inappropriateness	106	70.7
	Neither	13	8.7
	Not Applicable e	2	1.3
10. Exhibition of Professionalism	Appropriateness	119	79.3
	Inappropriateness	19	12.7
	Neither	12	8.0

From the table above, delivery of support services to the victims was fair indicated by scores: appropriateness (66%); inappropriateness (28%); neither appropriateness nor inappropriateness (4%); and not applicable (2%). The appropriateness of dealing with emotional and psychological

pain scored appropriateness (45.3%); inappropriateness (54%); and not applicable (0.7%). The scores for handling physical injury and pain were as follows: appropriateness (61.3%); inappropriateness (18.7%); neither appropriate nor inappropriate (8.7%); and not applicable (11.3%). Reduction of physical pain and injury was quite good (61.3%). Culture norms and cultural appropriateness to selected healing practices scored appropriateness (45.3%); inappropriate (50%); neither appropriateness nor inappropriateness (0.7%); and not applicable (3.3%). A cultural role to healing was very poor (45.3%). Religious appropriateness was indicated by the following scores: appropriateness (84%); inappropriateness (14.7%); and not applicable (1.3%). Follow-up after discharge accounted for only appropriateness (20.7%); the scores were inappropriateness (60.7%); neither appropriateness nor inappropriateness (3.3%); and not applicable (15.3%). Compensation for the losses caused accounted for appropriateness (67.3%); inappropriateness (28%); neither appropriateness nor inappropriateness (0.7%); and not applicable (4%). Sufficiency of the compensation funds accounted for (25.3%); inappropriateness (54%); neither appropriateness nor inappropriateness (7%); and not applicable (20%) as indicated above. The confidence in the administration of justice was so low at appropriateness (19.3%); inappropriateness (70.7%); neither appropriateness nor inappropriateness (8.7%); and not applicable (1.3%). Professionalism of service providers was indicated by appropriateness (60%); inappropriateness (12.7%); neither appropriate nor inappropriateness (15.3%); and not applicable (12%).

Qualitative Findings: Appropriateness of Psychological Trauma Interventions

1. Appropriateness

There was an indication of a combination of medical and psychological therapies as being most appropriate: *"I was unconscious after the blasts; I was treated by both a physician and a psycho-therapist. The therapies took me back to the scene a number of times during my recovery. I do not avoid places or anything that remind of the tragedy."*–Ntalo Julius, Kampala.

Psychological services were provided concurrently with first aid and treatment by the Uganda Red Cross society. *"I was helped by counseling and prayer. …we sought spiritual strength and healing,"* noted one of the victims in Naguru suburb, Kampala.

Religion was important part of healing as it facilitated the release of negative emotions from the loss of their loved ones ad subsequently felt better. *"Religious groups organised memorial services,"* said one of the victims in Naguru, Kampala.

2. Inappropriate

It was common to find victims off the treatment regime for reason ranging from costs of treatment to accelerated trauma condition:

> *"Patients dropped off treatment regimes without official discharge by health professions; they felt better being out of the hospitals. Overtime hospital life became so painful, so constraining and costly that patients could not sustain it anymore."*–Service provider: Muyenga, Kampala.

There was impropriety in handling dead and injured victims. A survivor: in Naguru, Kampala said:

> *"Some people died along the way to hospital as police rushed them to hospital. The injured victims under the seats of patrol vehicles [on the bare metal floor], and roads trained efforts to transport victims to hospitals due to too many potholes. Ambulances were without trained personnel, no trained first aiders. Police came after 20-30 minutes."*

The media was remembered for exaggerating stories and misrepresenting victims and their families. *'Media has been most torturing,'* a sister to the dead victim said. And on separate incidences another respondent said, *'television (TV) exposure overwhelmed the extent of the problem."*

There were concerns of bodies of the injured laying on the floor unattended to; there was perceived sense of negligence, the security personnel were hostile: *"Bodies of the injured were lying on the floor unattended to. There were considerable levels of negligence. Security personnel were hostile to families as they claimed for the bodies of their loved ones."* –Survivor in Kampala.

The observation from personal interviews showed two (2) bodies being dragged off the ambulance: one by the head, and another by the legs, and moved along the concrete service into the room. This coincided with what one of the victims, Junior, had said, *'my shoulder was*

dislocated because of being mishandled at the mortuary; my arm is now useless, I cannot do anything with it.' When a comment was sought from a client who had had his relative handled by the mortuary verbally shot back: '*bamanyi no gyisamba'* –meaning: they could even kick them (dead bodies). When research inquired why dead bodies were treated that way. He said *'ate oba aba affude*' –meaning: *'after all, he or she would have died.'*

The persisting threats of insecurity in the East African region hampered efforts towards recovery. *'I am still in need of medical attention. I was referred to Nairobi, Kenya, but because of terrorism there, I cannot go there,'* said an Eritrean victim in Kabalagala, Kampala.

3. Neither Appropriate nor Inappropriate

Causality management was poor. Robert Segawa, a severely injured victim lamented: *"I think many people contracted HIV."* And the services offered in the mortuary section left a lot to be desired *"Dead victims were found naked without explanation from mortuary staff."*–Head of bereaved family: Nateete, Kampala.

The police used recovered phones from thieves to call families of the injured and diseased. The items were never handed back to the victims. "*Thieves came and searched dead bodies, stealing bags and phones. The police used the recovered phones to call relatives of the victims,"* a member of the emergence response unit of the police said.

4.7 Assessing Efficacy of Psychological Trauma Interventions

Effectiveness of interventions was defined by 5 items, showing extent of improved wellbeing resulting from intervention done. These items were developed and factored into the study theme (efficacy), and got considered for analysis under the efficacy of interventions theme (See Table 21).

Table 21 Efficacy of Psychological Trauma Interventions

Items for Efficacy of Interventions	Responses	Frequencies	Percentages
1. Easing Emotional and Psychological Pain	Yes	27	18.0
	No	109	72.7
	Don't Know	2	1.3
	Not Applicable	12	8.0
2. Easing Physical Pain	Yes	28	18.7
	No	113	75.3
		1	0.7
		8	5.3
3. Gaining Sense of Psychological and Physical Security	Yes	32	21.3
	No	112	74.7
	Don't Know	2	1.3
	Not Applicable	4	2.7
4. Attaining Complete Physical and Mental Health Wellbeing	Yes	18	12.0
	No	113	75.3
	Don't Know	19	12.7
5. Getting to Normal of Life	Yes	46	30.7
	No	104	69.3

From the table above, the assessment of efficacy showed Efficacy (18%) for improved emotional and psychological states; inefficacy (72%); neither efficacy nor inefficacy (1.3%); and not applicable (8%). Efficacy of intervention on physical pain indicated efficacy (18.7%); inefficacy (75.3%); neither efficacy nor inefficacy (0.7%); and not applicable (5.3%). The sense of physical and psychological security was low indicated by efficacy (21.3%); inefficacy (74.7%); neither efficacy nor inefficacy (1.3%); and not applicable (2.7%). Complete physical and mental health states was very low, indicated by efficacy (12%); inefficacy (75.3%); and not applicable (12.7%). Only 12% were passed physically and mentally fit and ready to move on, on their own. The expression of situation health was indicated by efficacy (30.7%); and dysfunctional inefficacy (69.3%).

Qualitative Findings: Efficacy of Psychological Trauma Interventions

1. Efficacy of Psychological Trauma Interventions

There was progress from clinical stage (primary) to the level of applying secondary support systems. Direct exposure to the traumatic event was a moment so terrifying to the listening party. Survivors sustained injuries that they hardly imagined to have sustained. Interventions made a difference. Below are photos showing the recovery journey of a survivor: Kiyingi after the bomb blast (L); Kiyingi during his three-month recovery at Mulago Hospital (M); and Kiyingi now (R).

Figure 1: Journey to Recovery

Secondary Source: by Flavia Lanyero. Daily Monitor, Posted Tuesday, June 28th, 2011.

2. Inefficacy

There were serious complications from survivors still lingering on two years after the tragedy, just as Maureen Nakigozi, Uganda Picks Reporter, on July 11, 2012 wrote:

> Most of the victims are still nursing complications they sustained from the attack while many have health problems which developed because of the bomb particles in their bodies. Some of the survivors have become epileptic and many are still psychologically tortured by what they saw and have never recovered from that shock. Many of the families of those who died in the bomb blasts have never caught up with the situation. Many have failed to wipe out the bad memories they have gone through since they lost their loved ones (http://www.ugandapicks.com/2012/07/uganda-marks-2nd-anniversary-after-july-2010-bombings-76987.html).

The families of the deceased were still held back and finding difficulty to let go:

> *"…no longer wants to talk about it. The media has been most torturing. We still suffer from the loss. Her death should have been replaced. She was our bread winner and most treasured person in the family. She still lives in our lives, our mother often experiences nightmares."*
> –Bereaved Family in Makerere, Kampala.

The tragedy increased risk-taking. They felt lost-control of their ability to secure personal lives as much as the government: *"I have to enjoy my life fully because I will die anytime,"* said Coleb David in Kampala. The assistance given to aggrieving and injured victims did not cause permanent healing, both medically and psychologically and held strong fears about the future. *"I might get Parkinson disease later in life because of the damage I have on the nervous system,"* said one victim from Ntinda, Kampala.

CHAPTER FIVE:

DISCUSSION OF FINDINGS

5.1 Introduction

In chapter five, the results were re-evaluated, re-contextualized, and argued, to whether they deserved their place in the form presented by the study, and summed-up by conclusion and recommendations. From the study, the findings were as follows: 1) nature of trauma suffered: a) physical trauma: dead (38%), injured (40%), and no injuries (22%); b) psychological trauma: : exposure to traumatic events (99.3%); re-experiencing of the traumatic event (94.7%); avoidant-type characters (94%); and significant impairment (93.3%). 2) levels of preparedness of service providers (81%); 3) Forms of interventions: family and religious forms of intervention were predominant at 97.3% and 96%, respectively. Psychological forms of intervention very limited role (55.3%), only second to cultural forms of interventions (50%). 4) Appropriateness of interventions was so by (49.5%) while 5) Efficacy of interventions (20.1%). The finding for each study theme was discussed as was presented below.

5.2 Nature of Psychological Trauma Suffered

The variations in the nature of trauma suffered were: dead (38%), injured (40%), and no injuries (22%). On the event of a catastrophic event, the victims were inevitably subjected to risks various degrees of injury and psychological trauma. Psychological trauma show of: exposure to traumatic events (99.3%); re-experiencing of the traumatic event (94.7%); avoidant-type characters (94%); and significant impairment (93.3%), indicated high incidence of psychological trauma among survivors and bereaved families. It ranged in intensity according to the degrees of injuries and fate suffered. It was for example highest among severely injured, bereaved families, the less injured, and the non-injured, respectively. There were reactions of confusion, shock, and mental and physical injury; fears of death and struggles to keep life on the part of the victims, injured or not. It had temporary and long-term implications on the lives such as: never to go to crowded and noisy places; becoming more religious for being saved from having to die, living a more private life than before and avoiding friends, never at all wanting to talk about the event as it recollected horror and unwanted grief, permanent disabilities that worsens affected people's ability to cope, and higher economic challenges faced by dependants of the deceased victims. One year after the tragedy families still had not come to terms (Lanyero, 2011).

Serious mental illness made one feel sad, frightened, worried or angry. Patients were uncertain about what their situation. At their disposal, they faced the need to cope with pain of surgery, the side-effects of medication, wonders of whether treatment would help, felt out of control, and lonely, and separated him-self or her-self from the rest of the family and friends (World Federation for Mental Health, 2004). The event caused human suffering, disrupted normal functioning, and caused economic losses. The victims instantaneously developed somatic and mental symptoms, including; a feeling that the heart was about to burst, difficulty breathing, muscles felt like exploding and did not seem to work well, had feelings of terror and panic, a confused mental state, with extremes of actual shutting down of the cognition, of automatic reflexes, and a feeling of out of control (Bunney, 2001).

5.3 Levels of Preparedness of Service Providers to Handle Psychological Trauma

There were greater access and availability of support information (83.3%). Psychological response was poorest (53.3%) while emergence rescue and medical was just fair at (61.3%) and (64.7%), respectfully. Service providers were challenged by the extent of the tragedy. The overwhelming numbers of injured and unconfirmed dead bodies amidst stressed-up hospital facilities led to patient mismanagement as bodies of both the unconfirmed dead and injured victims lay on floor in a well of blood. It was such scenes that caused too much anxiety among survivors; they were worried that the situation could have allowed HIV/AIDS to spread. There must have been a cause to worry because by June 29th, 2012, over 130, 000 new HIV infections were received in the country (Kagolo and Mutesi, 2012).

While it could be thought that the 7/11 terrorist attacks were more like accidents, there had been signs of vulnerability to them. Having send troops to Somalia had already aroused anger from Somali nationalists in disfavor of foreign interventions. Besides, the extremist had highlighted their intentions to attack the foreign countries, to which the nation wither ignored or too lightly. If critics accused government for negligence or to have had justifications in having the terrorist act take place, they would be in a way pointing at that negligence when the nation well-entrusted it to oversee its welfare. It was insensitive on the part of government to provoke war and expect no reaction. Alienation of the people of Somalia, in turn, prompted identity seeking (Walker,

2011). It was insensitive on the part of the Kampala leadership to assume no reaction following eventual action of occupying the much-renowned, hostile, foreign lands.

Early warning for disaster reduction was a legitimate matter of public policy working to ensure highest possible public safety, through establishment of proper priorities, allocation of resources most wisely, development of institutional networks with clear responsibilities, understanding the nature of hazards and vulnerabilities, identify and sign-up a combination of actors from various areas, establish or strengthening legislative legal frameworks and mechanisms, motivation of disaster reduction agents, developing effective communication strategies, and securing substantial amount of resources to ensure monitoring and evaluation, adequate early warning, concerted disaster reduction and a return to normal (FAO Global Information and Early Warning System [FAO/GIEWS], 2003).

5.4 Forms of Psychological Trauma Interventions

Family, religious, group-based had the best day, scoring (97.3%), (96%), (94%), respectively. And medical intervention, at 90.7%, was good. This shows how relevant non institutionalized or non formal interventions were, a true show of *Ubuntuism* (human spirit) embedded in African way of life. It was the most sustainable form of category of health care, having beaten western types in popularity, including medicine and psychological support. As usual psychological form of intervention was among the worst at 55.3%, only second to culture form of interventions (50%). There were both formal and non-formal psychological trauma interventions. The most predominant was the non-formal, traditional, and unprofessionally-guided yet quite useful strategies. Whoever had the means to intervene or help offered did it: first, from the uninjured survivors with vehicles at the scene; second, professional help facilitated by the media through local stations; third, international community which sent into the country security experts to establish the cause of the horrible 7/11 attacks and later provided logistical support to improve national and regional security; and fourth, the compensation and the beefing of security in the country. From them all, the media is most critical way of managing disasters. While medical and emergency evacuations were primary, family-based and religious-based interventions proved most useful. Self-coping was prominent in absence of professional psychological interventions.

There were not many non-government organizations with specialties in psychological trauma handling, to save; the Uganda Red Cross (URC), Uganda Counseling Association (UCA), Basic Needs Uganda, Refugee Law Project, and the Media (Daily Monitor). Otherwise a community based approaches through working directly with the association formed, in cases there was one, of victims of the 7/11 terrorist attacks, and their care-givers to share their experiences, to break through stories, to create awareness, and to reduce social stigma, a strategy that was excellently employed by Basic Needs, Uganda would be very useful interventions tools, according to Basic Needs Uganda Strategic Plan (2011). Significantly, though; a multi-disciplinary or multi-sectoral approach proved most meaningful.

5.5 Appropriateness of Psychological Trauma Interventions

Over all appropriateness score was (49.5%). Psychological services until recovery (14.3%) was poorest. Justice and follow-up of victims (19.3%) and (20.7%) followed. A sense of fairness of the legal processes by having culprits suffer equal pain as their victims could have contributed to a sense of just and reduced emotion and psychological pain. 61.3% for appropriateness to dealing with physical, emotional and psychological pain was fair but a lot more was desired. Culture appropriateness was at 45.3% while religious appropriateness was highest at 84%. This indicated limited role of culture. Generally, delivery of support was fair (66%). However, the 34% of the unreached victims-in-need was injustice. Sufficiency of the resources to the needs of victims however left desirable (25.3%), leaving 74.7% dissatisfied and continuously in agony. Appropriateness and in crisis response, especially, for far unexpected ones, were rare unless the concerned country had a series of attacks to warrantee permanent structures in place for disaster Priorities were done with first consideration being made to direct victims yet non-injured victims too indicated signs of psychological trauma. This category remained unattended to. But even for direct victims, interventions were short-lived. They mattered most during the 'honey moon' period of two to three months, after which memories and concern diminished. After two years psychological trauma still stood in the lives of victims and some service providers. There was need to make follow-ups and to have resources mobilized to fully address psychological trauma effectively. Even the embassies of countries that were playing the world cup finals could have been approached for assistance to the victims and their families. And while arrests were made following the high level crime (Nampala, 2011), the punishment given to perpetrator was so light in relation to the terrible crime committed while less was known about the remaining culprits

that were still under trial. Punishment consistent with the crime committed was stronger would be an excellent addition to remedies designed to reduce emotional and psychological pain suffered.

Experience was best teacher for government and independent service providers. Response required both the efforts of service providers and victims, through compensation, formation self-help projects, seeking family support (Tumwebaze, 2011). The biggest lesson was to fill security gaps and scale-up security presence in Somalia, the source of trouble. Uganda, subsequently, sent troops 4,000 more soldiers to Somalia following a decision by the UN Security Council to increase the number of peacekeepers supporting the transitional government against al-Qaeda-inspired rebels from 8,000 to 12,000 (Olupot, 2010). Disasters were usually approached without any formula given the urgency it demanded to save lives, to reduce damage, to reduce further risks, and to ensure safety. It was an entirely emotional moment. The 9/11 which was devastating in terms of lives lost, where nearly 3,000 people were killed in the attacks; one month after 9/11 the National Institute for Mental Health gathered together a group of international experts to figure out how to best help a traumatized population, but the report in American Psychologist explained that there was no clear model of what to expect and how to proceed. Experts agreed that there were inconsistence and gaps, and called for a clear framework for disaster behavioural response. The largest lesson for the mental health field from the 9/11 had to be that when disaster strikes, practitioners should not get in the way of natural coping. Instead of trying to provide services to the entire population, they should, after a month or so, target the people who might need it most and then tailor their approaches, taking individual and cultural differences into account. (Konigsberg, 2011).

Suggested healthy adjustment line of actions for victims, according to APA Help Center (2011) were: giving oneself time to adjust, anticipating the difficulties to be faced as a result of the tragedy, allowing oneself to mourn the losses caused, attempting to be patience with the changes in the emotions, seeking support of people who care, and who can listen and empathize, keeping in mind the possibility of disrupted support system in cases too were affected, communicating one's experience in the most comfortable way to friends or through journaling, and finding out availability of local support groups, engage in group discussions led by professionals through

whom to identify people with similar feelings and reactions, engaging in healthy behaviours to enhance one's ability to deal with extreme stress (e.g. healthy diet, having plenty of rest, engaging in relaxation techniques, avoiding alcohol, pursuing one's hobbies and enjoyable life activities).

The response took place in the faster time possible within the emergence needs; however the modes of transport left a lot to be desired. The urgent need of attention required that most technical and ethical issues needed for effective interventions got omitted. However, it was unholy to focus interventions on individuals and their families alone. After a disaster the focus must shift towards public health (Heir, Hussain, and Weisæth, 2008). The aspect of psychological trauma suffered was less catered for during the interventions. In general mental health in Uganda was yet to be conceptualized in health dispensations, and development frameworks; it was never regarded as a health matter; not prioritized at all at local government levels; lacked persons in-charge, had limited effective demand, and data on the numbers affected (Basic Needs UK, 2005).

Dead bodies were assumed useless mass of non-functioning fresh, without pain, which regardless of the mistreatment, it made no different in its life. Some live beings were presumed dead (Lanyero, 2011a). However, cases as that were most likely to occur, given our poor health services and care, some of the people presumed dead, would be actually not. The media broke news of the dead to families, which was appreciated. Facilitating story-telling was welcomed, as well. But moving ahead to publish the stories was not welcome. The victims expected tangible tokens from whoever sought stories about how they were coping. The media misrepresented them and compromised their rights to privacy. This made them so sensitivity to it, and whoever asked them about their trauma experience. Besides, there was no chance for follow-ups of victims, even after pledging help, after agencies' data collection sprees. The victims were not happy about the lack of benefits from revealing their private lives and being exposed to the rest of the world. Even medical and mental health allied professionals did not pursue follow-ups unlike for those under African Medical Research Foundation (AMREF) medical funding. For many other service providers and victims who had soon run out of compensation money ceased their contact. It was common for non-psychiatrists to be hesitant not to treat people with severe

mental problems, and a lack of patients to seek medical follow-ups due to lack of motivation, and frequent changes of doctors and treatment facilities limits development of illness history, and there were not enough money for physical examinations in mental health care (World Federation for Mental Health, 2004).

The Uganda Police, which was reported to have been faster at the scene, did not have ambulances; they used pick-ups, which added much harm along the way to various hospitals around Kampala. Their hard bodies and the nature of the roads cause equal pain to already severe injuries sustained. The severe cases overwhelmed even the medical personnel (Banura, 2011). Security and justice, on the other hand, still eluded victims and their families, which cemented existing mistrust between them and government. It is little wonder that mob action increased countrywide from 383 (2011) to 466 (2012), according to the Police Annual Crime Report (2011) in an article by Muhereza (Daily Monitor, August 21st 2012 *p.3*). The reasons for that are relentless attempts by ex-victims to secure reconciliation and healing through justice at any cost.

5. 6 Efficacy of Psychological Trauma Interventions

Efficacy of psychological trauma interventions was very low (20.1%), showing 4 out of 5 items below 20%, with only 1 item at 30.7%, no above 50%. On average, efficacy was merely 20.14%. This was explained by inadequate facilities, lack of enough ambulances, and lack of enough manpower, the actors did well in those circumstances while letting a lot to be desired. For example, some so-called rescuers reportedly robbed victims of their valuables as they agonized in pain. Security of property and lives continued to elude families throughout the country. In just 7 months, from the month of August, 54 people were murdered in Kampala City, alone (Masaba, 2012). Despite making arrests were made and commencement of trials, as was reported by Candia (2011), the judicially remained questionable, as the outcome of terror trials remained unknown. This only maintained the feeling of psychological and physical insecurity as well as emotional and psychological trauma.

The interventions focused more on short-term medical needs and ignored the long-term economic implications on victims and bereaved families. For example, the handicapped victims, who could no longer work and provide for their children; the orphaned children, whose education, health, housing and spiritual needs go constrained; and the elderly parents, who no

longer had care from their deceased children, in whom they had invested highly; the looming injustice after no conviction being made against the perpetrators of terrorism, long after arrests were made; and the looming fear for personal safety as internal and external security threats continued to be evident in the lives of victims. Terrorism in its various manifestations also threatened critical business infrastructures, supply chains, and operations (Summit Report, 2008). As a consequence, lasting healing from interventions made was more of a dream.

Within 1 to 3 months injured victims had been discharged from hospitals, which marked the end of the noble role of service providers to make follow-ups and for some patients to pursue further medical care due to logistical challenges. However, home-based care is one of the options yet affordable compared to institutionalization. Over a period of one month, it is more human for patients to join the rest of the family and get nursed from home rather than stick around in hospitals for a very long time. Longer stay potentially accelerated pain, emotional, psychological and physical pain in the life of patients. The so much limited interventions could not improve the situations as much as it would have as, besides medical, health seeking was first to religious organizations or spiritual (Basic Needs UK, 2005).

Cultural aspects of interventions were particularly helpful to the bereaved families, which entailed payment of last respects to the deceased in company of family members, friends, and neighbors, with whom grief was shared. Family role could be traditionally embossed, much as the study placed it in modern times, as a place where stressors, distress, anxieties, depressions, and physical pain was shared, to eventually and gradually cause relief. That could have accounted for those who adjusted well from traumas; both physical and psychological trauma. Cultural beliefs could be labeled the cause of the tragedy and after-effects that amounted to mental illness or psychological trauma. While Ndyanabangi (2003) found that self-discharges from a mental health facilities were possible due to such beliefs, the 7/11 victims were more elitist to think that way.

The limited efficacy was mainly a contribution of religious traditions over all recovery among bereaved families and survivors lost control of themselves and the sense of government responsibility and ability to effectively secure their lives. Ndyanabangi further observed that the

majority of Ugandans were Christians, and religion played a vital role for their well-being. Survivors' Spiritual lives were strengthened more than before. The service providers did everything within their means save lives of the 7/11 terror victims; to restore hope, peace and provide safety assurances for the future. Traumatized persons (physically and mentally) felt the stigma of being told they were psychologically traumatized. They would not like to be associated to categories of people that were mentally-ill because it was socially derogatory and ridiculing. Such, as noted by the same author, adversely affected health seeking from established mental health facilities. Nevertheless, spirituality provided effective means of coping and exercising psychological resilience. Resilient individuals were characterised by their personal competence and determination, the supportive relationships they had formed, and their reliance on faith and prayer (Connor, 1996).

It was highly evident that mental health did not play its role on the aftermaths of the 7/11 and that psychological or mental health interventions were least popular in Uganda. It from those backgrounds that efficacy of interventions was compromised yet psychological strategies like 'psychological first aid' had been proved very effect in disaster responses. It involved approaching and offering support, ensuring safety, engaging in activities that comfort to victims and information delivery, protecting victims from further threats, provision of immediate care (of basic needs), orienting victims towards life goals and support reality-based tasks, facilitate reunions with loved ones, sharing experiences, linking victims to systems of support, facilitating self-masterly, and identifying needs for further counseling (Gauthamadas, 2005).

Recovery took different periods of time for different victims. Some people experienced acute distress and they were unable to recover; others suffered less intensely for shorter period of time; some people recovered quickly and then began to experience mental health problems as they used to; while many people endured the temporary upheaval of the trauma event remarkably well, and proceeded to new challenges of life with apparent ease. Bereavement was natural part of coping that could not be interfered with. Bereavement theorists believed that the absence of distress after the loss of a very important person in one's life was not normal, but rather an avoidant symptom. But while bereavement could be encouraged, there were some shortcomings as they still showed aspects of malfunctioning in the forms of cognitive disorganization,

dysphoria, health deficits, and disruption in social and occupation functioning. Coping efficacy was exhibited by widows by widows through experiencing positive attributes from their departed husbands. Hardiness, self-enhancement, and positive emotion trait influenced well functioning of individuals. Credible bodies of knowledge have provided evidence to that effect. Hardiness consisted of the dimensions of being committed to finding meaningful purpose in life, the belief that one can influence one's surroundings and outcomes of events, and the belief that one can grow from the positive and negative life experiences (Kabasa, Maddi, Kahn, 1982 cited in Bonanno, 2004). Self-enhancers exhibited high self-esteem. Self-enhancement was adaptive to individuals with several losses. Other people showing resilience appeared to cope through positive emotion and laughter. It reduced significantly distress by quieting or undoing negative emotions (Fredrickson and Levenson, 1998;Keltner and Bonanno, 1997 cited in Bonanno, 2004).

The 7/11 event was thus an opportunity in a way for effective future responses to incidences of that nature and increasing necessary logistical needs. It was quantifiably right to consider trauma compensation as enforcers of reduced impact of trauma suffered. However, there were a series of engagements with victims required, and even more costly to warrantee a much more token of money contribution from government to enable sustainable healing of psychologically traumatized people. For example, victims ceased seeking further treatment when they ran out of money; the free medical and the limited psychological attention was soon offer while no further follow-ups were made and people still showed signs of psychological trauma. These needed redress. Security was highest on the agenda as it provided an environment best for healing. With it, safety of life and property would be guaranteed, extreme cases of physical and psychological trauma would be prevented, and thus no associated recommendations would be necessary. However, it was still shaky characterized by fears and anxiety. Therefore, it was pertinent for government to take precautionary measures to that effect. There should be anticipation and willingness to contemplate possibilities of disaster. Effective early warning systems required strong technical foundations and good knowledge of risks. Complete and effective, people-centred early warning system, included spanning of knowledge of hazards and vulnerabilities through preparedness, and the capacity to respond (De León and Bogardi, 2006).

CHAPTER SIX:

CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

This chapter summed up findings of the study and made recommendations from aspects of the discussion, where some gaps were found awaiting filling, and it suggests critical areas for further research. The conclusions and recommendations were aligned to each of the study objectives, which included: to establish the nature of trauma suffered, to establish the levels of preparedness of service providers, to identify the forms of interventions applied, to assess appropriateness of interventions, and to assess the efficacy of interventions.

6.2 Conclusion

Psychological trauma was until the time of this study highly prevalent among all the categories of victims: bereaved families, injured, and the non-injured. There was every effort to reduced psychological trauma. Interventions however were short-lived and psychological trauma persisted. The psychological interventions were not popular while cases that underwent psychological handling showed greater improvements than those who sought unguided and untimed traditional 'psychotherapies.' While medical was key to meeting the physical needs of victims because of the holistic nature of mental health needs, and contributed to a level of psychological relief, mental health professionals missed out playing the complementally role, to raise that level and fully to realize better results. Greater expertise and appropriate number of rescue workers were missed during interventions; the numbers of victims overwhelmed service providers while equipments used (for example; use of pickups) and the mistreatment of dead bodies or victims presumed to be dead caused more grievous harm and deaths to victims on their way to hospitals. This yielded the 49.5% appropriateness. Complaints persisted about inadequacy as much as the signs of psychological trauma. While religion and families played the traditional therapeutic roles to assimilate and diffuse trauma effects, to eventually influence some positive outcomes (20.1%), many health improvements could have been registered. National and regional terror threats and lack of justice for the victims made psychological trauma even strong, and went on to weakened families' coping abilities. Questions remained about how justice was conducted (not being consistent with the gravity of crime), and about how the police relationship with civilians was too ugly to favour success in terror fight.

Securing the nation remains one of the main challenges as either community centers lack security monitoring systems or those systems only retrieve outcomes of security breaches rather than prevent crime. Besides the security monitoring gadgets were and are still costly for the majority of organizations. Even places with security personnel exhibited weaknesses in making proper security checks. In some places it was possible to be cleared without being checked while in others members of the public stood in the way of being checked. Poor internal security acerbated exiting psychological trauma among victims. While insecurity continued to be the order of the day, sustainable psychological trauma healing was being hampered.

Religion and the media were the most viable and trusted interventions in the form of memorial services. As the media relayed information on the forthcoming day to remember 7/11 victims, the churches and families organized to take part. The media further went ahead to retrieve information on the status of victims and their families. Religion tuned victims to respond positively towards peace-building efforts –through forgiveness, restoration, and healing.

For service providers, psychological trauma was dealt with quite well, given their knowledge, skills, an experience in self-diagnosis and coping. They indicated having seen people agonize and die before. The event was unexpected which made certain considerations secondary, such as ethical, age, and cultural considerations during emergency. There were challenges of inadequate funding for enable persistent care and follow-ups to ensure total healing. As a consequence two years after the tragedy psychological trauma was still prevalent. Improving capacity of service providers; both government and private to be prepared, appropriately and effectively handle psychological trauma interventions was very pertinent.

6.3 Recommendations

There is need to develop strong awareness programmes on psychological trauma and its linkages and develop strong guidelines for its management so that flaws in its management are sustainably handled to promote prevention of similar tragedies and long-term healing of affected families.

There is need to strengthen non-informal approaches, through standardizations, and professional supervision, to ensure appropriateness and efficacy of psychological trauma interventions.

There is need for further medical and financial assistance to bereaved families, injured victims, and non-injuries with psychological concerns as the media, religious institutions continue to highlight the plight of victims and to lead them through prayer, memorial services, and story-telling. Some of the assistance could be sought from the embassies to countries that played world cup finals when terrorists attacked.

There is need to create awareness on the importance of psychological trauma care-seeking and to have psychological care recognized by government through its ministry of health as critical part of healing, without which physical healing is hampered; and have mental health service deliveries decentralized through local government structures.

There is need to support 7/11 orphans with limited social support systems, with education, accommodation, and health care needs, through offering bursaries and scholarships, and employment support to caregivers. Forming associations of psychologically traumatized victims or victims of 7/11 would be instrumental in championing the cause of orphans and general welfare of survivors and bereaved families.

There is need to equip referral hospitals and private health centers with hi-tech medical equipment to effectively handle all forms of trauma: 6 ambulances for each medical department in referral hospitals, 3 for each private medical facilities, 3 for each sub-county, 2 for each parish, 1 for each village, and at least 1 ambulance located in every busy place. In addition, health professionals should be highly motivated to show commitment and relentless struggle to save lives as well as to recruit more staff, including paramedical (s), social scientists, and volunteers to support lives holistically while at the same time helping to fill the manpower gap. Where technological issues are the challenge for appropriate, quality and effective interventions, experts and experiences could be borrowed from advanced countries in the area of trauma response.

There is need to establish research fund to support research activities in psychological trauma, advocacy, public awareness and basic care trainings. For example the police and other paramedical (s) would need critical knowledge on emergence response and psychological trauma care. Research could as well be expanded to cover security issues surrounding terrorism; nationally, regionally and globally.

There is need for government to strengthen intelligent gathering, community policing, civilian trust, and collaboration on security issues and disaster responses: to provide critical information pertaining to national security to keep public vigilance; to avail security monitoring systems in busy public places; and to remove taxes charges on them to ease accessibility and quality. And security measures should include checking revelers at entrances of entertainment places, inside premises before commencement of the event, and during the event; institute terrorism hotlines across towns and cities; and tighten boarder security.

6.4 Suggestion for Further Research

The study suggests, uniquely, the need for further research in the efficacy of interventions conducted among service providers.

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APPENDICES

Appendix A: Structured Personal Interview Guide for Mixed Research Approaches

Psychological Trauma Evaluation Check-list

Introduction:

My name is Jacob Waiswa, a student of peace and conflict studies, Makerere University. In light of the 7/11 attacks and psychological trauma that followed, I am seeking to understand what really happened, what support was given to you, and how life has changed. From here harmonising policies will be developed. Your valuable time and contribution to this subject will go a long way towards developing national and international policies towards effective institutions to prevent terrorism and address its effects as well as achieve a global response to peace.

Your participation is **highly** appreciated.

BIODATA						
Date						
Respondent Name (Optional)						
Status of Respondent	1. Affected Family			2. Service Provider		
Status of Trauma	1.Dead Person	2.Injured	3. No Injuries			
Sex of Respondent	1. Male		2. Female			
Age of Respondent	1. 14-23	2. 24-33	3. 34-43	4. 44-53	5. 54+	
Religion of Respodent	1. Muslim		2. Christian	3. Other		
Level of Education	1. Degree	2.Diploma	3. UACE	4. Vocation	5. UCE	6. Not Applicable
Marital Status	1. Married	2.Single	3.Cohabiting	4. Divorced	5. Widow	
Family Size	1. 0-3	2. 4-6	3. 7-9	4. 10+		
Number of Children	1. 0-3	2. 4-6	3. 7-9	4. 10+		
Occupation of Family Head	1. Self-employed	2. Junior Staff	3. Senior Staff	4. Casual worker	5. Unemployed	
Nationality	1. Ugandan	2. Ethiopian	3. Eritrean	American	5. Other	

STUDY THEMES	**ITEMS TO MEASURE**	**MEASURES**	**OBSERVATIONS**	**DEDUCTIONS**
Nature of trauma	**Physical trauma** **Psychological Trauma** 1. Experiences at exposure, exposed to a tragedy. 2. Re-experiencing event, flashbacks. 3. Avoid aspects, things that remind you of it. 4. Significant Impairment, all the above in 1 month.	1.Dead Person 2.Injured 3. No Injuries 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA		
Nature of trauma interventions provided	***For families and Service providers*** 1. Medical. Support 2. Psychological. Support 3. Financial Support	1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA		

	4. Cultural. Support 5. Religious Support 6. Family support. 7. Individual-based Support 8. Group-based Support 9. Community support. 10. Political (Leadership) Support 11. Security Forms of Support 12. Diplomatic (international) Support 13. Legal Support 14. Other *(Specify)*.....	1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.N		
Appropriateness and quality of interventions used to address psychological trauma suffered by families of victims of 7/11	***For Families Only (Yes=Appropriate; No =Inappropriate; Don't Know = Neither Appropriate nor Inappropriate):*** 1. Service providers dealt with my emotional and psychological pain. 2. Services providers dealt with physical, pain, losses. 3. Services were in harmony with our culture. 4. Services were in harmony with our religion. 5. We were compensated for the economic losses. 6. Supplies (financial and material aid) met the equivalent of the losses. 7. Psychological services continued until recovery. 8. There was follow-up after being discharged. 9. Justice was granted. 10. Service providers were professional. 11. Other *(Specify)*.....	1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA		
Efficacy of Interventions	***Families only (Yes = Efficacy; No = Inefficacy; Don't Know =Neither Efficaicy nor Inefficacy)*** 1. Service providers saved many lives. 2. Support services met the immediate needs. 3. .We have come to terms with what happened. 4. Life is back to normal. 5. Support providers past us fit and able to survive on our own. 6. The future is secure. 7. Other *(Specify)*.....	1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA 1. Yes 2. No 88.Don't Know 99.NA		

Appendix B: Key Informants Interview Guide

BIODATA						
Date						
Respondent Name (Optional)						
Status of Respondent	1. Affected Family				2. Service Provider	
Status of Trauma	1.Dead Person	2.Injured	3. No Injuries			
Sex of Respondent	1. Male			2. Female		
Age of Respondent	1. 14-23	2. 24-33	3. 34-43	4. 44-53	5. 54+	
Religion of Respodent	1. Muslim		2. Christian	3. Other		
Level of Education	1. Degree	2.Diploma	3. UACE	4. Vocation	5. UCE	6. Not Applicable
Marital Status	6.Married	7.Single	8.Cohabiting	9. Divorced	10. Widow	
Family Size	1. 0-3	2. 4-6	3. 7-9	4. 10+		
Number of Children	1. 0-3	2. 4-6	3. 7-9	4. 10+		
Occupation of Family Head	1. Self-employed	2. Junior Staff	3. Senior Staff	4. Casual worker	5. Unemployed	
Nationality	1. Ugandan	2. Ethiopian	3. Eritrean	American	5. Other	

Actors and how prepared were they to handle psychological trauma	*Preparedness:* ***For Service Providers Only***	
	1. Staff (paid and unpaid volunteers) personally prepared.	1. Yes 2. No 88.Don't Know 99.NA
	2. Essential functions and services set.	.
	3. Trained and prepared staff (technical knowhow).	1. Yes 2. No 88.Don't Know 99.NA
	4. Multiple communication tools to reach internal and external stakeholders.	1. Yes 2. No 88.Don't Know 99.NA
	5. Staff and key stakeholders trained on Agencies' emergency plan.	1. Yes 2. No 88.Don't Know 99.NA
	6. Facility and staff prepared for an emergency evacuation.	1. Yes 2. No 88.Don't Know 99.NA
	7. Partner agencies identified to share resources and tasks.	
	8. Documentation and accessibility of vital information.	1. Yes 2. No 88.Don't Know 99.NA
	9. Emergency payment options established and streamlined.	
	10. Early warning system in place internal and external).	1. Yes 2. No 88.Don't Know 99.NA
	11. Ethics Concerns known.	1. Yes 2. No 88.Don't Know 99.NA
	12. Other *(Specify)*.....	1. Yes 2. No 88.Don't Know 99.NA

Appendix C: Secondary Literature Reviews for Qualitative Analysis

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Okanya, Andante (Friday, 11th March, 2011) Tanzanian Charged Over July 11 Bomb Blast @ http://webcache.googleusercontent.com/search?q=cache:fcnamvdit6ej:www.newvision.co.ug/d/8/13/748837+a+key+suspect+in+the+july+11,+2010+terror+attacks+in+kampala+was+released+by+tanzania.&cd=8&hl=en&ct=clnk&gl=ug

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http://ugandamediacentre.blogspot.com/2012/07/government-remembers-711-bomb-victims.html

Appendix D: Qualitative Notes

Police was not prepared.

It responded by sealing off the areas and conducted investigations.

We did not have volunteers. Doctors were needed to support at different levels. We were inadequate in responding to the tragedy. New protocols had to be devised to cope with such an overwhelming response. Medical facility was not well equipped as the only equipment to use was the MRI scan, which was only at the Kampala Imaging Center. Hellen Mbabazi, Former Employ of IHK.

Did not have volunteers

No follow-ups were made.

Meetings were made to provide protocols for the future.

We treated all the 45 patients to recovery part from the case of an aggravated head injury. Hellen Mbabazi, Former Employ of IHK

Recommendation were synonymous with the defects of the interventions

Coordinating rescue efforts is very important, involving the identification of which hospitals to work with; safety of hospital staff, empowerment of different hospital units, cleaning off of blood to avoid scaring new cases to handle, involve different players in the sector, including specialised persons, equipe hospitals, more personnel be recruited, secure more ambulances for public hospitals for emergency purposes, equipping private hospitals, permanent cokkaboration, improve collaboration and trauma support.

Disastified with the media, as it misinformed the public about some issues. It was very exergerating. Victm, Busega

Diana Sabiti was already suffering a development burden having grown up an orphan.

Asked to go for fellowship but did not go on with it.

The media attended to them, but were not tangibly helpful x 2
Still has lasting effects of trauma despite interventions. She still has fragments. Diana's Mother, Nakawa.

'Whenever I hear any blast I feel scared.' Victim, Kampala

Old man lost a daughter in the bomb blast. The death of another daughter left him hopeless. He too soon collapsed and died. He is one case of family that was not compensated due to lack of information.

Because of the emergences nature of the cases, most technical and ethical issues needed for effective interventions were omitted. Service providers were challenged by the extent of the tragedy.

Expression of revenge because of the ill-feeling about the tragedy. 'I am still tortured.' Victim in Nsambya.

'Human fresh was everywhere. I picked a shuttered leg of the woman.' Victim in Namuwongo

Still in need of medical aid.

'I believe that God keeps me alive.' Services were provided to those who needed them. It was impossible for all people to receive what they needed. Survivor, Kampala

My brother died in the tragedy. I cry when talk about.' Victim, Nsambya.
Service providers demanded money for surgery and did not meet our expectations.

My brother still died after paying for the medical bills expensively.. The army had the best facilities to deal with causalities, but did not intervene. Victim, Nsambya

People are still sick but lack money for treatment.

Felt the need to restrain the media from interfering in their privacy.

Found one case still in coma.

She fainted, and no longer wants to talk about it..'Media has been most torturing.' Our sister lost her head. We still suffer from the loss. Her death should have been replaced. She was our bread winner and most treasured person in the family. She still lives in our lives, and often experience nightmares. We need jobs to sustain our families.'

TV exposure overwhelmed the extent of the problem. The community was hostile, it took asylum seekers for terrorists.' Service provider, working with refugees, Kampala.

Lacked enough staff. Gained skills after the event. There is need to equip victims with care skills, life skills. We assess clients depending on the extent of their stories and connecting it to the gravity of the problem, looking at past and present triggers. During crisis no one focues on religion. Build capacities between organisations and coordinate various units to address the crisis. The workload was so huge and refugees are harder people to please. When each discipline does its part healing becomes natural.

Victims treated of trauma felt normal.
'I was unconscious after the blasts; I was treated by both a physician and a psycho-

therapist. The therapies took me back to the scene a number of times during my recovery. I do not avoid places or anything that remind of the tragedy. Security is not vigilant, checks are not adequately made, and security remains vulnerable.' Victim, Kampala

'We are still frightened, not safe.' Victims in Busega

'I can't carry heavy objects.' Berharu Eyob, Eritrea

Court action or the process of causing justice is on-going.

Information was false

Smell of blood was everywhere, smashed human flesh everywhere. Those who survived started helping. As security personnel at the scene, I called for police vehicles to remove the dead. The exercise of removing dead bodies ended at 2am. The police and the UPDF were the first at the scene. There is extra security at the borders and screen whoever enters. Security is not represented by the visible men and women in uniform. A survivor cop, Naguru.

A platform provided by the media for story-telling was highly therapeutic. Pr

Service providers served the dead, injured, and non-injured in different aspects.

Victims do not know the legal issues surrounding the 7/11 terror suspects.

There was more of confusion after the blasts.

Sometimes I feel depressed and bad about what happened, but what could I do. I could not waste time to see psychologist because they would not change anything.' Survivor, Kabalagala

Nothing could be done, without help, they had to leave with it.

Police came after 20-30 minutes.
I received tremendous support from family and friends.
Police placed victims in the back seats.
Good Samaritans were also helpful during the rescue efforts.

Thieves came and searched dead bodies, stealing bags and phones. The police used the recovered phones to call relatives of the victims. Survivor cope, Naguru.

'I took several of the photos and wrote the report, which was desensitising enough.' Service provider in Kampala.

'I would not have talked to you had my children not been doing research as you are.' Mother of Deceased, Busega

There was no confidence in institutions responsible for care as the quality of care wants. 'Only God can take us through this experience.'

Individual volunteers who would have played part in rescue efforts feared police arrests and kept away from the scene. Survivor, Naguru

The country graced itself for war without putting safeguards back home. Museveni provoked war; if he did not go to Somalia, it would have been a different issue.' Respondent in Naguru

People who rushed in to help were only arrested by police as suspects, which discourages rescue efforts from the rest of the community as a whole.

The leadership was branded as corrupt, unable to look after its people.

‘Lots of people died, children orphaned, and businesses collapsed, and children are not gong to school anymore.’ Survival in Naguru.

Life is hard, they expressed. Are not happy with government.

I survived by a whisker, I have only a scratch on my head, but my brother died.’ Abubakr Mujaheed, Naguru

Attending a food ball event was a social event involving family and friends moving to event places in groups to enjoy themselves. ‘it was not in my plans, a friend of mine colleted me to go.’ The blast went out without notice by many people. My friend died with a cigarret in his mouth. I failed to stand, and instead fell back to the ground, and soon develop blurred sight. The Hospital)IHK) was filled with bloodied bodies; my brother was severely injured. Personally I was coughing blood. I realized later on that I had been hit by fragments in my groin areas, and fel pain only after 30 minutes. My brother asked for me, and was able to locate me right next to him. He hekd my arm firmly. But suddenly his hand slipped off. I felt he had died, but the medics kept it a secret. My other brother was killed while running away by the second bomb.’ Anuari Sadat, 0752628323 (accepted to use his personal information.
‘I was confused; I do not know how I reached home.’ Victim, Kampala

Private car owners came to our rescue, and police showed high responsibility. Sadat

Eye witnesses revealed that police was at the scene before the blast.

‘Rugby ground was full, other [in attendance] were standing.’ Victim, Kampala

‘…Reduced hanging out and avoids crowded places.’ Victim, Kampala
‘For one month, I would not want to go back to the same place.’ Victim, Kampala

Psychological services were provided concurrently with with first aid and treatment by the Ugandan Red Cross society. ‘I was helped by counselling and prayer. …we sought spiritual strength and healing.’ Victim, Naguru

Foreign victims were more appreciative of government than their Ugandan counterparts, despite the financial package being inadequate for full recovery.

The initial blast was perceived as electric shocks. ‘first bomb killed most people’ ‘…saw smashed legs, a lady with intestines out, and a girl without a head.’ –Victims, Kyadondo Rugby Ground.

‘I sustained injuries on the head and leg, skull got cracked and nervous system damaged, and I could not walk for 5 months. Victim, Ntinda.

‘I felt bad like for 3 months.’ Victim, Naguru.
Sounds and noise cause flashbacks and discomfort. Victim, Kampala

Psychological help eluded even the very hurt as victims self-diagnosed themselves as normal
‘I felt normal after coming to my senses. Rescues robbed us of phones and property’ Victim, Namuwongo

‘There were fewer medics; people easily died.’ Victims, Naguru

Discontented with the justice system. ‘slight punishment was given as if thanking them, suspects are enjoying…’ Victim, Kawempe.

Victim’s careers came to an end. ‘I can’t do anything, I am only helped by well-wishers.’

Security systems are very expensive, many places do not have security checks. Law enforcement is still a challenge.’ Busega, Kampala

Emergency did not allow certain considerations like cultural and religious, use of right tools, consideration of generation context concerns, and execution of recommended guidelines of interventions.

Service providers were challenges in terms of capacity to deliver or respond to emergences of the time.

More professional organisations were engaged in debriefing of staff, and comfrimed existence of similar risks in the population.

Life in hospital made the situation of some victims worse, especially in the mortuary section. ‘I think the dislocation was due to the mishandling of dead bodies.’

‘I remember a girl lying on the floor with open tummy asking me for help. I avoid using Nakawa route to town; it reminds me about the horror.’ When asked what else he saw, he shouted, ‘I don’t want to talk about this! When asked to comment about patient management the respondent said, ‘I think many people contracted HIV.’ I have a plastic implant that holds my upper lip; upper lip was carried with me to hospital. I have scars around the lip, and lost some teeth. I was unconscious for two hours.

Witch doctors were not helpful, treatment is expensive yet I still have head injuries, limping, disabled, and have persistent headaches.’ Victim in Kampala.

Victims who did not receive professional help had it from family and friends, and emotional support from religious and memorial services.

Life is better than money. Support was vital to the family. The company I work supported me so dearly.’ Kazibwe Musa, Kampala

Religious groups led the memorial services, but government did not have any measures in place, only politicised it. It was government’s role but did not act to save lives.’ Rescue efforts were not appropriate; some people died along the way to hospital Police pushed injured victims under the seats of patrol vehicles, and roads trained efforts to transport victims to hospitals due to too many potholes.’ Ambulances were without trained personnel, no trained first aider.’ Survivor, Kampala

The long process of court action made it difficult for victims to justify existence of justice after the 7/11.

‘I cried, I fainted, I felt very bad…’ ‘I started accusing my father’s friends for influencing by father to attend the world cup foot ball match at Ethiopian Village.’ Daughter of the deceased in Bwaise.

‘I avoid crowded places and noise. I still have complications, which require more financial input’ Survivor in Ntinda.

Intervening parties sorted out those who were still alive.

Justice is one which happens immediately after criminal or aggravated actions. It is more felt as genuine and effective.

Assistance received was from both public and private sources.

2 years after the tragedy deformities still exist, non-treatment and rehabilitation, health seeking difficulties, and difficulties coping.

Those who received psychological assistance and are still in touch with concerned service providers feel much better today.

Instead of helping, some individuals came to steal phones and other valuables.
The victims who ran for their dear lives did and those severely injured did not have anything to reveal as part of their direct experiences after the attacks.

To some victims it was a double strategy; in addition to being physically and psychologically traumatized, they were saddened by the loss through death of their loved ones. The injuries ranged from very severe, severe, to minor injuries.

Bodies of the injured were lying on the floor unattended to. There were considerable levels of negligence.

Security personnel displayed hostilities against grieving families as they claimed for the bodies of their loved ones.

Families moved to new places.

Victims died either on their way to hospital or while there.

'The bomb blasts destroyed my intestines and shattered my face.' -- Names withheld, respondent.

No thorough checking is done in places that have security, some do not check at all.

The able-bodied (not injured) ones after the blasts took themselves to hospital.

The best justice to be given to culprits would be murder to equal their action of killing and injuring several innocent people.

Refugees were attended to by relevant non-government organisation namely UNFCR, Interaid, and refugee law society. Refugees complained of social exclusion, and threats from public because of the resemblance with Somali people.

While families of the dead and injured received financial assistance from government, it was not enough to reach every member of the family, who was greatly attached to the victims.

Families of the dead victims sought refugee in their faiths, and put much confidence and trust in their God than the earthly authorities entrusted to oversee their welfare.

The most devastating impact was the explosion of the second bomb; it caught up with the revellers, who were racing away from the scene.

Amnesia was prevalent among the severely hurt victims.

Essentially the relevancy of psycho-therapy is unknown to most Ugandans.
Unconventional therapies are powerful.

Medical services constituted provision of mortuary services, including cleaning and treatment of dead bodies. However, they were mistreated: they could be held at either feet or head and pulled across the concrete floor. Both the dead and severely injured bodies were piled up in a bath of blood. The mishandling of bodies caused worse injuries than the bomb blasts did. One respondent,

who was picked from the rest of the bodies after being discovered alive complained of broken shoulders and detached tendons, which until now put the arm out of use. There are also complaints that people who died were found undressed, not in their original clothes.

Government was blamed for the entire mess, arguing that, had it not gone to Somalia, innocent Ugandans would not have suffered terror attacks. Some respondents, however, chose to blame themselves and organizers of the event for not being cautious.

Patients dropped off treatment regimes without official discharge by health professions; they felt better being out of the 'prison' (hospitals) for a freer world. Overtime hospital life became so painful, so constraining that patients could not sustain it any more.

Media broke news of the dead to families, which was appreciated. Facilitating story-telling was welcomes, as well. But moving ahead to publish the stories was not welcome. Expected tokens from whoever sought stories about how they were coping. The media misrepresented them and compromised their rights to privacy. This made them so sensitivity to it, and whoever asked them about their trauma experience.

The psychological interventional done was largely traditional, involving family, friends, and the church.

The families of the dead could not confirm efforts made to rescue lives on the basis that their loved ones had passed away. It was not an easier response to make than it was for the families of the survivors.

Involvement of cultural rites as part of intervention to relief emotion and psychological pain was more meaningful to cases family members died than for survivors (both injured and non-injured). And attention was given more to the families of the dead than to the injured and non-injured.
Assistance received as part of intervention, for those who got it, was inadequate. It could not help families to survive through the difficult times after loss of their loved ones. It was common for foreigner to show gratuity to Ugandan authorities and service providers, which was so rare with indigenous victims.

Masculinity and personality traits suggested for brave responses to situations that were traumatic.
Still suffered from physical and mental trauma: 'when it shines, I smell. When I am shaving, I get too much pain. My upper lip had to be rebuilt to gain shape.' Survivor, Ntinda.

Dead victims left behind dependants in need of education, clothes, and food. They receive very little care from the large extended family, as each of the members has responsibilities over his or her immediate family.

The means of transport used to transport dead and injured victims was dire: bloody bodies were piled on hard metallic bodies of police pickup vehicles.
Families were left wanting after loss of loved ones they depended on for economic survival and care.

Physiotherapy was not done. And survivors have limited resources to sustain healing through it. 'I might get porkinson disease later in life because my of the damge on the nervous system. Survivor, Kampala.

Some people missed out on assistance yet were in dire need of it. The severely injured could not make it to find help from service

providers. Appropriate interventions strategy was to meet them home.

Call for sustained economic support to facilitate establishment tf non-physical income generating projects, to fill the physical deformities gaps.

Recommendations from service providers: recognition of counselling by government, public service should consider recruiting counsellors, recruitment of counsellors in hospitals.

The orphans left behind are a big challenge to the reat of the extended family as each member has children to look after. 'Food access is a problem.'

'Police should get extra training in trauma handling; non-injured people should be compensated in future, counselling should be set for the non injured; encourage story-telling through Bukedde news paper because the more we talk about the tragedy the better we feel.' Abu, Naguru

There is need to improve livelihood conditions of orphans and support their education.

Rehabilitation services are no where to be seen for sustained healing.

Security concerns

Welfare support concerns
Institutional capacity to deliver
Evaluate welfare

'There should a team created to periodically go around to check on the welfare of survivors and families of the deceased and write reports… and find suitable employment for survivors, respect for dead bodies, continued financing of the injured persons to meet rehabilitation costs, which costs 25,000 to 30, 000 a day (about $6 to $7).'
Vigilance and improved care.

Terrorists struck because there was no security, we are now not taking anything for granted. The public should join hands with the country's security by always reporting suspicious people. Police now has ambulances; it no longer carries victims in 999 patrol pickups.' Survivor Cop.

Sustained care
Ambulance services
Follow-up
Welfare support
Employment

Immediate needs for dependants are school fees, employment, accommodation/ rent.

Establish program for long-term treatment/ rehabilitation and to fight maladjustment. Public security is wanting.

Army had better medicine for the nature of injury.
Required specialized service providers.

There is need to support medical bills which are still costly.
'anics in case of sudden noise'

There is different between special care and general care, there is need for more specialized training, to build capacity, create a unit for further reviews, deal with long queaues, sustain family incomes, more resources allocation to the health sector, and motivation of health workers.' Survivor and a member of the police force, Jinja Road, Kampala.

…have security measures in place and ensure population vigilance. Busega

Follow-ups were religious done through memorial services, annually. Other than the compensation fees given by government, professional services eluded victims.

…impromptu response upon tragedy, value for life, laws that favour rescue efforts from volunteers without fear, improve economic life of families, and avail ambulances on busy streets.' Survivor, Naguru

…strength safety measures, public vigilance, sustained assistance to families, and follow-ups and monitor welfare of families of victims.' Busega.

Police need training in rescue efforts.
'First of all victims should thank God that they are still alive and have to pray to keep them strong.' Victim, Nyanama

'There is need to strength disaster management committees.' Muwonge Wilson, URC, Kawempe

'Church was most helpful.'
'We still have too much pain.'
Counselling
Sensitization
Precautionary measures
Continued financial assistance
Driving gently when ferrying dead bodies
Medical care

Homebased care
Training in first aid
Defense and security management systems
Follow-up
Right people to pay
Security x 6
Government responsibility

Build schools for victims
Free education for orphans
Avoid war provocation
Improve medication

Timeliness of police in case of an emergency
Police are timelier in case of political protests. They come much later when people are dead' Victims in Naguru

Security
Reviews
Follow-up
Physiotherapy
Security
Follow-up
Adequate medical facilities
Psychologiclal services
Followup
Economic support
Service Providers
Permanent checkpoints in public places

Check priori to th beginning f the function, when the function starts, and during the public function
Hotlines for terrorism department
Improve facilities in public health centres
Standby ambulances for hospitals
Adequate medical facilities
Decentralise mental health services delivery
Medical review
Security
Safety issues
Follow-up
Medical review
Sustained support
Security
Reviews
Security
Safety issues
Mental health care
Sustainable care
Sustained supprt
Protection
Follow
Follow-up support
Rehabilitation
Follow-up
Continuous
Rehabilitation

Safety
Sustained healing
Safety Measures
Follow-up
Follow-up
Psychological help
Expanded interventions
Support family assimilation of the problem
Psychological services
Follow-up
Personal security
Sensitization
Look after families
Medical bills
Look after orphans

The act of organization memorial services did good, and should be encouraged; families and friends felf greter relief soon after the occasion. 'I did not feel much bad better the memoral service was done.'

Improve boarder security.

Increase security in busy places
Financial motivation for medics
Increase number of medics
Meet medical bills for families

Support to orphans
Medical treatment
Continuous support/assistance
Psychological people to talk to
Economic
Caution
Education
Orphan support
Memorial services
Justice
Create jobs for disabled persons
Service organisation should ensure security of clients
Caution
Sensitisation
Organiser of events should take keen interest in security situation

Masses be security conscious more than before.
Improve security
More money for care
Medication
Help those in need
Follow-up
Security
Follow-up
Security
Have ambulances in accident prone areas and in every division.
Vigilance
Counselling
Prayers
More compensation
Antiterrorism
Security
Training in terror preparedness
Further Deductions
'Still miss parental love, he was so close to me, he left an irreplaceable gap.'

The immediate reaction was confusion, emotionless; in a long run was failure to speak about it and getting irritated by noise and crowds.

Families moved to new places to escape from the bad memories.

Transportation to hospitals was not comfortable. That could have caused deaths. The form of counselling received was traditions: church, friends and relatives.

Intervention necessitated addressing both traumas due to personal injury and from the loss of loved ones.
Over a period of one month, it is more human for patients to join the rest of the family and get nursed from there, rather than stick around in hospitals for a very long time. Longer stay accelerates pain, emotional, psychological and physical pain in the life of patients.

Security oversight was largely a duty of government. Self-blame was largely a symptom of lack of leadership, where individuals opt to take charge of their own safety in place of government. The rest of the nation only plays a complimentary role to it.

Information about identity of the dead was got at the city mortuary. Mortuary services involved cleaning and treatment of dead bodies.

The importance of culture today is limited to passing out of the dead; for the survivors arrangements of passage from threats to life centred on modern-day criteria like prayers and social comfort.

Given the under-capacitating situation of service providers, it was deemed fit to prioritise the allocation of resources by considering victims that died and those close to death. Despite suffering psychological trauma, the non-injured missed out.

The assistance given to aggrieving and injured victims (beneficiaries from the services provided) was insufficient to sustain healing, both medically and psychologically.

Telling stories to journalists was therapeutic, but damaging to reveal their privacy to the rest of the world, especially when it never came with practical assistance to family problem told.
Professional mental health interventional was inadequate for those who received it and inaccessible for the majority others.

Families of the dead could not acknowledge services made to save given the fact that they could not save the lives of the departed loved ones.

Dead bodies are assumed useless mass of non-functioning fresh, without pain, which regardless of the mistreatment, it made no different in its life. However, in cases, as most likely to occur, given our poor health services and care, some of the people presumed dead, might be actually not.

Orphans need continues care to further access to their basic needs as food and clothing, and development needs as education.

There is need to have ambulances to service providers as police, who often are fastest to the scenes of disaster.

Appendix E: Department Authorisation Letter

MAKERERE UNIVERSITY
P.O. Box 7062 Kampala Uganda
Cables: MAKUNIKA

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COLLEGE OF HUMANITIES AND SOCIAL SCIENCES
SCHOOL OF LIBERAL AND PERFORMING ARTS
DEPARTMENT OF RELIGION AND PEACE STUDIES

Dear Sir/ Madam,

TO WHOM IT MAY CONCERN

The bearer of this letter ..... Waiswa Jacob .....
is a Master of Arts student on the Peace and Conflict Programme in the Department of Religion and Peace Studies, Makerere University. He / She is to carry out research on Retrospective Evaluation of Interventions for Handling Psychological Trauma in Families affected by the July 11, 2010 Terror Attacks in Kampala.
.....

He/She is kindly requesting you to avail him/her with relevant data to his/her dissertation. The purpose of this letter, therefore, is to introduce him /her to you and to thank you in advance for the assistance you will render him or her during this period.

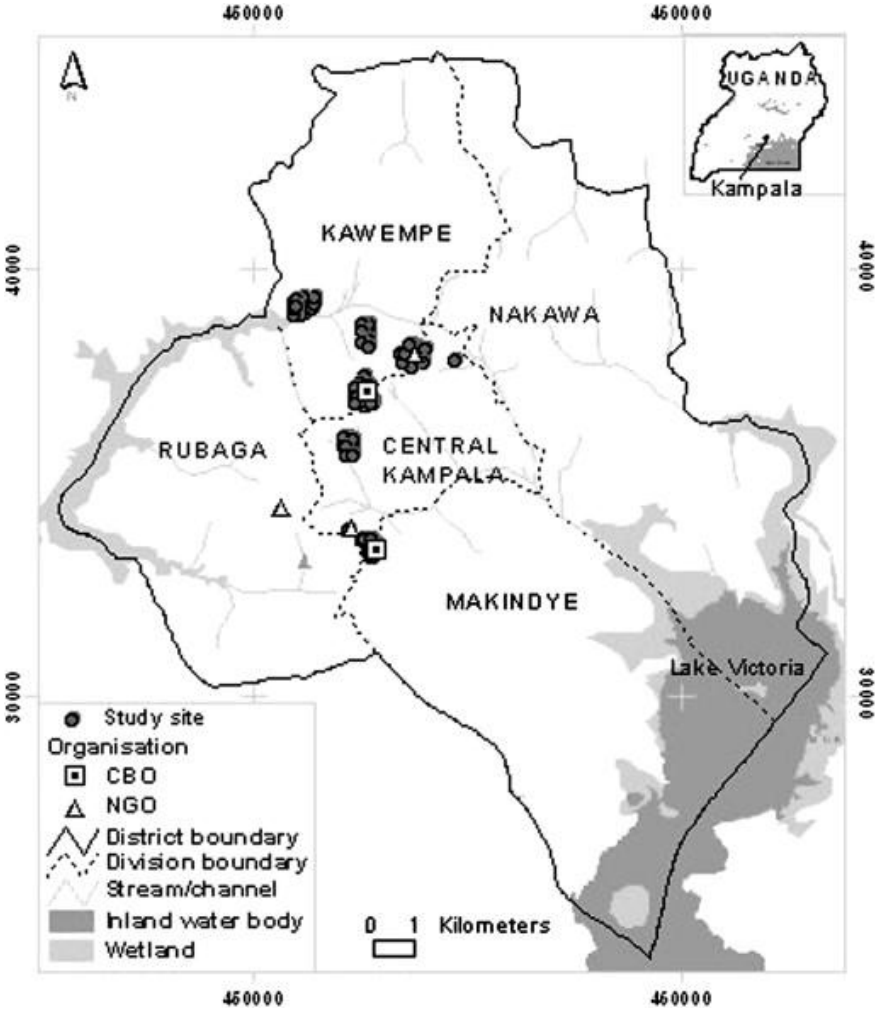
Yours sincerely,

MAKERERE UNIVERSITY COLLEGE OF HUMANITIES AND SOCIAL SCIENCES DEPT. OF RELIGION AND PEACE STUDIES CHAIR

15 MAR 2012

Haji Katende Abdu
Ag. Head of Department

Appendix F: Map of Kampala



Appendix G: Methodological Information

Estimate of Population Size (1640) of Affected Districts

Districts	Percentages (%)
Luwero	2.00
Wakiso	46.00
Mpigi	12.00
Mukono	20.00
Kampala	15.84
Others	4.16
Total	**100.00**

Affected Families: Participants in Personal Interview (150)

Places	Number of Respondents
Nakasero	1
Kanyanya	5
Kawempe	2
Kazo	1
Bwaise	5
Wandegeya	1
Makerere University	6
Makindye	1
Nsambya	2
Ndeeba	1
Kabalagala	13
Kasanga	6
Kibuli	3
Buziga	2
Salaama	2
Bugoloobi	8
Bukoto	7
Ntinda	6
Naguru	38
Nakawa	6
Mutungo	4
Busega	7
Kabowa	2
Muyenga	2
Lugala	5
Namuwongo	11
Luzira	4
Total (n)	**150**

Key Informants (10)

Mulago Hospital	2
Refugee Law Society	1
International Hospital Kampala	1
Interaid Uganda	1
Uganda Police	3
Uganda Counseling Association	1
Uganda Red Cross	1

Secondary Literature Reviews

Sources	**Number**
Reports	1
Articles	18
Journals	1
Total	**24**

Source: Primary Data.

Appendix H: Demographic and Associated Results

Document Analysis for the Extent of Psychological Trauma

Despite indicating proactive response to the tragedy, the life-saving efforts were so overwhelming and difficult to cope with.

Casualty cases were so overwhelming to medics	Yes (100%)	Limited resources	17 Documents Reviewed

Faiths like the B A P S Swaminarayan Sanstha –an international socio-spiritual Hindu organization with references to scriptures and personalities of the *Swami Narayan* group, also prayed for the victims and sent condolence messages to the victims and their families –led by His Divine Holiness Pramukh Swami Maharaj. Religious efforts were very supportive; psychologically and spiritually for their respective audiences that suffered in the 7/11 terror attacks.

Appendix I: Participant Lists

INTERVIEWEES, SOURCES, AND REFERRALS

Alice -Bwaise 0791292083/0715161295
Doreen Kasuule, Nakawa (refer)
Odera 0703534442
John Asiimwe Refer
Engineer Charles 0705783601, Naguru
Grace Bwaise
Segawa Robert, Ntinda
Junior, Kasangati
Coleb David, Nyanama
Sarah, Nsambya
Morris, Zana
Timothy Kiyingi, Kampala
Ambrose, 0702016646
Bugoloobi Kitintale?
Sadat, Naguru
Abubakr Mujaheed, Naguru
Kazibwe Musa 0701347034
Musa, Naguru
Anonymous, Naguru
Henry Kimuli, Kisozi Complex, 6/8
Kagwe Road, Kampala
Kataaza Railway, Nakawa
Kigula, Nateete Junior School
Macky High School, Busega
Mami Mengesha, Kabalagala
Referred 0713959733
Aluma SERVICE PROVIDER (MORTUARY)
Dan Atyeeni SERVICE PROVIDER (INTERAID)
Dr. Kyanda ICU
Joan Namuyomba (Rugby Ground)
Junior 0713950733
Head of Psychosocial Department - Refugee Law Project
Mama Mark 0775423601
Mami Mengesha -Ethipian Village 0772623440
Okonye, Ministry of Finance
Mugole (Detective: Uganda Police) 0752564530
Pastor -Jinja Road Police Baracks 0759241324
Referred 0773765327
Crespo 0703966406
Oponya Innocent 0787673727
Kiguli family 0782005515
Kiguli Refers 0781535361
Kimuli 0782222258
KMPG refers 0716337799
Mark 0712862543
Mzee Muyenga 0772140140
Preparedness Agency 0772907900
Raymond 0777660947
Sam 0750118853
Steven 0772913364
Dag Refer
Res,Sunday 0772792542
Vivian 0774265932
Kigula Refer 0782075105
Robert 0772379167
Salvation Army 0414322247
Yeeko 0752804609
Bonita 0701153345
DISO 0701420660
Flavia 0782126789
George Refers 0774171865
Nakato 0774000523
RES Refers 0713050733
BEN 0783895412
Abu 0774263337
EDGA 0700451046
Mariam Refers 0779243580
Morris 0792646448
Osike ERU 0700413386
Nalwadda 0701153345
Timothy Kiyingi 070078439
Sobrico 0783542581

Kalumba Mathius FB connect
Samuel Okot Ggaba
Kamya Julus facebook connect
Wasswa Daniel Refers (facebook Connect)
Jeff Williams facebook Connect
Katende Norman, Newvision
Vinny Panico facebook Connect
Steven Kinobe facebook Connect
Kityo Moses facebook Connect
Peter Mubiru facebook Connect
Late Alice Kyalimpa Family facebook Connect
Matto Vumbi facebook Connect
Kyle Klenn facebook Connect
Herbert Kasaijja facebook Connect
Alice Mutabazi Bwaise Pentecostal Churcg
Grace Mutabazi Refers
Ivan Mohammed facebook Connect
Kris Sledge facebook Connect
Joanne Heck facebook Connect
Abass Mohammed facebook Connect
Coled David Muwemba 0702067324 or 0782067324
Sarah Its 0701252590
Kikooyo Mathius Refers
Mark Keith Muhumuza facebook Connect
Tarushoke Norman facebook Connect
Solomon Tmwesigye facebook Connect
Justine Mumbere facebook Connect
Mengashi Mami –Ethipian Village

Info: temporary list of bomb attack victims killed or missing
2010-07-13 12:24:23
Read more:
http://ugandaradionetwork.com/a/story.php?s=27803#ixzz284cWUfLW

This is the latest police list of the dead and missing from the bomb attacks on Sunday July 11, 2010. The list of the dead is specific to those who died in hospital, not those who were killed on the scene.

This is not a news story, but merely information for you to use in your station's programming.

List of the dead

Denis Ssemanda
Henry Baruku
Peter Mutabazi
Jenny Akol
Joe Kalenzi
Jimmy Musinguzi
Edward Mawejje
Brenda Nabachwa
Brian Kivumbi
William Batanda
Stephen Okiria
Dan Turyahabwe
Dickson Bagenda
Margaret Nabankema
Tendo Nakitende
Peter Mutabazi
Philip Henn
Angela Kalyegira
Peter Oye
Mohammed Abaas

List of the missing

Patrick Omuse
Sam Okoth
S. Kyeyune
Amanda M.
M. Kigule
Henry Balongo
Niyiy Efrem
Esmelash Efrem
Caleb Tereste
Habton
Geoffrey Malcolm Muyinda
Dennis Otema
Tonny Lubimba
Najib Kabazi
Keziron Muwanga
Henry Bakulu

Sula Ssewanyana
Alex Adiro
Susan Nansubuga
Simon Mwebaze
Matthew Kaddu
Innocent Oponya
Bashir Senfuma
Boss Kassim
Gordon Kyonga
Olivia Nalubega
William Katto
Christina (Sri Lanka female)
Seyyid Seddi
Charles Matovu
Erick Mawuso
Ssengendo Sentongo
John Bosco Sekanjako
Benjamin Ojara
Issac Sam Okwir
Francis Ssemwogerere
Katamba Semakula
Muhammad Mukasa
Sulutan Sembatya

1. Read more: http://ugandaradionetwork.com/a/story.php?s=27803#ixzz284bCru6I

A provisional list of the bomb victims as released by police as of 12.07.10

Below is a provisional list of the victims as released by police as of 12.07.10. It contains only half the dead:

1. Angela Kalyegira
2. Peter Oye
3. Denis Ssemanda
4. William Katamba
5. Dan Kityo
6. Jimmy Musinguzi
7. Daniel Mutai
8. Brenda Namanda
9. Dick Beganda
10. Linda Mutama
11. David Kimera
12. Gabrael Komakec
13. Samalie Katasi
14. Bonita Nakato – MUK student
15. Moreen Nantale
16. Regina Vicky Aryokot – S6 Vac
17. Siraj Abiriga
18. Rebecca Nakityo
19. Sidonia Apio
20. Irene Nassozi
21. Julius Asiimwe
22. Kezeronia Mwanga
23. Henry Baluku
24. Shwan Khan
25. Lilian Kobusingye
26. Juma Shodi
27. Rebecca Nakitende
28. Jane Akol
29. Tom Opio
30. Sulaiman Kakooza
31. Augustine Luweeba
32. Solomon Vitus
33. Philips Hani
34. Efren Ninay – Ethiopian
35. Efren Ednelash – Ethiopian
36. Kaleb Tereste – Ehtiopian
37. Habton
38. Smith Maria – Irish
39. Allan Kalanzi
40. Samuel Okoti
41. Smith Karamuzi
42. Stephen Okiria
43. Joy Kiiza

The above list is just half of the carnage.Some of the bodies have not been identified due to the great damage they suffered. The number so far confirmed dead is 76 – but the list is growing. The list of the injured is as representative of Uganda as the above.

Peter Okello Maber
http://ugandansatheart.org/2010/07/13/a-provisional-list-of-the-victims-as-released-by-police-as-of-12-07-10/

Fw: kla world cup bomb blasts - open only if you must

Inbox X

kiiza daniel danielateenyi@yahoo.co.uk Mar 23

to waiswajacobo, me

--- On **Fri, 16/7/10, Ronald Musinguzi <*ronamuz@yahoo.co.uk*>** wrote:

From: Ronald Musinguzi <ronamuz@yahoo.co.uk>
Subject: Fw: KLA WORLD CUP BOMB BLASTS - OPEN ONLY IF YOU MUST
To: danielateenyi@yahoo.co.uk
Date: Friday, 16 July, 2010, 14:44

--- On **Fri, 16/7/10, aijuka aggrey <*aijukaaggrey@yahoo.co.uk*>** wrote:

From: aijuka aggrey <aijukaaggrey@yahoo.co.uk>
Subject: Fw: KLA WORLD CUP BOMB BLASTS - OPEN ONLY IF YOU MUST
To: "Ronald muhumuza" <ronamuz@yahoo.co.uk>
Date: Friday, 16 July, 2010, 15:50

--- On **Thu, 15/7/10, ahimbise jackson <*jackahimbise@yahoo.com*>** wrote:

From: ahimbise jackson <jackahimbise@yahoo.com>
Subject: Fw: KLA WORLD CUP BOMB BLASTS - OPEN ONLY IF YOU MUST
To: "kyomukama jane" <janekyomukama@yahoo.com>, "aijuka aggrey" <aijukaaggrey@yahoo.co.uk>, "Kyosimire Edna" <keibunuedna@yahoo.co.uk>, "caroline karungi" <casaka2003@yahoo.co.uk>
Date: Thursday, 15 July, 2010, 16:28

----- **Subject:** Fw: KLA WORLD CUP BOMB BLASTS - OPEN ONLY IF YOU MUST

Victims of bomb blast: an assessment working report for refugees and alylum seekers (7/11 victims

1. Efrem Neway Kidane (RIP)

Nationality : Eritrean
Age : Adult
Sex : Male
File No : Not available
Status : Refugee
Place of residence: Najjanankumbi

2. Kaleb Tetekeste (RIP)

Nationality : Eritrean
Age : Adult
Sex : Male
File No : Not available
Status : Asylum Seeker

Place of residence: Kansanga

3. Efrem Asmelash Beraki (RIP)
Nationality : Eritrean
Age : 23
Sex : Male
File No : Not available
Status : Refugee
Place of residence: Kansanga

4. Nardos Mebrahtu (RIP)
Nationality : Eritrean
Age : Adult
Sex : Female
File No : Not available
Status : Refugee
Place of residence: Kansanga

5. Simon Yemane (RIP)
Nationality : Eritrean
Age : Adult
Sex : Male
File No : Not available
Status : Refugee
Place of residence: Kansanga

6. Habtom Ghrmay (RIP)
Nationality : Eritrean
Age : Adult
Sex : Male
File No : Not available
Status : Asylum Seeker
Place of residence: Kansanga

7. Gatayawkal Tessema (RIP)
Nationality : Ethiopian
Age : 30
Sex : Male
File No : Not available
Status : Refugee
Place of residence: Kansanga

ADMITTED CASES

1. Winta Gergesh Yosef
Nationality : Eritrean
Age : Adult
Sex : Female
Status : Refugee
Place of residence: Kansanga
Contact : 0783916816
Hospital: International Hospital of Kampala
Nature of Injury : Sustained injuries on the foot and bomb fragments not yet removed.
Medical Intervention: Treated and given an appointment of 19th July 2010 to remove the fragments.

2. Berhane Eyob
Nationality : Eritrean
Age : 29
Sex : Male
File No : Promised to call IAU and give it later
Status : Asylum Seeker
Place of residence: Kansanga
Contact : 0784475506 (Biniam)
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the abdomen, chest and thigh.
Medical Intervention: Operation done and fragments removed but pending further examination to rule out the possibility of any fragments remaining.

3. Ruta Desta
Nationality : Eritrean
Age : 32
Sex : Female
Status : Refugee
Place of residence: Kansanga
Contact : 0783522498
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the back.
Medical Intervention: surgery carried out and further examination to be done after one week.

4. Asrat Teklemariam
Nationality : Eritrean
Age : 37
Sex : Male
Status : Refugee
Place of residence: Namuwongo
Contact : 0774398663
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the face and left leg.
Medical Intervention: Treated and given an appointment of 19th July 2010 to remove fragments.

5. Lidia Mokonen
Nationality : Eritrean
Age : 24
Sex : Female
File No : Promised to give it later
Status : Refugee
Place of residence: Kansanga
Contact : 0783333315 (Abraham Solomon)
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the left arm.
Medical Intervention: She was to be operated on that day 14th July at 05pm.

6. Jonie Lulu Dinkenhe
Nationality : Ethiopian
Age : 31
Sex : Male
Status : Refugee
Place of residence: Kansanga
Contact : 0779284949
Hospital : International Hospital of Kampala
Nature of Injury : Spinal and intestinal injury.
Medical Intervention: He was found being taken for surgery on 14th July 2010.

7. Kabrar Beyene
Nationality : Eritrean
Age : Adult
Sex : Male
Status : Asylum Seeker
Place of residence: Kansanga
Contact : 0702787572
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the leg and fragments not yet removed
Medical Intervention: Treated and given an appointment of 19th July 2010 to remove fragments.

8. Samson Tesfaye
Nationality : Eritrean
Age : 30
Sex : Male
File No : promised to send it to IAU after discharge
Status : Refugee
Place of residence: Kabalagala
Contact : 0701119282
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the leg, both arms and thigh.
Medical Intervention: Treated and given an appointment of 19th July 2010 to remove fragments.

9. Yemane Yahannes Desta
Nationality : Eritrean
Age : 39
Sex : Male
Status : Refugee
Place of residence: Kansanga
Contact : 0783625442
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the face
Medical Intervention: Treated and stitched but pending further examination to

rule out any fragments remaining.

10. Yehalem Abebe

Nationality : Ethiopian
Age : 27
Sex : Male
File No : promised to send it to IAU
Status : Refugee
Place of residence: Kansanga
Contact : 0701477901
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the leg and arm
Medical Intervention: Treated and given an appointment of 19th July 2010 to remove fragments.

11. Kasahun Legesse

Nationality : Ethiopian
Age : 22
Sex : Male
Status : Refugee
Place of residence: Kansanga
Contact : 0702766364
Hospital : Mulago Ward 2 A
Nature of Injury : Sustained injuries on the lower leg, thigh and knee.
Medical Intervention: Surgery done to remove fragments but the one in the knee is delicate to remove and the operation cannot be done in Uganda.

12. Zeresenay Tesfazion

Nationality : Eritrean
Age : 35
Sex : Male
Status Refugee
Place of residence: Kansanga
Contact : 0775981190
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the head and still has one fragment.
Medical Intervention: Treated and given an appointment of 19th July 2010 to remove the remaining fragment.

13. Daniel Amannuel

Nationality : Eritrean
Age : 29
Sex : Male
Status Refugee
Place of residence: Namuwongo
Contact : 0779318732
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the thigh, hip, right knee and arm
Medical Intervention: surgery done and fragments removed apart from the one in the thigh.

14. Fitsum Gebrmedhin

Nationality : Eritrean
Age : 23
Sex : Male
Status : Refugee
Place of residence: Namuwongo
Contact : 0773044370 / 0702555983
Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the right rib and chick and fragments are still inside.
Medical Intervention: Treated and given an appointment of 19th July 2010 to remove fragments.

15. Solomon Mekuriya Balcha

Nationality : Ethiopian
Age : 31
Sex : Male
Status : Asylum Seeker
Place of residence: Kabalagala
Contact : 0775210059

Hospital : International Hospital of Kampala
Nature of Injury : Sustained injuries on the head
Medical Intervention: Treated but still has the fragment that will be removed in case it does not come out on its own.

16. Abdisa Fafuri Wako
Nationality : Ethiopian
Age : Adult
Sex : Male
Status : Refugee
Place of residence: Kansanga
Contact : -
Hospital : International Hospital of Kampala
Nature of Injury: Sustained injuries on the leg and has backache Medical Intervention: Treated and discharged but still not in good condition.

17. Mathyos Mesfin
Nationality : Ethiopian
Age : Adult
Sex : Male
Status : Refugee
Place of residence: Kansanga
Contact : 0702-480638
Hospital : International Hospital of Kampala
Nature of Injury: Sustained injuries on the face,leg and back: Treated and discharged but has leg paralysis.

General complaints presented by patients

Mental disorders
All of them complain of the intrusive memories and flash backs of the incident and they have always failed to sleep and they have nightmares. They also have imaginary visual images of deformed dead bodies and sounds of casualties yelling and screaming in pain. Some have already been started on mental treatment.

Sensory defect
Most of them complain of hearing loss especially those who sustained head injuries. They are also complaining of memory loss and numbness of the parts of the body where they sustained injuries.

Insecurity
Apart from being victims society perceives them as terrorists. They say that, their relatives and friends have on several occasions been threatened verbally and accused of being terrorists. Others have been denied public transport despite their willingness to pay.

Request to UNHCR
They requested to meet with UNHCR and Community Services such that, they give details of their experience and the challenges they are currently facing such that they agree on the way forward in relation to their security and future life.

Recommendation.
All these victims have varying social, security and medical problems that need different forms of intervention. It is therefore necessary to attend to them individually such that proper assessment and intervention is done. Protection and Community Services UNHCR and OPM should consider meeting the victims for further intervention.

Appendix J: Budget Estimates and Period of Research

Item	Cost ($)	Cost (Shs)	Qty ($)	Qty (Shs)	Total Cost ($)	Total Cost Shs)
• Consultations	300	690,000	5x300	5x690,000	1, 500	3,450,000
• Testing Tools	50	115,000	5x50	5x115,000	250	575,000
• Internship • Data Collection • Transport Costs	50 50 50	115,000 115,000 115,000	5x50 5x50 5x50	5x115,000 5x115,000 5x115,000	250 250 250	575,000 575,000 575,000
• Stationery • Documentation	50 30	115,000 69,000	3x50 5x30	3x115,000 5x69,000	150 150	345,000 345,000
• Reviews • Submission • Dissemination	50 30 100	115,000 69,000 230,000	6 x 50 5 x50 5 x100	6x115,000 5x69,000 5x230,000	300 250 500	690,000 3,450,000 1,150,000
					17,050	**11,730,000**

Period of the Study

Period	Literature Review	Consultations	Research Design.	Internship	Piloting & Data Collection	Report Writing	Dissemination
2011							
Nov.							
Dec.							
2012							
Jan							
Feb							
Mar							
Apr							
May							
Jun							
Jul							
Aug							
Sep							