ARUA MHPSS SURVEY REPORT

STUDY CONDUCTED IN RHINO CAMP AND IMVEPI REFUGEE SETTLEMENTS

JULY 2020

UNHCR SUB OFFICE ARUA

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FGD at Ofua II Help Desk in Rhino Camp with Boys aged 12-17 years old

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List of Abbreviations/Acronyms

COO	Country of Origin
COVID 19	2019 Novel Corona Virus Disease
FGDs	Focus Group Discussions
IM	Information Management
KII	Key Informants Interview
MHPSS	Mental Health and Psychosocial Support
MHS	Mental Health Services
OPM	Office of the Prime Minister
PoCs	Persons of Concern
PSN	Persons with Specific Needs
PWDs	Persons with Disabilities
RWC	Refugee Welfare Council
SGBV	Sexual Gender Based Violence
TPO	Transcultural Psychosocial Organization
UASC	Unaccompanied and Separated Children
UNHCR	United Nations High Commission for Refuges
VHT	Village Health Team
WASH	Water, Sanitation and Hygiene

1.0 Introduction

This report is on the findings of the focus group discussions and key informants' interviews conducted on the causes of distress and suicidal ideation, the most affected population groups, the impact of SGBV and COVID-19 on Mental Health and Psychosocial (MHPSS) wellbeing of the Persons of Concern (PoCs) and the possible desired interventions to mitigate the suicidal tendencies among the PoCs.

Report Writer	Arua Protection Department (**SGBV & IM Units**)
Location	Arua Sub-Office
Target Groups	Boys, Girls, Men, Women, Ethnic and Religious minorities
Date	03/08/2020

2.0 Purpose

The purpose of the survey is to have a better understanding of the factors leading to increased Mental Health and Psychosocial problems faced by persons of concern in the Imvepi and Rhino Camp Refugee Settlements. During protection monitoring, sseveral attempted and complete suicides were closely linked to SGBV. The purpose of the survey is to track the prevalence of suicide and attempted suicide cases as a direct recommendation from the SGBV Sub Working Group Meetings in both Rhino Camp and Imvepi Refugee Settlements. The recommendations arising from the discussions will help in designing appropriate preventive and response strategies for improved prevention and response to Mental Health and Psychological problems or needs of women, men, boys and girls.

3.0 Methodology

The survey employed two data collection methods that is Focus Group Discussions (FGDs) and Key Informant Interviews (KII). A total of 40 FGDs (27 in Rhino and 13 in Imvepi) were conducted separately in groups of 10 members comprising of Girls aged 12 to 17 years old, including those in school and out of school, Boys aged 12 to 17 years old, including those in school and out of school, Women aged 19 to 45 years old, Men aged 19 to 45 years old, Women aged 45+ years old, Men aged 45+ years old, Persons with Disabilities, Ethnic Minorities and Religious Minorities.

The FGDs were sampled using the stratified sampling method where the Settlements were divided into Zones that represented the strata. The selected strata were of homogeneous characteristics representative of the entire population. The number of FGDs conducted were proportionately estimated from the population of the Settlement and later the Zone to conclusively determine the number of groups per each stratum.

Twelve (12) KIIs (7 in Imvepi and 5 in Rhino) were drawn from among Psychiatric officer, Social workers, OPM Protection staff, Village Health Teams (VHTs), Refugee Welfare Committee (RWCs) and Police. Both purposive and snowball sampling methods were used to draw the Key Informants during the survey.

The total sample size of 412 respondents was reached during the survey, and this was slightly higher than the estimated target of 383 respondents drawn from a population 186,252 Persons of Concern (PoCs). This was considered on the argument that the bigger the sample size the higher the precision of the results.

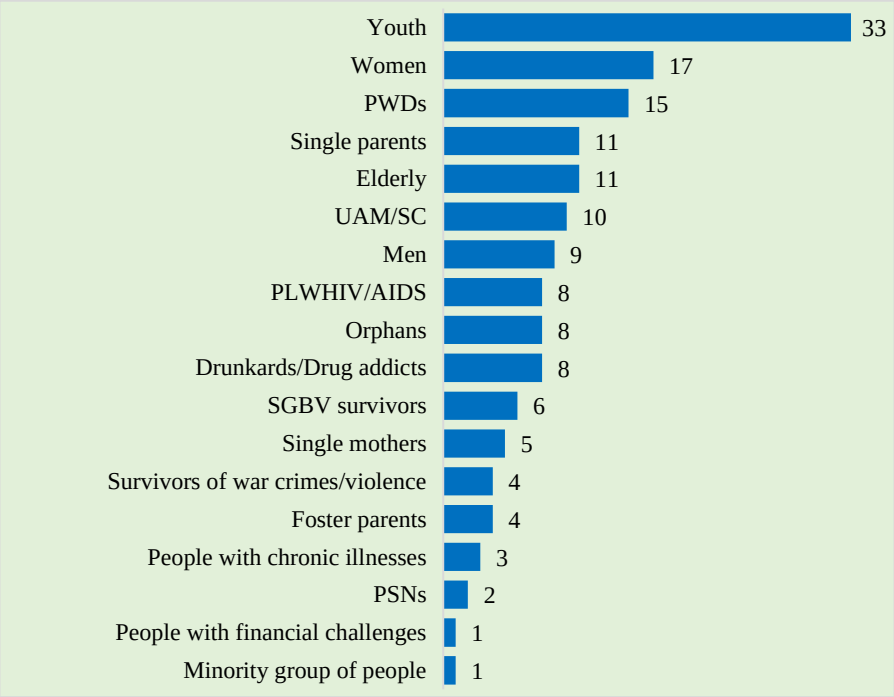
The choice of sampling methods did not pose any limitation or challenge to the study, but rather enhanced representative sampling where the results of the study can be statistically inferenced at the 95% confidence interval and acknowledged as credible representation of the entire population.

4.0 Findings of the study

4.1 People most overwhelmed with MHPSS problems/suicide tendencies

The study sought to understand the category of people most overwhelmed with Mental Health and Psychological problems/suicide tendencies and unable to cope with the situation or function normally. The findings are as in figure 1 below;

Figure 1: People prone to distress and suicidal ideation



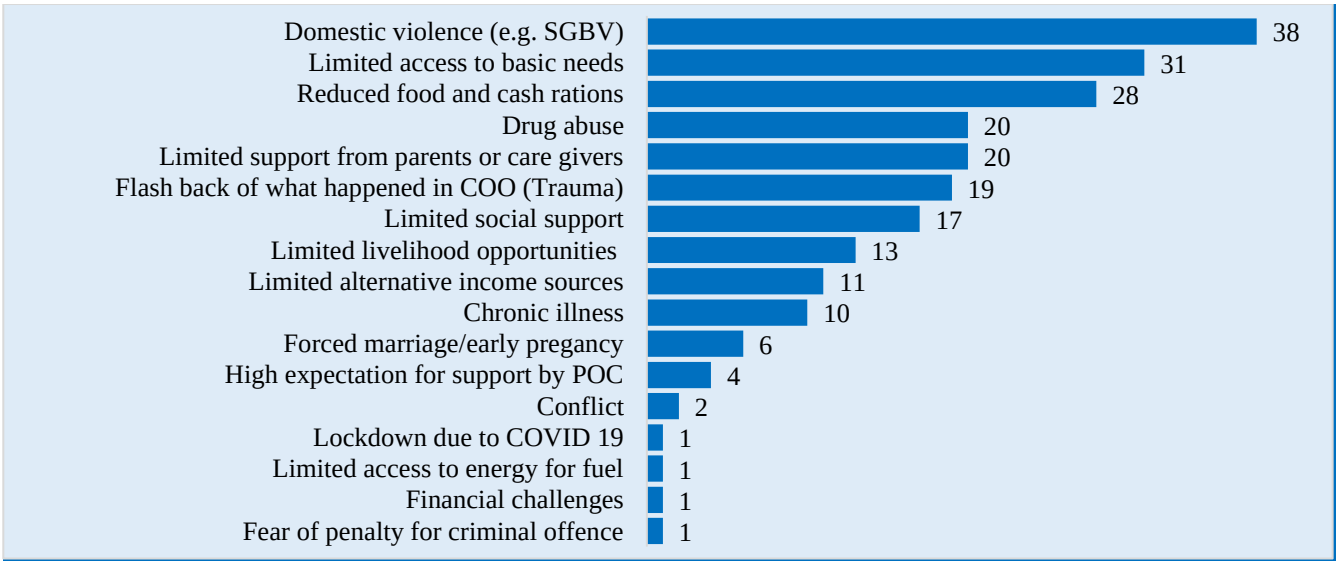
Source: Key Informant Interviews and FGDs

The survey revealed that the Youth, women, PWDs, single parents, UASC and the elderly are the most overwhelmed with Mental Health and Psychological problems/suicide tendencies and are unable to cope with the situation or function normally.

The greatest sources of distress and suicidal ideation include; SGBV especially intimate partner violence (over decision making and polygamy), limited access to basic needs, reduction in food and cash assistance, drug abuse and limited support from parents or caregivers' details as in Figure 2 below.

The study further revealed that some efforts have been put in place by different actors to mitigate distress and suicidal ideation among the persons of concern. These include; counselling by community leaders and partners, community sensitization and dialogue, assistance from humanitarian partners, livelihood support activities and timely reporting to Police, partners and RWCs among others as in figure 3.

Figure 2: Greatest current sources of distress, suicidal ideation (Root cause)



Source: Key Informant Interviews and FGDs

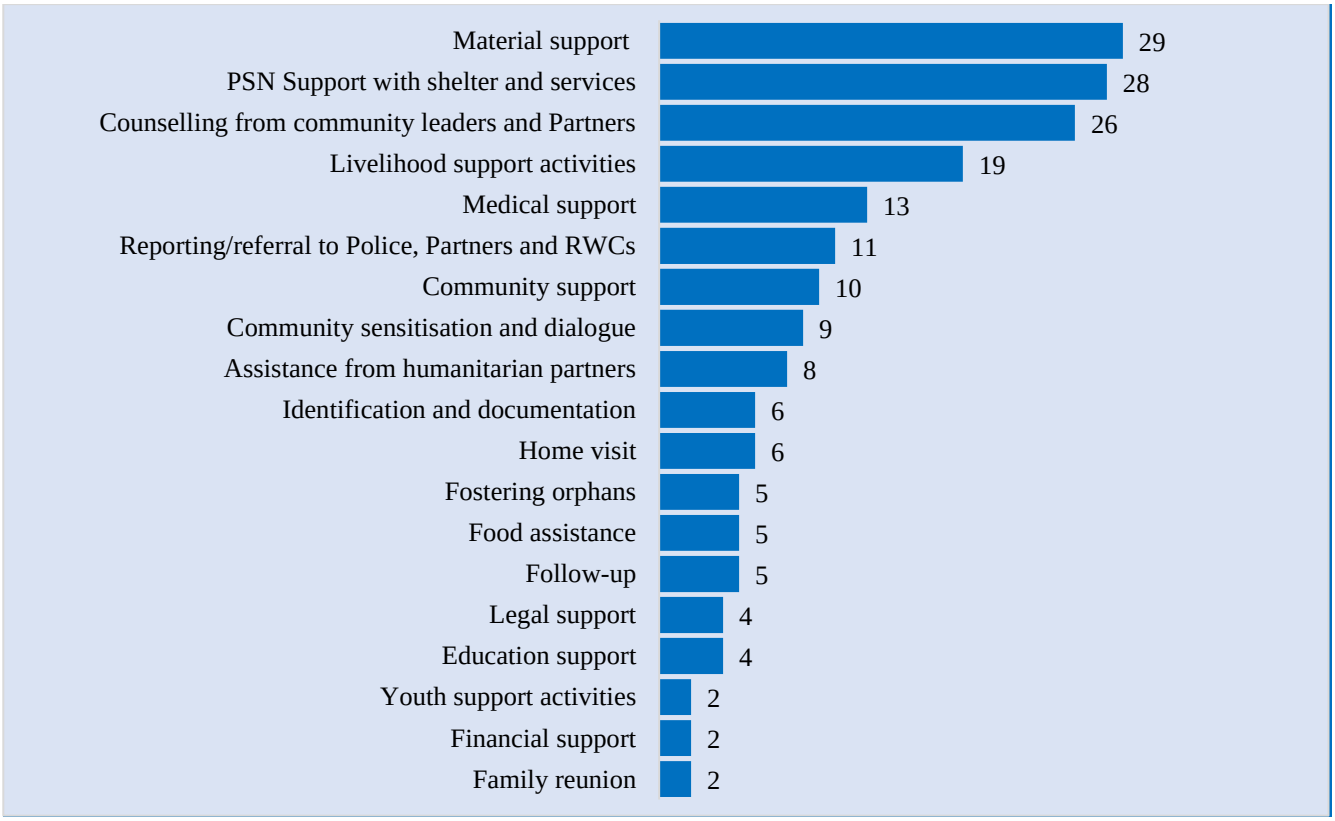
Figure 3: Efforts put in place to mitigate suicidal ideation in the Settlements

Source: Key Informant Interviews and FGDs

4.2 Interventions to support people without adequate care

In the interest of the survey to understand what has been done to support people without adequate care e.g. isolated persons, SGBV survivors and or separated children; the study revealed that material support, PSN support with shelter and services, counselling from community leaders and partners, livelihood support activities, medical support, reporting/referral of suicide cases to police, Partners and RWCs and general community support are some of the available support options.

Figure 4: Existing support to people without adequate care and assistance

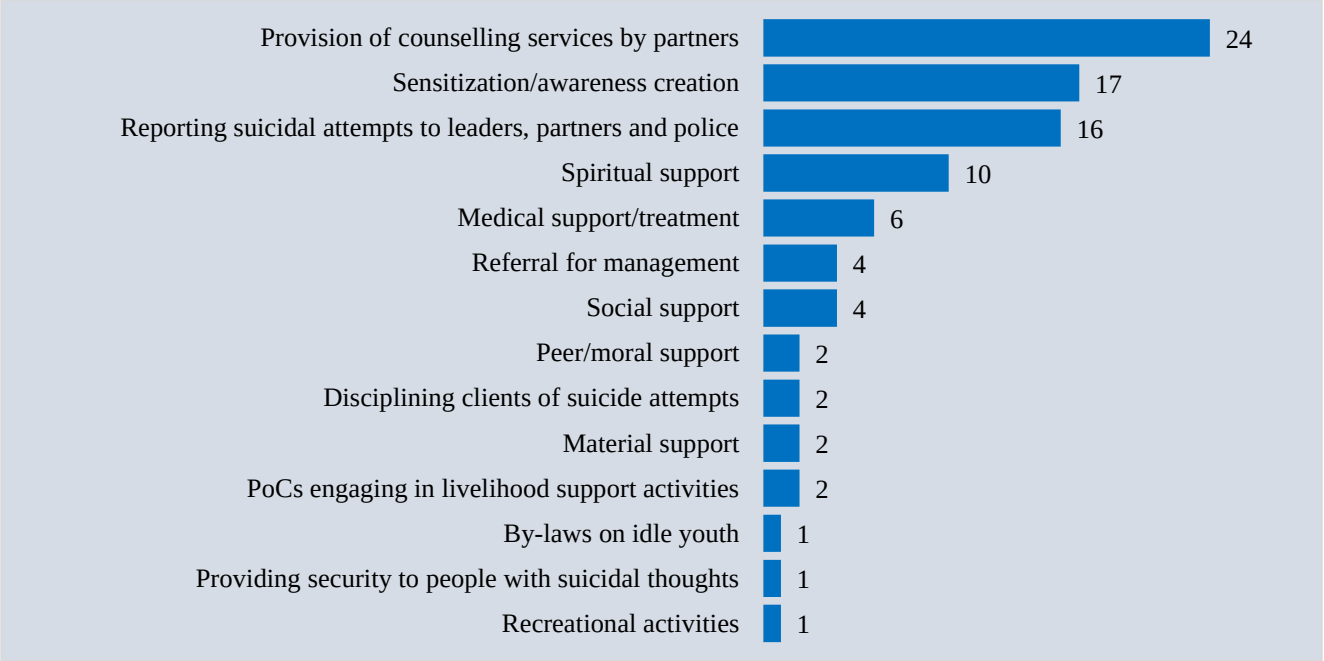


Source: Key Informant Interviews and FGDs

4.3 Community suicide prevention mechanisms

The survey sought to understand what the community does to prevent suicides and the following was revealed as detailed in figure 5 below;

Figure 5: Community interventions for suicide prevention

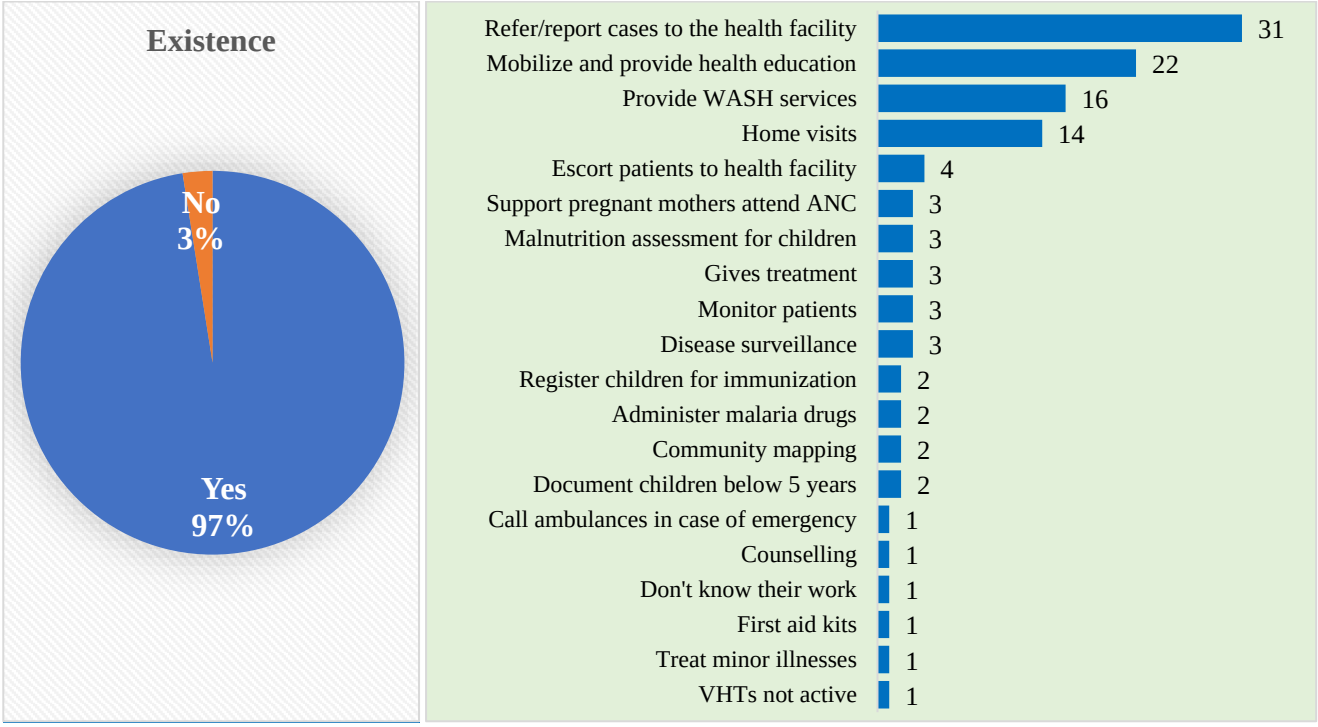


Source: FGDs

The FGDs revealed that communities have been responding to suicidal prevention through provision of counselling services with support of partners, sensitization/awareness creation, reporting suicide attempts to leaders, partners and the police and engaging in spiritual support of victims.

4.4 Village Health Teams (VHTs) and the role they play

Figure 6: Existence of VHTs and the roles they play

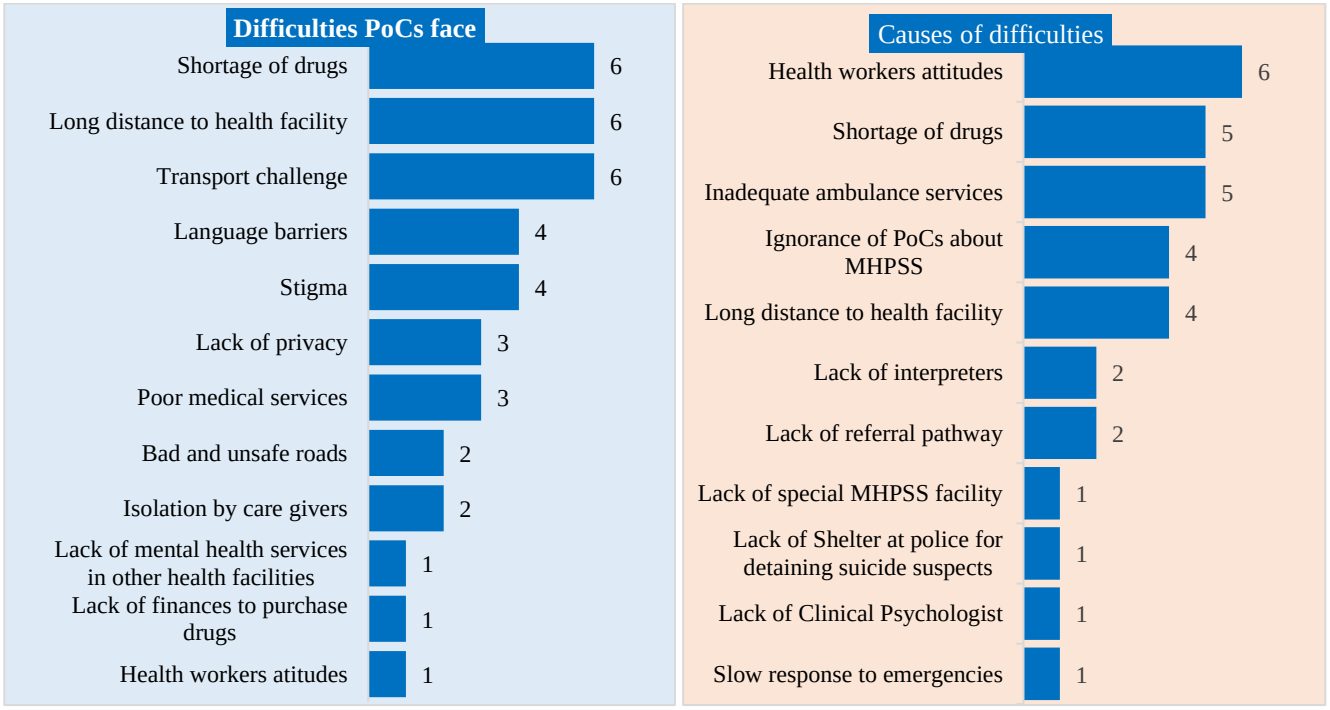


Source: FGDs

The FGDs revealed that there are Village Health Teams in the communities playing some of the following roles; referral/reporting of cases to health facilities, mobilization and provision of health education, provision of WASH services and conduct home visits among others as detailed in the figure 6 above.

4.5 Meaningful access/challenges in accessing Mental Health Services

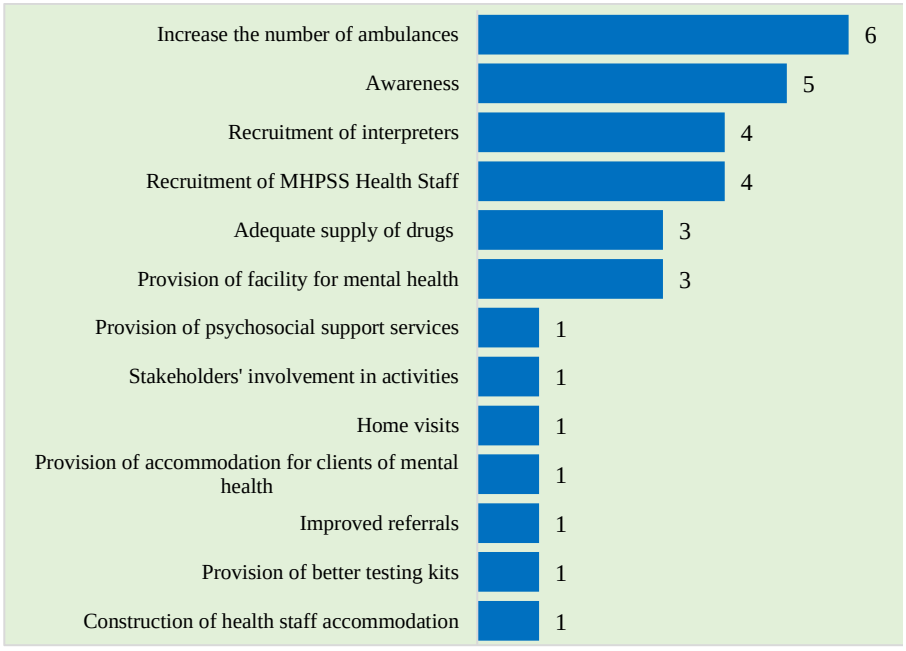
Figure 7: Difficulties PoCs face in accessing MHS and their causes



Source: Key Informant Interviews

The key informants cited shortage of drugs, long distance to health facility, transport challenge, language barriers and stigma are main difficulties PoCs face in accessing MHS caused by health workers attitude, inadequate ambulances, drug stockouts, long distance to the Health Facilities and ignorance of PoCs about MHPSS among others as detailed in figure 7 above.

Figure 8: Remedies to mitigate the causes of difficulty in accessing MHS



Some of the remedies advanced to mitigate the difficulties in accessing MHS include; increase in number of referral vehicles, awareness creation, recruitment of MHPSS Health staff, recruitment of interpreters, provision of facility for mental health and adequate drug supplies

Source: Key Informant Interviews

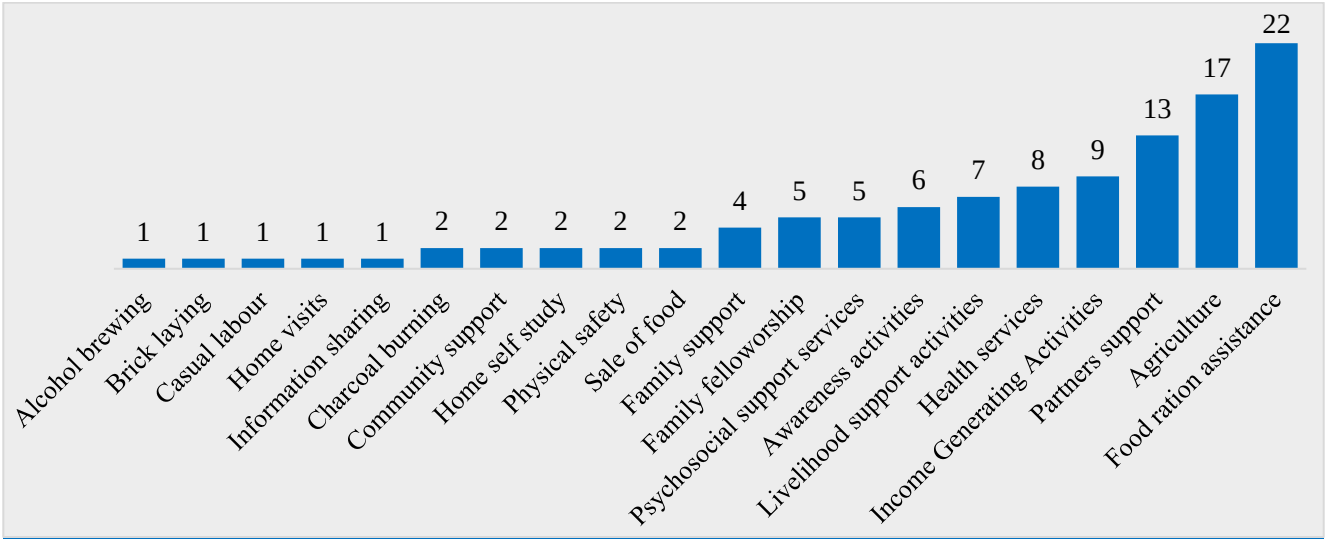
4.6 The current situation of COVID-19 and its effect on the MHPSS coping mechanisms

In the bid to understand how COVID-19 has affected the MHPSS coping mechanisms, the respondents cited the issues indicated in figure 9 below;

Figure 9: Effect of COVID-19 on the previously active MHPSS copying mechanisms

Source: Key Informant Interviews and FGD

Figure 10: People's greatest source of support amidst COVID-19



Source: Key Informant Interviews and FGD

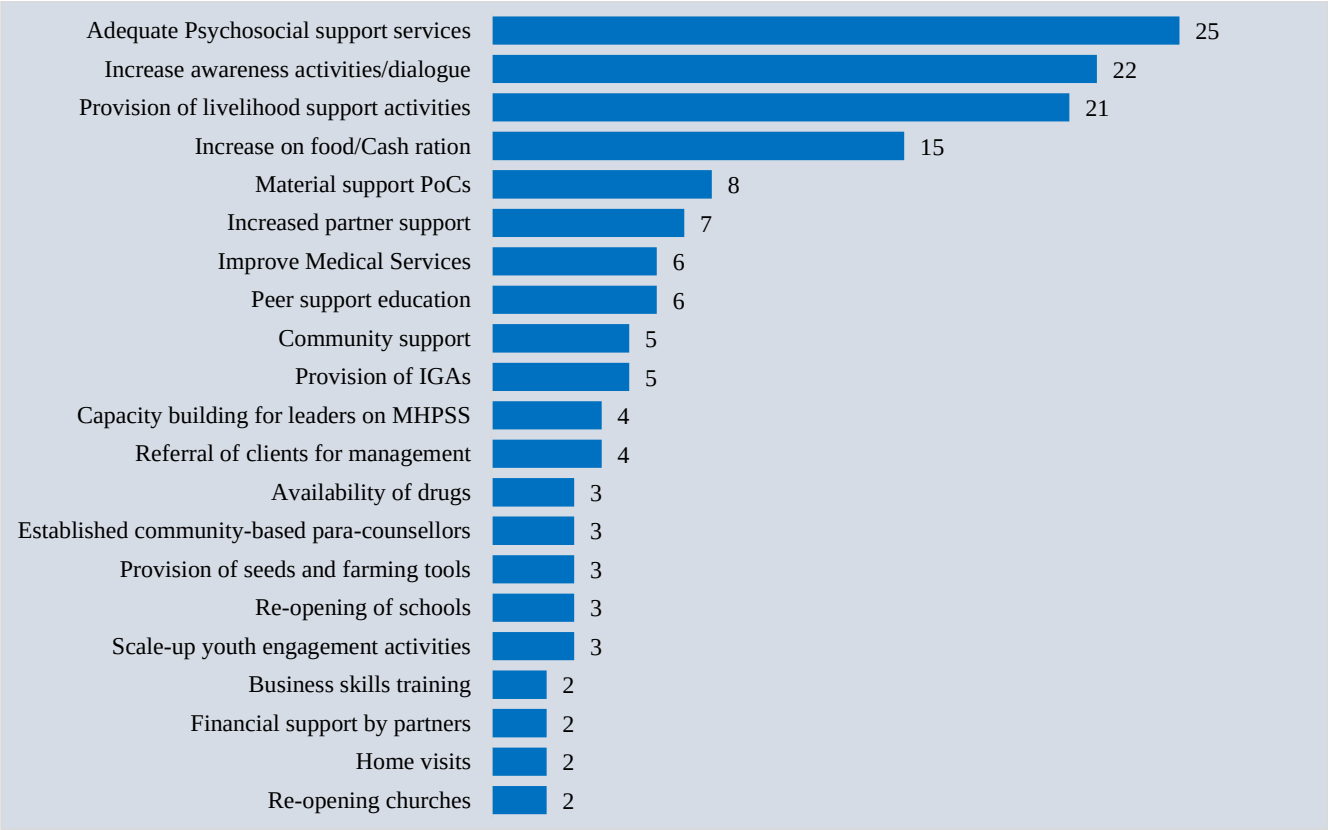
The study reveals that the restrictive guidelines on COVID-19 coupled with reduction in food ration, closure of schools and the limited social interaction has immensely affected the existing MHPSS copying mechanisms.

It further reveals that people view food assistance, agriculture, partners' support, income generating activities, health services, livelihood support activities and awareness sessions including about COVID-19 as their greatest source of support.

4.7 Desired interventions to prevent or respond to MHPSS problems/needs of the PoCs

The respondents cited the interventions enumerated in figure 11 below to prevent to respond to MHPSS problems/needs of the PoCs in their Settlements.

Figure 11: Preventive/remedial interventions on MHPSS problems/needs of the PoCs



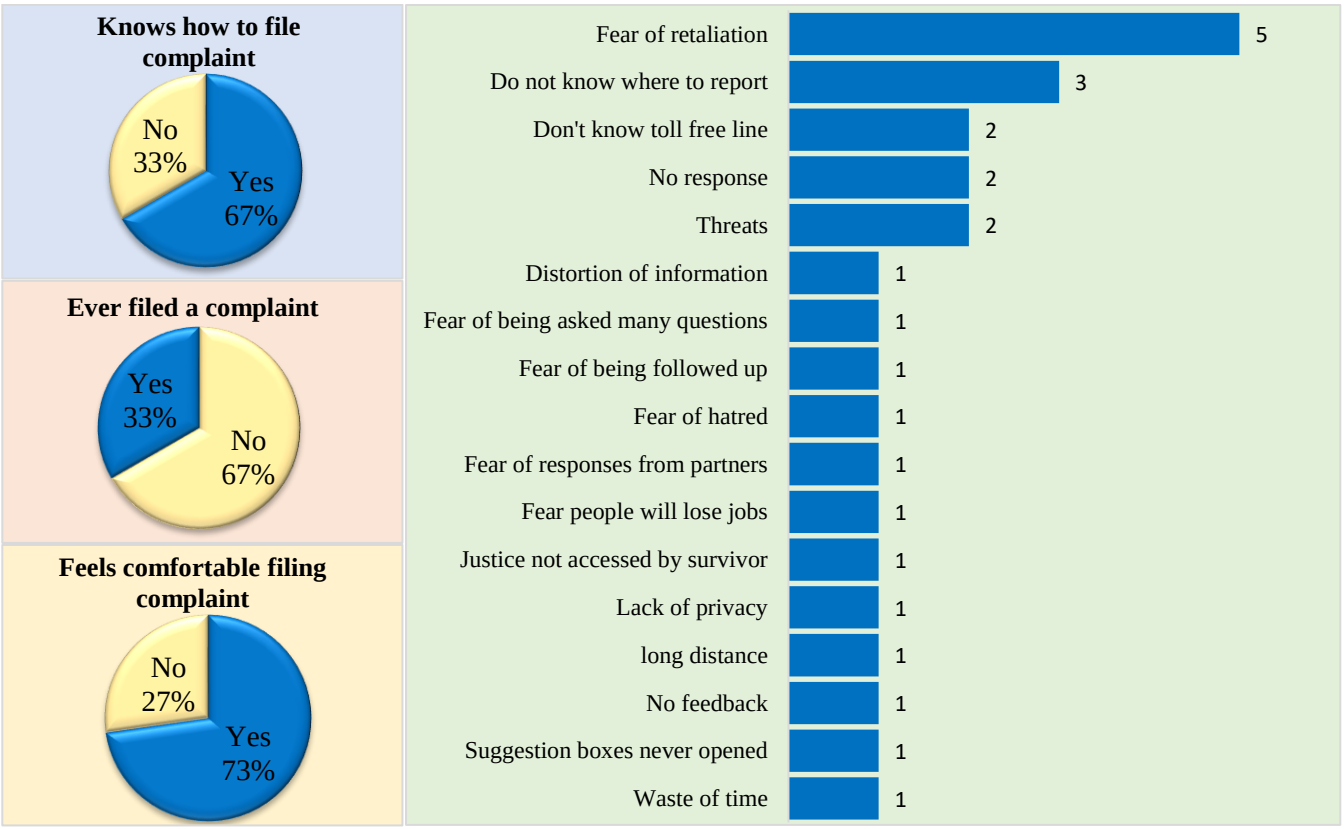
Source: Key Informant Interviews and FGD

FGD briefing for elderly and disabled at Ofua III RWC I Offices, Rhino Camp @Abusa UNHCR

4.8 Knowledge and experience on filing complaints to UNHCR about misconduct of Staff

The study sought to understand knowledge and experience on filling complaints to UNHCR about misconduct of staff or its partner staff. The following were the findings as detailed in the figure 12 below;

Figure 12: Knowledge and experience on filing complaints



Source: Key Informant Interviews and FGDs

The study reveals that PoCs know how to file complaints to UNHCR about misconduct of its staff or partner staff but majority of them never filed any complaints though they feel comfortable doing so. However, the few who feel uncomfortable to file complaints cited reasons like; fear of retaliation, not knowing where to report, threats by perpetrators, no response and not knowing the toll-free line among others.

Summary of Findings

This study showed that people commonly overwhelmed with psychosocial challenges and suicidal ideation are youth, women, PWDs, single parents, UASC and the elderly and are unable to cope with the situation or function normally.

The survey revealed that the greatest source of distress and suicidal ideation includes SGBV especially intimate partner violence, limited access to basic needs, reduction in food and cash assistance, drug abuse and limited support from parents or caregivers, The study further revealed that some efforts have been put in place by different actors to mitigate distress and suicidal ideation among the persons of concern. These include counselling by community leaders and partners, community sensitization and dialogue, assistance from humanitarian partners, livelihood support activities and timely reporting to police, partners and Refugee Welfare Councils (RWCs) among others.

The study further shows the interventions to support people without adequate care e.g. isolated persons, SGBV survivors and or separated children, includes material support, PSN support with shelter and services, counselling from community leaders and partners, livelihood support activities, medical support, reporting/referral of suicide cases to police, partners, RWCs and general community support.

The study listed community mechanisms on suicide prevention including provision of counselling services with support of partners, sensitization/awareness creation, reporting suicide attempts to leaders, partners and the police and engaging survivors in religion related activities.

The focus group discussions also revealed that Village Health Teams are playing the roles such as referral/reporting of cases to health facilities, mobilization and provision of health education, provision of WASH services and conducting home visits among others.

The study exposed challenges in accessing mental health services in the two Settlements. As cited by the key informants, these challenges include shortage of drugs at existing health facilities, long distances to health facilities, transport challenges including limited ambulances/vehicles, language barriers, stigma, health workers attitude, drug stockouts and ignorance of PoCs about MHPSS among others.

The study shows that key remedies to mitigate difficulties in accessing mental services include increase in number of referral vehicles, awareness creation, recruitment of MHPSS staff, recruitment of interpreters, provision of facility for mental health and adequate drug supplies.

The study shows the current situation of COVID-19 affected MHPSS coping mechanisms due to restrictive guidelines on COVID-19 coupled with reduction in food ration, limited church activities, closure of schools and the limited social interaction. It further reveals that people now see food assistance, agriculture, partners' support, income generating activities, health services, livelihood support activities and awareness sessions including about COVID-19 as their greatest source of support now.

Conclusion

In conclusion, Mental Health and Psychosocial problems affected a large segment of the refugee population in the Settlements, with the most affected being the youth, women PWDs, single parents and unaccompanied minors.

The main causes identified were domestic violence specifically among intimate partners, reduction of in-kind food and cash for food assistance, COVID-19 restrictive guidelines and lack of partners support to Persons of Concern.

The challenges identified during response to mental health cases were identified as inadequate funding to implement mental health programs, lack of specialized mental health unit to handle cases, inadequate drugs at the facilities, inadequate ambulance to respond to emergency mental health cases.

The proposed interventions include lobbying for funds to implement MHPSS programs, scaling up access referral vehicle for mental health clients, strengthening the capacity of VHTs, other community structures to identify and refer cases for management, conducting mass awareness on MHPSS to persons of concerns, provision of specialized mental health units with qualified staff, provisions of alternative livelihood support activities and material support to clients are key in addressing the mental health and psychosocial support needs of clients and PoCs in Arua Operation.

Key Recommendations

The following recommendations have been advanced for Improved Mental Health and Psychosocial Support Services;

- Lobby and advocate for MHPSS funds, partner to implement comprehensive Mental Health and Psychosocial Services for refugees, the fund to cover comprehensive mental health package.
- Establishment of specialized mental health unit in the Settlements; the mental health unit to be created with fully equipped specialized qualified staff.

- Adequate provision of mental health drug stocks and treatments for clients and other equipment to enhance effective mental health service provision as well as conduct regular home visits to clients to ensure adherence to treatment and continuously conduct family therapy and community awareness to eliminate stigmatization of clients with mental health problems.
- MHPSS partner such as TPO to map available community structures including village health teams and strengthen their capacity to enhance early identification of suicide cases, timely referrals for management as well as provide basic psychosocial first aid to clients as well as monthly share the statistics for suicide cases to inform interventions.
- Provision of specialized mental health vehicles to respond to mental health related emergencies in the refugee Settlements, having this in place will enhance timely response to cases, and clinical psychologists and doctors to give priority and attention to mental health cases at the different facilities.
- UNHCR, OPM and Partners to advocate for more livelihood support activities in the community for PoCs in order to respond to the livelihood support needs of clients and PoCs in Rhino camp and Imvepi as well as boost their economic wellbeing while prioritizing clients of mental health.
- Provision of specialized education to children with mental health challenges, this offers equal opportunity for them to access education services.
- Enhance collaboration between Mental Health and Psychosocial Support partners.
- Adequate provision of material support to mental health patients to respond to the basic needs challenge faced.
- Targeted awareness raising with most affected populations such as the Youth, Women, PWDs, Single parents, UASC and the elderly who are overwhelmed with Mental Health and Psychological problems/suicide. Refugees and host community should both be targeted.
- Integrate SGBV messages in Mental Health and Psychosocial Support sensitizations.
- MHPSS partners to consider psychosocial support, family therapy for both clients and families caring for Persons with disability.
- MHPSS partners (such as TPO) to conduct proper training and orientation of interpreters that help in case management both in the community and at facilities.
- MHPSS partners to explore the different approach used in responding to mental issues depending on the nature and harmonize delivery of mental health services to PoCs.
- Partners referring cases to MHPSS partners should closely follow up cases for feedback.
- MHPSS partners to enhance the screening for clients in all the settlement for advanced MHPSS
- Coordination of MHPSS partners should be improved including through monthly MHPSS Sub-Working Group meetings.
- The MHPSS partner to coordinate closely with Health partner to enhance timely access to drugs and treatment of clients.

Annex I: Focus Group Guide (FGD)

Introduction

The purpose of the discussions is to better understand the factors leading to increased Mental Health and Psychosocial problems faced by persons of concern in the Refugee Settlement. The recommendations arising from the discussions will help in designing appropriate preventive and response strategies for improved prevention and response to Mental Health and Psychological problems or needs of women, men, boys and girls.

Category of respondents

- **FG1: Girls aged 12 to 17 years old, including those in school and out of school**
- **FG2: Boys aged 12 to 17 years old, including those in school and out of school**
- **FG3: Women aged 19 to 45 years old**
- **FG4: Women aged 45+ years old**
- **FG5: Men aged 19-45 years old**
- **FG6: Men aged 45+ years old**
- **FG7: Persons with disabilities**
- **FG8: Ethnic minorities**
- **FG9: Religious minorities**

1. Who is the category of people who seem to be most overwhelmed with Mental health and Psychological problems/suicide tendencies and unable to cope with the situation or function normally?
2. What do affected people see as their greatest current sources of distress, suicidal ideation (Root cause) and what is being done to address those sources?
3. What is being done to support people without adequate care and support e.g. isolated persons, SGBV survivors or separated children?
4. What does your community do to prevent suicides? Are there Village Health Teams (VHT) in your villages, and what roles do they play? (probe: home visits, health education, referral, escorting patients, surveillance and reporting) – self-protection mechanisms / existing capacities within the community / community-based protection mechanisms)
5. How has the current situation of COVID-19 affected the MHPSS coping mechanisms that were previously active? What do people see as their greatest source of support now?
6. What can be done to prevent and or respond to Mental Health and Psychosocial problems/ needs of POCs in your Settlement?
7. Do you know how to file a complaint to UNHCR about misconduct of staff or UNHCR partners? Has anyone ever filed a complaint? Do you feel comfortable filing a complaint? If not, why not?
8. Is there anything else you would like to tell us?

Annex II: Key Informants Interview Guide

Introduction

The purpose of the discussions is to better understand the factors leading to increased Mental Health and Psychosocial problems faced by persons of concern in the Refugee Settlement. The recommendations arising from the discussions will help in designing appropriate preventive and response strategies for improved prevention and response to Mental Health and Psychological problems or needs of women, men, boys and girls.

Category of respondents

- Psychiatrist officer at the health centres
- Social workers from the partners
- OPM Protection staff from each Settlement
- VHTs
- Refugee Welfare Committee

1 Who is the category of people who seem to be most overwhelmed with Mental health and Psychological problems/suicide tendencies and unable to cope with the situation or function normally?

2 What do affected people see as their greatest current sources of distress, suicidal ideation (Root cause) and what is being done to address those sources?

3 What is being done to support people without adequate care and support e.g. isolated persons, SGBV survivors or separated children?

4 What are the main difficulties PoCs face when accessing mental health services? – meaningful access / challenges

CAUSE: What causes these difficulties? (Probe: Distance, waiting time, shortage of medicines, health workers attitude, language barriers, cost, lack of privacy, gender preference of the health workers, poor quality of services, referral.)

SOLUTION: What should be done to address these difficulties?

CAPACITY: What can the community do to address these difficulties?

5 How has the current situation of COVID-19 affected the MHPSS coping mechanisms that were previously active? What do people see as their greatest source of support now?

6 What can be done to prevent and or respond to Mental Health and Psychosocial problems/ needs of POCs in Imvepi?

7 Do you know how to file a complaint to UNHCR about misconduct of staff or UNHCR partners? Has anyone ever filed a complaint? Do you feel comfortable filing a complaint? If not, why not?

8 Is there anything else you would like to tell us?

MHPSS Survey Tool.pdf

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