

# Mental Health and Psychosocial Support in the Uganda Refugee Response

November 2019



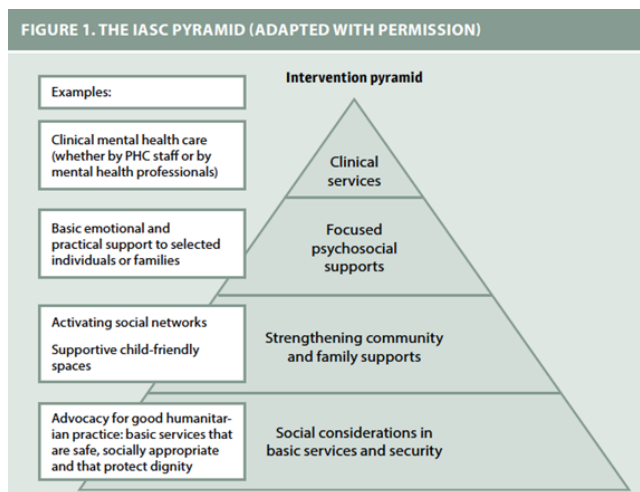
*Thousands flee violence in South Sudan; Uganda, April 2017. UNHCR / Rocco Nuri*

**In times of emergencies and humanitarian interventions, emotional wellbeing and mental health is still too often overlooked.** However, the mental and psychosocial consequences of forced displacement and armed conflict can be manifold, encompassing social problems, emotional distress and common mental health disorders (e.g. anxiety disorders, PTSD, depression), severe mental disorders (e.g. psychosis), alcohol and substance use disorders and intellectual disabilities. A recent WHO study estimates that one in five people in (post)-conflict settings suffer from depression, anxiety disorder, PTSD, bipolar disorder or schizophrenia.<sup>1</sup> The need for mental health and psychosocial support (MHPSS) in the context of forced and protracted displacement is immense and needs to be responded to in a comprehensive and coordinated manner. Mental health and psychosocial problems pose a threat to individuals, families and communities and can result in immediate, mid- and long-term consequences (including significant intergenerational effects).

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<sup>1</sup> 'New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis', The Lancet vol 394, issue 10194, p240-248, 20 July 2019.

## UNHCR approach to MHPSS



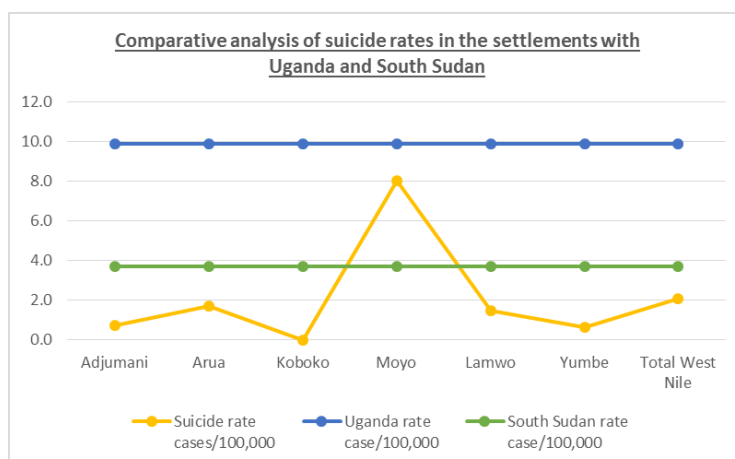
According to inter-agency consensus, UNHCR deploys the term MHPSS to describe “any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders”. The term “psychosocial” underlines that psychological and social processes are always interconnected and continually interact and influence the other. MHPSS activities and services

must be designed in a multi-layered and comprehensive way as shown in the diagram below, and should address groups, communities as well as individuals with more severe concerns. Since MHPSS is a cross-cutting concept, this issue is relevant for programming in various sectors, including health, community-based protection, education, nutrition, livelihoods and shelter.

## Magnitude of MHPSS needs in the Uganda Refugee Response

There are high needs for MHPSS amongst refugee communities in Uganda. During the joint inter-agency Multi Sector Needs Assessment (MSNA), 22 per cent of refugee households reported at least one member was in psychological distress or scared. The MSNA also identified poor psychosocial functioning among children, associated with poor community child protection structures and issues such as mistreatment and neglect of (foster) children, early marriage or teenage pregnancy.

Needs for MHPSS were similarly identified by refugee communities during the 2018 participatory assessment. Participants highlighted an increased rate of suicides and mental health disorders amongst refugee communities, combined with a lack of or limited access to MHPSS services in some refugee-hosting locations.



Generally, suicide rates in refugee settlements are less than those among the host community and within the country of origin (South Sudan) with the exception of Palorinya.

The trends in the number of suicides have however

varied from one settlement to another:<sup>2</sup>

Bidibidi settlement recorded 25 suicide cases (22 attempted and 3 completed suicides) in 2018,<sup>3</sup> whilst 29 cases (27 attempted, 2 complete) have been recorded between January-September 2019.<sup>4</sup> In Palorinya settlement, 42 cases (29 attempted, 13 complete) were recorded between January-September 2019.<sup>5</sup> Imvepi settlement recorded 11 cases in 2018 (6 attempted, 5 completed) and 12 cases between January-September 2019 (10 attempted, 2 completed).<sup>6</sup> Rhino settlement recorded 6 cases in 2018 (4 attempted, 2 completed) and 14 cases between January-September 2019 (12 attempted, 2 completed).<sup>7</sup>

The refugee community reports that incidents of SGBV including domestic violence, trauma experienced during displacement, loss of family, alcohol and drug abuse, inadequate basic needs, lack of access to meaningful education and livelihoods opportunities, lack of hope for the future, distress resulting from changing roles within the community and family, and inadequate family support are some of the factors which contribute to the rate of suicide within their communities.

## Current response to MHPSS needs

Limitations in MHPSS services targeting at-risk refugee communities has been identified as a risk factor contributing to the increasing rate of suicide. UNHCR and partners have taken concerted actions in areas which have seen an increased rate of suicides. These include: strengthening multi-sectoral coordination to address the issue through the establishment of MHPSS working groups; recruitment of community-based Crisis Response Team (CRTs) and Community Based Counsellors to identify signs of suicidal tendency, referring such cases for support and reporting cases of attempted suicides; sensitisation of caseworkers, volunteers and partner staff on signs of suicidal ideations and what should be done in case of suicide attempts; training of community structures on basic psychosocial skills to conduct awareness sessions, case identification in the community, and referral to MHPSS partners; conducting psychoeducation sessions; and supporting diagnosed mental health patients with medication and conducting routine home visits to monitor adherence to medication as well as offering emotional support to patients and caretakers. Social workers and the clinical team further provide psychological first aid to families of the deceased. In some settlements, a group of suicide survivors has been formed, and the members come together to share experience, work with counsellors to address triggers of psychosocial distress and engage in social skills training and

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<sup>2</sup> The statistics provided below on completed suicides have been further triangulated with partners and health authorities and therefore may differ slightly from previously reported statistics.

<sup>3</sup> Of the 22 attempted suicides recorded in 2018, 1 was a child (M), while the remaining incidents involved 21 adults (7M, 14F).

<sup>4</sup> Of the 27 attempted suicides recorded in 2019, 1 was a child (F), and 26 were adults (16M, 10F). The 2 completed suicides both involved adult females.

<sup>5</sup> Of the 29 attempted suicides, 19 involved males and 10 involves females (age disaggregated data is currently unavailable). Of the 13 complete suicides, one case involved a child (F), while the remaining incidents involved 12 adults (5M, 7F).

<sup>6</sup> The two completed cases recorded in 2019 both involved adults (1M, 1F).

<sup>7</sup> The two completed cases recorded in 2019 both involved adults (1M, 1F).

occupational therapies. However, current resources remain inadequate in order to address the vast needs and such efforts need to be significantly scaled up.

Over recent years, MHPSS has received more attention in the Uganda refugee response. UNHCR and multiple national and international NGOs are currently implementing various MHPSS activities from community-based interventions fostering social cohesion, psychosocial support and counselling to psychiatric and psychotherapeutic services by specialists. Uganda's Ministry of Health is strengthening its response and is including mental health into general health care provision, as outlined in Uganda's Health Sector Integrated Refugee Response Plan (HSIRRP) and UNHCR's Uganda Public Health Strategic Plan.

A working group on MHPSS has also been established to improve the quality and coverage of MHPSS services and provide technical support to the network of actors operating in the sector. The MHPSS working group in Kampala has been operational and meeting monthly since May 2019<sup>8</sup>, and similar groups have been or are being established at settlement level. The MHPSS working group maintains close coordination with the Ugandan Ministry of Health and the Mental Health Technical Working Group established by the Ministry, as well as with the other sectoral working groups in the Uganda refugee response, including Health, Education, SGBV, Peaceful coexistence and Protection.

## Current gaps in MHPSS provision in Uganda

With 1.3 million refugees present in Uganda as of the end of October 2019, the need for MHPSS is immense and major gaps and challenges remain. During the MSNA, 40 per cent of households reported that their family member in psychological distress was unable to access psychosocial care.

Limited availability/access to MHPSS services creates risks of individuals with needs for mental health and psychosocial support engaging in negative coping mechanisms such as alcohol and drug abuse, violence including SGBV, suicidal and other self-destructive behaviour, self-neglect, school drop-out, worsening mental health conditions including depression and psychosis amongst others. A lack of access to MHPSS services can also pose risks to peaceful coexistence as incidents of conflict and tensions between communities can increase if mental health issues are not addressed.

The Refugee Response Plan (RRP) 2019-2020 emphasises the reinforcement of MHPSS services and infrastructure as a key priority. However, limited progress has been made against the relevant RRP indicator, '# of individuals receiving psychosocial support', particularly within the South Sudanese refugee community where only 29% of persons identified as being in need of psychosocial support in 2019 have received such support as of September 2019.

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<sup>8</sup> The MHPSS Working Group in Kampala is co-chaired by Tutapona and the Centre for Children in Vulnerable Situations (CCVS).

A key challenge is a shortage of funding. As of October 2019, the RRP was funded at only 39% of the financial requirements for the year. This is generating serious challenges for MHPSS partners to continue existing activities, uphold high quality service provision and offer long-term and sustainable interventions. UNHCR estimates that 200,000 individuals in need of MHPSS interventions will be unable to access the services they need due to current funding constraints. Underfunding is especially affecting MHPSS as a cross-cutting issue as well as closely interconnected areas such as child protection, SGBV prevention and education.

Other gaps that have been identified in the MHPSS response include a need for enhanced coordination between actors, enhancement of clinical/specialised services, further community engagement, integration of MHPSS across sectors, strengthened referral pathways, guidance and minimum standards for MHPSS, prevention activities and also enhanced welfare and staff care for staff working on MHPSS activities.

## Recommendations

**Enhanced funding for MHPSS** is critical to continue and reinforce existing services. Existing resources are inadequate and there is an urgent need to scale up MHPSS interventions in order to meet the needs identified within communities. This is also vital in order to address the increasing cases of suicide which are of extreme concern to UNHCR, partners and the communities themselves. Some key areas which require additional funding include:

### A. Coordination

Strengthen mental health coordination at the Ministry of Health and ensuring coordination with other ministries such as Education, Gender, Labour and Social Development as well as local government. Intersectorial collaboration at national level creates synergies in solving determinants of mental health.

In addition, the draft National Mental Health and Psychosocial Strategic Plan needs to be finalized by the government ministries taking into account mental health and psychosocial support in complex emergencies.

The Mental Health Technical Working Group at the Ministry of Health needs to be strengthened to include other key stakeholders from other government agencies, humanitarian and development partners.

The district local governments especially within the refugee hosting districts need to be engaged so that they prioritize MHPSS interventions within their respective districts with more emphasis on refugees, vulnerable groups in the community as well as victims of trauma.

Due to the significant challenges outlined above, UNHCR believes that there is a need for a dedicated MHPSS specialist / coordinator to provide guidance and advocacy for this important area and further enhance efforts to coordinate, integrate and strengthen MHPSS services, resulting in better services and outcomes for persons of concern.

## **B. Clinical/Specialized Services**

Specialized psychiatric care is mostly available at primary, secondary and tertiary health facilities; however there is a need to strengthen mental health services at all levels of primary health care ie. District hospitals, health centre IVs, health centre IIIs and health centre IIs.

Due to the magnitude of mental health and psychosocial problems among refugees as well as host communities, there is a need to have psychiatric nurses at all health centre IVs and IIIs. The district hospitals in refugee hosting districts would need an operational psychiatric department with qualified staff, admission ward and a clinic to be able to provide appropriate care to patients.

## **C. Focused Psychosocial Support Services**

While lay counsellors exist in some settlements, the numbers and coverage is inadequate to provide the required impact in the settlements. This also includes establishing lay counselling facilities in the settlements. Due to the prevalence of mental health and psychosocial problems, there is need for focused psychosocial interventions to be scaled up such as focused trauma care, group therapy and self help interventions. Given that services by clinical psychologists or psychotherapists are not sufficient to cover the immense needs, scalable interventions that would make brief psychological services available for larger numbers of people are recommended.

## **D. Community and Family Support**

Since the normal social and community support structures that refugees benefited from in their countries of origin have been disrupted, there is a need to forge new social networks and support systems, including though community interventions that encourage socialization and foster social cohesion such as sports and recreational activities, establishing more community centres where community members can engage in joint activities, and scaling up activities for family strengthening.

Wider awareness raising activities in the community and training for leaders, village health teams, lay counsellors and partners are also important in order to ensure early identification and referral of persons suffering from mental health difficulties and to counter myths and stigma in the community regarding suicide / mental health.

Community counselling structures need to be scaled up through building the capacity of village health teams, lay counsellors, opinion leaders, elders and elected community structures such as the Refugee Welfare Councils.

## **E. Basic Services and Security**

Further support for preventative measures are equally important, including ensuring that the community members have meaningful and equal access to quality basic services such as health services, education and livelihoods opportunities and safety and security, and that they can participate in decision that affect their lives and well-being.

There is also a need to ensure adequate information sharing in the community regarding their rights and access to the different services for example changes in food distribution points, health facilities and services for survivors of SGBV, through strengthening diverse communication channels and feedback mechanisms.

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