

UNHCR Uganda Mental Health and Psychosocial Support Strategy

2019 - 2021

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List of acronyms

CBP	Community Based Protection
CBS	Community Based Sociotherapy
CBT	Cognitive Behavioural Therapy
CP	Child Protection
CRRF	Comprehensive Refugee Response Framework
IPT	Interpersonal Therapy
IASC	Inter Agency Standing Committee
mhGAP	Mental Health Gap Action Programme (WHO)
mhGAP IG	mhGAP Intervention Guide (WHO)
mhGAP HIG	mhGAP Humanitarian Intervention Guide (WHO/UNHCR)
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
PFA	Psychological First Aid
PM+	Problem Management Plus
POC	Person of Concern
PSN	Person with Specific Needs
PTSD	Post-traumatic Stress Disorder
RRP	Refugee Response Plan
SGBV	Sexual and Gender Based Violence
SH+	Self Help Plus
SOP	Standard Operational Procedure
SWG	Sub Working Group
UNHCR	United Nations High Commissioner for Refugees
VHT	Village Health Team
WHO	World Health Organization

Objective of this strategy

The objective of this strategy is to provide guidance to UNHCR and partners concerning strategic directions in mental health and psychosocial support (MHPSS) for refugees and host communities in Uganda. It will be relevant to all developing responses in health and protection, especially throughout community based protection (CBP), child protection and SGBV.

General Aspects

UNHCR does not understand MHPSS being a “stand-alone” sector, isolated from other services. MHPSS is recognized as a cross-cutting issue within the refugee response and many interventions by actors in the response have an effect on the mental health and psychosocial wellbeing of refugees and other persons of concerns. As such, MHPSS should be integrated into (sub) sectors such as health and nutrition, community-based protection, SGBV, child protection, education, and livelihood. Accordingly, strategies of these different (sub) sectors provide the basis of the strategic document at hand.

- UNHCR Uganda Community Based Protection Strategy 2016-2018.¹
- Multi-Year, Multi-Partner Protection and Solutions Strategy Uganda 2016-2020. Uganda Protection and Solutions Strategy. Internal update.²
- UNHCR 5-Year Interagency SGBV Strategy Uganda 2016-2020.³
- The Republic of Uganda, Health Sector Integrated Refugee Response Plan (HSIRRP) 2019-2024.⁴
- UNHCR Public Health Strategic Plan 2018-2021.⁵
- Uganda Country Refugee Response Plan. The Integrated Response Plan for Refugees from South Sudan, Burundi and the Democratic Republic of the Congo. January 2019-December 2020 (Revised in March 2019).⁶
- Ministry of Education and Sports. Education Response Plan for Refugee and Host communities in Uganda (2018).⁴⁹
- Ministry of Health. Child and Adolescent Mental Health Policy guidelines (March 2017).⁵⁰

The cross-cutting nature of MHPSS does not diminish in any way the importance of MHPSS in the response or the need for adequate resources to be allocated to MHPSS to be respond to the significant operational needs as elaborated below.

Global Strategies and Guidance UNHCR:

- Operational Guidance for Mental Health and Psychosocial Support Programming in Refugee Operations (2013)⁷
- Mental Health and Psychosocial Support in the Protection Responses of UNHCR’s Emergency Handbook⁸
- Community-based protection and Mental Health and Psychosocial Support (2017)⁹
- Understanding Community Based Protection (2013)¹⁰
- A framework for the protection of children (2012)¹¹
- Child protection Issue Brief: Mental health and psychosocial wellbeing of children (2014)¹²
- Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response 2003)¹³
- Age, Gender and Diversity Policy (2018)¹⁴

Interagency Guidelines:

- IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings (2007)¹⁵
- IASC Community-based approaches to MHPSS Programmes: A Guidance Note (2019)¹⁶
- Sphere Handbook. Humanitarian Charter and Minimum standards in humanitarian response. (2018)¹⁷
- WHO mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings. Version 2.0 (2016).¹⁸
- WHO, UNHCR mhGAP Humanitarian Intervention Guide (mhGAP-HIG) (2015).¹⁹
- Child Protection Minimum Standards (in press, 2019)

Guiding Principles

UNHCR's work in the area of mental health and psychosocial support shall be led by below principles:

- *Systems approach.* MHPSS services should be designed with a systems-based approach offering multiple complementary activities across interconnected layers. A strong referral system needs to be ensured.
- *Community-based, participatory and rights-based approach.* Refugees and other persons of concern (POC), including children, youth, women, elderly and persons with special needs (PSN) (including intellectual and physical disabilities/additional needs), should be involved in all steps of planning and implementation of activities supporting mental health and psychosocial wellbeing.
- *Integration.* MHPSS should not be conceptualised as a separate sector, but should rather be integrated into existing public health and community-based support programmes. Visibility and thorough coordination as well as specialised services need nevertheless to be ensured.
- *Complementarity.* A close partnership of UNHCR with government agencies, other UN agencies, non-governmental partners and communities shall contribute to the development of a strong and complementary interagency MHPSS response that maximises existing resources and complementarity of the partners' work.
- *Equity.* All refugees should be engaged with, in an inclusive and non-discriminatory way irrespective of their nationality and place of residence. Refugees and other POCs shall be provided access to quality MHPSS services which are similar in cost (similar or lower) and quality to the existing services for the host community.
- *Social cohesion.* Promote social cohesion and peaceful coexistence among refugee and host communities and the integration of refugees into their communities. Programmes should address potential impacts of the refugee influx on communities.
- *Inclusivity.* Develop a comprehensive MHPSS response which also addresses specific risks of women, men, boys, girls and people with severe psychosocial and intellectual disabilities.
- *Do No Harm.* Provide activities and procedures in a way that does not create further risk of harm for POCs and ensure that beneficiaries can provide feedback on the services. Be aware of any unintended consequences and potentially negative impacts of humanitarian interventions.

Mental Health and Psychosocial Support for Refugees

Forced displacement due to armed conflict, persecution or disasters sets individuals, families and communities under high psychological and social stress. A recent WHO study (2019) estimates that one in five people in (post)-conflict settings has depression, anxiety disorder, post-traumatic stress disorders (PTSD), bipolar disorder or schizophrenia.²⁰ These numbers are higher compared to prior estimates on being one in 14 people. Also, the 12-month prevalence of both severe and mild to moderate mental disorders appear to be higher than previously estimated.

In addition to existential threats, traumatic experiences of armed conflict, violence, loss etc. in the country of origin, refugees may also face challenges and daily stressors in transit and in the settlements, such as physical protection risks, access to basic services, livelihood opportunities and uncertainties concerning the future.

Experiences of daily stressors as well as violence, disruption, pain, loss, and grief can have impacts on psychosocial wellbeing and mental health, and can increase the vulnerability of developing mental health issues. Mental and psychosocial problems are manifold and can encompass social problems, emotional distress and also common mental disorders (e.g. anxiety disorders, PTSD, depression), severe mental disorders (e.g. psychosis), alcohol and substance use disorders and intellectual disabilities.^{21, 42, 45}

Often, psychological reactions and impacts on psychosocial wellbeing and mental health are normal in situations of significant psychological and social stress and most reactions can be managed with time. The majority of refugees will develop coping strategies to overcome difficult experiences and even build resilience. This is especially so if the individuals are integrated and receive social support by their community and family. On the contrary, people who have been separated from or have lost close ones and family members, or who are survivors of violence are more vulnerable to distress. Occurring problems range from “normal” emotional distress (often developed due to disrupted social support systems) to mental disorders that impact the individual’s daily functioning to varying extents (up to the loss of social functioning).⁸

In times of emergencies and humanitarian interventions, the emotional wellbeing and mental health is still too often overlooked. The need for MHPSS in the context of forced displacement and protracted displacement however, is immense and needs to be responded to in a comprehensive and coordinated manner. Mental health and psychosocial problems pose a threat to individuals, families and communities and can be of existential nature bearing immediate, mid- and long-term consequences for the individuals but also for the families and communities (including significant intergenerational effects). Adverse mental health can affect overall human development which also impacts education, economic productivity as well as physical health.⁴⁵

Latest figures reveal that 142 million children are living in high intensity conflict zones globally. As set out in the report ‘Road to Recovery: Responding to children’s mental health in conflict’⁵¹ and based on WHO analysis, Save the Children estimates that approximately 24 million of those children could be experiencing high levels of distress and have mild to moderate mental health disorders, needing an appropriate level of care. Despite this, child protection in emergencies, education in emergencies and Mental Health and Psychosocial Support (MHPSS) are critically underfunded. Save the Children

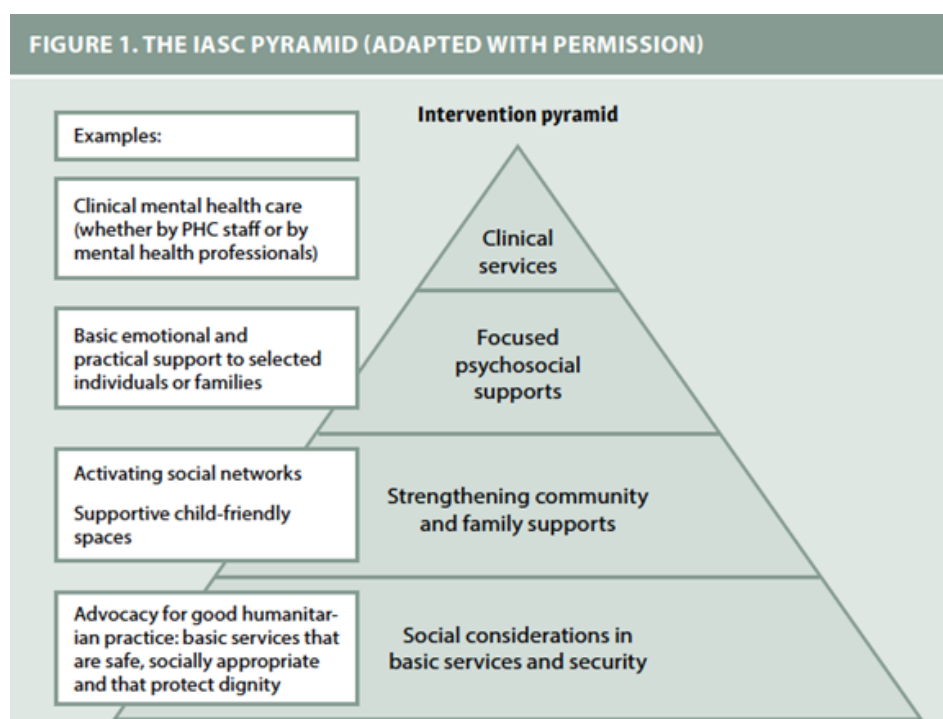
analysis has found that as a proportion of Overseas Development Assistance, mental health and psychosocial support programming accounted for just 0.14% of spend between 2015-2017.

According to inter-agency consensus, UNHCR deploys the term “mental health and psychosocial support” (MHPSS) to describe “any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders”.¹⁵ The term “psychosocial” underlines that psychological and social processes are always interconnected and continually interact and influence the other. MHPSS activities and services must be designed in a multi-layered and comprehensive way and should address groups, communities as well as individuals with more severe concerns. It is important to note that the way in which humanitarian services are provided has impacts on stress that POCs experience. It can diminish but also increase stress for affected communities. Since MHPSS is a cross-cutting concept, this issue is relevant for programming in various sectors, including health, community-based protection, education, nutrition, livelihoods and shelter.

UNHCR distinguishes between a MHPSS approach and MHPSS interventions. A MHPSS approach describes the way that any humanitarian response is provided in a manner that is beneficial to the psychosocial wellbeing and mental health of persons of concern. MHPSS interventions describe one or multiple activities that follow the primary objective of improving psychosocial wellbeing and mental health. MHPSS interventions are mostly implemented through actors in health, community-based protection and education. MHPSS approaches however, should be applied by all actors and sectors involved in the response. This includes the awareness for implications the interventions in the respective sectors can possibly have for the mental and psychosocial wellbeing of the POCs whom they are serving.

Below graphic illustrates the multiple layers MHPSS services should be offered across.

Figure 1: The multi-layered MHPSS Pyramid



Layer 1: Social considerations in basic services and security

Basic needs and essential services (food, shelter, water, sanitation, basic health care and nutrition, control of communicable diseases) should be provided in a way that contributes to psychosocial wellbeing and mental health. Services should consider norms of what is considered socially appropriate and should be inclusive for all including people with specific vulnerabilities while protecting their dignity and working against stigmatisation.

Layer 2: Strengthen community and family supports

Forced displacement often leads to disruptions in family and traditional community support systems which can have negative impacts on how people can support themselves and each other. Fostering social cohesion and strong community support is therefore key. Services targeted to this are mostly provided by protection actors and should aim towards strengthening, re-establishing or development of supportive networks and community-based structures. It is important that this is done in an age, gender, diversity sensitive way and through a participatory approach. Involvement of refugees and other POCs must be ensured at all stages of design, implementation as well as during feedback to MHPSS services being offered.

Layer 3: Focused, non-specialised psychosocial supports

Some people may need additional focused support which is provided on an individual basis or through family or group interventions. Services are for instance interventions offered by trained and supervised community workers, basic mental health care by primary health care workers and psychologists, and psychological first aid (PFA).

Layer 4: Specialised services

Additional support in the form of specialised, clinical services is needed to address severe mental disorders that create intolerable suffering and impact on fundamental daily functioning. The services are provided by trained and supervised general health care personnel as well as psychologists and psychiatrists. The need for such targeted specialised services should not be underestimated and supported by strong and well interconnected layers of the pyramid.

Relation of MHPSS with (community based) protection

Alleviating short- and long-term risks and consequences for mental health and psychosocial wellbeing of POCs stands at the core of UNHCR's protection mandate. In refugee settings, formerly existing traditional community structures including family, extended family networks and informal social networks may be disrupted. Lacking support of such networks regulating community well-being, individuals can increase the risk of exploitation and abuse within the community, the development of mental health problems as well as the use of negative coping mechanisms that may be harmful to themselves or others. Mitigating short- and long-term risks for psychosocial wellbeing and mental health of persons of concern, their families and communities lies at the centre of UNHCR's protection mandate.²¹

Important to note is however, that people possess resources and capacities to support the psychosocial wellbeing and mental health of themselves as of their community. These resources and existing family and community are important to build upon and to strengthen the support that members of the refugee community can give to each other to engage in their own protection. A

community based approach therefore forms the basis of UNHCR’s MHPSS interventions.⁹ At each layer of the intervention pyramid, skills and capacities of individuals, families and communities should be identified, mobilised and strengthened. Objectives should be to promote community self-management and their support and to encourage refugees and host communities to play a crucial role in planning, implementing and giving feedback to activities concerned with the psychosocial wellbeing and mental health of the community. Also, all interventions should be integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal education systems, general health systems etc.) in order to make them more sustainable, carry less stigma and for them to reach more people. It is important to apply an age, gender and diversity (AGD) perspective¹⁴ to such processes to ensure the diversity of the community is represented (including men, women of all ages, children, youth, elderly, and refugees with specific needs such as disabilities, refugees from different cultural backgrounds and areas of settlements).

Generally, many MHPSS activities on layer 2 of the IASC intervention pyramid aiming towards “strengthening family and community support” are similar to activities of community-based protection and may even describe the same from a different perspective. MHPSS and CBP must therefore be understood as being closely intertwined and having synergistic effects (see box 1).

BOX 1: Key messages: links between MHPSS and CBP

- Refugees have assets and resources to support their own mental health and psychosocial well-being and that of their communities.
- Promoting meaningful engagement of refugees, respecting their dignity and autonomy, and providing them with adequate information, can greatly reduce psychological distress.
- Community-based protection activities, such as support groups, community centres and safe spaces are a foundation for effective MHPSS
- With tailored training and supportive supervision, many MHPSS interventions can be done by refugees who are non-specialists.
- MHPSS should be seen as a multi-layered system; it is important to strengthen the community-based psychosocial supports in order to make best use of existing resources at community level for many MHPSS problems and to facilitate referrals for various social and clinical mental health services.
- Community-based protection work that strengthens community ties and structures can contribute to ensuring that clinical mental health services are accessed by those who need it.
- Community-based MHPSS capitalizes on the strengths of refugees and promotes their resilience, rather than focusing only on deficits (the weaknesses, suffering, pathology).
- Resilient individuals and communities can better contribute to their own protection and that of others.

Source: Community Based Protection and MHPSS (UNHCR, 2017).⁹

Relation of MHPSS with education

The Interagency-standing Committee (IASC) Guidelines on Mental Health and psychosocial support in Emergency Settings lays out key considerations for the integration of MHPSS in education settings:

- Promote safe learning environments
- Make formal and non-formal education more supportive and relevant
- Strengthen access to quality education for all.
- Prepare and encourage educators to support learners' psychosocial well-being

Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties

According to UNHCR Education 2030: A Strategy for Refugee Inclusion (2019 edition),⁴⁶ children and youth should be provided with conditions that foster social and emotional learning and, where needed, receive mental health and psychosocial support, allowing them to concentrate, learn and develop healthy relationships. The same document also notes that learning environments should make sure that students and educators are prepared to identify and report sexual and gender-based violence risks and know where to find help to address their mental health and psychosocial concerns.

Exposure to adversity, particularly in early childhood, can lead to lifelong impairment of learning, behaviour, and physical and mental health. MHPSS approaches and MHPSS interventions play an important role in mitigating these adversities and improving academic and social-emotional learning (SEL) outcomes for children who have been exposed to humanitarian emergencies. Education programming should include MHPSS approaches and interventions to ensure learning environments are secure and safe and promote the protection and the psychosocial well-being of learners, teachers, and other education personnel.

Teachers and education personnel not only aid in creating safe and healing learning environments but also serve as an important link to protection and health services. With appropriate training and support, teachers and education personnel can identify when a referral is needed to a higher level of care and ensure that children and their caregivers have access to safe referrals and MHPSS services. Also, teachers and education personnel serve a vital role in the children's lives and therefore need to be not only trained and mentored but supported to manage the stress they are living with on a day to day basis. By increasing the mental health literacy of teachers and education personnel, it not only supports them to thrive but provides them with knowledge and attitudes to better support their learners.

Access to MHPSS support must also be considered for children who are out of school, who have dropped out of regular studies or who do not attend school regularly. Such children are harder to reach and therefore MHPSS intervention programming should be targeted accordingly for this cohort. This is of particular importance to MHPSS programming for children of secondary school age – in Uganda, 85% of refugee children of the appropriate age are not enrolled in secondary level education. Secondary education plays a crucial role in the protection of young refugees when they are at a particularly vulnerable age.⁴⁷

The education pathway for children who are in upper primary school and out-of-school children aged 10-18 years is highly uncertain and fractured. Without a stable education pathway, the development of self-assertiveness, personal growth and transition to adulthood can be delayed and negatively impacted upon. A Global Review of UNHCR's Engagement with Displaced Youth⁴⁸ highlighted 'developmental gaps' as a result of interrupted education and the lack of opportunity 'to develop important social and cognitive skills.' Accordingly, targeted MHPSS approaches and interventions for young people should be prioritised.

Relation of MHPSS with health

The burden of mental disorders and / or psychosocial problems is huge in emergency and forced displacement settings (including people with psychological distress, mental disorders, substance use problems, unexplained medical complaints and epilepsy). People affected often present themselves to general health practitioners, but their concerns are frequently not sufficiently identified and managed. The treatment gap is large. If left untreated, mental health issues can create enormous suffering with the individual and also with the family and community. Mental health disorders can affect daily functioning of an individual to varying degrees and can even lead to the loss of daily functioning.⁴² Mental health concerns can affect education, livelihoods, and other socio-economic areas of life and can therefore not only have consequences for the individual but for the family and community. This includes long-term consequences.⁴⁵ The impact of chronic unemployment and associated financial hardship, experiences of discrimination, rights violations and conflict exposure as well as protection threats including SGBV and abuse are likely to result in increased demand for mental health and psychosocial services catering for depression, anxiety and post-traumatic stress disorder.

Given the lack of mental health specialists in humanitarian settings, the most viable way of closing the mental health treatment gap is therefore to integrate mental health into public health care. Major tools include mhGAP Intervention guide¹⁸ by WHO and the mhGAP Humanitarian intervention guide¹⁹ by WHO and UNHCR. The guides recommend the integration of mental health into public health by training general health care staff on MHPSS so that these are able to diagnose and manage mental health disorders.²³ Mental health service provision by general health providers needs to be continuously accompanied by a functional system of clinical supervision and continuous learning. As highlighted in the above paragraph, it is generally important to build sustainable local capacities that can provide comprehensive integrated and community based MHPSS activities that promote resilience and overall wellbeing of vulnerable groups. Strong community structures are important to ensure identification and timely referral of cases in need of further support.

Further, specialised support and psychological interventions are very important. Services by clinical psychologists or psychotherapists are however often not available / not able to cover sufficient numbers of cases. Therefore, it is recommended to look into scalable interventions that would make brief psychological services available for larger numbers of people. Such task-shifting approaches can be conducted by trained and supervised non-specialists who can also be refugees themselves. Such interventions include for example Self Help Plus (SH+), Problem Management Plus (PM+), Interpersonal Therapy (IPT) or Community-based Sociotherapy (CBS).

- Self Help Plus (SH+)^{24, 25}

This is a low level psychological intervention adapted for refugees. It consists of five audio-recorded sessions with an accompanying self-help manual addressing psychological distress. The sessions can be facilitated by trained lay helpers. The tool was developed by the WHO. It has recently been adapted and translated for Southern Sudanese context and currently research (and randomized controlled trial) is being undertaken by the NGO HRI, John Hopkins University, WHO and MoH, in cooperation with UNHCR in West Nile (Rhino camp). Following positive findings from the trial, WHO have agreed to a limited release of materials in Juba Arabic to be used with South Sudanese population.

- **Problem Management Plus (PM+)** ^{26, 27, 28}
This intervention uses elements of Cognitive Behavioural Therapy (CBT) and can be facilitated by trained non-specialists. It focuses on support for individuals with stress, depression and anxiety and has shown good results elsewhere.
- **Interpersonal therapy (IPT)** ²⁹
This is a worldwide used evidence-based psychotherapeutic intervention for depression. An adapted version for groups has been developed that can be led by non-specialists and is showing good results in low- and middle-income countries. ²⁸
- **Community-based Sociotherapy (CBS)** ³⁰⁻³⁵
This intervention has been launched in the context of post-genocide Rwanda. The group sessions can be led by trained non-specialists. It is unique in the sense that it focusses less in reduction of distress in individuals but rather focusses on fostering mutual support within the group (“Sociotherapy”). In this way, it fits well with UNHCR’s community-based approach in MHPSS.⁹ It is currently being adapted and tested for work with Congolese refugees in Kyangwali settlement. The research is supported by UNHCR and led by two NGOs (CBS Rwanda and HIJRA (Humanitarian Initiative Just Relief Aid)) and three academic partners (University of Liverpool, Makerere University and University of Rwanda). See: <https://www.liverpool.ac.uk/population-health-sciences/departments/psychological-sciences/research/costar/>

National Context in Uganda

Conflicts, violence and persecution in the Great Lakes region and the Horn of Africa are continuously causing forced displacement into Uganda. The numbers of registered refugees and asylum seekers stands at 1,362,269 (as of end of October 2019). The largest numbers of refugees are forced to flee from the conflict in South Sudan (854,859), followed by 389,276 forcibly displaced by insecurity and ethnic violence in the Democratic Republic of Congo (DRC) and 44,611 from political instability and human rights violations in Burundi. Further, smaller numbers of refugees and asylum seekers arrive from Somalia (35,924), Rwanda (17,022) and other countries in the region. This makes Uganda the third-largest refugee-hosting country in the world after Turkey and Pakistan. The response is co-led by the Ugandan Government’s Office of the Prime Minister (OPM) and UNHCR.

Uganda has a history of welcoming refugees for decades and is applying a progressive non-encampment policy and provides refugees with a plot of land for housing and cultivation, the freedom of movement as well as rights to work and access to education and health care. This favourable protection environment is regulated by the Refugee Act 2006 and 2010 Regulations and the Comprehensive Refugee Response Framework (CRRF) from 2017 which seeks to increase self-reliance and expand solutions for both refugees and host communities. Most refugees live in refugee settlements alongside with host communities across 11 districts (62 per cent in northern Uganda or West Nile, 21 per cent in Mid-West or central Uganda). Five per cent live in the urban area (mainly Kampala)

Mental health and psychosocial problems among refugees in Uganda

Despite the progressive policies and achievements in managing large influxes of refugees, many refugees and host community members are experiencing threats to protection and challenges concerning access to basic services, income opportunities and building self-reliance. Although refugee communities are showing strong resilience and positive coping mechanisms, many refugees are facing challenges dealing with the psychological effects of forced displacement, past experiences of violence, war, persecution as well as contextual factors related to insecurity about basic needs, income, education, legal status. In addition to this, especially women and girls are at high risk for multiple forms of violence including SGBV as a result of the conflict and displacement. Also, SGBV is being used as a weapon of war in the conflicts, both in South Sudan as well as in DRC and the issue of SGBV continues to be a threat in the settlements.^{40, 41, 44} The joint inter-agency Multi-Sector Needs Assessment (MSNA) further stresses poor psychosocial functioning among children which reveals itself through behavioural and conduct disorders.³⁶ This is associated with poor community child protection structures and the occurrence of issues such as mistreatment and neglect of (foster) children, early marriage or teenage pregnancy. Also, the current Ebola Virus Disease (EVD) in neighbouring DRC is acting as an additional stressor in the settlements (especially so in the west and mid-west).

Taking all factors into account, IASC and Sphere guidance is therefore to go beyond a clinical approach that restricts itself to the treatment of symptoms of past psychological traumas, not addressing current stressors and causes of distress. Approaches limited to trauma work only can in fact even be harmful.³⁷ Trauma focused interventions remain essential but should be designed in a broad approach which takes into account the variety of past and current factors and stressors the individual has gone through and is currently experiencing.

Throughout refugee communities in Uganda a high prevalence of mental health symptoms are reported. According to the MSNA, 22 per cent of refugee households reported that at least one member was in psychological distress or scared.³⁶ Mental health concern include such as anxiety disorders, PTSD, depression and also epilepsy, psychotic disorders and substance abuse disorders.^{40, 41} Such concerns are often linked to past traumatic experiences. For many, it is the sum of past experiences with extreme stressors in everyday life in the settlements that exacerbate levels of psychological distress. Refugee mental health is also affected by difficulties arising after entry into a host country, including a lack of resources, family separation, acculturation and discrimination.³⁸

The North-Western settlements are reporting high numbers of suicides and deliberate self-harm, which are understood as an expression of desperation, loss of hope and belonging and a lack of perspectives. In an internal UNHCR report, Palorinya settlement reported on numbers as high as one suicide case recorded per week for the month of April 2019.³⁹

MHPSS services for refugees in Uganda

Over the last years MHPSS has been receiving more attention in UNHCR's operation in the country as well as by governmental services. By now, multiple partners, national and international NGOs are on board implementing various MHPSS activities. Services range across the spectrum from community-based interventions fostering social cohesion, offering psychosocial support and counselling to psychiatric and psychotherapeutic services by

specialists. Uganda's Ministry of Health is strengthening its response to Mental Health and is including mental health into general health care provision, as outlined in Uganda's Health Sector Integrated Refugee Response Plan (HSIRRP) and UNHCR Uganda Public Health Strategic Plan.^{4, 5}

Despite the good efforts by agencies providing psychosocial support services as well as the inclusion of mental health into general health care provision, mental health and psychosocial problems remain a threat to POCs and communities. The need for mental health and psychosocial support is immense and there are still major gaps and challenges in the area of MHPSS to be responded to.^{43, 44} A huge number of refugees with mental health needs remains underserved and mental health conditions continue to go undetected.

Out of the households surveyed in the MSNA, 40 per cent reported that the family member in psychological distress was unable to access psychosocial care, with 77 percent in Kiryandongo district and 69 percent in Moyo district (both hosting South Sudan refugees).³⁶ Limited availability/access to MHPSS services is associated with negative coping mechanisms such as alcohol and drug abuse, violence including SGBV, suicidal and other self-destructive behaviour, self-neglect, school drop-out, worsening mental health conditions including depression and psychosis amongst others. The Refugee Response Plan (RRP) 2019-2020 therefore sees the reinforcement of mental health and psychosocial services and infrastructure as a key priority and stresses the importance of a multi-sectoral and multi-layered approach.

A challenge, however, is shortage of funding. As of October 2019, Uganda's refugee response was funded at only 39% of the financial requirements for the year. This is generating challenges for MHPSS partners to continue existing activities and uphold high quality of service provision and offer long-term and sustainable interventions. Underfunding is especially affecting MHPSS as a cross-cutting issue as well as closely interconnected areas such as child protection, SGBV prevention and education.

Challenges in MHPSS for refugees in Uganda

Many challenges in MHPSS are consistently mentioned in various meetings with relevant UNHCR colleagues, different agencies, governmental structures and NGOs. This includes:

- Lack of professional standards and guidelines for MHPSS and quality standards for interventions
- Gaps in referral pathways and feedback after referral
- Insufficient interagency coordination and service mapping to ensure complementarity and reduce overlapping
- Insufficient visibility/awareness and integration of MHPSS across other sectors, especially insufficient links to livelihood and basic services, need for continuous capacity building on MHPSS
- Insufficient interconnections among different community structures, community awareness and knowledge on MHPSS (prevention, identification, referral, family support and continuous follow-up, brief basic psychological interventions)
- Insufficient capacity among general health care staff to ensure integration of MH into general health care

- Stigmatisation of people with mental health disorders
- Insufficient monitoring of MHPSS activities ('beyond counting frequencies')
- Limited technical coherence around MHPSS within UNHCR, other agencies, NGOs, governmental structures
- Lack of scalable community-led interventions in order to reach more POCs despite the relatively scarce MHPSS workforce in light of the immense need
- Insufficient emotional welfare and counselling for staff including agencies, NGOs, government staff as well as community volunteers / incentive workers

Strategic Objectives

In Uganda, UNHCR will work on the following strategic objectives to support the mental health and psychosocial wellbeing of refugees:

1. MHPSS responses are well coordinated, dignified, participatory, community owned, socially and culturally acceptable and do no harm.
2. POCs (individuals, families and communities) are supported to better promote or preserve their own psychosocial wellbeing and mental health.
3. Refugees and members of the host community who are distressed by mental health and psychosocial problems have access to MHPSS services that are of high quality and integrated within interventions for (community based) protection and linked to other related sectors, such as livelihood and basic service provision
4. POCs suffering from clinical mental disorders are referred to mental health services, which are integrated within general health care structures

Objective 1: MHPSS responses are well coordinated, dignified, participatory, community owned, socially and culturally acceptable and do no harm

UNHCR will promote the use of an MHPSS approach across various sectors. This not only applies to protection and health services but also for the provision of basic services, security, livelihoods by the government, national and international civil society partners and UN agencies. Strong intersectoral and interagency coordination structures are necessary. Any service should be provided in a manner that is beneficial to the psychosocial wellbeing and mental health of persons of concern. Participatory approaches should be taken to assess needs, in designing and implementing services including MHPSS-sensitive approaches in registration procedures, as well as the application of Psychological First Aid (PFA) principles in dealing with people in distress in any sector of service-provision.

Objective 2: POCs (individuals, families and communities) are supported to better promote or preserve their own wellbeing and mental health

Community-based protection approaches shall be further strengthened within the operation. UNHCR will continue to support refugees to mobilise and develop their own capacities and resources. Self-organised community structures, traditional and religious leaders as well as community-based structures such as Refugee Outreach Volunteers, Refugee Welfare Committee, and Village Health Teams (VHT) shall be further strengthened and capacitated to spread knowledge around mental health and raise awareness within their communities, identify people in need of MHPSS and provide basic psychosocial support (incl. psychological first aid and organisation of self-help groups). Existing self-organised community structures must be explicitly supported and capacitated according to their needs. Interlinking community-based structures will help sharing information on available services widely to the community, facilitating identification of cases and efficient referrals. Increased knowledge within the communities will help to counter stigmatisation, neglect of individuals in need of support or clinical intervention and will provide alternatives to explanations through witchcraft. Therefore, knowledge around mental health, psychosocial and emotional wellbeing needs to be spread through formal and informal education mechanisms to children and youth.

The education sector therefore plays a crucial role in the field of MHPSS and strengthening awareness as well as supporting children in distress in collaboration with their families and communities. Research has shown that the loss of education is one of the greatest stressors in post-conflict settings. Community structures shall facilitate continuous follow-up of clients (including those returning from hospitalisation) and strengthen support for individuals among the families and communities. Increased knowledge and awareness will furthermore ensure that cases are identified and referred timely to the respective services. This will help reduce the number of late referrals and cases that could otherwise develop into severe MH cases, which then necessitate costly and intensive clinical interventions. Special focus shall be placed upon prevention and rapid identification of and response to suicidal behaviour, especially in West Nile region. Strong interventions around SGBV prevention (also addressing males) shall continue. Strong interventions which follow clear objectives are also needed for children and adolescents. Generally, community-based interventions shall also follow the objective of strengthening mutual support within communities, and foster social cohesion within refugee communities as well as between refugees and host communities.

UNHCR will encourage a good balance between “generic” volunteers who have some basic experience with a wide range of issues (SGBV, child protection, MHPSS, disability) with the need to have more ‘specialized’ volunteers. Continuous trainings and supervision need to ensure quality, dignity and do no harm is ensured. Particular attention needs to be given to the more “specialised” volunteers. In order to give more people access to MHPSS, peer-support mechanisms and easily scalable interventions shall be encouraged. Task shifting approaches for brief psychological therapies that can be facilitated by well trained and supervised non-specialists (including refugees) should be considered. Such interventions include for instance above mentioned Self Help +, Problem Management Plus (PM+),

Interpersonal therapy (IPT), Community-based Sociotherapy (CBS) and others. Limitations of self-help need to be kept in mind at all times and quality ensured by continuous supervision and thorough training. Such interventions will increase the number of POCs reached and foster community ownership and mutual support. In this regard, it is important to advocate for activities supporting the emotional welfare of community volunteers as well as staff engaged in service implementation.

Objective 3: POCs with mental health and psychosocial problems have access to MHPSS services that are high of quality and integrated within interventions for (community based) protection and linked to other related sectors

MHPSS activities by protection partners of UNHCR shall be further supported and strengthened. A close coordination and strong links between protection and (mental) health actors is needed. UNHCR will continue to have explicit attention for the integration of psychosocial aspects and clear psychosocial objectives in community-based protection, SGBV prevention and child protection. Trained MHPSS staff should be included in structures such as community centres. Also, MHPSS must be explicitly included into case management of Child Protection and SGBV. Strengthening MHPSS within CBP shall ensure that underlying causes and stressors leading to mental and psychosocial distress are being comprehensively addressed and each person in need of MHPSS receives a complementary and multi-layered response according to their needs. UNHCR and partners will advocate for integration of MHPSS across sectors. This includes strengthening links to other related sectors such as education, basic service provision and livelihoods. Actors at the foundational layer of the MHPSS intervention pyramid need to be strengthened and trained on MHPSS aspects in their work. There is also need for intervention in the education sector both in terms of strengthening education staff capacities and support, but also through close partnership considering how children wellbeing in education related centres is crucial to their development and ensuring identification of children at risk and in need of MHPSS. Links to partners across various related sectors must be strengthened to ensure effective identification and referrals and a comprehensive support to ease psychosocial and mental distress of POC.

Access to MHPSS services (including information on existing services), identification of cases in need of MHPSS and if needed, provision of psychological first aid (PFA) shall be facilitated at an early stage, ideally upon arrival in form of a standardised MHPSS package. UNHCR will support processes of standardisation/harmonisation including MHPSS professional standards, guidelines, quality of intervention, minimum training requirement of MHPSS staff, continuous training opportunities as well as clear referral pathways to ensure that MHPSS services of high quality. Interagency coordination around MHPSS shall be supported.

Objective 4: POCs suffering from severe mental disorders are referred to mental health services, which are integrated within general health care structures

UNHCR works in close partnership with government actors, NGOs and UN agencies to ensure access of refugees and neighbouring host communities to mental health care high of quality. Wherever available, national health service delivery programmes are preferred to setting up parallel services for refugees. According to Uganda's Health Sector Integrated Refugee Response Plan (HSIRRP) and UNHCR Uganda Public Health Strategic Plan^{4,5}, mental health shall be integrated into primary health care. Basic clinical mental healthcare should be made available at every healthcare facility. General health care staff and community health workers (e.g. VHTs) should be trained on basic knowledge on Mental Health and basic management of cases with MH problems (e.g. through mhGAP trainings). Integration of mental health into general health care will reduce stigmatisation of mental health among communities and decrease dependency on referral care for MH issues. Also, it will support mental health specialists (such as clinical psychiatric officers, psychiatric nurse and psychologists) by reducing the case load as they are currently often overwhelmed by high numbers of cases to attend to, which can ultimately compromise the quality of interventions. UNHCR therefore encourages mental health specialists to take up a role towards training and supervision of general health care workers and community workers.

UNHCR will continue to support specialized professional actors who are providing specialised interventions including counselling, psychological support and psychotherapeutic interventions (on an individual and group level). Also, efforts of NGOs to adapt, test and scale up low-intensity psychological interventions for common mental disorders among refugees shall be supported. Regular clinical supervision of mental health staff in the refugee settings by psychiatrists and psychiatric clinical officers visiting from regional / national referral hospitals is a further good practice in face of constrained of specialised MH workforce. As the number of staff available for supervision of MHPSS activities is a major bottleneck in the refugee operation, UNHCR will encourage rational use of specialised workforce to maximise the number of beneficiaries reached.

In order to ensure timely access to mental health services, a clear referral mechanism needs to be organised among mental health specialists, general healthcare providers, community-based support and other services. This will reduce false diagnosis / treatment and ensure timely referrals so as to ultimately reduce numbers of late referred severe cases which need longer-term and costly interventions. Links with and referrals from and to CBP and psychosocial partners need to be strengthened.

Strategic Approaches

Coordination

- MHPSS Working Group at the national level feeds into both Protection and Health Coordination Working Groups (e.g. as a fixed agenda point and one member representing the MHPSS WG)

- Ensuring input from both protection and health actors within the MHPSS WG through active involvement of UNHCR community-based protection and health staff
- Ensuring interlinkage with and support interagency MHPSS coordination efforts on subnational (settlement-level) by the national MHPSS WG

Increased focus on prevention

- Ensuring greater focus on the prevention of protection risks, child protection risks while continuing to support response services and interventions to identify children and youth at risk
- Awareness-raising among communities ensuring early identification of distress and mental health and psychosocial problems (incl. signs of suicidal behaviour)

Standardisation & harmonization

- Promoting harmonized guidelines and standards on MHPSS including SOPs, referral mechanism
- Promoting the development of a competency-based framework for MHPSS that describes roles and functions of various staff and the activities (not necessarily led by UNHCR)
- Encouraging protection partners to define clear objectives for psychosocial activities and include MHPSS related outcomes in their monitoring system

Advocacy and Integration of MHPSS across sectors

- Supporting capacity building on MHPSS of service providers, government counterparts and relevant UNHCR staff
- Firm integration into both protection and health sectors and defined responsibilities
- Ensuring strong links between community-based and clinical MHPSS services
- Working in collaboration with other technical areas to ensure services are provided in a way that promotes the wellbeing of refugees and awareness is raised of MHPSS being a cross-cutting issue
- Advocate for the emotional welfare of staff engaged in implementation of MHPSS services
- Support knowledge-building and systematic planning through research and studies concerning issues faced, needs and effectiveness of actions
- Support the development and dissemination of key information and advocacy messages on MHPSS as well as sharing of best practices derived from learning across MHPSS partners

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