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Risk Reduction and Management Strategies Surrounding Mental Health Crises Stemming from Continuous & Multiple Disasters

Karamoja Region, Uganda

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Global Health Disaster Preparedness and Response GPH - GU 5210

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Preface

With more than 61% of the population living in poverty, Karamoja Region, in northeastern Uganda, has been classified by the United Nations Population Fund as one of the world's poorest areas.[28] The majority of the population are pastoralists and agro-pastoralists who rely on cattle and sorghum.

The region is heavily affected by a number of adverse events, including flooding, drought, famine and armed-conflict, all of which greatly affect food insecurity.[12] The United Nations High Commission for Refugees states that a GAM level of >10% is of high public safety concern and action must be taken immediately.[8] In 2022, Global Acute Malnutrition (GAM) levels reached 21.9% and 19.6% in the northeastern districts of Moroto and Kaabong, respectively. This means that 1 in 5 children under the age of 5 in these districts, or 20% is experiencing wasting and an increased risk of illness and death.[12] Roughly 91,000 children under the age of 5 and 9,000 pregnant or lactating women in *all* districts were at risk for severe malnutrition throughout 2022.[26]

The Integrated Food Security Phase Classification (IPC) is a multi-stakeholder initiative formed to improve decision making, nutrition analysis and food security.[10] Figure 1, below, details IPC phases, descriptions and indicators linking acute food insecurity, chronic food insecurity and acute malnutrition to better offer strategic and coordinated responses. As of July 2022, from a total population of 1.4 million, approximately 518,000 people were facing high levels of food insecurity, with 428,000 experiencing Phase Three (crisis levels of food insecurity) and 90,000 people were at Phase Four (emergency levels of food insecurity).[12]

Phase	Description	Indicators
Phase 1	Minimal	Households can meet essential food and non-food needs without engaging in atypical and unsustainable strategies to access food and income.
Phase 2	Stressed	Households have minimally adequate food consumption but are unable to afford some essential non-food expenditures without engaging in stress-coping strategies.
Phase 3	Crisis	Households either: - Have food consumption gaps that are reflected by high or above-usual acute malnutrition, OR - Are marginally able to meet minimum food needs but only by depleting essential livelihood assets or through crisis-coping strategies.
Phase 4	Emergency	Households either: - Have large food consumption gaps, which are reflected in very high acute malnutrition and excess mortality, OR - Can mitigate large food consumption gaps but only by employing emergency livelihood strategies and asset liquidation.
Phase 5	Famine	Households have an extreme lack of food and/or basic needs even after full employment of coping strategies. Starvation, death, destitution, and critical acute malnutrition levels are evident. For Famine Classification, an area needs: - > 25% households meet > 25% calorific requirements from humanitarian food aid; - > 25% households meet > 50% calorific requirement from humanitarian food aid.

Figure 1. Integrated Food Security (IPC) Phase Classification v3.1 Acute Food Insecurity Phases

In 2022, there were 2,465 fatalities reported in these districts by the United Nations Office for Coordination of Humanitarian Affairs (UN OCHA) due to “food insecurity crisis”.[12] Insecurity in the region is increased due to cattle raids perpetrated by neighboring communities or government soldiers; cattle raiders intensified the hunger crisis, as many were too afraid to farm or cattle were stolen.[24]

Climate change and conflict have affected Karamoja for decades. The two are irrevocably intertwined. While there are many resiliency reports describing local, national and international efforts to strengthen capacities including early warning responses for shock-affected households[11] i.e., households experiencing immediate and severe distress due to unexpected single or multiple crises which impact their well-being and survival[3], none of these have addressed the impact of climate change and conflict on the mental health of the communities affected by exposure to these continuous disasters nor the effect of these disasters on the mental health and wellbeing of the multiple aid workers deployed to or living in the community.

Resiliency in the face of ongoing disaster risk exposure must address the impact of these ongoing, multiple and concurrent disasters on the mental health and wellbeing of the population in these high risk areas.

Signature Page

By signing below, I have reviewed and approved the adoption of Continuous & Multiple Disaster Risk Reduction and Management, and agree to support its implementation.

Robinah Nabbanja, Prime Minister of Uganda — Date

Hillary Onek, Minister for Relief, Disaster Preparedness and Refugees — Date

Esther Davinia Anyakun, Min. of State for Relief, Disaster Preparedness & Refugees — Date

Catherine Ahimbisibwe, Ag. Commissioner/Disaster Preparedness & Management — Date

Douglas Asiimwe, Ag. Commissioner/Refugee Management — Date

Timothy Pitt, Head of Office, OCHA Uganda — Date

Rose Bwenvu, Min of Relief, Disaster Preparedness & Refugees, Office of the PM — Date

Henry G. Mwebesa, Director General Health Services — Date

Dr. Charles E. Owubah, Chief Executive Officer, Action Against Hunger — Date

Anifa Kawooya Bangirana, State Minister for Health in Charge of General Duties — Date

Margaret Muhanga, State Minister PHC — Date

Nelia Ekeji, MPH Student, NYU School of Global Public Health — Date

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Mission Statement

Action Against Hunger is a non-profit organization whose mission is to work alongside community leaders/government to decrease food insecurity and to provide equitable quality mental health services to the Karamoja community by creating resiliency focused programs to prepare, respond, and recover from disasters.

Statement of Purpose

The purpose of this project is to raise awareness about mental health in Uganda, primarily the Karamoja region, amongst those affected by multiple disaster risk exposures, including aid workers, with the purpose of integrating mental health therapies and strategies into existing Food Security Early Warning Systems Awareness. The ultimate goal is to empower various communities in crisis, from our target populations to aid workers on the ground.

Plan Objective:

- Create an environment where people from the impacted communities, including humanitarian aid and medical responders, are encouraged and feel safe to seek mental health treatment
- Provide Psychological First Aid Exercises and Trainings to mitigate the effects of multiple disaster risk exposure on mental health outcomes for local stakeholders
- Engage the community in Community Based Disaster Risk Reduction (CBDRR) and Community Based Disaster Risk Management (CBDRM) through Food Security Early Warning Systems exercises
- Empower local citizens to collaborate with local leaders and government officials to promote safety in the region

Authorities:

Uganda's Disaster Preparedness & Management unit, under the Office of the Prime Minister, states the following as their objectives on their website:

To strengthen capacities for mitigation, preparedness and response to natural and human induced disasters through:

1. Enhancing the Country's capacity to contain and minimize the effects of disasters.
2. Addressing disaster vulnerabilities of the community and alleviating human suffering from disasters
3. Preventing, mitigating, and preparing the country against disasters
4. Guiding government Disaster Preparedness and Management
5. Maintaining a national warehouse for food and non-food items and produce relief

Uganda's National Response Capacity to Refugee Emergency Management unit, under the Office of the Prime Minister, states the following on as their responsibilities for Disaster Preparedness and Refugees response on their website:

1. Receiving and granting asylum to refugees in accordance with both international and national legal frameworks
2. Settling refugees granted asylum, developing and implementing humanitarian interventions
3. Advising government and other stakeholders on refugee matters
4. Providing physical protection to refugees
5. Improving the physical infrastructure of the Refugee settlements, ranging from roads; staff accommodation, offices, reception centres among others
6. Enhancing the Refugee livelihoods through provision of Income Generating Activities (IGAs)

Nearly all of Uganda's districts have their own District Disaster Management Committee (DDMC), with levels of effectiveness and functionality varying by district.

Karamoja Resilience Support Unit (KRSU) is "an initiative of USAID/Uganda aimed at increasing resilience and economic development in Karamoja. The KRSU works closely with the Karamoja Development Partners Group to provide reviews, studies and analyses of development and humanitarian programs in Karamoja, and related policy issues."

The World Food Programme (WFP) in Uganda "maintains an agile emergency response capacity, while supporting the Government to host the growing number of refugees, address the underlying causes of food insecurity and malnutrition, and strengthen the national social protection system".

United Nations Children's Emergency Fund (UNICEF) "works to ensure that all boys and girls in Uganda, especially the most vulnerable and disadvantaged, realize their rights and have an equal opportunity to survive and thrive".

Definitions

CBDRR: Community Based Disaster Risk Reduction

CBDRM: Community Based Disaster Risk Management

CHW: Community Health Workers

CPMD: Common Perinatal Mental Health Disorders

DDMC: District Disaster Management Committee is responsible for the emergency operations plan for the district. They will analyze and evaluate the effectiveness of emergency preparedness based on response, recovery, and mitigation.

Food Insecurity: Limited availability of safe and nutritious foods, or limited ability to acquire foods.

GAM: Global Acute Malnutrition is measured by the prevalence of a population considered severely acutely malnourished.

IGA's: Income Generating Activities are ways in which to make money such as starting a business to generate income.

IPC: Integrated Food Security Phase Classification

KRSU: The Karamoja Resilience Support Unit

MOH: Ministry of Health

MfKA: Ministry for Karamoja Affairs

MP: Member of Parliament

MRDPR: Ministry of Relief, Disaster Preparedness and Refugees

NDRMP: National Disaster Risk Management Plan

NECOC: National Emergency Coordination and Operations Centre

NGO: Non-governmental organization

NPDPM: National Policy for Disaster Preparedness and Management

OPM: Office of the Prime Minister

UNICEF: United Nations Children's Emergency Fund

UN OCHA: United Nations Office for the Coordination of Humanitarian Affairs

USAID: United States Agency for International Development

WFP: The World Food Programme is the world's largest humanitarian organization saving lives in emergencies and using food assistance to build a pathway to peace, stability and prosperity, for people recovering from conflict, disasters and the impact of climate change.

Communication Plans

Internal Communication: Internal communications among mental health response teams will be conducted via email and through the encrypted server, WhatsApp for use on cell-phones. Charging banks will be supplied for all employees. Critical alert settings will be utilized as will scheduled daily check-ins.

- Various government agencies within Uganda's administrative and emergency offices will need to strengthen coordination efforts
- NGOs will need to establish emergency plans that can be clearly communicated to governmental agencies to ensure efficiency in private disaster response
- Government agencies will establish uniform emergency plans that can be distributed amongst NGOs to ensure organized, collaborative responses to disasters

External Communication: The District Disaster Management unit is the primary agency for emergency public information and other external communications. Uganda's Disaster Preparedness & Management unit, Uganda National Response Capacity to Refugee Emergency Management Unit, and Uganda Red Cross Society are supporting agencies in distributing emergency information to the public. Information needed for distribution will be coordinated with the District Disaster Management and the primary method of contact will be through email.

- Communication materials will be developed in multiple languages to ensure most of the affected populations will understand (English, Luganda, Kiswahili)
- Educational/informational material that is easy to display and distribute, such as pamphlets and posters, will be displayed throughout Karamoja
- Up-to-date messages will be disseminated via multiple platforms, including but not limited radio, television, opt-in email, SMS messaging, etc.

Mutual Aid Agreement

Uganda's National Policy for Disaster Preparedness and Management states highlights that Article 110 of the 1995 Constitution gives the President the "mandate to declare a state of emergency in any part of the country in the event of a disaster", and that the Minister in charge of disaster preparedness and management provides the President with "all the relevant details on the cause and effects of the disaster and mitigation and relief measures to be undertaken". The Office of the Prime Minister, at large, is responsible for institutional coordination and service delivery.

Uganda's Ministry of Health is a responsible institution on various natural and man-made disasters in the country, and serves as the leading institution for responses to human epidemics and pandemics. The Ministry of Health is responsible for:

> Policy review and development, supervision of health sector activities, formulation and dialogue with health development partners, strategic planning, setting standards and quality assurance, resource mobilization, advising other Ministries, departments and agencies on health-related matters, and ensuring quality, health equity, and fairness in contribution towards the cost of health care.

PUBLIC HEALTH CONCEPT OF OPERATIONS
Addressing the Mental Health Needs of Continuous and Multiple Disaster Risk Exposures on Vulnerable Populations

"*In spite of their tragic nature, and notwithstanding the human suffering they create, emergency situations are also opportunities to build better mental health care. The surge of aid, combined with sudden, focused attention on the mental health of the population, creates unparalleled opportunities to transform mental health care for the long term."*

The World Health Organization
Building Back Better: Sustainable Mental Health Care After Emergencies

Specific Locations of Interest

Moroto, Nabiltuk and Kaabong Districts were most affected by the recent famine and rise in armed conflict, the latter of which further exacerbated food insecurity. Public health interventions designed to address famine and associated adverse mental health must be focused on these areas.

(1) Prevalence of Disease Burden

Food insecurity has been shown to severely affect physical and mental health outcomes.[1,7] In Karamoja, while conflict is mainly driven by male youth, they are seen as victims because the conflicts have been heightened by other players including traders, government soldiers, and neighboring (Turkana) tribes.[27] The result is a degradation in living conditions with high rates of famine. Furthermore, the conflict and the resultant impact on the affected population, and most especially on the most vulnerable members of the affected areas (women, children, elderly, disabled, etc.) lead to high rates of adverse mental health. In Karamoja, as in many LMICS countries, conflicts AND natural disasters are also common, and these are a direct cause of food insecurity and even famine. Famine and adverse mental health are inextricably entwined.

Vulnerable Populations: Perinatal population

The prevalence of common perinatal (during pregnancy and up to two years post birth) mental health disorders (CPMDs), including major depression, anxiety disorders and somatic disorders

among women living in LMICS is 20%.[9] For women who have been exposed to conflict, natural disasters, gender based violence and/or food insecurity the rate is much higher, at 31%.[18]
The average age in Karamoja is 15, with child bearing being between 15 - 49 and with an average of 8 children per woman.[29] Women with perinatal depression may find it difficult to maintain proper hygiene, attend or access prenatal and antenatal medical care, are at higher risk of substance abuse, and may have inadequate social support systems in place.[4] Higher rates of diarrhea, malnutrition, stunting, and low-birth weight have been associated with maternal CPMDS.[9] Additionally, CPMDs are negatively associated with the neurological development of children under 2, adversely affecting cognitive, language, and behavioral skills [6] and mental health later in life.[16] Rates of CPMDs amongst pregnant adolescents have been found to be three times higher than that of older mothers.[19,20] Additionally, prenatal famine has been shown to have adverse outcomes on adult health.[21]

(2) Interventions

Given that only 17% of the Karamoja population have access to a health facility within 5km [33] we propose utilizing two low-intensity interventions that utilize Community Healthcare Workers (CHWs) or Peer Volunteers (PVs) to (1) deliver food supplements to perinatal women and (2) provide psychological support. The interventions will be supervised by qualified nutritionists and mental health professionals. The interventions will need to be translated into Karamojong for cultural acceptability and validity.

Nutritional Support for Perinatal Women in Karamoja:

The intervention will be supported by UNICEF. CHWs will provide direct access to essential nutrition services for adolescent girls and women before, during and after pregnancy and while breastfeeding, including in fragile settings and during humanitarian crises. The CHWs, with the help and support of UNICEF, will provide necessary nutrition to at risk women and adolescent girls. Women's diets in many countries contain limited fruits, vegetables, dairy, fish and meat. During pregnancy, poor diets lacking in key nutrients – like iodine, iron, folate, calcium and zinc – can cause anemia, pre-eclampsia, hemorrhage and death in mothers. They can also lead to stillbirth, low birthweight, wasting and developmental delays for children. UNICEF estimates that low birthweight affects more than 20 million newborns every year. Poor nutrition during breastfeeding makes it more challenging for mothers to replenish their nutrient stores and meet their additional dietary needs.[30] The CHWs will promote UNICEF values through provision of donated foods that promote healthy eating, micronutrient supplementation (iron and folic acid or multiple micronutrients, and calcium), deworming prophylaxis, weight gain monitoring, physical activity, and rest to improve the nutrition of pregnant women. They will also help provide nutritional counseling and support during pregnancy, in line with global recommendations.[34]

Self Help Plus:

In low-resource humanitarian settings, the clinical workforce required to implement evidence-based mental health and psychosocial support (MHPSS) is very limited.[17] Self Help

Plus (SH+) is a low-intensity guided self-help intervention based on MHPSS that provides strategies on how to manage psychological distress and cope with a wide range of difficulties.[17] The intervention begins with a completed needs assessment and resources with partner organizations.[17] The assessment will be used to adapt SH+ to meet the needs of the population and how to embed SH+ into services and programs already being delivered by partner organizations.[17] Using a mental health support assessment called Ensuring Quality in Psychological Support, an assessment is conducted on the skills of non-specialists delivering the SH+ intervention before, during, and after to evaluate quality.[17] People experiencing mild to moderate forms of psychological distress will benefit the most from SH+.[17] An example of the intervention implemented in Uganda among South Sudanese refugee women includes access to care, an illustrated self-help book, and five 2-hour audio-recorded stress-management workshops led by trained facilitators.[33]

<u>New Self Help Plus 360</u>:

Self Help + 360 is an evolved model from Self Help+ which focuses on creating a technical support hub.[17] Under SH+260, SH+ will directly integrate the core components into the existing humanitarian programs to ensure the sustainability of the intervention.[17] This intervention has been tested in Uganda, Europe and Turkey among refugees and asylum seekers.[34]

<u>Thinking Healthy</u>:

To increase positive behavioral change in the community through the inclusion of maternal and child care programs in primary care,[32] using the "Thinking Healthy framework" will direct the implementation of mental health interventions around the area. The objective is the integration of the "Mental Health Gap Action Programme" (mhGAP) guideline by community health workers in their daily routine in order to decrease and manage perinatal depression.[34] Addressing antenatal depression in women can help in changing negative behaviors to decrease complications involving women's care during and after pregnancy by decreasing malnutrition, substance abuse, low birth weight, premature delivery, suicide, and postpartum depression. Furthermore, tackling depression in that group can help in reducing issues surrounding the psychological development of a child (Emotional, social, and cognitive).[17] Therefore, the intervention will consist of different sessions (1) Preparing for the baby, (2) the baby's arrival/the first month), (3) early infancy/Second to fourth, (4) middle infancy /Fifth to seventh month/, and (5) late infancy /Eighth to tenth month.

(3) Evaluating the Effectiveness of the Disaster Response

<u>Implementation Science Approach</u>:

The implementation outcome approach is fairly new, and it aims to close the gap between research evidence and practice.[14] Using such interventions can help in the evaluation of the intervention program's effectiveness and make modifications if necessary. Therefore, this

intervention will consist of different steps: (1) Identifying evidence-based policies/ evaluating the acceptability of the programs, and appropriateness to the community, (2) Adapting and piloting all interventions/feasibility, fidelity, implementation cost, (3) Evaluating the implementation all interventions /sustainability of the evidence-based practice), and (4) Scaling up all interventions using data for future qualitative studies. [14,23]

The Ugandan government recognizes the toll that civil unrest plays on mental health among their citizens, and various efforts have been taken in an attempt to ameliorate mental health. Kigozi et al.[15] assessed the role that district mental healthcare plans (MHCPs) can have on mental health outcomes. They found that the incorporation of MHCPs in primary care settings (at the health organisation/management, health facility, and community levels) led to greater detection and diagnoses of mental illnesses such as epilepsy, depression, and schizophrenia. Other interventions to strengthen mental health outcomes have been attempted, with varying levels of success. Richards et al,[5] for example, did not find a significant relationship between engagement in competitive sports and mental health outcomes in their randomized controlled trial (RCT), however, they *did* note that this does not necessarily translate to all forms of physical activity. Moreover, a wealth of research has found a positive relationship between physical activity and mental health - this intervention is worth further investigating in other contexts in Uganda.

Betancourt and Williams [22] investigated other approaches to improving mental health in their review. They found that for war-affected populations in general, psychosocial approaches that "restore[d] connections to families and communities or recreate[d] social networks" were common. They also found that the most impactful mental health interventions involved combined, integrated approaches (namely, psychosocial and psychiatric approaches).
Less traditional approaches are also being incorporated into various mental health interventions in Uganda, such as Self-Help Plus. Tol et al. described Self-Help Plus as an intervention that "builds on existing innovations in delivery of mental health interventions in humanitarian settings by relying on task sharing and addressing a broader range of mental health difficulties… [and] further reducing the burden and demand on a workforce of non-specialists through a preformatted multimedia delivery package, and to more quickly reach larger numbers of people". This intervention was found to improve psychological distress, PTSD, depression symptoms, and more. The promising results of this cluster randomised trial could lead to a scaling up and greater implementation throughout Uganda.

Identifying effective interventions is only one component of disaster response that must be assessed. Once an intervention is found to be successful, the *application* of this intervention in wider settings must be undertaken. Implementation science is a crucial component to disaster preparedness, and public health at large - understanding its core components is critical to strengthening population health outcomes. Khadjesari et al.[13] conducted a systematic review of implementation science research, and found that across nearly 60 publications, the most pertinent components of implementation outcomes include "acceptability, appropriateness, adoption, feasibility, penetration, and sustainability". The findings from this review will inform this concept of operations to ensure the success of various proposed interventions to improve mental health outcomes in Uganda.

The existence of these studies and reviews, amongst numerous others, demonstrates the efforts being made to implement effective programs, policies, and practices to strengthen mental health in Uganda.

ANNEX 1: Threat and Hazards Assessment Table (THIRA) KARAMOJA REGION UGANDA 2019-2022

Natural	Technological	Human-caused
Resulting from acts of nature	Involves accidents or the failures of systems and structures	Caused by the intentional actions of an adversary
➢ Desert locusts & African armyworm (AAW) ➢ Other sorghum/crop diseases ➢ Agricultural drought ➢ Livestock diseases ➢ Human diseases ➢ Flooding ➢ Wild animal damage in gardens	➢ COVID restrictions severely affected livelihoods and food security ➢ Poor land and water management ➢ Lack of secure land tenure exacerbate tensions amongst the pastoralists and government and ability to graze their cattle ➢ No mental health needs assessment has been done to gauge the impact of multiple disaster risk exposure and the ability of those affected to access economic, political or social capital for either the community or the aid workers	➢ Livestock raiding ➢ Armed conflict ➢ Insecurity ➢ All of the above constrain income-earning and marketing / trading activities ➢ Insecurity limits land preparation, ploughing, and planting ➢ Reports of soldier brutality and cattle thieving ➢ Thousands have been killed between cattle raiding and armed governmental forces

Annex 2: Drills and Exercises

We offer two distinct and important Training Exercises to mitigate the effects of drought and food insecurity as well as mental health outcomes due to disaster risk exposures.

1. Famine Preparedness : Food Insecurity Early Warning System Exercises

Scenario: A severe drought has struck a country in East Africa, leading to crop failures and widespread food insecurity. As a participant in this exercise, you are a member of a local and/or government task force responsible for responding to the crisis. Your task force has access to the The Food Security Climate Resilience Facility (FSCRF) data and information, and you must develop a response plan to mitigate the impact of the drought.

Scenario Planning Exercises: Participants are presented with hypothetical scenarios related to climate-related risks to food security and are asked to develop response plans based on the information provided. This scenario planning exercise is designed to help participants understand the complex and multi-faceted nature of responding to food security emergencies. By working through this exercise, participants can develop the skills and knowledge needed to use the FSCRF effectively and to respond quickly and effectively to emerging food security risks.

A Focus Group Discussion undertaken by the Karamoja Resiliency Report found that Elders "...stated clearly that they had forecast severe hunger outcomes in 2020, 2021, and 2022 as they witnessed first-hand the impacts of multiple hazards on their livestock and crops. Importantly too, elders in all the focus groups forecast severe levels of hunger in the 2023 lean season" it is essential that Elders be at the table in these exercises.[2,3]

(see Table 1 below)

2. Psychological First Aid for Disaster Responders and Survivors

Many disaster responders including medical workers, humanitarian aid providers, local and governmental officers, and the military are also affected by the disasters they respond to. Many are also community members. Understanding how extreme stress/distress and/or trauma affect the nervous system is essential in destigmatizing mental health. Utilizing mindfulness based stress reduction

strategies can help mitigate the effects of trauma for both physical and mental health outcomes and can be shared across platforms. This training will allow first and second responders to utilize strategies for themselves and the communities they serve.[25]

(see Table 2 below)

Table 1. Food Security Early Warning Exercises	
Background & Objectives	The Food Security Climate Resilience Facility (FSCRF) is an early warning system developed by the World Food Programme (WFP) to monitor climate-related risks to food security in vulnerable countries. The FSCRF uses climate data, satellite imagery, and other information to identify areas at risk of droughts, floods, and other extreme weather events that could lead to food insecurity. Conduct Early Warning System Exercises that help communities detect and respond to potential food shortages before they occur.
Estimate Length of Training	2 Days
Target Audience and max size of audience.	District Level Government and Local Stakeholders including Tribal Chiefs, Village Heads, Elders, Health Officials & Aid Organizations 50 attendees
Facilitator(s)	Local District Health Officer (Karamojong). It is necessary for a local Karamojong to conduct the training as her/his knowledge of the land, changing climate, language and cultural acceptability affect the implementation science outcomes of the mitigation.
What do you want community members to do or learn as a result of their attending this session?	1. Review the FSCRF data and information related to the drought. Analyze the data to identify the areas of the District that are most affected by the drought and the populations that are most at risk of food insecurity. 2. Identify the immediate needs of the affected populations, including food, water, and healthcare. Develop a plan for providing these essential services, taking into account the logistical challenges of delivering aid to remote and hard-to-reach areas. 3. Develop a longer-term plan for addressing the underlying causes of food insecurity, including improving agricultural practices and building resilience to future droughts. Consider how the government can work with NGOs, international organizations, and local communities to implement these interventions. 4. Consider the potential risks and challenges associated with the response plan, including security risks, political challenges, and resource constraints. Develop contingency plans to address these risks and ensure the success of the response. 5. Present your response plan to the other task force members and receive feedback. Revise your plan as needed based on feedback received.
Strategies to increase community uptake of your mitigation	Provide transport and data costs, cash vouchers, training materials, certificates of completion, lodging and meals

Table 2. Psychological First Aid for Disaster Responders and Survivors	
Objectives	Mindfulness Based Stress Reduction Strategies for Mental Health
Estimate Length of Training	2.5 Days
Target Audience and Max Size	District Level Government and Local Stakeholders including Tribal Chiefs, Village Heads, Health Officials, Community Health Workers & Aid Organizations 100 attendees
Facilitators	Two Local District Health Officers (Karamojong) trained in MBSR skills. It is necessary for local Karamojong to conduct the training as her/his knowledge of the land, changing climate, language and cultural acceptability affect the implementation science outcomes of the mitigation.
What do you want community members to do or learn as a result of their attending this session?	1. Learn how stress/distress and trauma affect the nervous system 2. Learn trauma informed awareness 3. Discuss mental health stigma and the effects of it on the community 4. Practice Mindful Breathing Exercises: This exercise involves guiding participants through a series of deep breathing exercises, with an emphasis on paying attention to the breath and the sensations in the body. The purpose of the exercise is to help participants develop a sense of calm and focus by engaging the parasympathetic nervous system. 5. Practice Body Scan Exercise: This exercise involves guiding participants through a scan of their body, paying attention to sensations and areas of tension or discomfort. The purpose of the exercise is to help participants develop awareness of their physical sensations and learn to release tension. Utilizing restorative yoga poses such as "legs on a chair" will also engage the parasympathetic nervous system 6. Guided Imagery Exercise: This exercise involves guiding participants through a visualization exercise, such as imagining a peaceful scene or a safe place. The purpose of the exercise is to help participants develop a sense of calm and relaxation. 7. Gratitude Exercise: This exercise involves reflecting on things for which participants are grateful, such as people or experiences that have brought them joy or support. The purpose of the exercise is to help participants develop a sense of appreciation and positive emotions. 8. Compassion Exercise: This exercise involves guiding participants through a series of compassion practices, such as sending themselves and others positive messages or imagining giving themselves a hug. The purpose of the exercise is to help participants develop compassion and kindness towards themselves and others. 9. Learn how to share the above practices with others
Strategies to increase community uptake of your mitigation	Provide transport and data costs, cash vouchers, training materials, certificates of completion, lodging and meals. Offer continued support through electronic and in-person supervision.

Annex 3 Short-Term Strategies

Necessities	Possible Resources	Distribution Strategies
Food	World Food Programme Uganda (WFP) Uganda Red Cross Society Food for the Hungry Uganda	• Strategically Located Food Distribution Centers • Mobile Food Distribution for communities that do not have access to transport • Food vouchers • Food for Work Programs through schools, health centers, and community projects • Cash Vouchers • Farming support to local farmers
Water	Uganda Water and Sanitation NGO Network (UWASNET) WaterAid Uganda Water.org	• Improving water quality through constructing water supply infrastructures such as wells and water treatment plants • Distributing water treatment kits for water purification • Community water points in strategic locations • Mobile water distribution using trucks or other vehicles to deliver water • Education and awareness on promoting good hygiene practices and preventing water-related illnesses
Security	United Nation African Union Mission (AMISOM)	• Requesting help to increase security in rural, poor areas, and border control • Conflict-resolution • Management of counter-terrorism • Establishing Checkpoints in major villages • Trained Ugandans soldiers or police force • Providing surveillance and supplies • Decrease violence against women and children • Harsher penalties/prison sentences
Transportation	African Development Bank World Bank	• Providing transportation to health facilities • Increase distribution of goods and potable water in rural areas • Road Safety Budget • Campaign to increase Awareness for Safe Driving • Law addressing personal vehicle condition • Regulation of Public Transportation • Enforcement of Traffic Laws/ increased Traffic Citations

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