

IMPACT REPORT | OCTOBER 2026

Screening 4,270 people for mental health across Northern Uganda

What 18 child development centres in six districts told us, and what it will take to care for them

Stress Clinic Uganda | Gulu, Uganda

Prepared by the Media Team

ABOUT

About this report

Title	Screening 4,270 people for mental health across Northern Uganda
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A note on the data

All results in this report come from screening tools. A screening result tells us that a person needs a closer look from a trained professional. It is not a diagnosis, and none of the percentages show how many people in a community have a mental disorder. To protect privacy, we report in aggregate and we do not name individual people or centres.

Acknowledgements

We thank the children, caregivers, staff and volunteers who answered our questions, often about painful things, and the centre leaders and committees who welcomed us. Our counsellors and psychologists carried the work in the field, in some places over long distances. Photographs were taken with signed consent.

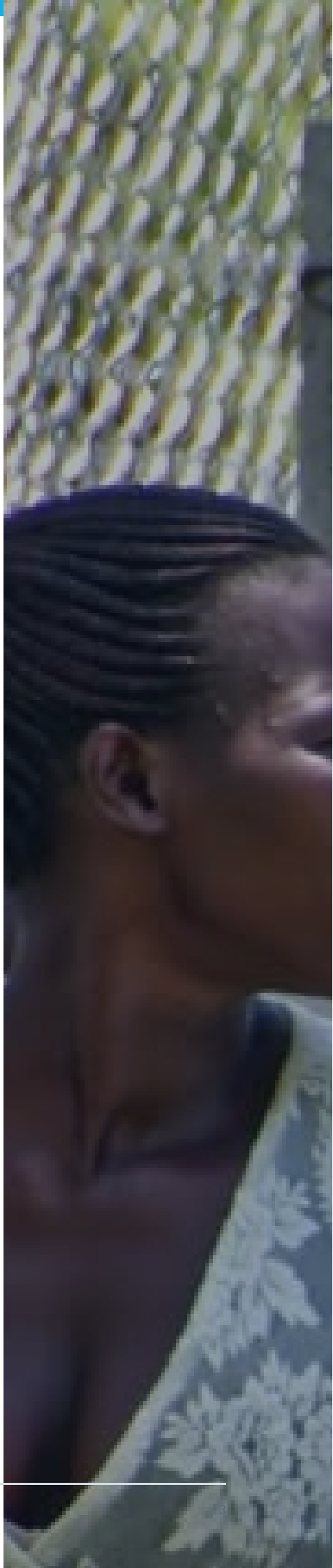
Abbreviations

Term	Meaning
CATS	Child and Adolescent Trauma Screen
PCL-5	PTSD Checklist for DSM-5
PHQ-9 / PHQ-A	Patient Health Questionnaire, adult and adolescent versions
PTSD	Post-traumatic stress disorder
SDQ	Strengths and Difficulties Questionnaire
WHO	World Health Organization

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EXECUTIVE SUMMARY

4,270	18	6	1 in 4
people screened	child development centres	districts	need active follow-up

In 2026 Stress Clinic Uganda screened 4,270 children, young people, caregivers and adults for mental health difficulties at 18 child development centres in Gulu, Nwoya, Amuru, Omoro, Agago and Pader districts. Every person received an individual case file that explained their result in plain language, and every centre received a report.

The screening shows a lot of need. 1,066 people, one in four, scored in a tier that calls for clinical follow-up, rapid support or urgent attention. Among 500 adolescents, 60 told us about thoughts of ending their lives or a past attempt. These are screening results, not diagnoses, but they match what published research from this region would lead us to expect.

The harder fact is that none of these people has yet received follow-up care, because it has not been funded. We can say who needs help and where. We cannot yet say that they were helped.

KEY MESSAGES

The reach is wide

2,424 children and young people and 1,846 caregivers and adults, across six districts.

Need is high everywhere

Between 19% and 36% of people screened in each district needed active follow-up.

Young people are at risk

One in eight adolescents (60 of 500) disclosed suicide-related risk.

Caregivers carry a heavy load

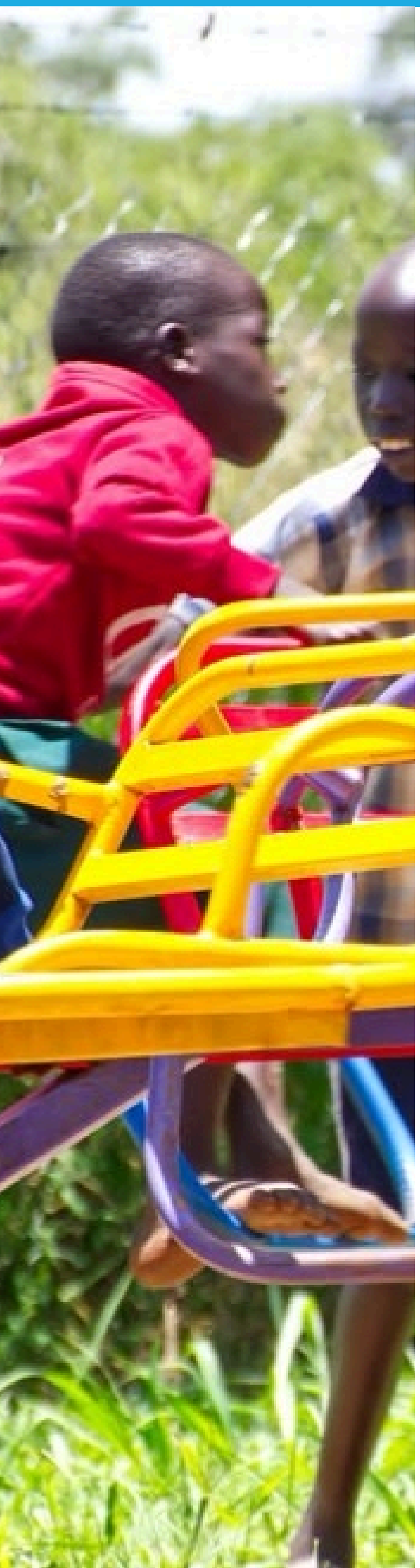
65% show signs of depression and nearly half of adults show signs of trauma.

Staff are struggling too

Elevated symptoms at every one of the ten centres where staff were screened.

Follow-up is the gap

Screening finds people. Care keeps them safe. Care is not yet funded.



SECTION 1

Why this matters

Mental health conditions are common among young people, and Northern Uganda carries a particular burden. People here have lived through years of conflict, and many families still face violence, alcohol misuse, poverty and the loss of loved ones.

1 in 7

adolescents aged 10 to 19 lives with a mental disorder, and suicide is the third leading cause of death among 15 to 29 year olds. *World Health Organization*

2.4%

of development aid reaches adolescents, who are 25% of the world's population and carry 9.1% of its disease burden. *2025 Lancet Commission on Adolescent Health*

34.1%

of 2,821 school-going adolescents in Gulu and Masaka had at least moderate depressive symptoms. *Mugisha and colleagues, BMC Psychiatry, 2025*

Against that background, screening at scale matters. It tells us who needs help, where it is most needed and how big the response must be.



SECTION 2

What we did

Stress Clinic Uganda counsellors and psychologists visited 18 child development centres in 2026. They did more than screen: during each visit they gave psychological first aid to people in distress and ran sensitisation sessions on mental health. They used internationally recognised tools: the PHQ-9 and PHQ-A for depression, the PCL-5 and CATS for trauma, and the Strengths and Difficulties Questionnaire (SDQ) for children's emotional and behavioural difficulties. Because the SDQ has no question about suicide, our counsellors and psychologists also asked a direct verbal question about risk at every centre.

Each person received a one-page case file with their result, a plain-language explanation and a recommended action tier. Each centre received a report. Results were grouped into tiers from No Immediate Action to Urgent, and the tiers guide who needs attention first.

WHO WAS SCREENED

Group	People
Children, adolescents and young people	2,424
Caregivers and adults	1,846
Total	**4,270**

Tools: SDQ, PHQ-A and CATS for young people; PHQ-9 and PCL-5 for adults.

REACH BY DISTRICT

District	Centres	Screened	Follow-up	Share
Omoro	5	1,083	203	19%
Nwoya	5	992	219	22%
Amuru	3	839	301	36%
Agago	2	651	158	24%
Pader	2	594	160	27%
Gulu	1	111	25	23%
All	**18**	**4,270**	**1,066**	**25%**

SECTION 3

What we found

3.1 EVERYONE SCREENED

2,471 people (57.9%) needed no immediate action and 683 (16.0%) needed routine or proactive monitoring. A further 710 (16.6%) fell in the clinical follow-up or review tier, 178 (4.2%) needed rapid support and 178 (4.2%) were urgent. The last three groups together are the **1,066 people** who need active follow-up.

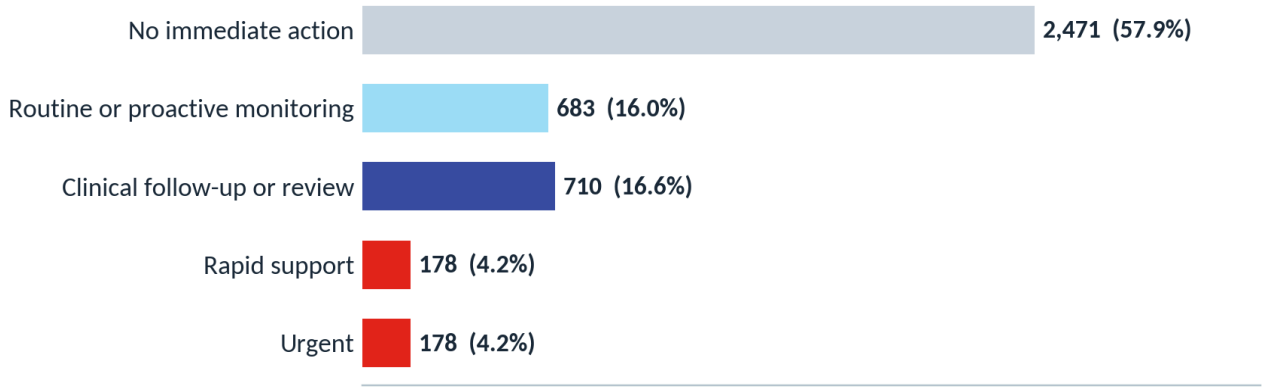


Figure 1. Everyone screened, by response tier (n = 4,270).

3.2 ADOLESCENTS AND YOUNG PEOPLE

Adolescents answered for themselves, so their results are the strongest part of the data. Of 500 screened for depression with the PHQ-A, 129 (25.8%) scored beyond No Immediate Action and 73 (14.6%) needed an active clinical response. **In total 60 of 500 (12.0%), about one in eight, disclosed suicide-related risk**, including 21 who confirmed suicidal thoughts in the past month and 10 who reported a past attempt with current thoughts.

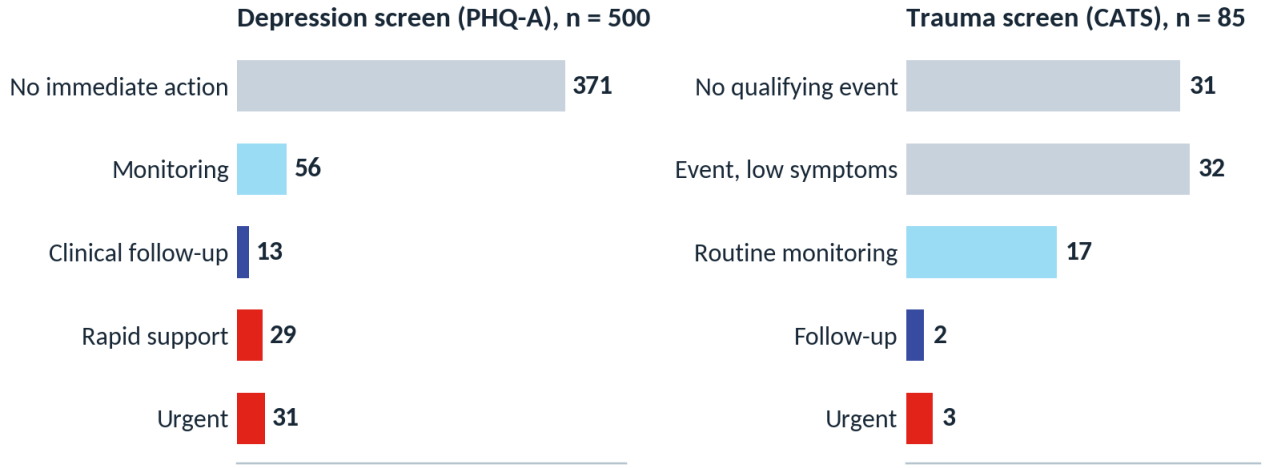


Figure 2. Adolescent depression screening tiers (PHQ-A, n = 500) and trauma screening tiers (CATS, n = 85).

On the trauma screen, 31 of 85 young people (36.5%) reported no qualifying frightening event. Of the 54 who did, 22 (40.7%) needed monitoring or follow-up. The trauma sample is small, so this is an early signal and not a rate for the whole region.

3.3 YOUNGER CHILDREN

Among 1,772 children and young people screened with the SDQ, 299 (16.9%) were flagged for follow-up or review. The SDQ also measures hyperactivity and attention. Overall, 18.2% showed borderline or abnormal scores, and the rate was highest among 2 to 4 year olds.

This is a screening signal. Many of these children need support with attention and learning, and not only counselling.

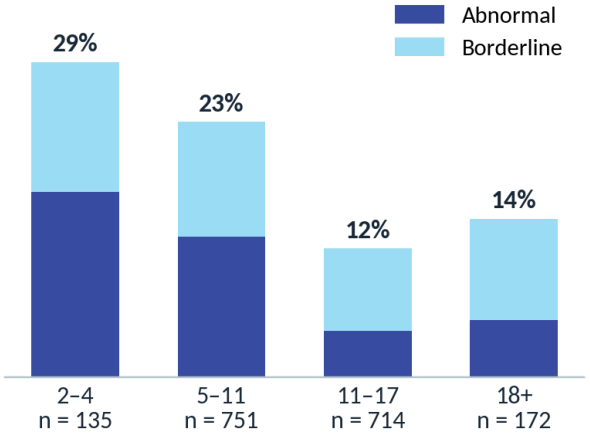


Figure 3. Children with elevated hyperactivity scores on the SDQ, by age group.

3.4 CAREGIVERS AND ADULTS

Of 1,272 caregivers and adults screened for depression with the PHQ-9, **829 (65.2%)** scored at mild severity or worse. 39 were in the severe range and 108 in the moderately severe range: 147 people who need active clinical treatment.

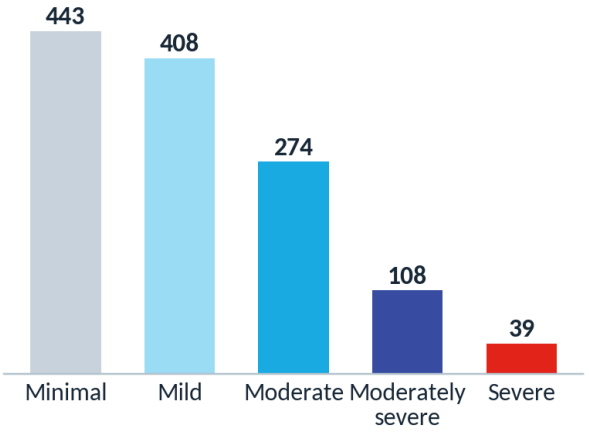


Figure 4. Depression severity among caregivers and adults (PHQ-9, n = 1,272).

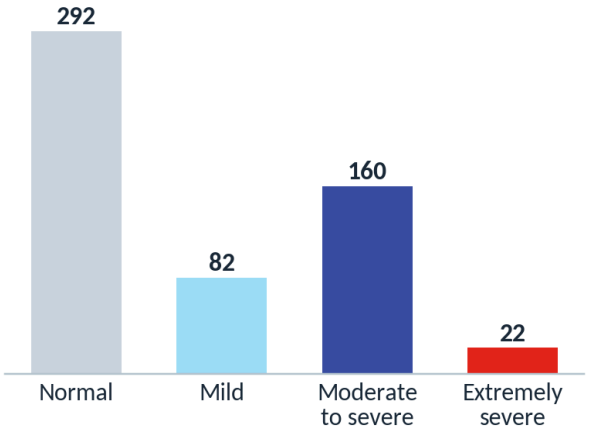


Figure 5. Post-traumatic stress severity among adults (PCL-5, n = 556).

Of 556 adults with a complete trauma checklist (PCL-5), **264 (47.5%)** scored at mild post-traumatic stress severity or worse, including 22 in the extremely severe range who need urgent specialist assessment. Depression and trauma appear together, so they should be addressed together.

3.5 WHAT LIES BEHIND THE NUMBERS

Field teams recorded the same causes again and again: gender-based and domestic violence, the lasting effects of conflict, alcohol and substance misuse in the home, poverty and family breakdown.

> **"A 12-year-old boy disclosed wanting to leave home because of his father's alcohol use."**
>
> Recorded by one of our counsellors. Details changed to protect identity.

Counselling alone will not remove these causes. They need livelihood support, family strengthening and violence prevention alongside clinical care.

3.6 ACROSS THE DISTRICTS

Need is present in every district. The share of people needing active follow-up ranges from 19% to 36% and is highest in Amuru. Differences between districts partly reflect which tools were used and how many people were screened, so we use them to decide where to send scarce follow-up capacity first, not to rank communities.

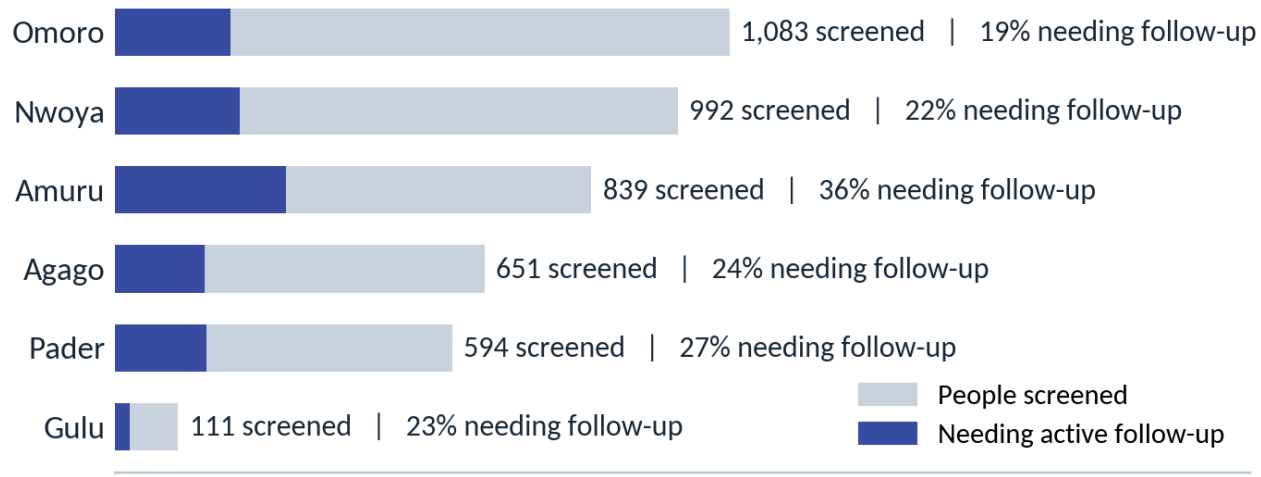


Figure 6. People screened and the share needing active follow-up, by district.



Counsellors and psychologists listen to young people and caregivers during screening.

SECTION 4

The people who run the centres

We also screened the staff and volunteers who look after children at the centres. So far this covers 65 people at 10 of the 18 centres. Elevated symptoms of depression or trauma were found at every one of those 10 centres. Two staff members disclosed a serious risk to their own lives and received the same immediate psychological first aid and safety response we give anyone.

> **Why this matters.** The people who care for children are carrying a heavy load too. Staff wellbeing needs its own support, and it should be part of any follow-up plan.

SECTION 5

What has happened, and what has not

WHAT HAS HAPPENED

Every person screened has an individual case file. Where someone scored in the Urgent or Rapid Support tiers, the file recommends contact on the same day. Each centre received a report and its raw data, and a consolidated report has been shared with our funder. Staff screening has started, and where risk was disclosed, staff were helped immediately.

WHAT HAS NOT

Follow-up care has not yet been delivered, because it has not been funded. Our clinical team is one clinical psychologist and seven counsellors, who also serve other programmes. 1,066 people cannot be followed up without new funding.

> **Screening has found the people who need help. Care is what keeps them safe, and care is not yet funded.**





SECTION 6

What we are asking for

We are looking for partners who will help us turn screening into care. Together we can:



Fund follow-up care
Clinical and counselling follow-up for the 1,066 people in the active-response tiers, starting with those who are urgent.

Support caregivers and families
Counselling, case management and links to livelihood and family-strengthening programmes.

Look after staff and volunteers
A support and referral pathway for the people who care for children.

Back work on the causes
Violence prevention, family strengthening and income support.

Get in touch

If you fund or deliver child and youth wellbeing work and would like to help, write to us at **info@stressclinic.africa**.

If you are struggling, talk to someone you trust.







SECTION 7

Limits of the data

Readers should keep five limits in mind.

- Screening tiers are not diagnoses. Only a clinical assessment can diagnose.
- Different tools were used for different groups, and the SDQ does not measure the same things as the PHQ and PCL, so we analyse each tool separately.
- Children and caregivers were recorded on separate forms and cannot be linked person to person.
- Some samples are small, for example the trauma screen for young people (85 people), so those figures are early signals.
- Staff screening covers 65 people at 10 centres and is not a full picture of the workforce.

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Photographs were taken with signed consent.

Screening finds.
Care keeps safe.

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