MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT NEEDS ASSESSMENT REPORT

BURUNDI 2025

DRC REFUGEE RESPONSE

UNHCR
The UN Refugee Agency

Netherlands Enterprise Agency

Acknowledgments

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Cover Photo: A woman sits lost in thought, her eyes fixed on the river Ruzizi, the border between Burundi and the Democratic Republic of Congo, where many people lost their lives fleeing for safety. (Photo: Ana Reina/UNHCR)

All the names in this report have been changed to protect the participants.

UNHCR The UN Refugee Agency

GLOBAL DEVELOPMENT COMMUNITY BURUNDI

AFEMB Association des Femmes Médecins du Burundi « Femmes médecins,unies pour le bien être familial »

Save the Children

HEALTHNET TPO

TABLE OF CONTENTS

List of Acronyms

AFMB Association of Female Doctors Burundi / Association des Femmes Médecins du Burundi

ABUBEF Association Burundaise pour le Bien-Etre Familial

ALUMA Association Lutte contre le Malaria

BPS Basic Psychosocial Skills

CNP Centre Neuro-Psychiatrique

CSM Centre de Soins Mentaux

CWs Community Workers

DRC Democratic Republic of the Congo

Health Professionals

HealthNet TPO

IASC Inter-Agency Standing Committee

IPT Interpersonal Therapy

IRC International Rescue Committee

FGDs Focus Group Discussions

GBV Gender-Based Violence

GDC Global Development Cooperation Burundi

HHS Household Surveys

JRS Jesuit Refugee Service

KII Key informant interviews

mhGAP Mental Health Gap Action Programme

mhGAP-HIG mhGAP-Humanitarian Intervention Guide

MHPSS Mental health and psychosocial support

MNS Mental, neurological and substance use

MoH Ministry of Health

MSNASDPHG Ministère de la Solidarité Nationale, des Affaires Sociales, des Droits de la Personne Humaine et du Genre

MHPSS MSP Mental health and psychosocial support Minimum Service Package

ONPRA National Office for the Protection of Refugees and Stateless Persons / Office National de Protection des Réfugiés et Apatrides

OSAR Organisation suisse d'aide aux réfugiés

PFA Psychological First Aid

PHC Primary Health Care

PM+ Problem Management Plus

PNILMCNT Programme national integré de lutte contre les maladies chroniques non transmissibles du Ministère de la Santé Publique et de la Lutte contre le Sida

PTSD Post-Traumatic Stress Disorder

SCI Save the Children International

SMDH Survey of mental distress and help-seeking in humanitarian settings

SV Sexual Violence

THARS Trauma Healing and Reconciliation Services

UASC Unaccompanied and Separated Children

UNHCR United Nations High Commissioner for Refugees

WHO World Health Organization

WFP World Food Programme

Executive Summary

Since January 2025, over 70,000 refugees from the Democratic Republic of Congo (DRC) have sought protection in Burundi, with children representing 53% of this population. This unprecedented influx causes serious humanitarian challenges, including around mental health and psychosocial wellbeing. This assessment was conducted by UNHCR and partners between July and September 2025 in Gitara transit centre and Musenyi refugee site. It aimed to identify key needs for mental health and psychosocial support (MHPSS), barriers to accessing care, and actionable strategies for integrating MHPSS into the emergency response. The assessment collected data from Congolese refugees through 591 household interviews, 30 focus group discussions, and 21 key informant interviews.

Findings show widespread emotional distress among refugees with high levels of anxiety, depression, post-traumatic stress, insomnia, and psychosomatic symptoms. According to the survey carried out, 83% of refugees reported feeling so severely upset about the war, that they tried to avoid places, people, conversations or activities that reminded them of such event, with 31% feeling this way most of the time. In Gitara transit centre 83% of refugees reported feeling so afraid that nothing could calm them down, with 47% feeling this way most of the time. In Musenyi refugee site, 84% of refugees reported feeling so angry that they felt out of control. 36% feel this way most of the time and 22% all of the time. Mental health problems are now the second leading cause of reported morbidity in Musenyi health centre, after malaria.

The assessment also identified several local idioms of distress used by Congolese refugees to describe emotional suffering, revealing the cultural framing of mental health experiences. Expressions such as *“msongo wa mawazo”* (literally, “confusion in the mind”) are used to describe stress, anxiety, or persistent negative thoughts, while *“huzuni”* denotes deep sadness or grief. Terms like *“kuchamganikywa”* and *“musazi”* refer to mental disturbance or “madness,” often with negative connotations,

highlighting stigma surrounding mental illness.

Gender-based and sexual violence (GBV/SV) emerged as major contributors to psychological suffering. Both women and men reported shame, guilt, and isolation following abuse in the country of origin. Shifts in traditional gender roles—especially men's loss of income and perceived status—fuelled family tensions and alcohol abuse. Substance use, including cannabis, is increasing among adolescents, with 70% in Musenyi reporting feelings of hopelessness and suicidal thoughts.

Despite this burden, less than half of those in distress seek professional help. Refugees primarily turn to religious leaders (32%) and family members (30%), while only 1% access trained mental health professionals. Lack of awareness, perceived ineffectiveness of services, and cost misconceptions were the main barriers. Many frontline workers lack training in basic psychosocial skills and do not know referral pathways.

Contextual stressors compound the crisis. Refugees face restricted freedom of movement, inadequate food and shelter, limited education and livelihoods, insecurity, and disrupted mourning rituals. Aid delivery processes, including food and shelter distributions, were cited as major stressors due to perceived unfairness and lack of transparency. Women and girls reported significant safety concerns, especially at night due to poor lighting and insufficient patrols.

The assessment underscores the urgency of integrating MHPSS into all sectors of the refugee response and national health systems. Strengthening awareness, community-based psychosocial supports, and access to specialized care are critical for restoring dignity, resilience, and protection.

Key Recommendations

1) Enhance the integration of MHPSS into humanitarian aid, including shelter, wash and food distributions
2) Increase access to information on the current situation, relief efforts, and available services that address basic needs.
3) Improve access to the distribution of food and non-food items:

4) Advocate for freedom of movement of the communities currently being hosted in transit centres and refugee site
5) Improve site security for women and girls
6) Support and create community-based initiatives
7) Support the community in their mourning process and cultural traditions
8) Improve access to psychological support in community settings
9) Ensure essential mental health is integrated in general health care
10) Promote the integration of refugees into national mental health systems

RÉSUMÉ EXÉCUTIF

Depuis janvier 2025, plus de 70 000 réfugiés originaires de la République Démocratique du Congo (RDC) ont cherché refuge au Burundi, les enfants représentant 53% de cette population. Cet afflux sans précédent pose de sérieux défis humanitaires, notamment en matière de santé mentale et de bien-être psychosocial. Cette évaluation a été menée par le HCR et ses partenaires entre juillet et septembre 2025 au centre de transit de Gitara et au site de réfugiés de Musenyi. Elle visait à identifier les besoins essentiels en matière de santé mentale et de soutien psychosocial Selon l'enquête menée, 83% des réfugiés ont déclaré se sentir tellement bouleversés par la guerre qu'ils essayaient d'éviter les lieux, les personnes, les conversations ou les activités qui leur rappelaient cet événement, 31% d'entre eux ressentant cela la plupart du temps. Au centre de transit de Gitara, 83% des réfugiés ont déclaré ressentir une peur telle que rien ne pouvait les calmer, 47% d'entre eux ressentant cela la plupart du temps. Dans le camp de réfugiés de Musenyi, 84% des réfugiés ont déclaré ressentir une colère telle qu'ils se sentaient hors de contrôle. 36% ressentent cela la plupart du temps et 22% tout le temps. Les problèmes de santé mentale sont désormais la deuxième cause de morbidité signalée au centre de santé de Musenyi, après le paludisme.

(MHPSS), les obstacles à l'accès aux soins et les stratégies concrètes pour intégrer le MHPSS dans la réponse d'urgence. L'évaluation a permis de recueillir des données auprès des réfugiés congolais grâce à 591 entretiens avec des ménages, 30 discussions de groupe et 21 entretiens avec des informateurs clés.

Les résultats montrent une détresse émotionnelle généralisée parmi les réfugiés, qui présentent des niveaux élevés d'anxiété, de dépression, de stress post-traumatique, d'insomnie et de symptômes psychosomatiques.

L'évaluation a également permis d'identifier plusieurs expressions locales utilisées par les réfugiés congolais pour décrire leur souffrance émotionnelle, révélant ainsi le cadre culturel dans lequel s'inscrivent les expériences de santé mentale. Des expressions telles que « msongo wa

mawazo » (littéralement « confusion dans l'esprit ») sont utilisées pour décrire le stress, l'anxiété ou les pensées négatives persistantes, tandis que « huzuni » désigne une profonde tristesse ou un chagrin intense. Des termes tels que « kuchamganikywa » et « musazi » font référence à des troubles mentaux ou à la « folie », souvent avec des connotations négatives, soulignant la stigmatisation qui entoure la maladie mentale.

La violence basée sur le genre et sexuelle (VBG/VS) est apparue comme un facteur majeur de souffrance psychologique. Les femmes comme les hommes ont fait état de honte, de culpabilité et d'isolement à la suite d'abus au pays d'origine. L'évolution des rôles traditionnels des genres, en particulier la perte de revenus et de statut social perçu chez les hommes, a alimenté les tensions familiales et l'abus d'alcool. La consommation de substances, notamment de cannabis, est en augmentation chez les adolescents, 70% d'entre eux à Musenyi déclarant des sentiments de désespoir et des pensées suicidaires.

Malgré ce fardeau, moins de la moitié des personnes en détresse sollicitent une aide professionnelle. Les réfugiés se tournent principalement vers les chefs religieux (32%) et les membres de leur famille (30%), tandis que seulement 1% d'entre eux ont recours à des professionnels de la santé mentale qualifiés. Le manque de sensibilisation, la perception d'inefficacité des services et les idées fausses sur leur coût constituent les principaux obstacles. De nombreux travailleurs de première ligne ne sont pas formés aux compétences psychosociales de base et ne connaissent pas les voies de référencement.

Les facteurs de stress contextuels aggravent la crise. Les réfugiés sont confrontés à des restrictions de liberté de mouvement, à une alimentation et à un logement inadéquats, à des possibilités limitées en matière d'éducation et de moyens de subsistance, à l'insécurité et à la perturbation des rituels funéraires. Les processus d'acheminement de l'aide, notamment la distribution de nourriture et de logements, ont été cités comme des facteurs de stress majeurs en raison de leur perception d'injustice et de leur manque de transparence. Les femmes et les filles ont fait état de préoccupations

importantes en matière de sécurité, en particulier la nuit, en raison du mauvais éclairage et de l'insuffisance des patrouilles.

L'évaluation souligne l'urgence d'intégrer la santé mentale et le soutien psychosocial dans tous les secteurs de la réponse aux réfugiés et dans les systèmes de santé nationaux. Le renforcement de la sensibilisation, des soutiens psychosociaux communautaires et de l'accès à des soins spécialisés sont essentiels pour restaurer la dignité, la résilience et la protection.

Recommandations clés

1) Renforcer l'intégration de la santé mentale et soutien psychosocial dans l'aide humanitaire, notamment dans les domaines de l'hébergement, de l'eau et assainissement et de la distribution alimentaire.

2) Améliorer l'accès à l'information sur la situation actuelle, les efforts de secours et les services disponibles qui répondent aux besoins fondamentaux.

3) Améliorer l'accès à la distribution de denrées alimentaires et d'articles non alimentaires.

4) Promouvoir la liberté de mouvement des communautés actuellement hébergées dans des centres de transit et du site pour réfugiés.

5) Améliorer la sécurité du site pour les femmes et les filles.

6) Soutenir et créer des initiatives communautaires.

7) Soutenir la communauté dans son processus de deuil et ses traditions culturelles.

8) Améliorer l'accès au soutien psychologique dans les communautés.

9) Veiller à ce que la santé mentale essentielle soit intégrée dans les soins de santé généraux.

10) Promouvoir l'intégration des réfugiés dans les systèmes nationaux de santé mentale.

I. INTRODUCTION

Since January 2025, more than 70,000 people arrived in Burundi from the Democratic Republic of the Congo in need of international refugee protection and humanitarian assistance. More than half of this refugee population (53%) are children.[1]

WHO estimates that one in five conflict-affected people is likely to develop mental health problems, such as depression, anxiety, and post-traumatic stress disorder (PTSD).[2]

For children, these multiple causes of stress manifest themselves in various ways, with research highlighting significant behavioural changes and psychosomatic symptoms, and in the worst cases children turning to substance abuse, self-harm or even attempting suicide.[3]

"MHPSS is not an optional 'nice to have' intervention but an essential part of the emergency response."

For adults, adverse conditions in emergencies can disrupt emotional and social support and hinder their ability to recover, to raise their children and contribute to their community.

This needs assessment report outlines the MHPSS specific needs of Congolese refugees and aims to help partners involved in the Congolese refugee response (including humanitarian agencies, donors and coordination mechanisms), to integrate and advocate for MHPSS across the whole response.

The integration of MHPSS into emergency services is crucial and can be lifesaving.

Effective MHPSS programming in refugee emergencies provides critical services and supports across the life course to reduce suffering and improve people's mental health and psychosocial well-being.[4] This can improve people's abilities to meet their basic needs to survive, recover and rebuild their lives.

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[1] UNHCR CORE Burundi: Influx out of Eastern D.R. of Congo (9 September 2025). Document - CORE - Burundi: Eastern DRC Displacement Overview - 09 September 2025

[2] Charlson, F., van Ommeren, M., Flaxman, A., Cornett, J., Whiteford, H., & Saxena, S. (2019). New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. *Lancet*, *394*(10194), 240-248. See link here

[3] Reed, R. V., Fazel, M., Jones, L., Panter-Brick, C., & Stein, A. (2012). Mental health of displaced and refugee children resettled in low-income and middle-income countries: risk and protective factors. *Lancet*, *379*(9812), 250-265.

[4] UNHCR. (2024). Mental Health and Psychosocial Support. In *Emergency Handbook* See here.

Through the integration of MHPSS, protection outcomes are improved, and the protection response becomes stronger.[5]

Inclusion, sustainable peace and development cannot be achieved in a divided, traumatized society. Individuals and communities need MHPSS to heal and build a future of union and hope. This is a shared responsibility that concerns all humanitarian and development actors. It is not too late, if we act now.

Photo: Boniface, refugee and SCI animator at Gitara transit centre, shows a truck made of cardboard that he made for the children there, who have no toys to play with.

[5] Harrison, S., Hanna, F., Ventevogel P., Polutan-Teulieres, N., Chemaly, W.S.. (2020). MHPSS and protection outcomes. Policy Discussion Paper. Global Protection Cluster. See here

II. OBJECTIVES

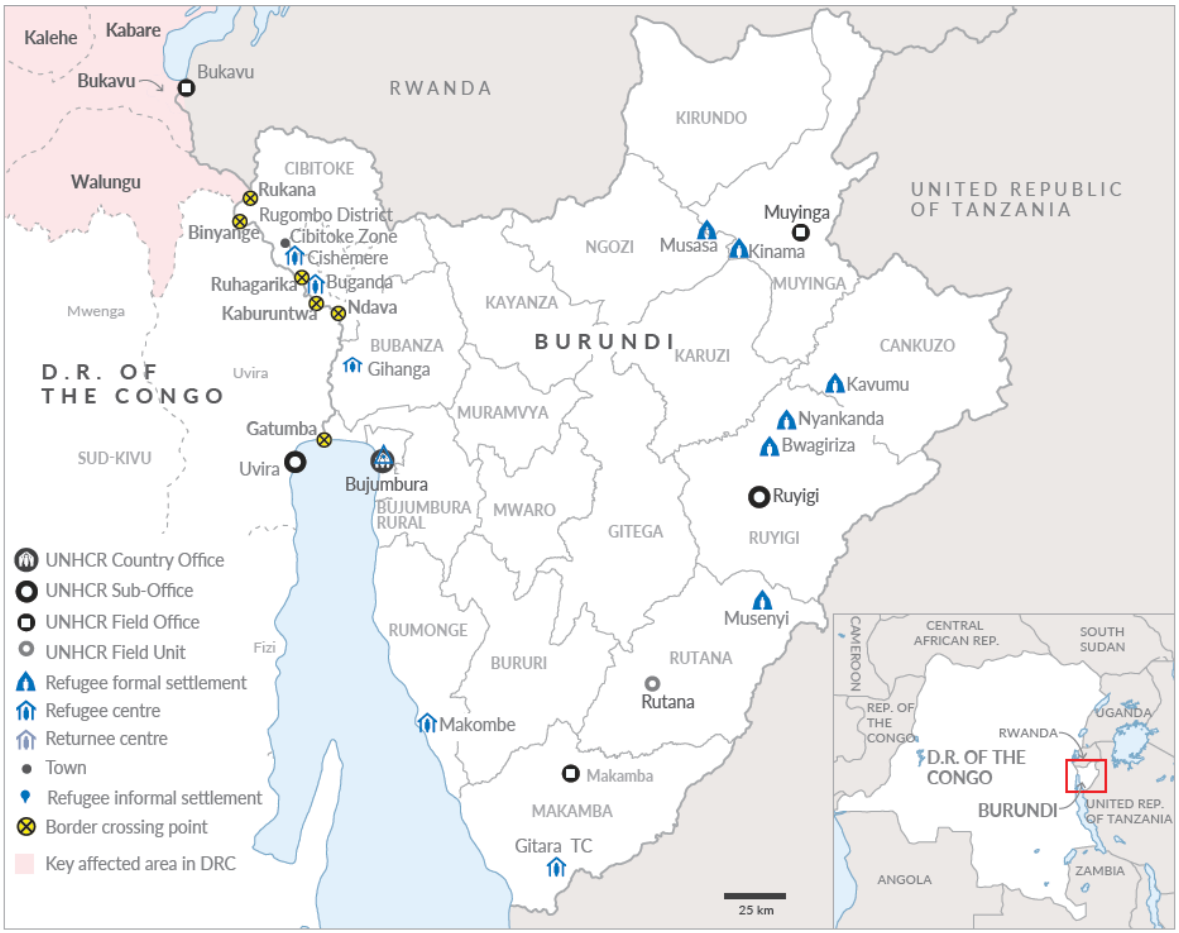
- Identify key needs for mental health and psychosocial support services (MHPSS) and barriers to accessing support services faced by Congolese refugees in Burundi (Gitara transit centre and Musenyi refugee site);
- Identify MHPSS actors and services in order to understand the scale and nature of the MHPSS response and identify gaps;
- Explore refugee perceptions of MHPSS issues and coping strategies;
- Share recommendations with relevant sectors and stakeholders for an integrated emergency response for mental health and psychosocial support.

III. BACKGROUND AND CONTEXT

Since January 2025, more than 70.000 people[6] (UNHCR) have crossed into Burundi, fleeing from violence in eastern Democratic Republic of the Congo (DRC). As stated by UN Regional Spokesperson for East and Horn of Africa and Great Lakes, this has become the largest influx Burundi has experienced in decades.[7]

With no end in sight to the conflict, there is an increasing pressure on both the government's and aid agencies' refugee response capacity.

Going now into its fourth year, Burundi's fuel crisis has crippled daily life, causing prices to soar, and widespread hardship in a country already facing a serious economic crisis.



UNHCR Comprehensive Overview of Response to Emergencies | dimaehagl@unhcr.org | Sources: UNHCR, Government

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Published 10 September 2025 | Page 1

[6] UNHCR CORE Burundi: Influx out of Eastern D.R. of Congo (9 September 2025). Document - CORE - Burundi: Eastern DRC Displacement Overview - 09 September 2025

[7] Faith Kasina, UN Regional Spokesperson for East and Horn of Africa and Great Lakes at a press briefing at the Palais des Nations in Geneva. 7 March 2025 https://www.unhcr.org/news/briefing-notes/aid-efforts-burundi-buckling-more-congolese-arrive-largest-influx-decades

Dramatic funding shortfalls in humanitarian aid have also resulted in a decrease in human and financial resources available for the response. According to WFP, as of June 2025 available daily rations for Congolese newcomers were drastically reduced from 75 percent to 50 percent of the recommended daily calory intake.[8]

With overcrowded camp sites and resources becoming scarcer by the day, there are numerous stressors impacting the daily life of entire communities. Conflict, loss of and separation from loved ones, sexual and gender-based violence[9] have taken a toll on the mental health and psychosocial wellbeing of both adults and children. With the suspension of the United States of America (USA) resettlement programme undertaken in partnership with UNHCR, many refugees have lost hope for a better future.[10] Congolese refugees were the largest refugee population being resettled in the USA before the suspension of the country's Refugee Admissions Program.[11] For many, this programme was a life-saving solution and a chance to rebuild a future safely.

It is therefore urgent to address the mental health and psychosocial support needs of the communities. This could be seen as an opportunity for the government to invest in its mental health system and contribute to the inclusion of refugees in the national mental health plan, building it back better for Burundians and Congolese refugees alike.

[8] World Food Programme 2025. https://www.wfp.org/countries/burundi

[9] Save the Children. Surge in number of children facing sexual abuse as they flee DRC to Burundi with aid cuts reducing support. 23 June 2025 https://reliefweb.int/report/burundi/surge-number-children-facing-sexual-abuse-they-flee-drc-burundi-aid-cuts-reducing-support-save-children

[10] El Pays. UN's global refugee resettlement program crumbles after US withdrawal. 2 May 2025. UN's global refugee resettlement program crumbles after US withdrawal | U.S. | EL PAÍS English

[11] The Porsesh Policy Research Institute. New Lives, New Challenges: The Congolese Refugee Experience in Washington State. 7 March 2025. https://prresearch.us/2025/03/07/challenges-of-congolese-refugee-experience-in-wa/

II. METHODOLOGY

For this report, UNHCR and its partners spoke to 360 Congolese children and adults hosted in formal settings in Burundi:

- **transit centre** (Gitara) in Mabanda and;
- a **refugee site** (Musenyi), in Giharo former province of Rutana.

These settings were identified as the locations hosting most refugees and with relatively high concentrations of inhabitants when compared to other similar facilities: Gitara (**1,908)** and Musenyi (**17,729)**[12]. The decision to cover these two settings was also based on their proximity to each other and ease of access from the MHPSS expert's duty station (Makamba). Given the absence of baseline data on the MHPSS situation of the Congolese refugee response in Burundi, a mixed-method approach proved to be the best option to achieve

[12]UNHCR CORE Burundi: Influx out of Eastern D.R. of Congo (9 September 2025). Document - CORE - Burundi: Eastern DRC Displacement Overview - 09 September 2025

accuracy and reliability of information. In this way, this assessment, combined:

- qualitative methods (brief desk review, site visits, direct observation, coordination meetings, key informant interviews (KII), community group discussions) and;
- quantitative methods (household surveys).

The conclusions of this assessment were achieved were based on multiple findings. To guarantee its quality, evidence was triangulated, i.e. the different methods used drew on each other to support a particular finding and conclusion.

Duration

This assessment lasted for a total of nine weeks, from July to September 2025.

A range of assessment methods were used including

Community Focus Group Discussions (FGDs). A total of 24 focus groups discussions were held. Each focus group consisted of 15 participants (around 360 people in total). In each of the two sites twelve FGD were held:

- two groups of adult women and 15 adult men aged 35-60,
- two groups of older people aged 60+,
- two with unaccompanied and separated children aged 13-18,
- two with young men and women, aged 18-30,
- two with women survivors of GVB,
- two with men survivors of sexual violence.

Key Informants interviews

24 interviews were held with key informants such as local authorities, healthcare providers, humanitarian workers, volunteers, religious leaders and community members, including people with a lived experience of a mental health problem.

Household interviews

A structured interview was carried out by 17 data collectors (9 women and 8 men) familiar with the language and culture, following a one-day training in the use of the survey and the purpose of the assessment and basic psychosocial skills (BPS).

	Population size	Targeted sample size	Analysed sample
Gitara	1864*	329	220
Musenyi	17677*	371	371
Total	19541	700	591

The sample size was selected using the Slovin formula:

$$n = \frac{N}{1 + Ne^2}$$

N = Population Size
n = Sample Size
e = Margin of error
= (0.05)

The Slovin's formula is used in statistics to calculate the minimum sample sized needed to estimate a statistic based on an acceptable margin of error.

Simple random sampling was used to ensure unbiased representation, and it included 700 households (329 in Gitara 329 and 371 in Musenyi).

In the analysis we could not use the first 109 interviews because of data quality issues. The analysed sample consisted of **591 persons**.

Households were selected randomly in the different areas of each setting. The survey was administered through Kobo collect by using tablets and cell phones. Questions were read aloud to respondents, upon informed consent.

Procedures

Interviews took place in Gitara transit centre and Musenyi refugee site. Participants were selected with the support of Save the Children and refugee

committees in each location, given their knowledge of the context.

Interviews were conducted by the Mental health specialist and a Save the children protection assistant, who spoke the local language. Answers were collected with pen and paper with the Mental health specialist and one to two other staff taking notes, for further comparison and consolidation purposes. Notes taken in French were double checked against notes from other staff to complete information and to verify possible losses in the translations of Kiswahili into English. Questions were asked with the help of an interpreter using the back-translation method: simultaneously translated from French to the local language (Kiswahili spoken in Eastern Congo) and then back to French, by an experienced protection UNHCR staff.

Ethical considerations

This assessment followed the IASC recommendations on MHPSS research in emergency settings.[13] Thinking about violent or horrific events can place individuals in a state of psychological distress. The tools used in this assessment were structured and specifically designed not to ask for details. When the respondents wished to talk about such events, they were allowed do so to a certain extent, but no further details were asked. At the end of the interview/FGD, participants who required further support were referred to the best available psychosocial and mental health service. During the training, a list of support organizations was also handed out to enumerators.

Confidentiality and Informed consent

Participants were informed of the purpose of the interview and that they could stop it at any time. They were also informed that they could decide not to participate. We made sure they knew the data collected did not include any personal information and was only used for assessment purposes.

In order to protect participants' identity and to protect them from social consequences of being identified as GBV/SV survivors, FGDs were held privately in a closed space. Even though we informed participants at the beginning of each interview of the importance of keeping all information shared private, this is not a guarantee that there was full confidentiality.

Tools

Data was collected using tools from the MSP Multi-Sectoral MHPSS Assessment Toolkit[14] :

- *tool 1 (Brief Desk review)*
- *tool 3B (Simplified MHPSS 4Ws mapping for referral pathways and service directories)*

[13] Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2014. Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings. IASC Recommendation for Ethical MHPSS Research in Humanitarian Settings - Emergency Toolkit - The MHPSS Network

[14] Assessment Tools - MHPSS MSP

- *tool* 5 (*Survey of mental distress and help-seeking in humanitarian settings (SMDH))*
- *tool* 6A (*Topic guide for community members: adults, including caregivers)*
- tool 6B (*Topic guide for children and adolescents)*
- tool 7 (*Topic guide for formal and informal service providers)*
- Tool 8 (*Topic guide for people with lived experience of mental health conditions)*
- tool 9 (*Checklist for site visits to psychiatric hospitals in humanitarian settings)*
- tool 13 (*Checklist for camps and other sites where people have been displaced)*

These tools were translated from the French version to Kiswahili (local version, spoken by Congolese refugees), and were submitted to partners and proofread by members of the refugee community for revision, comprehension and context adequacy.

Additionally, data was collected through:

A. A **desk review** included relevant documents from UNHCR[15,16], WHO[17], WFP[18], UNICEF[19], Save the Children[20], Ministère De La Sante Publique et de la Lutte contre le Sida[21] [22], Organisation suisse d'aide aux réfugiés (OSAR)[23], Association Lutte contre le Malaria (ALUMA) Burundi[24].

B. **Visits and direct observation** were conducted across selected sites:
   1. Cishemere transit centre
   2. Makombe transit centre
   3. Gitara transit centre
   4. Museyni refugee site
   5. Gitega Mental Health Care Centre
   6. Ngozi Neuro-Psychiatric Centre
   7. Kamenge Neuro-Psychiatric Centre

Both structured and unstructured observation were used to understand the context better.

C. Meetings with relevant stakeholders were held at a national level in Bujumbura with government officials from the National Office for the Protection of Refugees and Stateless Persons (ONPRA) and the Ministry of Health's Department of Non-Communicable Diseases (PNILMCNT). Participation in the child protection coordination meeting at national level, which is led by UNICEF and the Ministry of

[15] Document - CORE - Burundi: Eastern DRC Displacement Overview - 12 August 2025
[16] Document - Plan de Réponse Inter-Agences pour les Réfugiés au Burundi (Résumé) - Situation RDC (mars–septembre 2025)
[17] Microsoft Word - Rapport_OMS_Burundi Final 31_03_08_mg.doc
[18] Burundi | World Food Programme
[19] Burundi-Refugee-Response-Flash-Update-No.-9-(Impact-of-DRC-Crisis)-30-June-2025.pdf.pdf
[20] Surge in number of children facing sexual abuse as they flee DRC to Burundi with aid cuts reducing support – Save the Children | Save the Children International

[21] République Du Burundi. Ministère De La Sante Publique et de la Lutte contre le Sida. Directives nationales pour l'intégration des soins de santé mentale dans le système de santé du Burundi. Octobre 2019
[22] Burundi Politique Nationale de Santé 2016-2025. Burundi Politique Nationale de Sante 2016-2025 | Country Planning Cycle Database
[23] Bericht
[24] Rapport-annuel-2023-b-1-1.pdf

Solidarity, took place. Meetings were also held with humanitarian actors and other key players, such as UNHCR colleagues, Save the Children, HealthNet TPO, and the Swiss Cooperation.

Limitations of this assessment

As the mental health specialist did not speak the local languages, UNHCR and SCI staff with good knowledge of Kiswahili language mediated as interpreters during group discussions and interview sessions. This limited direct interaction between the specialist and respondents could mean some pertinent views could have gone lost in the process. Due to the sensitive nature of some questions in the household surveys, particularly regarding alcohol and substance abuse, the information obtained regarding these topics may not represent true opinions or may be limited in terms of the depth of information shared.

The fact that alcohol and drugs are forbidden in the transit centre and on the refugee site and that the enumerators asking these questions are also part of the community is another reason to why this information may not be reliable.

V. FINDINGS

HOW CONGOLESE REFUGEES FEEL*

We asked in group discussions, what problems people had with their feelings, thoughts and behaviours since they've arrived in Burundi.

*I have **headaches all the time** and when I walk, **I feel dizzy.***
Kadidja, 23, Musenyi

*I have a **lot of troubled ideas** in my head, and **I drink to forget** what I saw.*
Pascal, 28, Musenyi

*I am **always tired,** but **I can't sleep.***
Irene, 43, Gitara

*The **anger** in you can't really end. It's impossible.*
Christian, 18, Gitara

*My daughter gets so **upset** at times, **we must tie her up**. The whole family is disturbed by this.*
Suleimane, 36, Musenyi

*Whenever I hear a noise, my **heart starts beating really fast.***
Aisha, 32, Musenyi

*I wonder about the future and my **heart hurts.***
Samuel, 16, Gitara

*These quotes from refugees were collected using tools 6A (*Topic guide for community members: adults, including caregivers),* 6B (*Topic guide for children and adolescents) during* FGDs in the Gitara transit centre and the Musenyi refugee site between the months of July and August.

SIGNS OF DISTRESS

The signs of emotional distress seen on participants are consistent with the violence endured in the country of origin and on their journey to safety.

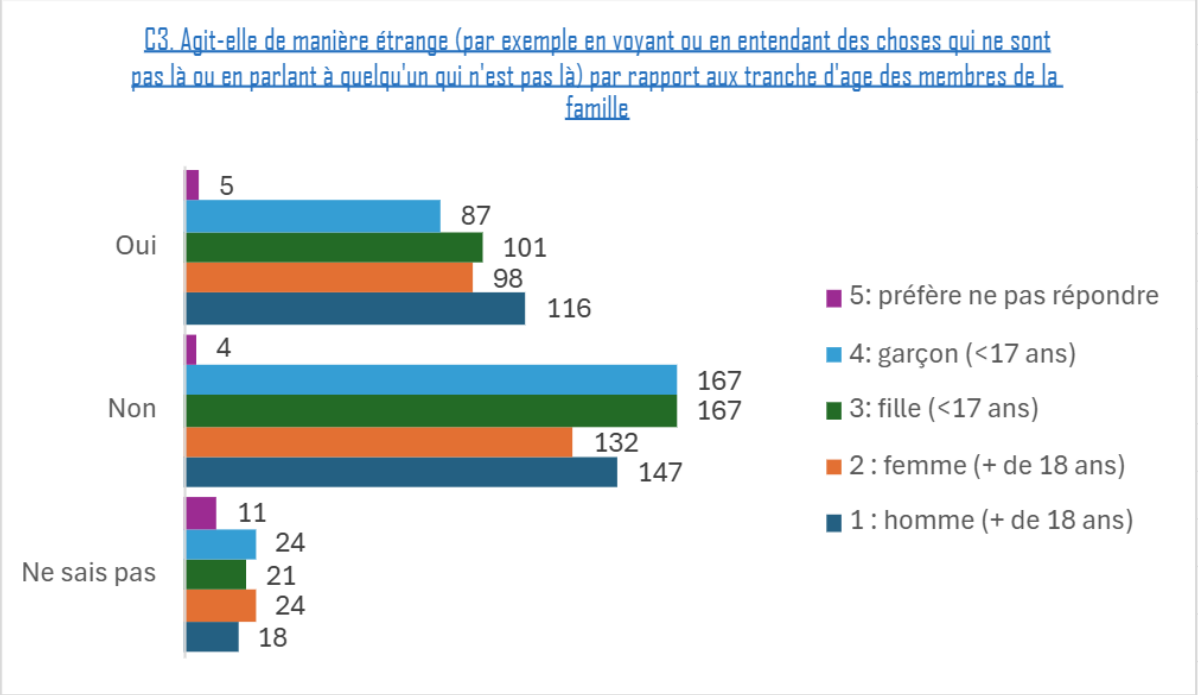
83% of refugees reported feeling so severely upset about the war, that they tried to avoid places, people, conversations or activities that reminded them of such event, with **31% feeling this way most of the time.**

Household survey, tool 5
Survey of mental distress and help-seeking in humanitarian settings (SMDH)

During FGDs, held both in Gitara transit centre and Musenyi refugee site, participants mentioned being easily startled by outside noises, feeling dizzy, as if one was going to fall,

having headaches and heart palpitations, not being able to sleep, having nightmares, feeling sad and/or angry all the time, and wanting to isolate oneself. Some people also mentioned seeing things that aren't there, and having an incoherent, disorganized speech.

> ***'Sometimes it's like I'm back in Congo all over again, I start saying things that don't make any sense. My children ask me, - "Daddy why are you talking strange?"***
>
> *Moïse, 38, FGD, Musenyi*



Respondents were asked to answer if they had noticed any strange behaviour in their family members, like seeing things that weren't there or speaking to someone who wasn't there. Of the 407 positive answers, this behaviour was most observed in men (29%), in girls (25%), followed by women (24%) and boys (21%).

The impact of gender-based violence and sexual violence on mental health and psychosocial wellbeing

We talked to women and girls, boys and men survivors of GBV and SV during FGDs about the problems they had with how they felt, thought or behaved. According to UN sources[25] [26] and as reported by SCI[27], GBV and SV have been widely used in Eastern DRC as a

[25] DRC: UN Officials Raise Alarm at the Dramatic Impact of Prolonged Conflict on Women and Children, Including Increased Risk of Conflict-Related Sexual Violence on Displaced People – Office of the Special Representative of the Secretary-General for Children and Armed Conflict
[26] Sexual violence systematically used as a weapon of war in the DR Congo | The United Nations Office at Geneva
[27] Surge in number of children facing sexual abuse as they flee DRC to Burundi with aid cuts reducing support – Save the Children | Save the Children International

weapon of war. Participants mentioned having flashbacks and feelings of worthlessness. Feelings of shame and guilt were equally reported with the fear of stigma being one of the causes people do not look for help. The sexual violence experienced by women and men in the country of origin has deeply affected their self-esteem and sense of worth, impacting the way they relate to one another and their ability to care for their children.

A shift in gender roles

As they left everything behind and with income opportunities being scarce in the transit centres and on the site, many boys and men find themselves with little to no income. In a culture where men are expected to be the bread winners and sole providers at home, many claim feeling worthless and not respected. This not only affects their identity but also impacts their authority at home, as well as their relationship with their spouse and children.

In Congo, men are encouraged to keep their problems to themselves and not show any emotion. With no ways of easing their grief, worry, anxiety and anger many turn to violence, risky sexual behavior and alcohol or drug abuse.

THE IMPACT OF GBV AND SV*

> *"In Congo, **being raped** means you are **stained forever**. If you were single or promised to someone, it means that **you will never get married**."*
>
> *"People look at you differently and **they judge you**, once they know you were raped. They ask: **why did you let it happen?"***
>
> ***"They forced my son to watch while they raped me. I don't know how I will ever look at him again."***
>
> ** Quotes from women survivors of GBV in Musenyi refugee site, FGDs, August 2025*

The same goes for women and children. With the loss of a husband or parent, they are often the ones to seek humanitarian assistance, work in the fields, and go to market. This exposes them to heightened protection risks, particularly sexual violence.

According to the latest health report in Musenyi, dated July 2025, **mental health problems are the second biggest cause of morbidity in the site**, after malaria.

Household survey, tool 5
Survey of mental distress and help-seeking in humanitarian settings (SMDH)

The testimonies given by participants during FGDs are consistent with the latest internal Public Health report[28] of the Musenyi site and with data obtained from HH surveys.

The most common mental health problems registered in the health centre of Musenyi refugee site, as of July 2025, by descending order, are as follows:

1. **Grief**
2. **PTSD**
3. **Depression**
4. **Anxiety**
5. **Acute Stress**

HH surveys helped us estimate the extent of mental distress in the community, understand help-seeking behaviours and identify gaps in access to care.

According to the survey carried out, **83% of refugees** in Gitara transit centre reported **feeling so afraid that nothing could calm them down**, with **47% feeling this way most of the time.**

In Musenyi refugee site, **84% of refugees** admitted **feeling so angry that they felt out of control. 36% feel this way most of the time and 22% all of time.**

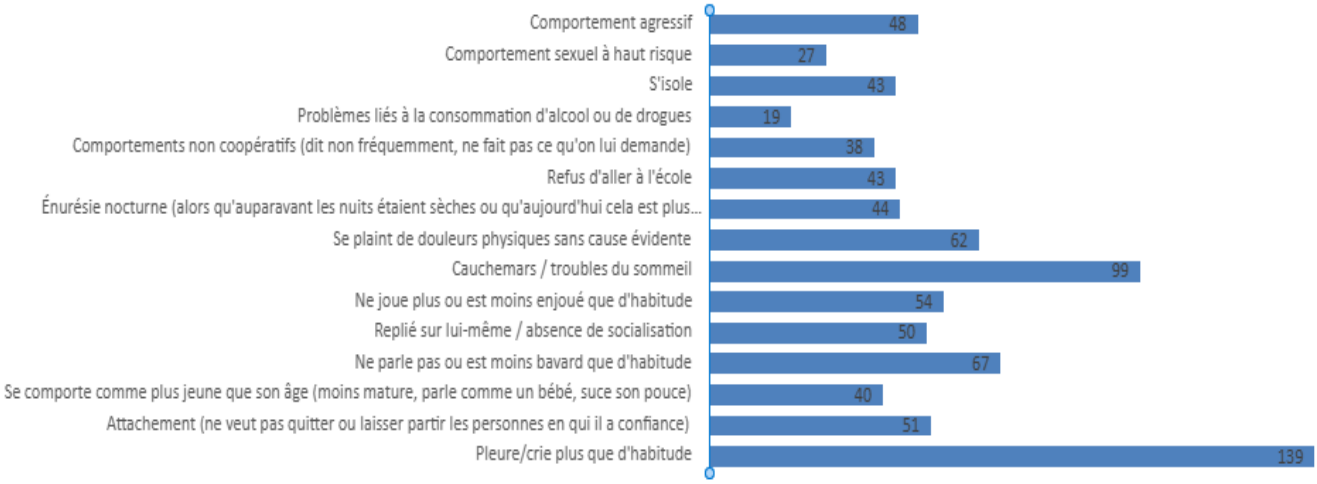
50% heads of household in Musenyi were unable to carry out essential activities for daily living because of feelings of fear, anger, fatigue, loss of interest, hopelessness or upset.

Household survey, tool 5
Survey of mental distress and help-seeking in humanitarian settings (SMDH)

"Children aren't joyful anymore. They fight each other all the time.' *Amina, 32, Musenyi*

[28] UNHCR. July 2025. Public Health Report of Musenyi Refugee site (Internal).

Parents and caregivers[29] from both Gitara and Musenyi were asked if they had noticed problems in the way their child/ children felt or behaved in the last two weeks.



Those who answered positively reported the following signs as being the most common:

[29] This can include parents, grandparents, legal guardians, teachers and childcare staff among others.

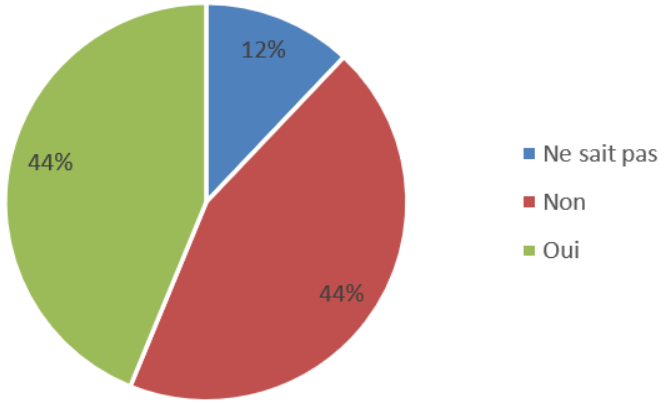
1. **Crying/screaming more than usual**
2. **Nightmares / sleep disturbances**
3. **Not talking or less talkative than usual**
4. **Complaining about physical aches and pains with no obvious cause**
5. **No longer playing, or less playful than usual**

Help Seeking Behaviour

Have you tried to find support for this problem?

It is safe to conclude that, in both settings, less than half of the population seeks help if they are feeling emotionally distressed.

Household survey, tool 5
Survey of mental distress and help-seeking in humanitarian settings (SMDH)



Of the respondents who answered positively to whether they had any problems with how they felt, their thoughts and behaviours, **only 44% looked for help.**

Amongst the reasons to why people did not seek support, the six most reported are as follow:

1. Not knowing where to seek help
2. Not having the time to seek help
3. Thinking that available services will not help
4. No services exist for this problem
5. Not feeling comfortable with who the service providers are
6. The service was too costly

The reasons stated above are consistent with the FGDs held in both Musenyi and Gitara. In fact, most people stated being unaware that there were psychologists or psychiatric nurses available in the site or in the transit centre.

Refugees are overburdened between regular daily duties and a wide array of problems, either conflict or aid induced. This may lead them to delay seeking help or not seeking it at all, prolonging their distress and suffering.

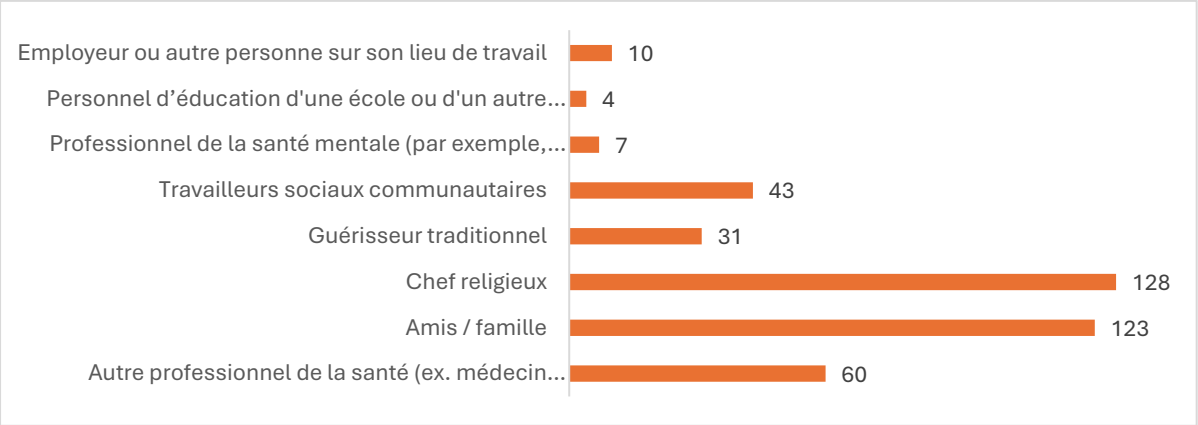
Mental health services in both settings are free of charge. The fact that services are considered too costly by respondents may be explained by the fact that refugees seek help primarily from religious leaders and traditional healers before going to a mental health professional. Some might also want to be treated in Bujumbura at their own expense, which is for most unaffordable.

From whom do refugees seek support?

Out of the 406 respondents who seek help when in distress, 32% stated they look for help from the religious leader and 30% from friends and family. Only 1% of the refugees mentioned looking for a mental health professional.

Religious leaders and friends or family are, by far the ones the community turns to the most, when in distress.

Household survey, tool 5
Survey of mental distress and help-seeking in humanitarian settings (SMDH)

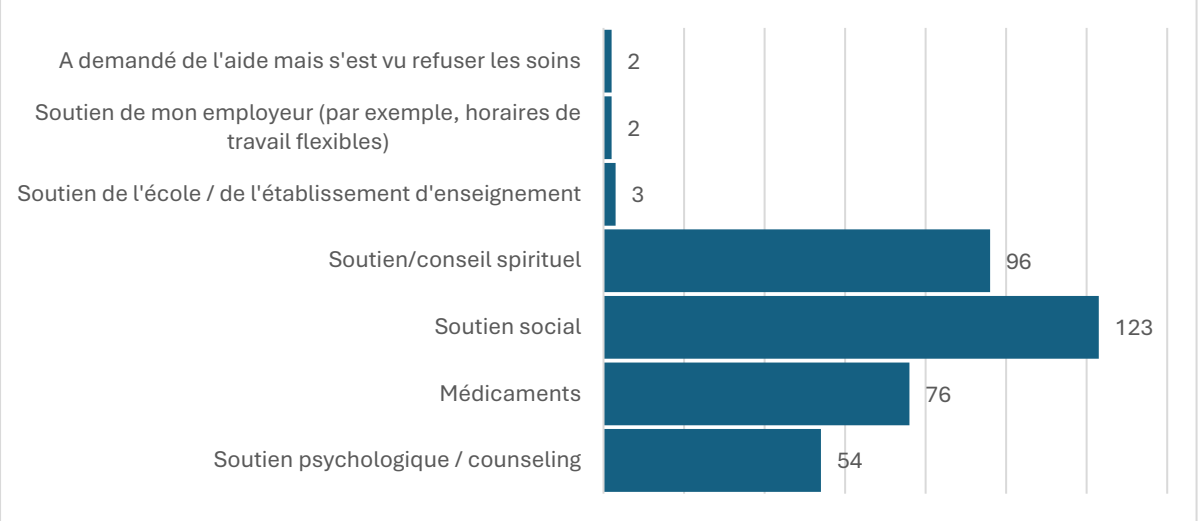


According to the FGDs that were had, most refugees seek support from religious leaders in the form of prayer and advice.

During FGDs, religious leaders from different professions of faith, reported that many people don't come to the church anymore and instead they isolate themselves. **Religious leaders also admitted to feeling as traumatized as the people that look for them and not being able to help themselves either.** They mentioned, however, that if

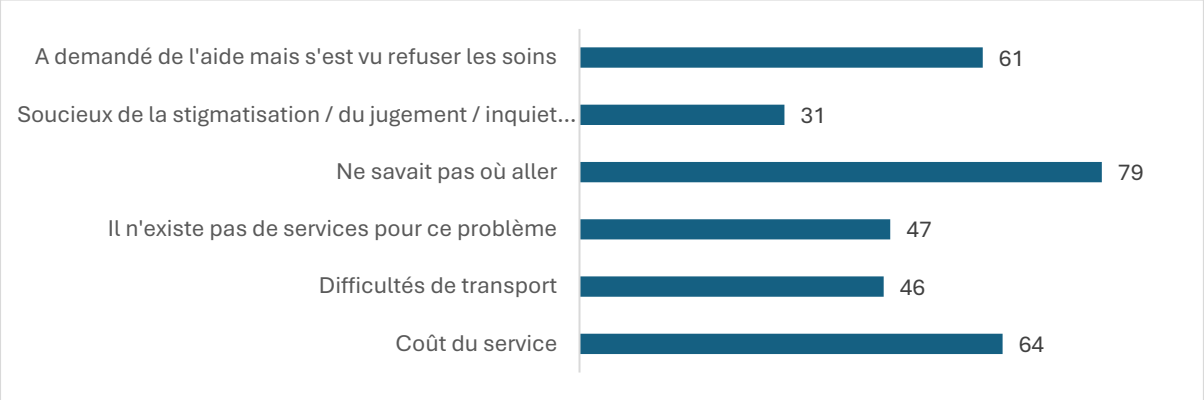
there were no churches or places of cult, life in the site would be even worse. They also reported only referring the person to the health centre as a last resource, when nothing else worked, or not referring at all. Prayer rooms are reported to be vastly used. When asked if they would be receptive to learning how to support people in emotional distress and how to refer them, if necessary, most answered in a positive manner.

Type of support received



35% out of 356 refugees looking for help received social support followed by spiritual counselling, 27% and medication, 21%. Despite not many people knowing that the service is available, 15% received some kind of psychological support or counselling showing that they might have been referred by other health professionals or community volunteers.

Obstacles to accessing services



Again, people not being aware of the available services is the number one obstacle to accessing care, with a whopping 24% of 328 refugees not knowing where to go for help. Even though services are all free of charge in both sites and transit centres, refugees often mentioned having to travel to get themselves treated and to buy medication, which is not available on site.

Many refugees turn to religious leaders and traditional healers for help, which can be quite expensive. This would explain the cost of service being the second most important obstacle (20%) to getting help.

Local construct Eastern Congo Kiswahili	Translation or Common Mental Disorder (Western Concept)	Observations
Kuchamganikywa	Mental health problems (disorders)	-
Musazi	*Crazy* or mad person	Negative connotation. This word describes a state that is irreversible. Someone who is violent, agitated. Who behaves strangely (talking to someone who isn't there, screaming, taking off their clothes etc.)
Mwehu	*Crazy* or mad person	A state that could be temporary. There is still a hope for recovery.
Hakiri inapunguka **or** ***Hakiri haieney***	Mentally Impaired, *retarded*	Literally meaning someone who has 'Diminished thought or diminished intelligence'
Manumuniko, Uchungu	Sadness, Pain	
Huzuni	Depression (Sadness in the sense of sorrow and grief)	The word refers to a state of deep sadness. Having a *heavy heart, an aching heart*
Msongo wa mawazo	Stress/anxiety, negative thinking, ruminating thoughts	Literally translates to 'confusion in the mind' Usually described as 'having a lot of bad ideas/thoughts in your head.' 'The head is spinning'
Kuvamiura na mapepo	Visual and auditive (pseudo) hallucinations?? Can be normal in this context	Haunted by spirits/demons Being visited by ancestors
Mapepo mabaya/ Pepumbaya		Evil spirits. Someone seeing evil spirits

Local Expressions of Distress and Concepts of Mental Health Conditions

These cultural concepts of distress that emerged through qualitative interviews. Humanitarian actors, particularly, Health and Protection actors should avoid using clinical jargon such as PTSD, depression, trauma etc. and instead use terms that are culturally meaningful and understood.

At-risk groups

The violence and loss experienced by Congolese refugees in their country of origin, coupled with the restrictions on their freedom of movement, access to food and financial resources in Burundi, render this group particularly vulnerable. Even among those who are already vulnerable, there are further groups that are particularly exposed.

- Unaccompannied and separate children
- Older people
- Young men (above 18) living on their own
- People living with pre-existing MNS conditions
- Women survivors of GBV
- Male survivors of sexual violence
- Children and youth with no access to safe spaces, recreational and structured activities
- People with disabilities

Coping mechanisms

Alcohol and Substance Abuse

> ***'People drink because they are locked up. They drink to relieve their worries.'***
> *Moïse, 27, Gitara*

Many children, adolescents and adults in Gitara transit centre and Musenyi refugee site are turning to drugs and alcohol to escape their surroundings. Parents and caregivers have reported that their children are increasingly engaging in high-risk sexual behaviour and turning to drugs available, such as cannabis.

According to the household surveys conducted, 70% of the heads of household in Musenyi reported that for the past 30 days, they had more than six drinks of alcohol in one day[30] compared to 61% in Gitara transit centre. The drinks most mentioned were *savana, kuka, sukuruka, pendo, etc.*

[30] One standard drink consists of half pint of "regular" beer, lager or cider, half a small glass of wine, or 1 single measure of spirits. For a more detailed individual assessment of alcohol use, see WHO AUDIT: https://iris.who.int/bitstream/handle/10665/67205/WHO_MSD_MSB_01.6a-eng.pdf?sequence=1

In August, there was one confirmed death by alcohol abuse in Musenyi.

When it comes to drugs, only 6,7% of respondents in Gitara reported taking drugs, against 13,61% in Musenyi site, with 5,24% taking them most of the time. The most mentioned drug was cannabis, also known as *chanvre* or *bangi*.

It is worth mentioning that the in the transit centre and refugee site where the HH surveys and FGDs were carried out, such actions are forbidden. Since they remain taboo, they may potentially be under-reported by communities.

Suicide

> **70% of the respondents in Musenyi refugee site have felt so hopeless in the last two weeks, they did not want to carry on living.**
>
> Household Survey, Musenyi, August 2025

70% of the respondents in Musenyi refugee site have felt so hopeless in the last two weeks, they did not want to carry on living, with 26% saying they feel this way most of the time.

In Gitara, 61% of the heads of household responded having felt that way, while 26% felt like this most of the time.

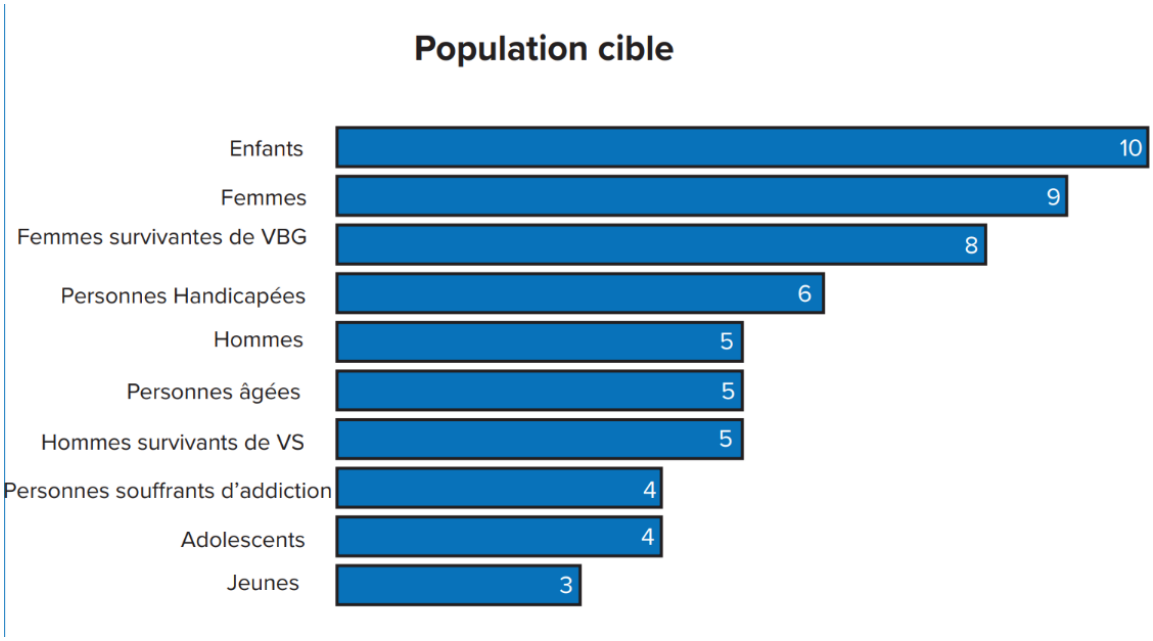
When asked in group discussions, if they ever feel like no longer wanting to live, most people say they have felt that way and that they think about it often.

MHPSS Presence in the refugee response

Currently, there are 11 MHPSS actors in the Musenyi refugee site:

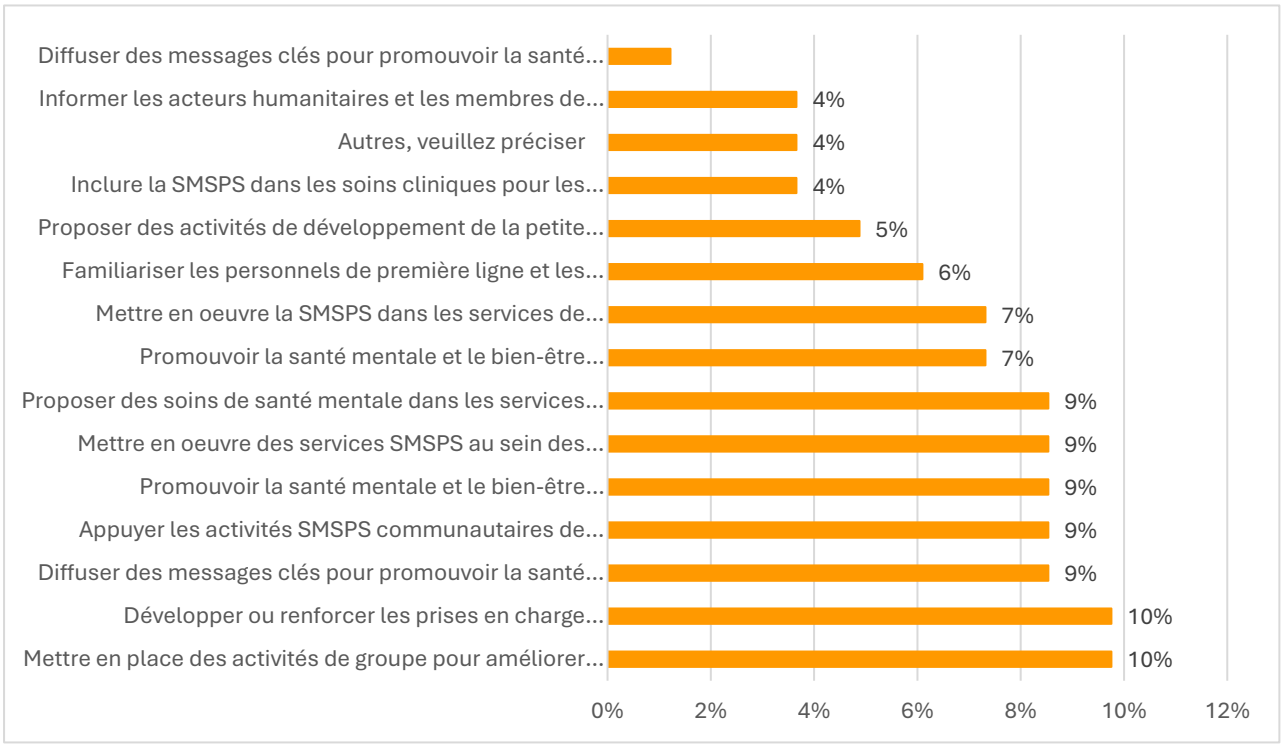
- **Five national actors:** Association Burundaise pour le Bien-Etre Familial (ABUBEF), Global Development Community Burundi (GDCB), AFMB, Social Action for Development (SAD), Plateforme des Intervenants en Psychosocial et Santé Mentale (PPSM).
- **Six international actors:** Medica Mondiale/AST, Street Child, Save the Children International, Terre des hommes, Jesuit Refugee Services (JRS), International Rescue Committee (IRC).

Health Net TPO is UNHCR's partner delivering MHPSS services permanently in the transit centres of Gitara, Makombe and Cishemere.



The most targeted groups by MHPSS actors are children, women and women, survivors of GBV, while people suffering from addiction, adolescents and young people are the less targeted by partners.

MHPSS activities implemented in Musenyi



The data above shows a clear gap in awareness raising of the community on MHPSS as well as a gap in familiarizing frontline workers and community leaders in Basic Psychosocial Skills.

The activities in the chart are part of the MHPSS MSP and describe the minimum MHPSS activities that should be implement during an emergency. Data on community and group-based support and services also show there is a lot of room for improvement. The same can be said for activities targeting children and their caregivers.

Ngozi Neuro Psychiatric Centre

Reference Mental Health Centres

The mental health sector in Burundi is underdeveloped, because apart from a few organizations working in this field, the CNPK, CNP de Ngozi and CSM de Gitega are the only psychiatric hospitals in Burundi. The Kamenge neuro-psychiatric centre (CNPK), located in the northern district of Burundi's capital, is the country's national referral hospital for mental health care. This being said, the three psychiatric centres/hospitals are run by the Frères de la Charité, a religious brotherhood with Belgian background. In terms of mental health, there are geographical gaps, since not all the regions are covered by MH services.

When services in the site or transit centres are not able to support people with mental health problems, they are referred to one of the three centres mentioned above, according to geographical location.

In the case of Musenyi, for instance, a person would be first referred to CSM Gitega (three to four hours by road and only then to CNPK (five hours away). The fact that refugees cannot afford to travel to any of these locations and that there is no public transportation

available, means that they are dependent on transport provided by NGOs such as AFMB and IRC.

Availability of psychotropic medication

Accessibility of the main psychotropic and antiepileptic drugs is a key factor in the successful integration of mental health care into the health system. In Burundi, professionals capable of prescribing them are rare, and psychotropic and antiepileptic drugs pose various problems.

Although they appear on the country's official list of essential medicines, they are only available in national mental health referral structures and certain district hospitals targeted by CNPK interventions, which distributes psychotropic drugs from its own stock.

Mental Health integration into Primary Health Care

The project *Ni Abacu*, in cooperation with the CNPK and the national NGO THARS Trauma, Healing and Reconciliation Services- Burundi, financed by the Swiss Cooperation, has started the integration of MH in Primary Health Care in 2021. The project is in line with and supported by the government:

The pilot-project was implemented in Rumonge and the project itself was currently being implemented in Bujumbura.

The project is implemented by three institutions:

- THARS- in charge of the community aspect
- CNPK- clinical aspect
- University of Burundi – Training

In the 2nd semester Ni Abacus project will extend its scope to all the provinces in the country. The first phase is meant to start on 1st November with community awareness raising, led by THARS.

An opportunity to build back better

As the project expands to all the provinces, UNHCR should support the integration of MH into PHC facilities by encouraging referrals to the nearby health centres and including them into their referral pathways. UNHCR should also advocate with the Swiss Cooperation so refugees are also integrated in this project.

STRESSORS caused by how humanitarian aid is delivered

Beyond the conflict-induced problems, Congolese refugees also identified problems caused by how humanitarian aid is delivered. These problems are what we can call daily stressors and may exacerbate their distress, while undermining people's ability to 'bounce back'.

The way aid is delivered also has an impact on people's mental health and psychosocial wellbeing. In fact, many refugees speak of how their state is worsened by the daily stressors and challenges they face in the site/transit centre.

> ***'I arrived in good health, but here I feel very stressed.'***
>
> ***Deodata, 34, Gitara***

Although the tool we used sought to explore MHPSS-related problems, the answers to this question generated a list of perceived problems and stressors in the community that are broader in focus and relate to other sectors. The following list seeks to support coordination efforts with other sectors and highlight overarching needs.

No freedom of movement

> ***'We're in prison, like animals.'***
>
> ***Bikar, 45, Gitara***

Having no freedom of movement is taking an enormous toll on refugees. The fact that people are not able to go out of the transit centre, makes it impossible for them to find a job, that would allow them to complete the aid they receive. Even if there are job opportunities, qualified people can't come forward for lack of freedom of movement. Some participants refer to the Gitara centre as a "military training centre". This is having an enormous impact on both adult's and children's psychosocial wellbeing and has critical implications for the community's ability to cope.

Insufficient Food and Non-Food Items

With aid cuts reducing support, daily rations have been reduced from 75 percent to 50 percent of the recommended daily calorie intake.[31] Due to funding shortfalls, the quantity of food distributed is scarce and insufficient: it barely covers five days, whereas refugees are told to feed their families for a whole month.

Refugees living on their own, aka *Taille Familiale Un,* are particularly vulnerable as they have nobody to help them complement the food they receive. Most of them are young men, who during FGDs, were seen *as problematic* and engaging in risky behaviours, such as drinking, smoking and stealing.

[31] Burundi | World Food Programme

Lack of economic or recreational opportunities

'Every time I'm alone, I remember the gunshots, family members lost or killed during the flight. I wish there a place where I could play music, watch a film or play football.'

Though refugees have repeatedly appealed for support to start businesses and receive training from development and humanitarian actors, income generating activities are scarce. Providing men and women with livelihood opportunities is shown to increase self-esteem, self-agency and help people rebuild their lives.

'In Congo, we farmed, traded, worked in mineral deposits, we were civil servants... but at the transit centre, we have nothing to do.'

Poor housing

My children shiver at night.

Didier, 28, Gitara

There is a lot of noise. I can't pray or rest.
Coralie, 65, Gitara

Daily life in the transit centre of Gitara is not easy. Poor housing conditions add to the stress and uncertainty of when people will be transferred to the refugee site of Musenyi. **Since April 2025, refugees have been living in overcrowded tents** (the centre has long surpassed its limit capacity).

Many refugees shared that they have been sleeping on the floor since they arrived, with just a piece of cloth underneath.

Poor insulation means it gets very hot during the day and very cold at night, with freezing temperatures, causing a lot of illnesses and respiratory diseases. There are

testimonies of people saying they have pain in their body, and they have a hard time bending their knees and moving due to the cold and having to sleep on the floor.

> ***'We don't have sex with our wives anymore. We're overwhelmed by desire, and some of us are about to explode because we've had enough of abstinence while our partners are here.'***

Lack of privacy means adults must change clothes in front of their children, which is not well regarded or culturally accepted.

Family separation is taking a toll on family life and harmony, as parents and children of different genders cannot not live together. Parents complain that this is having an impact on their children's upbringing as they must leave them unsupervised and exposed to dangers. Spouses complain from the fact that they're relationship is being impacted by having to stay apart.

Education interrupted

Parents and caregivers at Gitara transit centre have expressed their desire for their children to continue their education. Having already missed, at least, one year of school, children and young people constantly ask when they will be able to go back to studying again.

2236 Congolese children in transit centres do not attend school. Of the 2236 refugee children, 1082 are girls (48.39%) and 1152 are boys (51.52%).

Internal report shared by Jesuit Refugee Service, September 2025

With the school year having already started, children in transit centres have no date to resume their education. The prospect of missing yet another school year causes both parents and children a lot of worry and anxiety about the future.

Out-of-school children and young people are at greater risk of violence, rape, and recruitment into fighting, prostitution, and other life-threatening, often criminal, activities.[32]

It is essential to address the needs of people at sensitive developmental stages and during more vulnerable periods of life, such as infants, young children and adolescents.

Education plays a key role in the protection and promotion of children's mental health and psychosocial wellbeing. In situations of conflict and forced displacement, it helps to restore a sense of hope, normalcy and routine to children's lives.

No Sense of safety/Insecurity

Women and girls don't feel safe to walk freely around the site, especially at night. During group discussions in Musenyi, women shared stories of other women being beaten and robbed. They also mentioned they do not go to the toilet at night, for fear of being attacked, as there is no lighting.
There are certain areas/paths in the Musenyi site, such as the trail that leads to the market, and the tents inhabited by young menTF1 that are not considered safe and are

[32] NORRAG. Education in Conflict Emergencies in Light of the post-2015 MDGs and EFA Agendas. 2013 Education_in_conflict_emergencies_Talbot.pdf

avoided by women and girls. Women living by themselves also mentioned feeling unsafe and reported that men have tried to break in. When this happens, they make as much noise as they can, so they alert the neighbours.

All the groups interviewed complained about theft and of people cutting the tents to steal what's inside.

Disregard for the deceased and for mourning traditions

Participants in FGDs, shared they were not able to fulfil their mourning traditions as their culture dictates and to pay their respects to the family of the deceased.

> *"I had to burry my child alone."*
>
> *"In Congo, the whole village accompanies the bereaved family to support and console them. Others bring food to support the family of the deceased. Here, however, there is not enough food, we have nothing to give and it's as if there were no funeral."*

In the case of a bereavement, authorities only allow certain family members to accompany the body to the funeral, and not the community as it normally happens.

There have been cases in Gitara where refugees were not given an appropriate casket to bury their family member. Due to the casket being too small, the deceased was buried with their legs out.

Congolese refugees also shared that prepare their mourning rituals normally takes time (from weeks to months). Usually, they have access to cold chambers where they can keep the bodies until all the preparations have been done. Given the impossibility to do this here many burry their loved ones when the body is already decomposing.

Lack of transparency and no sense of justice

Distribution is the source of stress most mentioned by participants during the FGDs in Musenyi, after the lack of food and money.

Most refugees complained about the way food and cash are distributed in the site as well as about the way houses are being distributed. Taking place in a cramped space, the way distributions are organised is not suitable for the number of people present and it increases the risks for the most vulnerable people such as women, children, people with disabilities and older people.

There are mentions of refugees who, because they didn't hear their name being called, lost their right to money or food. There are others who also experience this because they can't get through the crowd in time. Others complained that when their turn arrives, someone has already signed on their behalf, meaning they lose their right to food or cash.

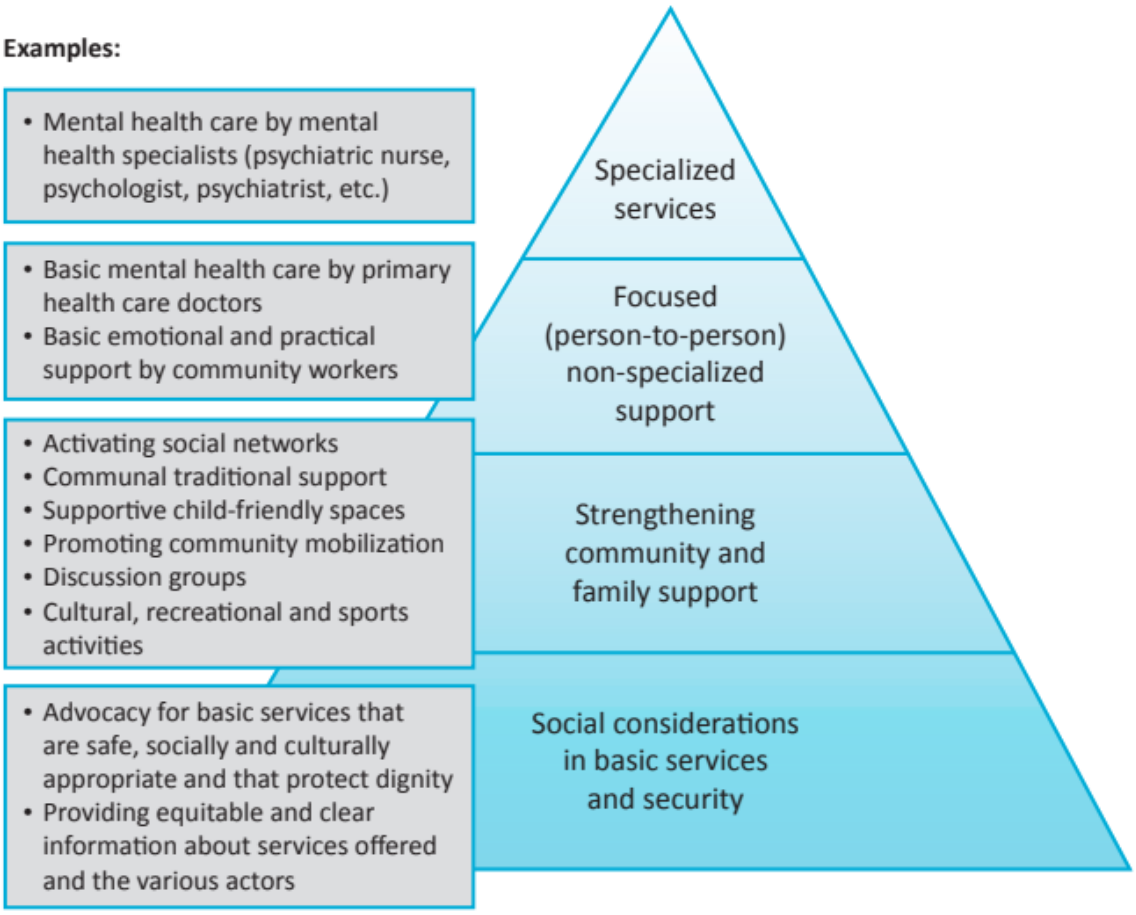
Regarding the distribution of houses in the site, refugees say that the order of first come, first served is not being applied. There are people who arrived recently and that made it to the list, while others who have been in the site for longer are not considered. Some have even received one house, while they already had one. They start renting it for profit.

Arriving at a refugee site, does not put an end to one’s anxiety. The current situation has had the greatest impact on refugees. They feel powerless as if they have lost control over their lives and their future. They feel treated unfairly and the stressors mentioned above all contribute to a sense of helplessness, as well as high levels of anxiety, stress, frustration, anger and, ultimately, a loss of self-esteem.

RECOMMENDATIONS

The psychological well-being of a community can be impacted by all aspects of a humanitarian response, including the behaviour and attitudes of staff and volunteers. Therefore, it is crucial that all sectors deliver their activities in a way that promotes mental health and psychosocial well-being. Actors working in different sectors can also help to improve the effectiveness of MHPSS activities.

Figure 1: Intervention pyramid for MHPSS in emergencies



Source: IASC, 2008.
Note: For an explanation of the different layers, see IASC, 2008, pp. 12–13.

The MHPSS pyramid of intervention describes a holistic approach that involves different kinds of complementary support. As it goes up, the more specialized the services become, and the less people will need them. UNHCR recognizes the importance of MHPSS in its work and of its partners and provides guidance to all parts working in an emergency response on how to integrate MHPSS into emergency services.[33]

[33] Mental Health and Psychosocial Support (MHPSS) | UNHCR

A. SOCIAL CONSIDERATIONS IN BASIC SERVICES AND SECURITY

1) **Enhance the integration of MHPSS into humanitarian aid, including shelter, wash and food distributions**
   - Provide basic information on mental health and psychosocial well-being to frontline workers, community leaders and those identified as potential entry points (community workers and volunteers) and on identifying and referring people in need.
   - Train MHPSS and other humanitarian actors on the MHPSS MSP
   - Train frontline workers on psychological first aid and how to identify and refer cases in need of specialized support by conducting workshop of ½ to 1 day provide by the MHPSS staff of organisations present on the site.

2) **Increase access to information on the current situation, relief efforts, and available services that address basic needs.**
   - Share clear and accessible information about available support services and resources with UASC, older people and their caregivers using plain language and adapted to accommodate different needs, including those related to visual or auditory impairments, to ensure information reaches everyone.

3) **Improve access to the distribution of food and non-food items:**
   - Ensure a distribution line / give priority to the most vulnerable groups: pregnant women, elderly people, people with disabilities
   - Increase the number of information points on the days and times of the distribution throughout the site and organize a team to notify people of the distribution in each neighborhood.

4) **Advocate for freedom of movement of the communities currently being hosted in transit centres and refugee site**
   - Prioritize transferring to the site those who have been in transit centres the longest to ensure they have access to a wide range of services and better living conditions

5) **Improve site security for women and girls**
   - Select the security team in a participatory and transparent manner (through elections)
   - Include women in the security teams that patrol the site
   - Increase the number of security guards
   - Light up the site, including toilets

B. COMMUNITY AND FAMILY SUPPORTS

6) Support and create community-based initiatives

- Ensure access to a safe and appropriate space for community members (children and adults) to convene
- Create and/or strengthen structured activities for children and their caregivers and youth
- Invest in Community-Based Sociotherapy and in Trauma, Healing and reconciliation projects

7) Support the community in their mourning process and cultural traditions

- Support community members by allowing them to leave the transit centre to participate in funerals.
- Support the bereaved family with food
- Give access to a refrigerated morgue to preserve the body so that people have time to organize the burial and related ceremonies
- Assist the family by providing an appropriate casket (measures corresponding to the size of the deceased's body)

C. FOCUSED NON-SPECIALIZED SUPPORT

8) Improve access to psychological support in community settings

- Integrating evidence-based psychological interventions that can be delivered by trained and supervised non-specialists and that are proven to work in low-income countries and are more likely to be scalable, cognitive behavioural therapy (CBT) and interpersonal therapy (IPT).

D. CLINICAL SERVICES

9) Ensure essential mental health is integrated in general health care

- Support access to psychotropic medication
- Enhance coordination and referrals
- Adress the needs of people with intellectual disabilities

10) Promote the integration of refugees into national mental health systems

- Advocate with government and development actors to include refugees in the national MH plans and policies.

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