A Synopsis of the MHPSS Rapid Situational Analysis in Assosa, Ethiopia 2023

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June 2023

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With funds from UNHCR & BPRM

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Abbreviations

DICAC	Development and Inter-Church Aid Commission
FGDs	Focus Group Discussions
IASC	Interagency standing committee
IRC	International Rescue Committee
MHPSS	Mental Health and Psychosocial Support
MSP	Minimum service package
NRC	Norwegian Refugee Council
PHC	Primary Health Care
PIE	Plan International Ethiopia
PTSD	Post-Traumatic Stress Disorder
RADO	Rehabilitation and Development Organization
RRS	Refugee and Returnee Service
UNHCR	United Nations High Commissioner for Refugee
WASSS	WHO-UNHCR assessment schedule of serious symptoms in humanitarian settings
WHO	World Health Organization
WVE	World Vision Ethiopia

Introduction

Assosa is in Benishangul-Gumuz, one of the nine regions of the Federal Democratic Republic of Ethiopia. It is situated in the west of the country bordering Sudan and South Sudan. According to the Assosa UNHCR population data of 1st March 2023, Assosa had received 76,628 persons of concern, 75,567 registered as refugees, 909 as asylum seekers and 152 others of concern. Assosa has three refugee camps which include Bambasi, Tsore and Sherkole. Out of the total population, Bambasi hosts 20,221, Sherkole 12,359 and lastly Tsore hosts 44,048.[1]
UNHCR together with IRC and RRS conducted this MHPSS assessment with the support of other partners in Assosa i.e. Plan International Ethiopia (PIE), HelpAge, RaDO, DICAC, Nkomo Ko. The assessment was conducted to enable a better understanding of existing MHPSS needs at individual, family, and community levels to inform the MHPSS programming and better service deSummary of findings and recommendations.

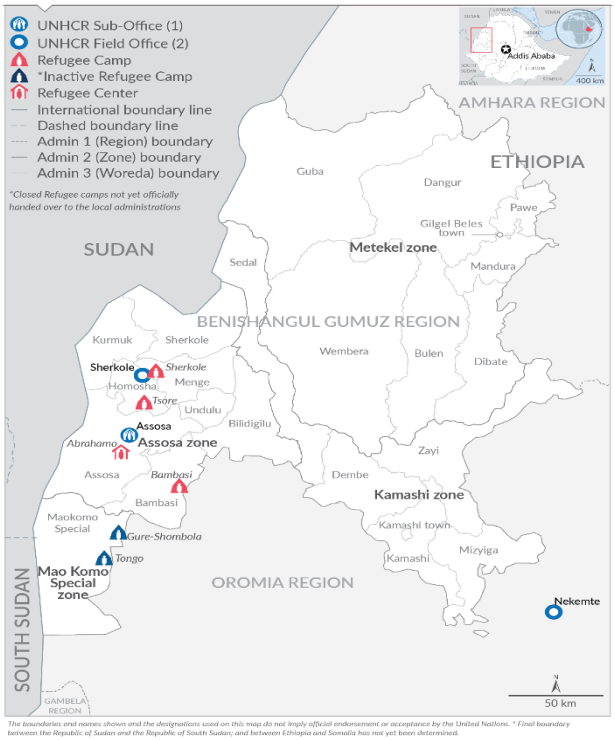

Figure 1: BENISHANGUL GUMUZ REGION

Summary of findings and recommendations

The report has provided direction for UNHCR'S current MHPSS programming in Assosa and for future development of more comprehensive mental health and psychosocial support activities. It has also opened important recommendations for other actors in the camp.

From the findings, almost half of the respondents (47%) shared that they have experienced mental health problems related to forced displaced. According to data collected and interviews conducted with health facility staff, epilepsy, psychosis, depression, and other mental disorders (including anxiety disorder, PTSD, somatoform disorders and substance use disorder) were found to be most common. Sadness, hopelessness, frightening flashbacks, self-talking, guilt, anger, loss of interest, and loneliness are the main ways of expressing mental health problems. This was echoed in the WHO-UNHCR assessment schedule of serious symptoms in humanitarian settings (WASSS) as 12.59% experienced feelings of fear, 2.56% feelings of anger, 1.63% loss of interest, 4.90% hopelessness, and 1.86% severely upset. 2.10% felt unable to carry out essential activities that reminded them of stressful events they went through.

[1] Assosa, Ethiopia Comprehensive Registration, Population Data (March 1, 2023)

Suicidal behaviors were also expressed during the assessment. 22% of the respondents shared having experienced suicidal ideation in the camp. 44% of those who experienced suicidal ideations reported having attempted suicide.59% of those who had attempted suicide, expressed thoughts of suicide and were referred to UNHCR, RRS, and IRC for immediate care and support.

Alcohol and substance use was found to be both a mental health problem and a means of coping especially among those aged between 18-59 years. The respondents shared that 9% use alcohol, 6% smoke cigarettes, and 7% chew khat. Difficulty in quitting was associated with negative bad feeling of withdrawal and unavailability of alternate supportive methods of dealing with recurrent thoughts of stressful situations.

Displacement and long-duration stay in the camp are known risk factors for mental health problems. Other factors shared include wars, conflicts, discrimination, family conflicts and poverty. Limited access to basic services was also a risk factor as 52% shared that the inaccessibility /unavailability of services especially energy, livelihoods and shelter affect the mental well-being of the community to a greater extent.

People with mental health problems receive support from health facilities, family members, religious leaders/churches/mosques humanitarian workers/service providers, community leaders, traditional healers, holy water and from peers. Despite the support available, persons with mental health problems still face stigmatization and social exclusion.

Barriers to accessing MHPSS services include distance (29%), feelings of shame (22%), language barrier (22%), lack of services (19%), and lack of medications (17%). 87% of the respondents reported access to pharmacological intervention as an option while 82% say Access to psychological intervention as an option. A limited supply of drugs at the health facilities was raised and echoed by the community as the main challenge in accessing mental health care. Several other challenges were reported by the health facilities including limited funding to support specialized referrals to Addis Ababa, a limited number of skilled mental health professionals, lack of safe space to manage clients with elevated risk of suicide and severe mental disorders, and stigma towards mental health.

Copying mechanisms to distress were;15% talking to their families, 34% to friends, 17% to humanitarian workers, 17% to traditional healers, 13% use holy water, and 12% pray to cope with stress. 2.53% mentioned that they would chew khat, 7% use alcohol, and 6.03% smoke to deal with stress.

Recommendations.

A. For MHPSS service provider

1.Address socio-cultural and other environmental influences on mental health
2.Build on natural coping systems that currently play a positive role in mental health problems.

3.Set up a community-based rehabilitation initiative in conjunction with the regional health bureau
4.Strengthen Mental health integration in Primary health care and linkage with communities
5.Initiate implementation of IASC Suicide prevention and response guidelines
6. Strengthen MHPSS Coordination
7.Conduct MHPSS MSP Gap analysis

B. For UNHCR and other donors.

1.Reset the definition of mental health
2.Ensure service providers uphold the principles and values for MHPSS programming
3.Advocacy for increased funding for MHPSS activities

Objectives of the study

- Mapping the existing coordination and mainstreaming structures within UNHCR and partners in Assosa.
- Establishing the capacity, quality, and efficiency of UNHCR-supported PHC to identify gaps in the care given to refugees suffering from mental health conditions.
- Develop long-term and sustainable recommendations to comprehensively improve mental health and psychosocial services.
- Establish the common mental health problems in the community to inform on strengthening of community resources in promoting, preventing, and supporting quality MHPSS service delivery.

Methodology.

The assessment applied both quantitative and qualitative survey methods including 23 Focus Group Discussions (FGDs) were conducted, and 509(153M, 356F) Key Informants Interviews. Nonprobability, purposive and convenience sampling techniques were used to identify the key informants to represent the entire population. FGDs were held with the following categories: Women survivors of violence, children, people living with disabilities, caregivers of people with mental health problems, older persons, women representatives, youth committees and camp management.

The following were the ***tools*** used:

1. The MHPSS 4 W s-MSP Mapping tool.
2. Checklist for integrating Mental Health in Primary Health care (PHC) in humanitarian settings was used alongside Site visits, interviews with PHC program managers and staff.
3. WHO-UNHCR Assessment Schedule of Serious Symptoms in Humanitarian Settings (WASSS) (field-test version)[2] as Part of a community household survey will be used representative sample.
4. IASC (2007) Guidelines on Mental Health and Psychosocial support in emergency setting.

[2] World Health Organization & United Nations High Commissioner for Refugees. (2012). *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings.* Geneva: WHO.

Findings.

Local Expressions of Distress and Concepts of Mental Health Conditions

The assessment finding shows (Figure1) that 47% of the respondents shared that they have experienced mental health problems which are described as in most communities as Majunun /Yiong/Amma in the local language. According to the respondents, a person with mental health problems is defined as a person with a brain disorder/ a crazy person/ one who talks to self/ a person possessed with an evil spirit/ running from home/a dangerous person.

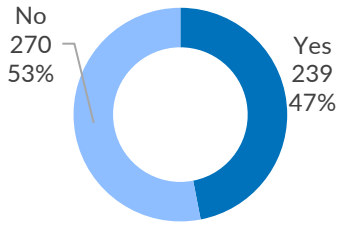

Figure 2: Rate of mental health problems

In the study, epilepsy, psychosis, depression, and other mental disorders (including anxiety disorder, Post Traumatic Stress Disorder (PTSD), Psychosomatic disorders malingering, and substance use disorder) were found to be most common. Sadness, hopelessness, traumatic flashbacks, self-talking, feelings of guilt, anger, loss of interest and loneliness are the main ways of expression of mental health problems which concurs with World Health Organization, 2021[3] on mental health among displaced populations. This was echoed in the findings from the WHO-UNHCR assessment schedule of serious symptoms in humanitarian settings (WASSS) as 3.20% experienced feelings of fear, 2.56% feelings of anger, 1.63% loss of interest, 4.90% hopelessness and 1.86% severely upset. 2.10% felt unable to carry out essential activities that reminded them of stressful events due to the psychological reactions above.

Ecological Influences on Mental Wellbeing

Displacement and long duration stay in the camp are known risk factors for mental health problems. According to the assessment, 62% of the respondents shared that they were displaced once, 21% twice, 8% never, 5% thrice, and 4% more than thrice. Other factors shared include wars, conflicts, discrimination, family conflicts and poverty as shown in figure 2. Limited access to basic services was also a risk factor as 52% shared that the inaccessibility /unavailability of

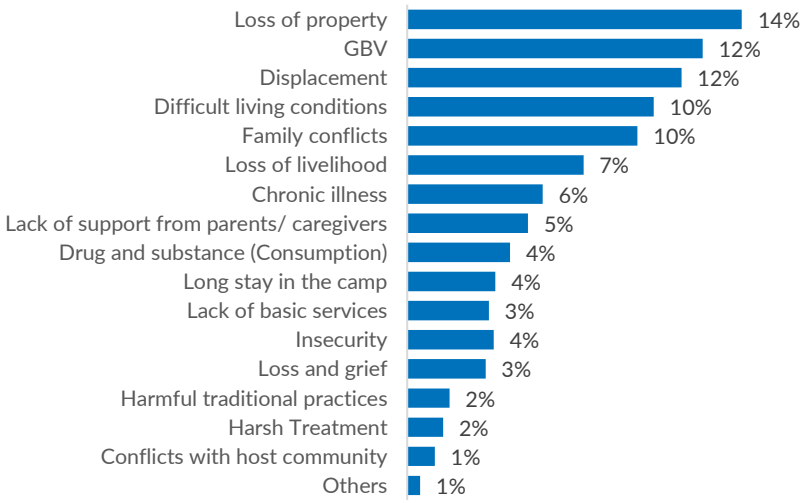

Figure 3: Common causes of mental health problems

[3] WHO. (2021, August 31). *Mental health and forced displacement*.

services especially energy, livelihoods and shelter affect the mental well-being of the community to a greater extent.

Suicidality

Findings show that 22% shared having experienced suicidal ideation with those aged 18-59 years being the most at risk as shown in figure 2. Out of the 22% of those who experienced suicidal ideations, 44% reported having attempted suicide in their lifetime. Evidence shows that the prevalence of suicidal behavior among refugees and asylum seekers lie within the range of 3.4%-34% depending on supporting services[4]. According to the findings, suicidal behavior is associated with various factors with the main ones being family related conflicts, difficult life situation and mental health illness as highlighted in figure 3, agreeing with other studies that suicidal behavior is a complex mental health issue as it not only multifaceted but also inter-sectoral[5].

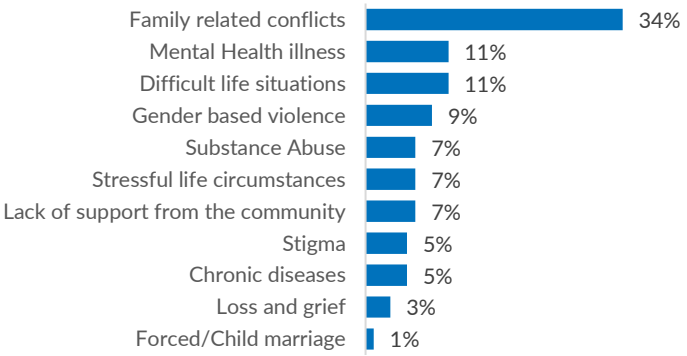

Figure 4: Risk factors for suicidal attempts

During the study, it was revealed that it is culturally not acceptable to share details about a person who died by suicide as this would bring stigma and discrimination to the family. According to Kučukalić & Kučukalić, (2017)[6], suicide is associated with public and self stigma which can cause social isolation, demoralization and feelings of hopelessness that can limit one's functioning. Due to this, the families would therefore rather not report the cause of death.

During the assessment, 59% of the 49 persons who had attempted suicide, expressed thoughts of suicide during the assessment. They were referred to UNHCR, RRS, and IRC for immediate care and support.

MHPSS Layers	Summary	Partner	Focal Person
Layer 1 - Social considerations in basic services and security	Provision of basic services and security in a manner that protects the dignity of all people, including those who are particularly marginalized or isolated and who may face barriers to accessing services and deliver the response in a participatory, rights-based way.	RRS, IRC, RaDO, Plan International, World Vision, NRC	Dr. Nagash Tassew (RRS); Melisew Minalu (Plan International); Wondwosen Tegene (NRC). Tsegaye Aragie (RaDO), Zewdu Tefera Nigatu (IRC). Haile Assefa Belew (WVE)

[4] Vijayakumar, L., & Jotheeswaran, A. T. (2010). Suicide in refugees and asylum seekers. In M. H. Seekers, B. D, C. T, & B. K (Eds.). Oxford: Oxford University Press.
[5] American Psychological Association. (n.d.). *Suicide Is a Complex Problem, But It Can Be Prevented*. Retrieved June 6, 2023, from American Psychological Association: https://www.apa.org/advocacy/suicide-prevention/testimony
[6] Kučukalić , S., & Kučukalić, A. (2017). Stigma and Suicide. Psychiatry Danub, (Suppl 5):895-899.

MHPSS Layers	Summary	Partner	Focal Person
	In Assosa, psychoeducation and community sensitization and dissemination of key messages to promote mental health and psycho wellbeing are the most common.		
Layer 2 - Community and family support	Strengthening community and family support through the promotion of activities that foster social cohesion and the restoration or development of community-based mechanisms to protect and support individuals using participatory approaches. *Supporting community action through facilitating meetings/ spaces, supporting caregivers to promote the mental health and psycho-well-being of children, Provision of MHPSS through safe spaces for women and girls and provision of group activities for children's mental health psycho wellbeing are the most common in Assosa.*	IRC, RaDO, Plan International, World Vision, NRC	Melisew Minalu (Plan International); Wondwosen Tegene (NRC); Tsegaye Aragie (RaDO), Zewdu Tefera Nigatu (IRC). Haile Assefa Belew (WVE)
Layer 3 - Focused non-specialized support	Provision of focused psychosocial support through individual, family, or group interventions to provide emotional and practical support to those who find it difficult to cope within their own support network. Non-specialized workers in health, education, community-based protection, or child protection usually deliver such support, after training and with ongoing supervision. *Identification, referral and follow-up by community workers, provision of mental health care as part of health general services, orientation of frontline workers and community leaders in basic psycho-support*	IRC, RaDO	Mistre Tekleselassie (IRC). Tsegaye Aragie (RaDO),

MHPSS Layers	Summary	Partner	Focal Person
	skills and provision MHPSS through protection case management services are the most common in Assosa.		
Layer 4 - Specialized services	Clinical mental health and psychosocial services for those with severe symptoms or whose intolerable suffering renders them unable to carry out basic daily functions. Such interventions are usually led by mental health professionals but can also be done by trained and supervised general health workers. *Clinical management of mental disorders by specialized health care providers through provision of psychotropic medications* ***however*** *there is still a gap in the provision of psychological interventions including psychotherapy in Assosa.*	RRS, IRC	Dr. Nagash Tassew (RRS). Zewdu Tefera Nigatu (IRC)

Alcohol and substance use

From the study, alcohol and substance use was found to be both a mental health problem and a means of coping especially among those aged between 18-59 years followed by aged 12-17 years as shown in figures 4 and 5.

The respondents shared that 10% use alcohol, 6% smoke cigarettes and 7% chew khat. Of those using alcohol 51 reported to 6% taking it daily, 3% weekly, 0.39% monthly and 0.19 % annually. The respondents shared the difficulty of stopping using alcohol due to being sick, having mental health problems, talking alone, difficulty sleeping and having recurrent thoughts of stressful situations.

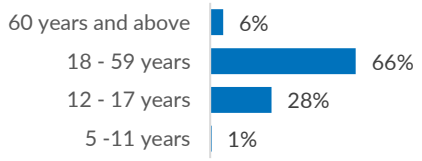

Figure 5: Age vs Use of Khat

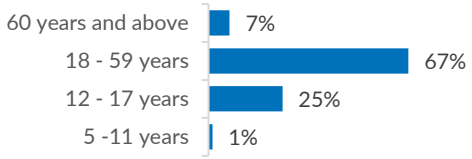

Figure 6: Age vs Alcohol Use

Accessibility and Barriers to mental health care

According to the respondents, people with mental health problems receive support from health facilities, family members, religious leaders/churches/mosques, humanitarian

Table 1: Summary *of MHPSS actors and their intervention levels in Assosa*

workers/service providers, community leaders, traditional healers, holy water and from peers. 86% of the respondents reported the persons with mental health problems receive medications at the health centres and 81% can talk to a psychologist/ counsellor/psychiatric nurse when they go to hospital.

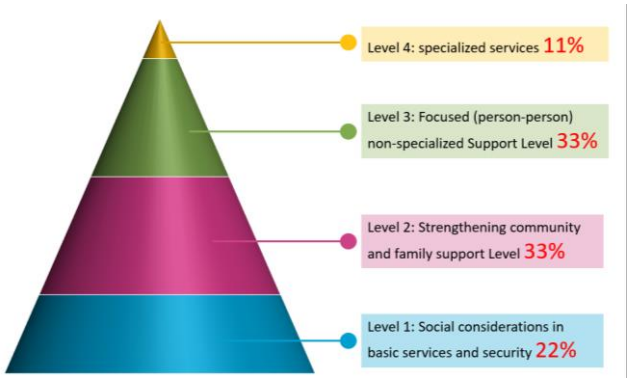

Figure 7: Level of intervention as per MHPSS Intervention Pyramid

Humanitarian emergencies can cause significant psychological distress and can be a contributing factor to developing mental health problems. To meet the diverse needs of the persons affected, the Inter-Agency Standing Committee (IASC) developed a layered model of services that is known as the IASC MHPSS Intervention Pyramid

Figure 7 illustrates the MHPSS intervention pyramid; Level 1 – basic services and security, II) Level 2 – community and family support, III) Level 3 – focused, non-specialized supports, IV) Level 4 – Specialized services. In Assosa, it was found that strengthening community and family level support (level 2), basic services and security focused non-specialised support (level 3) were the most common levels of interventions implemented. However specialised services are still highlighted as major challenge, provision psychotherapy or psychological intervention is still a major challenge. Table 1 highlights a brief of the interventions implemented in Assosa with the respective agencies

Despite the support received, research has shown that persons with mental health problems face several challenges including abuse, discrimination, lack of social support from family/caregiver, neglect and exclusion from decision making.[7] Distance, feelings of shame, language barrier, lack of services and lack of medications were listed as the main existing barriers to accessing MHPSS services as shown in figure 7. Limited supply of drugs at the health facilities was raised and echoed by the community as the main challenge in accessing mental health care. Several other challenges reported were limited funding to support specialized referrals to Addis Ababa, limited

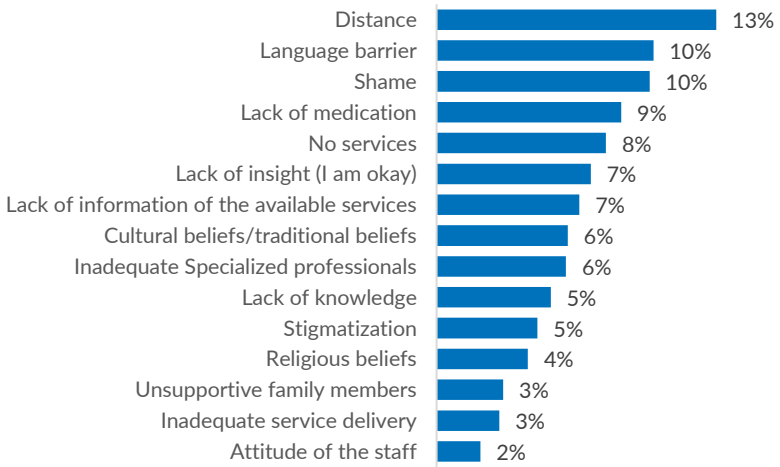

Figure 8: Existing barriers to accessing MHPSS services

[7] Troup, J., Fuhr, D. C., Woodward, A., Sondorp, E., & Roberts, B. (2021). Barriers and facilitators for scaling up mental health and psychosocial support interventions in low- and middle-income countries for populations affected by humanitarian crises: a systematic review. *Int J Ment Health Syst*, 15, 5. doi:10.1186/s13033-020-00431-1

number of skilled mental health professionals, lack of safe space to manage clients with elevated risk of suicide and severe mental disorders and stigma towards mental health.

Copying mechanisms

Despite the numerous challenges faced, displaced persons are known to having coping mechanisms that help them in coping during distressing situations.[8,9] Talking to family members and friends, use of medications, community members, approaching humanitarian workers and traditional doctors and use of holy water were among the common coping mechanisms as shown in figure 8.

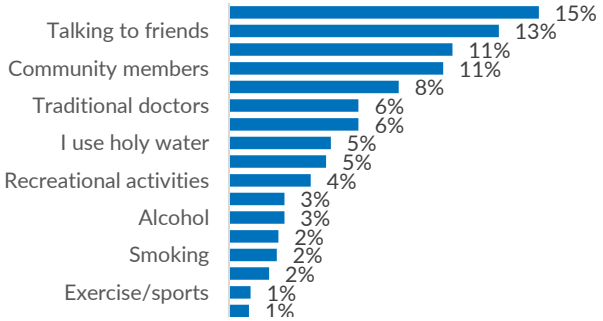

Figure 9:Coping mechanisms

Mental Health Integration

It was revealed that MHPSS is integrated in all sectors however little attention and budgets are allocated to activities that promote MHPSS.

Recommendations.

MHPSS service providers

a. Address socio-cultural and other environmental influences on mental health

- Interventions should thoroughly consider the impact of displacement-related ecological stressors as well history of exposure to war and violence to guide – e.g., intervention for unresolved grief will be different for stress caused by inadequate living conditions.
- Integration of interventions that directly address environmental influences with MHPSS. For example, the inclusion of a livelihood's component into support group processes or facilitation of community-led social support activities.
- Strengthening of non-specialized interventions that foster the natural coping strategies of these communities. Useful models for this include new guidelines from WHO on Interpersonal Psychotherapy (IPT), Self Help + and Group problem management plus.
- Creation of awareness and sensitization on mental health in the community on basic mental health, positive messaging, coping skills and in turn addressing stigma
- Community level dialogues on social cohesion and positive coping skills to promote peaceful coexistence.
- Strengthening communal cultural, spiritual, and religious healing practices as a form of community based MHPSS.

[8] Arenliu, A., Weine, S. M., Bertelsen, N., Saad, R., & Abdulaziz, H. (2020). War and Displacement Stressors and Coping Mechanisms of Syrian Urban Refugee Families Living in Istanbul. *J Fam Psychol*, 34(4): 392–401. doi:10.1037/fam0000603

[9] Theodoratou, M., Valsami, M., Dritsas, J., & Bekos, V. (2015). Refugees' Coping Strategies towards Stressful Life Events. *J Psychol Clin Psychiatry*, 4(4): 00227. doi:10.15406/jpcpy.2015.04.00227

b. Build on natural coping systems that currently play a positive role in mental health problems.

- Agencies should capitalize on the natural resources already available at the community Participatory activities that allow community discussions on the themes of mental health and wellbeing should be prioritized. Core resource persons in the community (family members, community, and religious leaders etc.) should be engaged for prevention and promotion of wellbeing at the community level.
- The youth should be engaged in recreational and income generating activities to reduce their involvement in risky behaviors.
- Provision of education programs to the youth for holistic growth and shaping career paths. This will be impactful in enhancing feelings of hope and motivation for the future.
- Strengthen the provision of scholastic materials, food, uniforms, and dignity kits for efficient school retention of both boys and girls.
- Strong linkages of MHPSS with peace building activities to reduce conflicts in the community. This can be achieved through sessions of anger management, MHPSS trainings, sharing of untold stories and promotion of communal healing with the community-based approaches.
- Setting up clinical settings that will promote safe and confidential support for people who have expressed suicidal behavior and/or people with severe mental health conditions that need admission.

1. Setting up of a rehabilitation center with different motivational and recreational activities for children, adolescents and adults with substance and alcohol use disorder.

c. Mental health integration

- Integration of mental health with other sectors food and nutrition, health, GBV, child protection, education, shelter, and WASH namely with a special focus on advocacy on enhanced access to services.
- Enhanced integration of mental health services in primary health care and community health to enhance access to mental health care,
- Advocacy for consistent access to psychotropic medications in health centers to reduce the relapse rate of mental health disorders and promote psychotherapy services to facilitate the recovery process
- Enhanced training and implementation of mhGAP for health workers in a bid to promote the treatment of severe mental health disorders.

d. Suicide prevention and response

- Initiation of an intersectoral suicide prevention and risk mitigation intervention that will focus on the creation of awareness, gatekeeping training in the community, restriction of access to means of suicide, fostering socio-emotional life skills in adolescents and early identification, assessment, management and follow up of people affected by suicidal behaviors.
- Capacity building of staff to streamline response activities and referral pathway.
- Enhanced surveillance and reporting of suicidal behavior cases.

e. Coordination

- Setting up of the MHPSS Technical working group to streamline the coordination of different activities.
- Strengthen the referral pathway for persons with mental health problems.

For UNHCR and other donors.

- *Reset the definition of mental health*
- Ensure service providers uphold the principles and values for MHPSS programming during the program cycle.
- Advocacy for increased funding for the management of mental health disorders and community based psychosocial activities. Increased resources will result to better understanding of needs and implementation of impactful interventions
- During the Mid -year review critical areas of MHPSS should be considered and allocated for a budget.

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