

Evaluation of Network for Africa (N4A) and BasicNeeds UK in Uganda (BNUU)'s Mental Health Programme in Northern Uganda

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Executive Summary

BasicNeeds UK in Uganda (BNUU) in Agago District – a remote corner in the north east of Uganda, which was the battleground of a sustained and brutal conflict between the Lord's Resistance Army (LRA) and the Ugandan army (the UPDF) for more than 20 years. This protracted conflict left a legacy of severe, widespread mental health issues including post-traumatic stress disorder (PTSD), depression and anxiety. BNUU works in partnership with Network for Africa (N4A) who partner with local NGOs in sub-Saharan Africa to help survivors of conflict or genocide and their families overcome trauma and rebuild their lives through access to mental health care and livelihoods support.

Since 2017, BNUU has been offering community mental health services in Agago District. In 2022 Fondation d'Harcourt funded BNUU to extend their community mental health programme to two new sub-counties in Agago District, specifically Lapono and Adilang, under the project title of Wic Ma Yot Kwo Maber (Healthy Minds, Good Lives). Through this project, over the last 3 years, BNUU has: run 176 community outreach/awareness raising sessions and health talks about mental health for 3,908 people, so they can understand and recognise the symptoms of mental illness, reduce stigma and encourage people to come forward for treatment; run monthly mental health clinics in these two sub-counties, reaching 1,168 people with mental illness or epilepsy; offered individual and group counselling sessions to 960 people; conducted 902 home visits to the most vulnerable patients; trained 22 primary health care staff and 141 individuals in village health teams (VHTs) to enable individuals to identify people with mental disorders and/or epilepsy, diagnose effectively, provide low level support and make the correct referrals for more serious cases; and set up ten Self-Help Groups (SHGs) so that 178 people with mental disorders/epilepsy (PMDEs) and their 52 caregivers have a support network, start group savings both for themselves and for a 'drug bank' of emergency medication supplies, prepare for livelihood support, and have a group voice for advocacy.

The case studies reviewed, and the focus groups undertaken as part of this evaluation, illustrate how the Wic Ma Yot Kwo Maber (Healthy Minds, Good Lives) Project has enabled individuals to improve and maintain their mental health, reduced the burden of caring, reduced stigma, improved individuals' ability to take part in normal activities and gave them hope for the future. Beneficiaries also highlighted that the Self-Help Groups were crucial in both sustaining and enhancing recovery but also for starting to plan for the future. Quantitative data collected by BNUU support these outcomes. E.g. CORE-10 assessments from clients from the mental health clinics needing, and referred to, counselling shows that 272 individuals (93% of the sample) were at moderate to severe psychological distress at the outset of support, whilst at the end of support, 220 (75% of the sample) were in the non-clinical range, 67 people (23%) were in the mild psychological distress range and just 5 (2%) were in the moderate psychological distress range – a significant reduction in psychological distress; Pre- and post-training surveys show both Health Workers and VHT workers improved their knowledge about mental health; of those clients who received home visits, 97% felt they no longer feel stigmatised by family members for their mental health issues (an improvement from the 7% at baseline); 90% were able to engage in some daily activities (compared to 41% at baseline); and 77% were adhering well to treatment; and Key Informant Interviews with PMDEs found that 84% had plans in place to manage their mental illness symptoms, or a plan in place for if these reoccurred.

During the grant period, the level of need for local mental health services was clear and considerable. In the first mental health clinics held in the health centre IIIs (one in Adilang and one in Lapono) over 200 people attended hoping for support. To try to deal with the overwhelming number of clients, BNUU rolled out mental health clinics to 6 more health centre IIs. This brings clear benefits to clients – they can access mental health support closer to home without needing to travel large distances and reduced waiting times. Unsurprisingly, this has increased client retention, improving the possibilities of patients seeing improvements.

However, this decision was taken without really considering the impact of this on the project's (and project staff's) capacity. As a result, the project counsellors have had to spend more time 'out in the field' than envisioned at project outset, which has had one clear negative outcome: only CORE-10 data from 292 people who had attended individual counselling (30% of the total individual counselling clients) has been uploaded to BNUU's database. There was also no CORE-10 data uploaded for people who had received group counselling. As such, we cannot assume the mental health improvements seen for the 292 individuals are representative of the entire cohort. Ideally, BNUU would update the database with all the CORE-10 data they have to determine this; However, at the outset of this evaluation, BNUU believed it would be too lengthy a process and would have delayed this evaluation. However, since reading the draft evaluation they have decided to input all the data (this will be reviewed by this evaluator, with findings to be added as an addendum to this report). Going forward, this evaluation strongly recommends that BNUU carefully consider capacity when taking decisions on scaling up delivery (in this project, scaling up to more health centres rather than more beneficiaries), including frontline staff's ability to maintain accurate digital records (which will include ensuring that frontline staff have the technology e.g. smart phones to allow for this). This recommendation is especially important given the very high level of need for mental health services, as BNUU will always be under pressure to deliver more.

There were other issues found with monitoring. Project staff used both off-line and on-line reporting processes e.g., counsellors kept paper records of their own observations on individuals' mental health. In addition, there is evidence BNUU haven't accurately recorded the number of caregivers provided with support. Furthermore, once BNUU counsellors had submitted their data into KoBo, they were then unable to see the data again without requesting it from BNUU's M&E Officer. The M&E Officer did this for data protection, however it meant that counsellors were unable to correct errors. Overall, these issues mean it is impossible to determine the number of carers the project supported and cannot compare the mental health improvements seen across project activities to determine if some interventions are more effective than others. BNUU has recognised the issues with its M&E system and are working with an M&E consultant to resolve these. As part of this process, BNUU should review its monitoring processes to allow real-time data input, only gather data that is really needed and allow counsellors to access client's records, to ensure data is accurate. BNUU should also collect and analyse CORE-10 data from/across all project activities, enabling BNUU to understand what interventions (or combinations of interventions) are most effective.

In the original bid, there was a focus on sustainability. In terms of individual outcomes, beneficiaries showed a clear understanding of mental health issues/epilepsy and the steps they could take to maintain their health in the future; knowledge which is likely to outlast the end of support. The Self-Help Groups created through the project have also built a support network for individuals, to help maintain mental wellbeing and the built in drug banks should ensure the supply of medication, again supporting the longer-term sustainability of individual improvements in mental health and epilepsy management. The training of local health workers and VHTs has improved knowledge of mental health and follow up surveys administered as part of this evaluation provided evidence that individuals had maintained, and in the case of the VHT workers, improved their knowledge of mental health since the original training, indicating this knowledge is likely to endure beyond the life of this grant. However, given the high turnover in Health Worker staff, going forward, it would make sense to offer training on a rolling/regular basis, so that new Health Workers can also be trained. There was also a desire that over the longer-term the project will be implemented through existing government structures. There has been some progress around this in part due to BNUU's advocacy e.g. the District Health Office is currently recruiting for a psychiatric nurse and a psychiatric clinical officer. However, despite these positive steps forward, it is unlikely that if BNUU stopped delivering services that these would be taken over by existing health structures. As such, BNUU should aim to secure ongoing funding for the project to be able to continue addressing the high demand for mental health support, whilst continuing to build the capacity of, and advocating for, local health services to take on this work over the longer-term.

Methodology

The Bright Ideas Partnership was appointed by Network for Africa (N4A) and Basic Needs UK in Uganda (BNUU) to support the evaluation of BNUU's Wic Ma Yot Kwo Maber (Healthy Minds, Good Lives) Project, funded by the Fondation d'Harcourt. The evaluation covers the period funded by the Fondation d'Harcourt, from the 1st of March 2022 to the 28th of February 2025.

Bright Ideas has experience of producing evaluations of projects on behalf of organisations including Victim Support, the Basement Project, Porchlight, Help for Carers and Justlife. The Bright Ideas Partnership is a Social Value Pioneer with Social Value UK. Jo Ryan, the lead evaluator, also has a Masters in Forensic Psychology and Criminology, which covered in detail qualitative and quantitative research methodologies, and is a member of the UK Evaluation Society.

In Spring 2025, Jo Ryan, of the Bright Ideas Partnership, Florence Adong, Programme Manager, BNUU, Annabel Harris, CEO, N4A and Tom Doughty, International Programmes and Research Manager, at N4A, confirmed the aims and objectives of the evaluation and the proposed research methodology. A schedule for completing the evaluation in Summer/Autumn 2025 was agreed.

The following research has been conducted to produce this evaluation:

- Desktop analysis of all documents associated with the project. This included data from the Baseline Survey, reports to Fondation d'Harcourt, meeting notes, notes from Network for Africa staff following visits to the project and reports from the Staff Mental Health Support provided through the project.
- Findings from the CORE-10 data collected by BNUU staff and analysed by N4A.
- Analysis and review of beneficiary case studies.
- Desktop analysis of top line financial figures for project spend versus the original budget.
- Reviewing responses to questions with/from the BNUU team, and follow up interviews with Florence Adong, Programme Manager, BNUU, Annabel Harris, CEO, N4A and Tom Doughty, International Programmes and Research Manager, at N4A.
- Five focus groups with 30 beneficiaries (23 were people with mental ill-health and/or epilepsy and 7 were caregivers) to discuss their experiences. The interview questions were developed by the evaluator but administered, transcribed and translated from the local language Acholi to English by BNUU staff. The evaluator then analysed the provided transcripts. It should be noted that there was some paraphrasing in evidence in the provided transcripts, so some of the quotes in the below report may not be word-for-word, but we have assumed the content is faithful to the original speaker.
- Follow up surveys with Village Health Teams and Health workers who BNUU had provided mental health training to, again administered by BNUU staff.

This evaluation is based on the information provided. If any of the information supplied is incomplete or inaccurate, the findings of this evaluation may be rendered invalid.

The Bright Ideas Partnership would like to take this opportunity to thank everyone who contributed to and took part in this evaluation. Photos used in the evaluation are credited to Simone Fior and Luca Galbiati.



Psycho-Education /
Counselling.
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BNUU worker and a counselling client
Photo © Simone Fior

Project background and need

BasicNeeds UK in Uganda (BNUU) originated as part of BasicNeeds UK but evolved as its own independent organisation in 2017.

BNUU works in Agago District – a remote corner in the north east of Uganda, which was the battleground of a sustained and brutal conflict between the Lord’s Resistance Army (LRA) and the Ugandan army (the UPDF) for more than 20 years. The LRA killed and terrorised thousands of civilians, and abducted at least 30,000 children, forcing them to be soldiers, porters and sex slaves (The Wilson Center, 2018). Some 1.7 million internally displaced people (IDPs) were herded into overcrowded IDP camps, ostensibly for their own safety, yet without any infrastructure, adequate protection or sanitation, leaving them vulnerable to abuse from both the LRA and UPDF, and prone to sickness and starvation.



This protracted conflict left a legacy of severe, widespread mental health issues including post-traumatic stress disorder (PTSD), depression and anxiety (Musisi, S and Kinyanda, E, 2020). An estimated 35% of Ugandans suffer from mental illnesses, with 15% requiring treatment; however, the actual figures may be much higher because of underreporting and limited research (Molodynski and Cusack, 2017). A study in Eastern Uganda revealed that 60.2% of respondents had a diagnosable mental illness, with the majority classified as moderate or severe (Abbo et al, 2009). Despite the high burden, approximately 90% of those affected never seek treatment according to the World Health Organization (cited in Atewologun et al, 2025). Uganda also faces a critical shortage of mental health professionals, with a rate of only 0.08 psychiatrists per 100,000 people, a statistic which places Uganda among the countries with the lowest psychiatrist-to-population ratios worldwide (Atewologun et al, 2025). These mental health services are also concentrated in urban areas; Given that 87% of the population in Uganda lives in rural areas, this means that most Ugandans have little access to mental healthcare (Shah et al., 2017). To illustrate this, in 2021 (the start of this project), Agago District, where BNUU works, had a population of 344,658 but no psychiatric personnel in the whole District. Resource constraints are also a major issue, with only 1% of the healthcare budget being allocated to mental health (Asiimwe et al, 2023). Most funding focuses on treating severe psychiatric disorders in inpatient facilities, leaving common conditions like depression, anxiety and PTSD largely unaddressed (Kigozi et al, 2010). Cultural beliefs and misconceptions such as attributing mental illness to spirits and witchcraft further hinder access to evidence-based care. Many patients initially consult traditional healers who, although compassionate, often employ unscientific and harmful practices such as chaining patients. This delays medical intervention and reduces the likelihood of recovery (all from GlobeMed Northwestern University, 2020).

Overall, the lack of available support for people with mental health issues means that family members (usually women and girls) shoulder the burden of care (Verity et al, 2021). This is not without cost – caring responsibilities hinder an individual’s ability to earn an income and go to school (International Labour Organisation, 2018). The high burden of care, high social stigma and low social support for caregivers of people with mental ill-health can also lead to

burnout and jeopardise a caregiver's own physical and mental health (Akbari et al, 2018) meaning caregivers themselves can also often be considered hidden patients (Hudson et al 2013).

To begin addressing the high level of mental ill-health, Network for Africa (on behalf of BNUU) secured a grant in 2017 from Comic Relief, to bring community mental health services to four new sub-counties in Agago District. Between 2018 and 2021, BNUU provided treatment to 2,041 people with mental disorders and/or epilepsy (PMDEs) at monthly mental health clinics, offered mental health training to 26 government health workers, established 61 self-help groups (SHGs) composed of 1,174 members and provided community education sessions to 2,046 community members, to raise awareness about mental illness and epilepsy - including where to seek treatment. There was a clear positive impact on mental health - at the start of support, 92% of clients interviewed were experiencing some level of psychiatric distress (as measured by CORE 10). By the end of the three-year project, this percentage had now fallen to just 9%.

Given the successes seen, Network for Africa (on behalf of BNUU) approached Fondation d'Harcourt in 2021 to extend this community mental health programme to two further areas in Agago District, specifically the sub-counties of Lapono and Adilang, under the project title of Wic Ma Yot Kwo Maber (Healthy Minds, Good Lives). These sub-counties were chosen as there were no mental health services in these areas, but the level of need was high, with people walking long distances to attend the nearest of BNUU's existing mental health clinics (with people walking 38 kilometres from Lapono and 56 kilometres from Adilang, often sleeping on the way). Adilang also recorded the highest number of suicide cases in 2020 in Agago District (Agago District Police Report 2020). A grant was secured in 2022; the baseline survey conducted with 338 community members at the project outset supported the need for the work. This found that 80% of people with mental illness do not seek help, and of those that did more had sought help from a traditional healer/shrine (9%) than from a health worker (6%). The level of psychological distress in the community also appeared to be high, with more than 60% of people responding either 'sometimes', 'often' or 'most of the time' to whether they had difficulty sleeping, felt unhappy, were distressed by unwanted images or memories, felt anxious or nervous and/or felt unable to cope when things go wrong, all potential symptoms of depression, anxiety and trauma. In addition, 44% of respondents highlighted that they had experienced suicidal thoughts. As such, at the project outset, there was a clear need for mental health support in the two target sub-counties of Lapono and Adilang.

Three years on from this baseline survey, this evaluation aims to assess the impact of the Wic Ma Yot Kwo Maber (Healthy Minds, Good Lives) Project, focusing on the impact on mental health, as well as to identify learning and best practice.



**Mental illness and Epilepsy Services
Available In This Health Facility.**

**Kony me two wic ki two olili
nonge i ot yat kany.**

**"Mi kony bot jo ma tye ki two wic ki two olili,
ci wek cimo tok gi"**

BETTER MENTAL HEALTH, BETTER LIVES

**BNUU's Programme Manager
at a Health Centre**

Photo © Luca Galbiati

Project description, outputs and outcomes

Wic Ma Yot Kwo Maber (Healthy Minds, Good Lives) project

The project is located in two sub-counties of Agago District, Lapono and Adilang, where there was previously no mental health provision. Over the last three years, it has offered a combination of interventions which include:

- Monthly mental health clinics where participants receive assessment, diagnosis, treatment and support. When the project first began, BNUU started offering mental health clinics in two health centre IIIs (the highest level of health centre in the district below hospitals – there is one HCIII per sub-county). Over the 3-year period, BNUU extended to offer mental health clinics to six additional health centre IIs (HCIIIs are located at parish level – smaller, but closer to communities), bringing the total to 8 health centres. This has reduced congestion in the two original health centres, and enabled BNUU to treat more clients, reduce waiting times and ensure clients don't have to travel such long distances to be treated. According to BNUU's clinical database, over the three-year grant period, these mental health clinics have engaged 1,168 people with mental illness or epilepsy (of which 358 were men and 810 women). Of the clients who re-attended for reviews, 98% reported that they have improved because of the treatment (medication and/or counselling). This exceeds the original target of 975 people with mental illness or epilepsy in the bid to Fondation d'Harcourt. Over the life of the grant, BNUU have offered individual and group counselling sessions to 960 people with depression and anxiety (prioritising clients with suicidal tendencies, clients with poor drug adherence, clients who missed clinic appointments, and those exposed to a high risk of trigger factors for mental ill-health) and conducted 902 home visits to the most vulnerable patients who, for example, aren't able to visit the mental health clinics to ensure that their treatment isn't disrupted. The original bid included the target of working with 850 caregivers. However, BNUU haven't accurately recorded the support provided to caregivers over the three project years. This is because according to the original programme design, caregivers were not required to have a mental health diagnosis to receive group counselling support (in groups with other carers), as this intervention was meant to focus on problem-solving, psychological first aid and psychoeducation support to relieve the burden of care, with the aim of strengthening their ability to support and sustain the recovery of their family members living with mental health conditions. However, separate records/database of the number of carers receiving group counselling were not maintained by BNUU. Caregivers whose level of distress could not be relieved through group counselling were referred to a mental health clinic for assessment, and those diagnosed with moderate to severe depression were subsequently referred for individual counselling. It was only at this point that an individual's caregiving status was recorded. Only 20 people who received individual counselling were registered as caregivers. BNUU's M&E Officer did share with Network for Africa the number of caregivers supported at both the end of 2022 and 2023, which came to a total of 541 caregivers over this 22-month period (as the project started in March 2022). However, BNUU and Network for Africa report that it seems that this record was not maintained after the M&E Officer left. These figures cannot also be corroborated against e.g. the KoBo database. Consequently, the evaluator cannot determine the exact numbers of caregivers supported, and thus if BNUU had met its target. This is discussed more in the sections below.
- Training (directly or through a train-the-trainer model) 22 primary health care staff and 141 individuals in village health teams (VHTs) from across Lapono and Adilang sub-counties (slightly below the original targets of 24 primary health care staff and 146 individuals in VHTs in the original bid). This training enables individuals to identify people with mental disorders and/or epilepsy (PMDEs) and refer them to the mental

health clinics for treatment and follow-up. The training also covered signs and symptoms of less acute and more severe mental illness, enabling individuals to diagnose effectively, provide low level support and make the correct referrals for more serious cases e.g. to the Gulu regional referral hospital mental health unit.

- Setting up ten Self-Help Groups (SHGs) so that 178 people with mental disorders/epilepsy (PMDEs) and their 52 caregivers have a support network, start group savings both for themselves and for a 'drug bank' of emergency medication supplies, prepare for livelihood support, and have a group voice for advocacy.
- Running 176 community outreach/awareness raising sessions and health talks about mental health for 3,908 people, so they can understand and recognise the symptoms of mental illness, reduce stigma and encourage people to come forward for treatment.

To support the above, BNUU have, over the last three years, invested in their frontline team by providing external clinical supervision, delivered by Dr Lynda Nakalawa, a Kampala based psychologist. This supervision supports BNUU's counsellors with difficult and often traumatic cases, builds their capacity to support their clients as well as ensuring their continuing professional development. Furthermore, BNUU have established, and maintained, good relationships with local stakeholders (e.g. the District Health Officer, the District Community Development Officer, the District Chief Administrative Officer and the Dr. Ambrosoli Hospital in Kalongo) to promote engagement and investment in the project.

Outcomes agreed with Fondation d'Harcourt

The overall objective of the project is to improve mental health services for vulnerable and disadvantaged people in two new sub-counties in Agago District, northern Uganda. The outcomes – only and specifically those relating to mental health and mental health structures - agreed with the Fondation d'Harcourt for this project were:

- Healthcare workers and village health teams demonstrate appropriate knowledge and skills in the WHO mhGAP intervention guide, and have expertise in the provision of quality mental healthcare.
- PMDEs demonstrate significant reductions in psychological distress.
- Local government councillors work to strengthen government mental health structures and ensure sustainability.
- BNUU's frontline staff have the expertise, resources and confidence to support the widening provision of quality, sustainable mental healthcare in Agago district.
- PMDEs feel supported in their recovery at home, with their family members/households contributing positively to their recovery.
- Caregivers and PMDEs feel they have the tools and resources to ensure that PMDEs' recovery is sustainable and long-term.

The related indicators for the above outcomes can be seen below:

- Pre- and post- training questionnaires with healthcare workers and VHTs and key informant interviews (KIIs) with a sample of healthcare workers in each sub-county at endline to determine if the healthcare workers/VHTs have developed their knowledge and skills of the WHO mhGAP intervention guide, meaning they have the expertise needed to provide quality mental healthcare.
- Regular CORE-10 assessment surveys of PMDEs referred from the mental health clinics for counselling sessions, to track their levels of psychological distress. CORE-10 refers to a set of 10 standardised questions/statements that are used in many healthcare contexts (including the NHS in the UK) to measure a client's level of clinical distress, with clients falling into distinct categories (non-clinical range, mild psychological distress, moderate psychological distress, moderate-to-severe psychological distress and severe psychological distress).

- Pre- and post- training questionnaires with local councillors, and KIIs with a sample of councillors at endline, to monitor progress and plans for local mental health structures.
- Annual key information interviews (KIIs) with frontline project staff, to monitor development in their expertise, resources and confidence.
- Annual KIIs with a sample of PMDEs, to determine how supported they feel in their homes.
- Annual KIIs with a sample of caregivers to determine whether they feel they have the tools and resources to support PMDEs' recovery.

Report against the project's outcomes and indicators

Not all of the above evidence is /will be available, for example, the endline survey will not be undertaken (BNUU and N4A believe the endline survey would be resource heavy and yield limited relevant data, which this evaluator concurs with). However, from the available data:

- Training in mental health has been provided to 22 Health Workers from Adilang and Lapono Health Centres. Pre- and post-training surveys were conducted, to test trainees understanding of mental ill-health. From those Health Workers directly trained, the average score went from 61% to 73%, and for those trained through a train-the-trainer model, the score went from 57% to 70%. Overall, 18 participants improved their knowledge. As part of this evaluation, the survey was re-administered to the 7 health workers who remain who remain in BNUU's operational area (others have moved to new areas), who scored 66%. This is a reduction in the percentage immediately after training, but still higher than the pre-training figure.
- Training in mental health has been provided to 141 individuals from VHTs across Adilang and Lapono Health Centres. Again, pre- and post-training surveys were conducted, to test trainees understanding of mental ill-health. The average pre-training score was 64%, which increased to 77% post-training. In total, 85 individuals improved their knowledge through the training. As part of this evaluation, the survey was re-administered to a sample of 40 VHTs, with a score of 90%, higher than the post-training score. There are several possible reasons for this – it may be VHTs have increased their knowledge by applying it through their work supporting BNUU (e.g. at mental health clinics or during home visits), or it may be that the sample re-surveyed the most engaged of the original cohort, which would skew the score.
- BNUU has also been supported by the Senior Clinical Psychiatric Officer from Dr. Ambrosoli Memorial Hospital who provided further clinical supervision, mentorship and support to BNUU's psychiatric nurse and the trained health workers. Staff report this routine clinical supervision has helped to increase their skills and confidence, treatment effectiveness, client retention and clients' satisfaction.
- Annual KIIs were not undertaken with BNUU's frontline project staff. Instead, BNUU staff received regular training and skill assessments throughout the 3 years, provided by Dr Lynda Nakalawa. Training included report writing, trauma-counselling and group counselling. There are clear indications of increased staff expertise (e.g. for the trauma counselling training, pre- and post-training tests revealed an increase in knowledge among all participants) and increased confidence (e.g. after the group counselling training, BNUU staff reported they felt confident to run group sessions). Dr Nakalawa also provided BNUU/N4A with quarterly reports, in which she fed back on BNUU staff's expertise and confidence.
- BNUU has collected CORE-10 assessments from all clients; however, only data for 292 individual counselling clients (out of a total of 960) was uploaded to the database (and thus able to be analysed). Analysis shows that 272 individuals (93% of the sample) were at moderate to severe psychological distress at the outset of support, as determined by the CORE-10 thresholds, with the other 20 showing mild psychological distress. At the end of support, 220 (75% of the sample) were in the non-clinical range, 67 people (23%) were in the mild psychological distress range and just 5 (2%) were in

the moderate psychological distress range. This is clearly a significant reduction in psychological distress, which is discussed further in the sections below.

- Instead of annual KIIs to determine how PMIEs feel at home, BNUU's counsellors and psychiatric nurse conducted extensive home visits to clients, and kept records of their progress, which they reported on a quarterly basis. During these visits they asked clients whether they feel stigmatised; whether they can engage in daily activities such as farming; and asked them or their caregivers/family members whether they're adhering well to their treatment (e.g. medication). Analysis of this finds that: 97% of clients no longer feel stigmatised by family members for their mental health issues (an improvement from the 7% at baseline); 90% were able to engage in some daily activities (compared to 41% at baseline); and 77% were adhering well to treatment.
- The annual KIIs with a sample of caregivers to determine whether they feel they have the tools and resources to support PMDEs' recovery have not happened. However, KIIs with PMDEs in July – December 2023 found that 84% of KII participants said they have plans in place to manage their mental illness symptoms, or a plan in place for if these reoccurred – e.g. ensuring their farming activities can be kept going by their families or adhering to a medication plan.
- Questionnaires with local government councillors have not happened. However, there are examples of duty-bearers improving mental health structures after advocacy by BNUU and the SHGs e.g. after highlighting to the Sub County Chief that Lira Kato Health Center III only had 13 health workers when the policy says that they should be 19, causing delays in the mental health clinics, six additional health workers were recruited. In addition, BNUU interviewed two duty bearers (the LC III Chairperson, Mr Ojok Kite Okidi, Lapono Sub County and the Community Development Officer, Mr Oboke Washington, Lapono Sub County). They mentioned improvements in health centre staffing, in the supply of medication and in the inclusion of PMDEs in government programmes, all due to BNUU's advocacy.

A community mental health awareness session


Photo © Simone Fior



Project spend

This evaluation considers the work of BNUU's Wic Ma Yot Kwo Maber (Healthy Minds, Good Lives) Project, covering the period from the 1st of March 2022 to the 28th of February 2025, funded by Fondation d'Harcourt. The total budget for the three-year grant period was £352,778.55 and budget spend was £353,664.83. There were some underspends e.g. due to exchange rate gains and overspends in other places (e.g. developing BNUU's website was more costly than originally budgeted). However, overall spend across all budget lines was broadly in line with the overall original budget.

The per beneficiary cost of the project, just considering the 1,168 people supported by the mental health clinics, was £302.04 (the figure for the wider project, when considering professionals trained and family members supported, will of course be lower, but as this evaluation is focusing on the mental health benefits delivered, and as there are questions around the exact numbers of caregivers supported, this evaluation will focus just on the potential mental health costs and benefits). It would require a full Cost Benefit Analysis (CBA) to assess the value for money and economic return of the project, based on these input costs, which falls outside the scope of this evaluation. However, other assessments of similar mental health services do demonstrate high levels of returns. For example, an analysis carried out for the World Bank found a 3 to 5 times return on investment for mental health services (World Bank, cited in the article 'Mental health in Africa: The need for a new approach' published in *African Arguments*, 2019). In addition, an assessment modelling the potential return on investment of using the WHO Mental Health Gap Action Programme (mhGAP) intervention guide (the approach utilised by BNUU for its community mental health programme) to treat depression and anxiety disorders found that the benefit to cost ratio of the investment was 2.3–3.0 when only workforce issues were considered, increasing to 3.5–5.7 when the implicit value of years of health gained were included (Chisholm et al, 2016). A more recent study found that for most conditions and country contexts there was a return of >1 for each dollar or unit of local currency invested in mental health services when productivity gains alone are included, and >2 when the intrinsic economic value of health is also considered. Furthermore, population-based preventive measures and treatment of common mental, neurological and conditions showed the most attractive returns when all assessed benefits are taken into account (Cross-country analysis of national mental health investment case studies in sub-Saharan Africa and Central, South and South-East Asia, Chisholm et al, 2023). Based on these studies, it is therefore a reasonable possibility that this project could represent fair value for money.



**Mother and baby attending a
community mental health
awareness session**

Photo © Simone Fior

Wider/Qualitative assessment of impact

External Evidence

In terms of the available evidence, it is recognised that improving mental health services in Sub-Saharan Africa requires increased funding, expanded training programmes for mental health professionals, and incorporation of mental health into basic healthcare systems. Training and deployment of community health workers have been shown to bridge the gap between formal healthcare services and the community by providing essential support, education, and referral services. Community-based models and advocacy efforts are deemed essential for reducing stigma, promoting sustainable mental healthcare, and enhancing the overall wellbeing of citizens in sub-Saharan Africa. Community-based models also play a pivotal role in delivering sustainable and culturally appropriate mental healthcare. Peer support programmes have also improved service delivery, reduced stigma, fostered peer support, reduced isolation and promoted social reintegration (all from A comprehensive review of mental health services across selected countries in sub-Saharan Africa: assessing progress, challenges, and future direction, Atewologun et al, 2025). Many of these elements are included in BNUU's work. Barriers to engagement in mental health services in sub-Saharan Africa include lack of or little knowledge of mental disorders and professional services; cultural and religious beliefs leading to over-reliance on traditional and spiritual interventions; and stigmatising beliefs that included self-stigmatisation, stigma and discrimination from family, the community, and healthcare providers (Barriers and Facilitators to Accessing Mental Health Services for Adults in Sub-Saharan Africa: A Systematic Review, Komu et al, 2025). By raising awareness in the community of mental health issues, BNUU is likely overcoming these barriers to engagement.

BNUU also uses the World Health Organisation (WHO)'s mental health gap action programme (mhGAP) as a guide to its community based mental health programmes. The mhGAP has been extensively applied and studied in several global settings, demonstrating a considerable impact on healthcare services worldwide, with use in over 100 countries (Keynejad et al, 2017). A meta-analysis of 162 peer-reviewed studies describing mhGAP implementation in Africa and Asia found that training Primary Health Care staff using mhGAP-based training (which BNUU have done through this project) increased mental health knowledge and awareness, improved attitudes towards mental ill-health and people living with mental health problems, improved attitudes towards psychiatry, improved confidence in managing mental health problems in primary health settings, increased job satisfaction and interest in mental health training. Analysis of the use of mhGAP in clinical practice finds a range of positive impacts, including mental health awareness, clinician-confirmed case identification, improved mental health symptoms, improved clinical recovery, improved experiences of discrimination, food security, quality of life, intervention adherence and retention in treatment (all from WHO mental health gap action programme intervention guide: updated systematic review on evidence and impact, Keynejad et al, 2021).

As such, there is external evidence that BNUU's approach is likely to be having a positive effect. This was confirmed in the Independent Evaluation of BNUU's Comic Relief funded community mental health project in Agago District (which took place between 2017-2020), which found promising achievements by BNUU around: providing adequate training that allowed BNUU staff and duty bearers to provide adequate and appropriate treatment to PMDEs; integrating counselling into mental health care (which increased both mental health seeking behaviour and service user satisfaction); supporting caregivers; reducing levels of stigma; and that the creation of self-help groups (SHGs) were sustaining and enhancing recovery. The evaluation also highlighted that the widespread awareness of good mental health care by BNUU created opportunity for community members to access mental health services; services which had been brought closer by BNUU. The extension of psychoeducation sessions at home (through the home visits offered through this project) had

also helped to maximise the efficiency of treatment and contributed to faster achievement of recovery. The use of VHTs and local health centres to provide mental health knowledge to communities and provide support to PMDEs and SHGs was also highlighted as an efficient approach to achieving the project's outcomes. These findings lend weight that BNUU's model, rolled out to Lapono and Adilang sub-counties through the Fondation d'Harcourt grant, is likely to be delivering positive outcomes for PMDEs and their caregivers.

Internal Qualitative Evidence

To develop an understanding of the actual outcomes/impact of Wic Ma Yot Kwo Maber (Healthy Minds, Good Lives) Project, beneficiary case studies were analysed, and five focus groups undertaken with 30 people with mental illness/epilepsy and their caregivers.

The below case studies illustrate how the Wic Ma Yot Kwo Maber (Healthy Minds, Good Lives) Project has improved beneficiaries' mental wellbeing, reducing the burden of caring, improved individuals' ability to take part in normal activities and gave them hope for the future:

Acan, a mother of ten from Abilnino village in Lapono Sub-County, had her life defined by hardship. Abandoned by her husband and burdened with the responsibility of raising her children alone, she faced relentless poverty. Providing food, clothing, and school fees was a daily struggle. Despite trying hard, her children were often sent home for unpaid school fees, leaving her anxious and hopeless. *"I don't sleep at night,"* she told BNUU, *"because I am always thinking about what my children will eat, and how I can at least get the two big boys to school so they can later help me out."* The weight of her challenges pushed Acan into severe depression. Loneliness and constant worry consumed her days, and she felt trapped, unable to provide for her family or envision a better future. In early 2024, hope came when BNUU held a community awareness session on depression in Abilnino village. As Acan listened, she recognized her own struggles in the symptoms described. Encouraged to seek help, she went to the Abilnino Health Centre, and she was found to have severe depression. She was enrolled in BNUU's support programme receiving antidepressants and weekly group counselling. The counselling sessions became a turning point. Within weeks, Acan began to sleep better, regain energy, and rediscover joy. Surrounded by other women facing similar struggles, she found strength in solidarity. *"As a single parent, I thought I was the only one not paying my children's school fees,"* she reflected, *"but I realised there were many women struggling like me even those with husbands."* Months later, Acan's symptoms moved from severe to mild depression (as measured by CORE-10). She later joined a self-help group and with renewed confidence, she was elected chairperson of her savings group where she later borrowed money to start a vegetable-growing business and began cultivating turmeric in her backyard. The income allowed her to clear outstanding school fees and secure education for her children. Today, Acan is more than a survivor - she is a leader and mentor. She supports her family, inspires women in her community, and is transitioning from subsistence to commercial farming. She told BNUU: *"When I started growing turmeric commercially, I didn't just lift myself; I inspired other women to believe in themselves and use available resources like land to change their lives"*.

Paska, a 38-year-old mother of four from Lapono Sub-County, once dreamed of living a happy married life. Those dreams were shattered when her husband took a second wife and brought her to live in the same compound. The betrayal left Paska heartbroken. She cried endlessly, suffered sleepless nights, and had no energy to work or provide for her children. Worse still, her husband neglected his responsibilities, leaving her to struggle alone with the burden of raising four children. *"I had lost hope,"* Paska recalls, *"and I couldn't see a way out of my situation."* A close friend noticed Paska's distress and told her to go to one of the mental health clinics held at Amyel Health Centre II. There, she was diagnosed with depression, scoring 25 on the CORE-10 scale, which showed she was experiencing severe psychological distress. With her consent, she was enrolled in BNUU's support programme. This included medication, counselling, and group therapy with other women facing similar struggles. In the

group sessions, Paska found comfort, encouragement, and the strength to focus on what was within her control. With support from her peers, she gained courage to speak to her husband about child support and began shifting her focus towards rebuilding her own life. After six counselling sessions, her symptoms improved significantly, her CORE-10 score dropped from 25 to 11 (to mild psychological distress), her appetite and sleep patterns returned, and her overall health improved. As Paska continued with her group therapy sessions, the BNUU team also reached out to her husband. Through counselling, he began to recognise the emotional harm he had caused and the impact of neglecting his children. Gradually, his attitude changed. He acknowledged his responsibilities and took steps to support Paska in caring for their children.

This shift brought a new sense of relief and stability for Paska, she no longer carried the burden of raising her children alone. The renewed support from her husband, combined with the encouragement of her group members, helped her regain hope and confidence. With reduced stress at home, Paska had more energy to focus on farming and saving with her self-help group. She began planning for her children's future with optimism, knowing that she was no longer struggling alone. She told BNUU: *"At first, I thought my life was over, but now I have the strength to care for my children, and my husband is also standing with me. I have hope again."*

Opilo is a 34-year-old father of six from Adilang Sub-County. His dream was simple: he wanted to provide his family with a permanent home. In pursuit of this goal, he secured a loan to complete the construction of his family house. However, life took an unexpected turn. Trusting his wife with the loan money, Opilo later discovered that she had secretly diverted it into her personal ventures. The betrayal shook him to his core. Left unable to complete his house or repay the loan, Opilo sank into despair. The pressure of looming debt, the fear of losing his house, and the bitterness of betrayal weighed heavily on him. He began to lose appetite, struggled with sleep disturbances, and was consumed by persistent sadness. His energy drained away, and he increasingly isolated himself. He started to use alcohol as a way to escape negative thoughts, and his situation worsened to the point where he felt overwhelmed and hopeless. One day, during a routine home visit, a Village Health Team (VHT) member working with the BNUU project was informed about Opilo's situation. The VHT reached out immediately and referred him to Ligiligi Health Centre II. There, Opilo was assessed and diagnosed with depression. His score of 24 on the CORE-10 indicated moderate to severe psychological distress. As a result, health workers provided him with both antidepressant medication and individual counselling sessions. A trained BNUU counsellor began meeting with him regularly to provide support, restore hope, and equip him with coping and problem-solving skills. Over the course of six counselling sessions, Opilo began to process his situation differently. With encouragement, he faced his financial burden head-on. Guided by his counsellor, he accepted the painful but necessary decision to sell his unfinished house in order to repay the loan. Equally important, he was supported to address the deep emotional wound caused by his wife's actions. Through family meetings that involved his in-laws, Opilo and his wife reconciled. His wife expressed remorse, asking for forgiveness, and his father offered to support him by allowing the sale of part of the family land to help him rebuild his life. These reconciliations gave Opilo a renewed sense of stability. With the loan cleared, the reconciliation with his wife, and financial support from his father, Opilo began to feel life returning to normal. His dependence on alcohol reduced significantly, his energy improved, and he once again took up his small business activities. When re-assessed using the CORE-10 tool, his score dropped from 24 to 16, showing significant improvement from severe to moderate distress. More importantly, Opilo regained hope for the future. Opilo told BNUU: *"I had lost everything my home, my trust, my peace of mind, but with support, I have rebuilt not just my life but also my family. I am now focusing on my children again, and I believe we can start afresh."*

Betty is a 32-year-old mother from Adilang Sub-County, who battles with poverty and the overwhelming responsibility of caring for her child John, who has epilepsy. John is entirely dependent on Betty for feeding, bathing and carrying him to different places at home i.e. taking him to the toilet, bed, outside to sit under the tree. No one else in Betty's family was willing to help her with her caring responsibilities. Betty is devoted to John, but her caring responsibilities took a toll on Betty's mental wellbeing, and she began to feel every day was an endless struggle to find even a glimmer of hope. One-day Betty was at home listening to a radio station when she heard about BNUU. She shared *"I was feeding my son under the mango tree when I heard the news on the radio talking about all epileptic children taken to the nearby health centre to get help from BNUU team"*. She went the next day to Adilang Health Center III. BNUU provided John with medication and provided Betty with counselling. Betty poured her heart out to her counsellor, expressing her struggles, fears, and worries, and she was offered guidance and support through their conversations. Betty began to understand that her feelings were valid and that she was not alone in her journey. Over the course of five counselling sessions, Betty started to see a transformation within herself, the burden of care for her son was reducing because he was getting free medication from the health centre and her perspective shifted. She learned coping mechanisms to manage stress and anxiety, allowing her to better navigate the challenges they faced. The counsellor helped her identify her strengths and encouraged her to focus on self-care. BNUU with the support of the VHT visited Betty and John three times at home, where BNUU staff explained to the wider family how important it was to help with John's care; as a result, Betty's family started helping more with caring. Betty told BNUU: *"It has been God that has changed my life, because it's God that brought BNUU to me so that they can help me and my family, thank you BNUU"*.

Attendees of the focus groups confirmed a finding from the external evaluation of BNUU's Comic Relief funded work – that BNUU was raising awareness of mental health issues and creating opportunities for community members to access mental health services that are located close to home:

"I am a caregiver and when I heard that BNUU offers treatment for epilepsy through a radio talk show, I went to Adilang health center III so that I could get help for my family member".

Caregiver - Focus Group participant from Rubanga Aye Twero Self-Help Group in Adilang Sub County

"I am a patient and during an awareness sensitisation meeting held in my village, I realised I had all the signs of depression as per the description of the visitors from BNUU. I then got enrolled where I started getting medication and counselling".

PMDE with depression - Focus Group participant from Rubanga Aye Twero Self-Help Group in Adilang Sub County

"I first found out about Basic Needs from my friend at a time when I was having lots of worries in my life, then this friend...told me...these worries will kill you, she told me that there is an organisation called Basic Needs working in our health centre who are giving treatment for those having a lot of worries in their lives and they provide counselling, treatment and also form them in groups for other support which makes you forget about your stress. My friend also found out about Basic Needs from a friend".

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

"I had been treating the epilepsy I was suffering from using traditional herbs since I was a child. After I attended the VHT training organized by BNUU in Lira Kato I got to realise that there are modern ways and drugs to treat epilepsy and because of that I immediately got myself enrolled in the BNUU programme and am now the chairperson of this Self-Help Group".

PMDE with epilepsy - Focus Group participant from Odii Cwiny Wuu Self-Help Group in Lapono Sub County

“I had gone to Abim government hospital to seek treatment, and I was told by the health workers there to go to Kalongo and look for an organisation called Basic Needs and they told me I would get better treatment from them and it’s near me. Fortunately, when I travelled back home, I was told Basic Needs is treating people in Lira Kaket health centre II which is a stone throw away from my home”.

PMDE with depression - Focus Group participant from Odii Cwiny Wuu Self-Help Group in Lapono Sub County

Beneficiaries – both people with mental illness/epilepsy and their caregivers - also highlighted that the Wic Ma Yot Kwo Maber Project had helped improve and maintain their mental health:

“The medication I received has been very helpful in reducing the level of depression I was experiencing, and I am now feeling better and now able to associate and also participate in the Self-Help Group activities”.

PMDE with depression - Focus Group participant from Rubanga Aye Twero Self-Help Group in Adilang Sub County

“When I first got in contact with Basic Needs, my four year old child who had epilepsy could frequently fall down...this made me develop fever, rapid heartbeats and body panics, have sleepless nights, because I was so stressed about my child’s condition, the burden of caring for my child, I really needed help but when I could explain it to health workers they couldn’t give me any treatment saying that I am not sick...when Basic Needs came to the health centre I came and explained my condition, I was given treatment for depression and my condition got better”.

Caregiver - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“When I started receiving treatment [for depression] and taking it as instructed and began to recover, I can now sleep very well, I got to realise that this medicine has helped me”.

PMDE with depression - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“There is a great change in my life, I am no longer depressed because of the treatment I received and the counselling services that I got”.

PMDE with depression - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“Mine also started with constant headaches that would induce fever and vomiting...Initially, I [thought I was] suffering from typhoid, for which I took medication, but it yielded no improvement...however, I soon began to experience profound sadness and found myself unable to socialise or even endure noisy environments or even listen to radio. This was further coupled by the burden of caring for my patient [family member], who is deaf and mute. Honestly, I wasn’t around when the BNUU team came, it’s a friend of mine...who told that, there are some people who came here last time and tomorrow they are coming back, please take yourself there, they might help you...I was given form, got treatment, so in the [Self-Help] Group we have experienced sharing and counselling, I started getting improvement, I am now able to return to work, engage socially, and enjoy restful sleep. I have made a full recovery”.

PMDE and caregiver - Focus group participant from Yotkom Ber Self-Help Group in Lapono Sub County

“I lost my husband and three children in one year, the pain in my heart was unbearable, so when this programme came, I joined the group, I was counselled and given medication and the [Self-Help] Group members also helped me a lot, thank God I am moving on with life now”.

PMDE - Focus group participant from Yotkom Ber Self-Help Group in Lapono Sub County

Attendees of the focus group were clear that improvements in their mental health conditions/epilepsy had brought widespread benefits, allowing them to take part in normal activities again:

“[With my epilepsy] I used to experience serious headache, felt fire burning my body, develop fever, saw visions of a mad person, became unconscious and felt down. [With BNUU’s support] I recovered and currently farming, I also go for hunting, I attend Sunday church services, I attend social gathering like football, not like before when I couldn’t to that all”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“The mental health treatment that I got made me to recover and I have the ability to work hard and pay my children in school unlike before when I could barely do anything, my neighbours supported me to fetch water but now am able to go to the well myself”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“The treatment and counselling for depression has changed my social life with my family, friends and neighbours previously I use to isolate myself and I was unproductive but now am able to cook for my family and do farm work”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“After me undergoing treatment, counselling, training and withdrawn from medication, I have experienced significant improvement. I now sleep soundly through the night till morning, diligently tend to my garden and also actively engage in work for financial gain, and take my children to school. I am also now in a harmonious relationship with my husband, otherwise, I might have succumbed to death long ago. So, feel the training and counselling rendered to me has added more years [to my life]”.

PMDE - Focus group participant from Yotkom Ber Self-Help Group in Lapono Sub County

Many caregivers highlighted that the support provided had reduced the burden of caring (which was also a finding of the evaluation of BNUU’s Comic Relief funded activities):

“The health education services offered by BNUU have been very helpful and made my care giving easier. My child would have even been dead if I had not got the services of BNUU, but since we started getting medication for him and also the other teachings he received from BNUU taking care of him became easier, he lives a normal life now and he even supports in other work at home”.

Caregiver - Focus Group participant from Odii Cwiny Wuu Self-Help Group in Lapono Sub County

“I am a caregiver who had also developed depression because of worrying for my patient’s condition. But ever since my patient [family member] started getting medication she has improved and does not experience so many convulsions and can now support some housework and I can now sleep well since I no longer worry much”.

Caregiver and PMDE - Focus Group participant from Rubanga Aye Twero Self-Help Group in Adilang Sub County

“I am a caregiver and I used to tie my patient with a rope in the house because his condition was severe and he was very aggressive but ever since I got in the programme and started giving him medication he has recovered and I can now do other work in the garden and leave him at home since he can now leave a fairly normal life”.

Caregiver - Focus Group participant from Rubanga Aye Twero Self-Help Group in Adilang Sub County

“My child’s condition has improved, and the burden of care has been reduced I am able to carry out farm work that gives me money to pay their school fees and buy for them clothes”.

Caregiver - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

Many felt they now faced less stigma than at the start of the project, which again replicates findings from the previous evaluation:

“What really changed for me and this community is that ever since BNUU started operating here the perception of this community towards epilepsy has changed greatly. In the past people thought whoever is suffering from epilepsy is useless and they even used to fear associating with everyone treating epilepsy but when BNUU came it all changed, and people started believing it can also be cured”.

PMDE with epilepsy - Focus Group participant from Odii Cwiny Wuu Self-Help Group in Lapono Sub County

“What changed positively is that am not stigmatised, I walk freely to get my drugs from the health centre and my health improved, I socialise freely, my savings in the [Self-Help] Group will help me to do something great in future.”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“My neighbours also don’t abuse me anymore”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

Beneficiaries also highlighted that there were benefits for being part of the Self-Help Groups, both in sustaining and enhancing recovery (a findings of the previous evaluation) but also for starting to plan for the future:

“I am a caregiver, the Self-Help Group has enabled me to save and borrow and has been very helpful. Me and my fellow group members used to get very stressed when looking for money to pay school fees, feeding and medication but ever since we started saving in this Self-Help Group that has changed because there is now easy access to money and I believe next year will be better since we have invested a lot in the garden and if all goes on well I will get good harvest which will give me good money”.

Caregiver - Focus Group participant from Odii Cwiny Wuu Self-Help Group in Lapono Sub County

“For me, me the trainings on financial literacy, VSLA [Village Savings and Loan Associations] and IGA [income generating activities] have opened my eyes and I am now able to plan for the future for my family”.

Caregiver - Focus Group participant from Odii Cwiny Wuu Self-Help Group in Lapono Sub County

“I very much appreciate the Self-Help Group where we come and chat, laugh which helps in reducing the rate of thinking and I am also now able to save and borrow which has also helped in reducing the level of poverty in our households”.

PMDE - Focus Group participant from Rubanga Aye Twero Self-Help Group in Adilang Sub County

“I am healed now, because by the time I was still on drugs, I was depressed all the time, being part of this group has been transformative for me. I am now able to borrow funds and engage in business ventures, I sell silverfish, tomatoes, and a few other items. Previously, I was sad and low on energy, but as you can see, I have gained weight and can now socialise freely. This has had a profound impact on my life, the bitterness that once resided in my heart has disappeared. I am now free to share my burdens with my peers, and I feel a sense of freedom”.

PMDE - Focus Group participant from Peiling Self-Help Group, Adilang Sub County

“Putting us in group and teaching us on how to live in harmony with each and everyone like we came [from the] same womb, and giving us advice, something that has enabled me to get

out of depression. This brought us together like we are from the same family, so that's really made me so happy".

PMDE and caregiver - Focus Group participant from Peiling Self-Help Group, Adilang Sub County

Focus group participants were also asked what BNUU activities they had found particularly helpful; no one intervention emerged on top, with participants remarking they had found the provision of medication, counselling, home visits, Self-Help Groups and health education sessions all useful:

"To me the medicines we received has been the best for me followed by counselling, the Self-Help Group and the trainings we received from there and the last is the drug bank services".

PMDE - Focus Group participant from Odii Cwiny Wuu Self-Help Group in Lapono Sub County

"I am a caregiver and my best ranked of the services offered by BNUU has been the medicines we receive on monthly basis followed by the health educations which has helped me as a caregiver...my third ranked service is the counselling services. I am also grateful for the Self Help Group that has been so helpful to us for peer support.

Caregiver - Focus Group participant from Odii Cwiny Wuu Self-Help Group in Lapono

"The services that was so helpful to me was constant trainings that I had from BNUU, especially on how to adhere to drugs,...which was helpful to me".

Focus Group participant from Peiling Self-Help Group, Adilang Sub County

"As for me, the counselling and [BNUU] advising us, giving us hope in life, and training us especially training on Human Rights, [about] living positive life...So you should be free, not to get stigmatised and that was the beginning of my healing. [That] was very important".

PMDE - Focus Group participant from Peiling Self-Help Group, Adilang Sub County

"Counselling was tremendous in changing my life, home visiting was also very import, putting us in a group was so important to us because, we started saving and giving ourselves advice which was a good thing".

PMDE - Focus group participant from Yotkom Ber Self-Help Group in Lapono Sub County

"I liked the way you people put us in a group, then sharing our experiences and thoughts one by one, helping one another, laughing together, then go back and take care of the family, so putting us in a group has made us happy".

PMDE - Focus group participant from Yotkom Ber Self-Help Group in Lapono Sub County

Those that have used the drug banks have also reported to BNUU how useful they have found this:

"I am so grateful, our plight over drug shortages has been resolved and even with the drug shortage in government facilities we can now buy the drugs on our own, since we know where to buy the drugs from and I really believe our recoveries will improve more".

Feedback to BNUU from PMDE from Adilang

"We had always been going on low drug dosage due to the inadequate drugs at the health centre, which had so much affected the recovery of my child. But with the drugs we have bought, I am assured of full dosage for my child and a good recovery".

Feedback to BNUU from a carer from Adilang

Focus group attendees were asked how the Wic Ma Yot Kwo Maber Project could be improved or what else BNUU could be doing to support them. Many people were keen on receiving livelihoods support now they had recovered:

“BNUU should at least support us with some income generating activities to help boost our savings and offer us some income to take care of our patients”.

Caregiver - Focus Group participant from Odii Cwiny Wuu Self-Help Group in Lapono Sub County

“I think we should be supported with income generating items or capital for starting up a business and we sell in the market so that we continue operating it”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“I request that we should be supported with income generating items like soap, cooking oil which we can sell in the market here or support us with capital because this will help us to save in the group Village savings and loan association to because we have recovered”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“For the way I see now, since we are healed and improved, we really need financial support so start up something like business”.

PMDE - Focus group participant from Yotkom Ber Self-Help Group in Lapono Sub County

“BNUU improved our lives, you even followed us up home, whilst asking us how we are feeling and so on, so we are healed now since we have been withdrawn from medication, since some of started some small businesses, I request, you support or add more IGA to...heal our conditions forever, so [we] can feel free and live peacefully”.

Focus group participant from Yotkom Ber Self-Help Group in Lapono Sub County

Network for Africa has now secured funding for BNUU (e.g. from Charles Hayward Foundation) to provide livelihoods inputs to all 10 of the Self-Help Groups. Other focus group participants asked that BNUU, or the health centres, keep offering mental health support, either to existing patients or to other community members in need:

“My hope is that the health centre have continue to offer medication to the patients whenever we are in need”.

PMDE - Focus Group participant from Rubanga Aye Twero Self-Help Group in Adilang

“My only request is that BNUU should continue coordinating with the government to ensure constant supply of medicines so that the patients here don't relapse”.

Caregiver - Focus Group participant from Rubanga Aye Twero Self-Help Group in Adilang Sub County

“Basic Needs UK in Uganda should continue with providing mental health services so that we recover fully”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“[BNUU] should continue with providing home visits to clients”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“Community mental health services should continue to sensitise people about mental health services so that it's not forgotten”.

PMDE - Focus Group participant from Rwot Oyer Self-Help Group in Lapono Sub County

“I request BNUU to continue with the support, because there are so many people out there with same conditions that we are going through, so if you don't come, people without knowledge won't get help”.

Focus Group participant from Peiling Self-Help Group, Adilang Sub County

BNUU's ability to do this, or the health centres' ability to do this is discussed below.



BNUU Counselling providing one-to-one counselling

Discussion and key conclusions

Following interviews/feedback with BNUU and N4A staff, desktop research, analysis of case studies and beneficiary feedback (through the focus groups), it is clear that there have been several successes, as well as lessons learnt, during this project. These are:

Impact of the project on mental health

It is clear to the evaluator that BNUU's community mental health awareness talks are very effective. In the reports read by the evaluator, BNUU states that between 40% to 70% of new people attending the mental health clinics each quarter are doing so after hearing about BNUU's support in community talks. Several focus group attendees also spoke about hearing about the project, and the support it offers, after attending a talk, or from a friend or family member who had attended a talk.

The level of need for local mental health services is clearly considerable. In the first mental health clinics held in the health centre IIIs in Adilang and Lapono over 200 people attended hoping for support. To try to deal with the overwhelming number of clients, BNUU have, over the 3-year grant period, rolled out mental health clinics to 6 health centre IIs. This brings clear benefits to clients – they can access mental health support closer to home without needing to travel large distances (which also reduced the security risk to people travelling long distances, as throughout the project there has been ongoing local violence related to thefts of livestock) and reduced waiting times. Unsurprisingly, offering support in more health centres has increased client retention (BNUU reports by 40%), which will improve the possibilities of patients seeing improvements in their health.

In the face of overwhelming need, it is more than understandable why BNUU decided to work in more health centres. However, this decision was taken without really considering the impact of this decision on the project's (and project staff's) capacity. As a result, the project counsellors have had to spend more time 'out in the field' either delivering activities or travelling to activities than envisioned at project outset, which has had one clear negative outcome: Whilst BNUU report that CORE-10 data has been collected for all individual counselling clients, only data from 292 people (30% of the total individual counselling clients) has actually been uploaded to BNUU's counselling KoBo database, and is thus analysable. One key reason is the counsellors' workload, increased due to the additional mental health clinics in more health centres, which meant they were out early and late back each day, and some would not have time/forget to add information to the counselling/KoBo database. Exacerbating this issue, not all staff had smart phones, so data input had to be done back in the office at the end of (an often long) working day. In addition, project staff used multiple reporting processes, both off-line and on-line, which led to discrepancies between manually recorded data and the data captured by the formal M&E processes (i.e. CORE-10 readings on paper and those uploaded digitally to the counselling/KoBo database). For example, whilst people receiving group counselling did have CORE-10 readings taken, these were not uploaded to the database; instead the counsellors uploaded to the database their own observations on if/how individuals' mental health was improving. Further impacting the trustworthiness of the data was how the counselling/KoBo database was formatted. The CORE-10 data was not always switched to 'mandatory', meaning it was possible to upload data that was incomplete and missing CORE-10 data. Furthermore, once BNUU counsellors had submitted their data into the counselling database/KoBo, they were then unable to see the data again without requesting it from BNUU's M&E Officer. The M&E Officer did this for data protection (to limit people being able to see others' confidential counselling notes), however it meant that counsellors were unable to easily double check/correct errors in the data they had entered. This caused issues such as some clients having multiple records, or session data inputted in the wrong order. These issues have also been exacerbated by how

complicated BNUU's monitoring processes are: the KoBo database is in really four different databases, one for individual counselling, one for group counselling, one for clients attending the mental health clinics and one to record the home visits.

Network for Africa, who support BNUU with monitoring/evaluation and reporting, were unaware of these monitoring issues as the reports submitted to them by BNUU (and seen by the evaluator) always had qualitative and quantitative data provided. Network for Africa also highlighted that BNUU's M&E Officer was always able to answer questions and/or provide clarifications as needed. The M&E Officer left BNUU suddenly at the end of 2024, so the evaluator is unable to ask this Officer how they managed to report so fully against outputs and outcomes when there were ongoing issues with data collection and input. However, BNUU were aware of the issues in data collection - for example, this was flagged up by Dr. Lynda Nakalawa in her reports to BNUU. Concerns were also raised by BNUU board members after they asked the M&E Officer for a couple of reports, which he did not provide. BNUU did attempt to try to address these issues, recognising that the protocol for data entry wasn't good enough, with BNUU's Programme Manager developing a tracking tool for the Head of Counselling and M&E Officer to reconcile their records on a weekly basis, however the counsellors didn't use the tracking tool (possibly due to the issues with their workload, outlined above), meaning issues were not resolved.

Network for Africa also believe the fact that BNUU started working on their schools mental health project a year after the Harcourt grant started is a contributing factor; this was the first grant BNUU managed directly (without N4A's support) and it had rigorous reporting requirements, which increased both the amount of data being collected and the workloads of both BNUU's frontline and management team. This may well have impacted on their ability to address the issues being identified in the monitoring and evaluation processes.

However, these issues are not new to this project/grant period. The external evaluation of BNUU's Comic Relief funded project from March 2021 also found weaknesses in BNUU's monitoring systems, such as the clinical symptoms of each enrolled PMDE not being consistently followed up from enrolment till recovery, which led to challenges in objectively making conclusions about patient recovery. Whilst there is evidence on the database that in their casework, counsellors did consistently follow up with individuals from enrolment to recovery, CORE-10 data was not uploaded, and even where it was uploaded, the available data is really only from individuals' first and last CORE-10 readings, and as such, does not objectively track individuals' recovery across sessions using the CORE-10 tool (although there is some evidence that there is some correlation between the number of sessions, and length of time receiving counselling, and the change in CORE-10 score).

Overall, these issues with monitoring and evaluation processes mean it is impossible to determine the specific number of carers the project has supported (as most accessed group counselling, where caregiver status was not recorded). Furthermore, we cannot compare the mental health improvements seen across project activities to determine if some interventions are more effective than others as e.g. there was no CORE-10 data uploaded for group counselling, so we cannot objectively monitor changes in mental health. However, the main issue is that we cannot assume that the mental health improvements seen in those individuals with CORE-10 data (30% of individual counselling clients), are representative of the entire cohort. That is a real shame, as the average change in CORE-10 reading at the end of support compared to the beginning is significant, with a clear shift from moderate to severe psychological distress at the outset of support to mild distress or even being in the non-clinical range at the end of support. To determine if these findings are representative of the wider cohort, BNUU should upload all hard copy CORE-10 reading they have to the KoBo database, so they can be analysed. However, at the outset of this evaluation, BNUU believed it would be too lengthy a process and would have delayed this evaluation (although they did enter more data during this evaluation). However, since reading the draft evaluation BNUU have

now decided to input all CORE-10 data they have, in order to determine if the results above are truly representative of all counselling clients (this data will be reviewed by the evaluator once it is available, with findings to be added as an addendum to this report).

As a result of the issues identified above, this evaluation strongly recommends that BNUU carefully consider capacity when taking decisions on scaling up delivery (in this project, to reach more health centres rather than beneficiaries), including the impact on frontline staff's time and ability to maintain accurate records. It is likely, from the available CORE-10 data and feedback from the focus group participants, that the project is positively impacting on the mental health and wellbeing of PMDEs and their carers. The fact that the project is delivering closer to people's homes is also likely to be boosting mental health outcomes. However, BNUU can't fully demonstrate that across their entire cohort of beneficiaries, as delivery has outpaced BNUU's capacity. This recommendation is especially important given the very high level of need for mental health services, so BNUU will always be under pressure to deliver more to reach more people.

In addition, BNUU should review its monitoring processes. BNUU is currently working with a new M&E consultant to introduce a better client management system. As part of this process, BNUU should ensure their M&E systems (a) are streamlined (e.g. ideally using one database for all project activities); (b) allows real-time inputting of data, so BNUU can collect data on all clients, including group counselling clients, without the need for separate paper records (this will include ensuring that frontline staff have the technology e.g. smart phones to allow for this); (c) only gathers data that is really needed, to reduce BNUU frontline staff's workload and (d) allows counsellors to access client's records, to ensure data is accurate and to track individuals' improvements over time. The new M&E processes should also clearly outline how and when data will be analysed by BNUU and how learning/finding will be shared by other stakeholders such as funders. BNUU should also collect and analyse CORE-10 data from/across all project activities, including group counselling, enabling BNUU to understand what interventions (or combinations of interventions) are most effective. Finally, any issues identified with monitoring and evaluation, or in the accuracy of reports provided to Network for Africa and BNUU's funders, should be flagged up to funders upon discovery in the interests of transparency/openness.

Sustainability of the programme and its outcomes

In the original bid, there was a focus on the sustainability of the project's outcomes.

In terms of individual outcomes, focus group participants showed a clear understanding of mental health issues/epilepsy and the steps they could take to maintain their health in the future:

"For me health educations which was given by BNUU staff from the hospital has helped me in reducing the levels of depression and how I can avoid things that will make me relapse".

PMDE - Focus Group participant, with members of Rubanga Aye Twero SHG in Adilang

This knowledge is likely to outlast the end of support. The Self-Help Groups created through the project have also built a support network for individuals, to help maintain mental wellbeing and to save money for the future:

"Sharing experiences in a group, because even if you come sad, [you have] togetherness, sharing ideas and chatting together...[we are also] saving, in case of any problems, you can borrow money".

PMDE - Focus group participant, Yotkom Ber SHG, Lapono Subcounty-Alinino Parish

Assuming the Self-Help Groups continue to meet, these outcomes should also outlast the end of the project. The Self-Help Groups have also set up drugs banks, to save money to buy

drugs during drug 'stock outs' (shortages of drugs) which happens regularly in most health centres even with BNUU's efforts to e.g. have drugs reallocated from nearby districts. These drug banks are already having a positive effect:

"I appreciate the drug bank management committee for supporting me to buy my antidepressant drugs, because I already missed it during the last clinic as it was out of stock from the Adilang Health Centre III."

PMDE from Adilang sub-county

"I am extremely excited to receive my anti-depressant drugs with support from the drug bank management committee, Adilang health centre III health workers and Basic Needs UK in Uganda because this shall help to improve on my adherences to medication that will ensure my recovery".

PMDE from Adilang sub-county

Again, this initiative should support the longer-term sustainability of individual improvements in mental health and epilepsy management. In fact, the drug banks address the key issue identified in the external evaluation of BNUU's Comic Relief funded project from March 2021, which is that drug stockouts were primarily resolved by BNUU staff negotiating for drugs to be made available, which was not be sustainable long-term.

The original application also outlines how training local health workers will raise awareness of mental health and improve the support on offer, and that is likely to endure beyond the life of this grant. As part of this evaluation, surveys from the original training were re-administered to the 7 health workers and 40 Village Health Team (VHT) workers who had undertaken the original training. This provided evidence that individuals had maintained, and in the case of the VHT workers, improved their knowledge of mental health since the original training – although not everyone was re-surveyed, so there are some caveats on e.g. sample bias. In addition, many of the health workers trained have moved to work in new areas, outside of BNUU's operational area, so whilst they may still have improved knowledge, this won't be benefitting people in Adilang or Lapono. However, overall, it is likely that these improvements in knowledge will continue to benefit people in Adilang or Lapono over at least the medium-term.

There was also a desire that over the longer-term the project will be implemented through existing government structures. There has been some progress around this during the 3-year project. In part due to BNUU's advocacy, the District Health Office is currently recruiting for a psychiatric nurse and a psychiatric clinical officer. BNUU's psychiatric nurse has applied for the psychiatric nurse role and been shortlisted for interview. If BNUU's psychiatric nurse is recruited by the district, he will no longer be paid by BNUU, but will still work on BNUU's projects. Patongo Health Centre has also been upgraded to a Health Centre 4, which means it now has the power to control movements of medication between health centres without having to go via the District Health Office every time, cutting bureaucracy and supporting the longer-term supply of mental health medication to patients in Adilang or Lapono.

However, despite these positive steps forward, it is unlikely that if BNUU stopped delivering services, especially the mental health clinics, that these would be taken over by existing health structures. A recent comprehensive review of mental health services across sub-Saharan Africa (Atewologun et al, April 2025) found that whilst Uganda had made significant efforts toward mental health policy development and the development of community-based mental health care, it was primarily doing this in collaboration with NGOs to enhance awareness of mental health and to mobilise resources. Therefore, it is not very likely that the Ugandan Government will change tack and decide to directly take on the delivery of mental health support locally. As such, BNUU should aim to secure ongoing funding for the project to be able to continue addressing the high levels of local demand for mental health support,

whilst continuing to build the capacity of, and advocating for, local health services to take on this work over the longer-term. Given the high turnover in Health Worker staff, it would also make sense to offer training on a rolling/regular basis, so that new Health Workers can also be trained to offer the best care to PMDEs they come into contact with.



**Self-help group member
attending human rights
training**

Photo © Simone Fior

Recommendations

This report makes several recommendations:

1. BNUU should carefully consider capacity when taking decisions on scaling up delivery (in this project, to reach more health centres), including frontline staff's ability to maintain accurate records. This recommendation is especially important given the very high level of need for mental health services, so pressure to deliver more to reach more people will always be high.
2. BNUU must review its monitoring processes. BNUU is currently working with a new M&E consultant to introduce a better client management system. This new system should (a) be streamlined (e.g. ideally using one database for all project activities); (b) allow real-time inputting of data, so BNUU can collect data on all clients, including group counselling sessions, without the need for separate paper records (this will include ensuring that frontline staff have the technology e.g. smart phones to allow for this); (c) only gather data that is really needed, to reduce BNUU frontline staff's workload and (d) allow counsellors to access client's records, to ensure data is accurate and to track individuals' improvements over time. The new M&E processes should also clearly outline how and when data will be analysed by BNUU and how learning/finding will be shared by other stakeholders such as funders. Finally, any issues identified with monitoring and evaluation, or in the accuracy of reports provided to BNUU's funders should be flagged up to funders upon discovery in the interests of transparency/openness.
3. BNUU should collect and analyse CORE-10 data from/across all project activities, including group counselling, enabling BNUU to understand what interventions (or combinations of interventions) are most effective.
4. BNUU should aim to secure ongoing funding for the project so they can continue addressing the high levels of local demand for mental health support, whilst continuing to build the capacity of, and advocating for, local health services to take on this work over the longer-term.
5. Given the high turnover in Health Worker staff, it would also make sense to offer mental health training on a rolling/regular basis, so that new Health Workers can also be trained to offer the best care to PMDEs they come into contact with.

Addendum to the evaluation – December 2025

Since the evaluation was conducted, BNUU have entered as much CORE-10 data that is available from their hard copies, specifically:

- CORE-10 data from individual counselling clients. They now have uploaded CORE-10 data (for the first and final sessions) for 421 individuals on the individual counselling section of the KoBo database (i.e. they have re-entered data on a further 129 clients from their hard copy forms since the evaluation).
- They have also entered the available CORE-10 data (again from the first and final counselling sessions) onto their group counselling section of the KoBo database, which now contains data on 247 group counselling clients. It should be noted that 112 clients appear in both databases, having received both individual and group counselling.
- Overall, this represents 58% of the overall number of people receiving individual and/or group counselling (up from 30% in the original evaluation).

Through this process, it has become clear that one key data gap is from clients from year 1. BNUU believe this is because they did not use paper records in year 1, trying to do everything online (with counsellors inputting data offline to the KoBo database, with the idea this would be synced/uploaded once they had an internet connection). However, this didn't often happen, and without paper records, much of this data has been lost. That said, it does mean (given most of the data is from clients in year 2 and 3) the sample uploaded will be from a significant number of the overall number of clients in year 2 and 3, meaning the data is most likely broadly representative of the entire year 2 and 3 cohort, so we can assume the analysis below is generalisable to the BNUU's client group overall.

An analysis of this expanded CORE-10 data shows that 84% of all individual counselling clients were at moderate to severe psychological distress at the outset of support, as determined by the CORE-10 thresholds, with the other 15% showing mild psychological distress. At the end of support, 85% of the sample were in the non-clinical range, 14% were in the mild psychological distress range and just 1% were in the moderate psychological distress range. As outlined in the evaluation, these are impressive results. A paired t-test (comparing the first reading to the last CORE-10 readings) was conducted which shows, unsurprisingly, that these results are statistically significant (i.e. the observed differences are not due to random chance). In addition, these statistics are similar to, and in some cases better than, the statistics drawn from the smaller sample provided for the evaluation, highlighting the smaller sample in the main evaluation was also representative of the overall counselling cohort. Overall, it can be concluded that the support BNUU provides leads to clear, substantial, statistically significant reductions in psychological distress for individual counselling clients.

An analysis of the CORE-10 data for group counselling clients is now also possible. This analysis shows that 75% of the sample were at moderate to severe psychological distress at the outset of support, with 23% showing mild psychological distress and 2% being in the non-clinical range. At the end of support, 91% of the sample were in the non-clinical range, 8% were in the mild psychological distress range and just 1% were in the moderate psychological distress range. A paired t-test was also run on this data, which again showed these were statistically significant changes in mental health. Having this data means we can also compare individual to group counselling - this shows that the group counselling is also targeting people with significant mental health support needs (although at a slightly lower level of need than individual counselling clients) and shows a similar substantial mental health improvements compared to individual counselling.

In addition, during the additional data inputting process, BNUU realised that they did in fact have a record of the number of caregivers supported during their home visits (recorded in the Home Visits section of the KoBo database). From this, they have calculated they have directly supported 735 caregivers over the three-year duration of the project (406 women and 329 men). This is lower than the targets in the original bid (to work with 850 caregivers) and unfortunately, does not enable us to understand how many of these caregivers went on to receive group counselling. However, the updated carers figure does enable us to more accurately calculate the per direct beneficiary of the project. Adding the 735 caregivers to the 1,168 people supported by the mental health clinics, brings the per person costs down to £185.85 (from £302.04).

A follow up conversation with Florence Adong, Programme Manager at BNUU, in December 2025 shows progress has been made since the evaluation. Florence reports that they have learnt from the evaluation process that they will need to spend more time on monitoring and evaluation planning (and planning more generally) before beginning a new project, to ensure they have the tools in place to measure, understand and report on their impact. Furthermore, BNUU have also been investing in improving their monitoring systems since the evaluation. They have been working with an external consultant, to really understand what they need from a new/improved monitoring system. This has enabled them to identify ways in which their monitoring and evaluation processes can be simplified, how they could bring all strands of their work together into one database/system (enabling them to track individuals as they move from e.g. group to individual counselling) and to start developing a clear specification from what they need from a database (such as a dashboard for better oversight and easier analysis processes). They have also approached the Ministry of Health (who have a clinical database), local companies who develop databases and IT students at local universities, to understand who can help them develop the database they need, and the likely costs involved. This is all positive progress and will hopefully result in BNUU developing a fit-for-purpose database that will enable them to track - and more importantly evidence - their positive impact over the medium- to long-term.



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