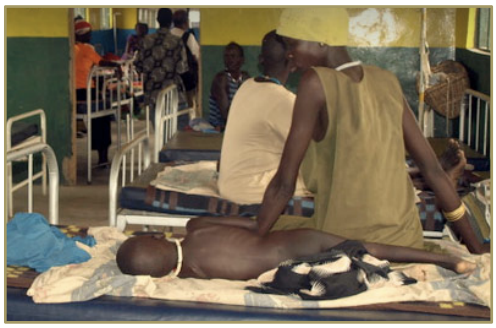
International Medical Corps

UNHCR
United Nations High Commissioner for Refugees
Haut Commissariat des Nations Unies pour les réfugiés

IMC South Sudan

Maban Refugee Camps

Gendrassa, Batil, Doro, Jammam



Rapid Mental Health Situational Analysis:

Mental health priority conditions, community practices and available services and supports

April, 2013

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Acronyms

FGD	Focus Group Discussion
GBV	Gender Based Violence
IASC	Inter-Agency Standing Committee
MHPSS	Mental Health and Psychosocial Support
UNHCR	United Nations High Commissioner for Refugees

Acknowledgements: We want to thank UNHCR for their collaboration and for facilitating and supporting this assessment. We also want to thank expat and national staff at health facilities (Regional hospital, MSF-B, MSF-H, Medair, Goal, Samaritans Purse, IMC) for their time and for sharing valuable information. This rapid assessment would not have been possible without the efforts and support of IMCs South Sudan team. Many thanks for facilitation and technical support to Dr. Blaise Bathondoli, Dr. Naseer Nizamani, and Dr. Aymen Jarboui. We also want to thank all our key informants and Focus Group Participants for sharing their knowledge, insights and experiences with us.

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1. Goals

The overall goal of this situational analysis was to inform planning of the new ECHO funded IMC mental health program and inform potential program expansion in Maban refugee camps. The assessment included the following aspects

1. Community priorities, beliefs and practices and practices regarding mental health
2. Integration of mental health as part of health facilities (PHCU, PHCC, Hospital levels) and current practice
3. Scope and reach of current mental health services provided in the camps

Data was collected on the mental health context (e.g. causes of distress and local concepts of mental health, coping and community sources of support; help-seeking patterns); and on currently existing mental health services as part of health facilities. This assessment focused on identifying needs as well as resources. The situational analysis concludes with recommendations aimed to inform IMC program implementation and shed light on further program needs and opportunities.

2. Methodology

The situational analysis was conducted from April 9th to 14th 2013 in Gendrassa, Batil, Doro and Jammam refugee camps. Data was collected by the IMC Mental Health and Psychosocial Support advisor with support from the IMC South Sudan country team and in collaboration with UNHCR.

2.1. Desk Top Review

A desktop review of current data, policy documents, previous assessments included:

- BPHS mental health activities outlined in the South Sudan MoH Strategy, 2010
- UNHCR Refugees in South Sudan information sharing portal http://data.unhcr.org/SouthSudan/region.php?id=25&country=251
- Murthy (December, 2011). Mental Health Strategy for South Sudan, WHO.
- Peer Reviewed Literature:
    - Kim,G., Tobay, R., Lawry, L(2007) Basic health, women's health, and mental health among internally displaced persons in Nyala Province, South Darfur, Sudan, American Journal of Public Health, 97: 353-361.
    - Bayard Roberts, Eliaba Yona Damundu, Olivia Lomoro, and Egbert Sondorp (2009). Post-conflict mental health needs: a cross-sectional survey of trauma, depression and associated factors in Juba, Southern Sudan, BMC Psychiatry. 2009; 9: 7.

2.2. Interviews, Focus Group Discussions and Site Visits

Refugee community key informant interviews and FGDs:

- 2 sheikhs (one from east and one from west area) and 2 FGDs with general community members in Gendrassa

Administration and Service providers:

- Representatives from the following agencies were interviewed:
    - UNHCR, IMC, MSF-Holland, MSF Belgium, Medair, Goal, Samaritans Purse, DRC
- Types of service providers interviewed:
    - General Health Staff (Doctors, Clinical Officers, Nurses, Midwifes)
    - Mental health staff (3 psychologists)

Site visits and data collection: Data information was collected from PHCUs, PHCCs and hospitals in all four camps as detailed below

Camp	Affiliation	Type
Gendrassa	IMC	PHCC
Gendrassa	IMC	2 PHCUs
Gendrassa	MSF -H	Hospital
Batil	Goal and Medair	2 PHCU
Batil	MSF-H	Hospital
Doro	MSF-B	PHCC
Doro	MSF-B	3 PHCUs
Doro	MSF-B	Hospital
Jammam	MSF-H	PHCC
Jammam	MSF-H	3 PHCUs
Bunj PHC	Relief International	Gov PHC
Bunj Hospital and PHC	Samaritans Purse	Regional Hospital

2.3. Assessment Instruments and Analysis

International Medical Corps used the WHO/UNHCR (2012) "Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings" [1] including an IMC specific comprehensive version of the "Checklist for integrating mental health in primary health care (PHC) in humanitarian settings" as well as the "Participatory assessment: perceptions by general community members". The data were entered and analyzed using Microsoft excel software. All qualitative data from key informant interviews and FGDs was theme coded and grouped for analysis.

3. Background and Context

3.1. Sociopolitical Context

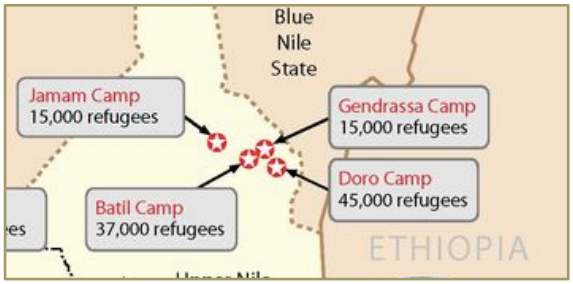
After more than four decades of conflict in South Sudan, the Comprehensive Peace Agreement (CPA) was signed in 2005, giving South Sudan autonomy and its people the right to self-determination through a referendum on independence after six years. The referendum took place in January 2011 and the Republic of South Sudan became a sovereign state on July 9, 2011. However, despite many successes under the CPA, South Sudan remains one of the most underdeveloped areas in the world.

Conflict between the Sudan Armed Forces (SAF) and the forces of the Sudan People's Liberation Movement/Army-North (SPLM-N) in the Kordofan and Blue Nile States of Sudan have forced an estimated 110,000 people to flee into neighboring South Sudan.
Although the priorities on the ground continue to evolve, the refugee population in Maban has stabilized for the time being. Currently there are about 115,000 refugees in Jammam, Gendrassa, Doro and Batil camps. In May of 2013, a new camp is planned in Kaya to host about 25,00 refugees from flood prone Jammam and congested Doro camps.

[1] World Health Organization & United Nations High Commissioner for Refugees. *Assessing Mental Health and Psychosocial Needs and Resources:*

3.2. International Medical Corps in Maban

International Medical Corps (IMC) has been implementing programs in Maban since the start of the crisis in May 2012. IMC is currently providing primary health care services and nutrition programs in Gendrassa camp. UNHCR has chosen IMC to be the primary health care and nutrition provider in the planned Kaya camp. IMC has recently received funding from ECHO to include mental health services in Gendrassa and Kaya. This project will support the integration of mental health care with existing health clinics in the camps by training staff in mental health case identification and management. Comprehensive and holistic mental health services will be integrated with genera health care and supported by IMC mental health staff and refugee incentive workers.



IMC conducted this initial mental health assessment to inform program planning and potential expansion. UNHCR has requested for the assessment to include all four camps as well as the regional Bunj hospital and has asked for IMC to consider providing mental health services in all camps and to be the overall focal point for mental health.

3.3. Mental Health Policies and Strategies in South Sudan

Mental health in South Sudan falls under the Ministry of Health and there are plans to establish a Department of Mental Health as of April 2013. Specialized mental health care is centralized and provided at Juba Teaching Hospital.
No mental health strategy and plan has been published yet for South Sudan. However, a 2011 draft Mental Health Strategy for South Sudan (WHO) outlines six strategic components including: 1. Strengthening leadership and political commitment for mental health, 2. Scaling up integration of mental health in primary health care, 3. Strengthening secondary and tertiary care mental health services, 4. Identifying and prioritizing vulnerable persons, 5. Intersectoral coordination and collaboration to promote mental health and prevent mental disorders and 6. Promoting operational research. Strategic component 2 specifically mentions training of PHC personnel using the WHO mhGAP intervention guide to which IMC has contributed, which outlines psychosocial and pharmacological management of mental health priority conditions.

Mental health activities and levels of care from the catchment villages to PHCUs, PHCCs to the County Hospitals (CH) are also proposed and specified in the South Sudan Basic Package of Health Services (BPHS), as in the table below.

Table 1. BPHS mental health activities outlined in the SS MoH Strategy, 2010

Services and Activities	Village	Boma PHCU	Payam PHC Center	C Hospitals
Mental health education and awareness	✓	✓	✓	✓
Case detection	✓	✓	✓	✓
Anxiety disorders (e.g. post-traumatic stress-; panic disorder)	refer	follow up	✓	✓
Depression: identification and bio-psychosocial management	refer	follow up	✓	✓
Epilepsy: identification and treatment	refer	follow up	✓	✓
Psychotic and psychiatric cases: bio-psychosocial management	refer	follow up	✓	✓
Mental retardation: identification, education to parents	✓	✓	✓	✓
Community based care and rehabilitation incl. support groups	✓	✓	✓	
Inpatient treatment			refer	✓+ refer
Reporting	✓	✓	✓	✓
Monitoring and supervision		✓	✓	✓

However, the BPHS mental health component yet has to be implemented in South Sudan. General health staff has not received training in mental health and psychotropic medication distributed for PHCUs and PHCCs only provide Diazepam injectable (mostly used for convulsions). Psychotropic Medications are not yet on the list of national essential medicines for PHCCs and PHCUs, Although WHO is advocating for this.

4. Assessment Results

4.1. Current problems and stressors among refugees

The difficult living conditions in the camp and past stressful experiences can contribute to psychological distress and mental health problems. IMC key informants and focus groups were asked about current problems affecting people in their community and about vulnerable groups. Results are shown below.

<table>
<tr><th colspan="2">Current problems among people in the community</th></tr>
<tr><td>

Physical health (e.g. Sickness, Diarrhea, Eye problems, dizziness from heat, back pain from grinding)
Available Medical treatment (e.g. People at the health center give tablets without examining what the problem is, at home injections and syrup for children were available but not here (children throw up pills))
Food and Nutrition (e.g. lack of tea, coffee sugar, salt, and milk, green vegetables, only sorghum and lentens available, no balanced diet, supplementary food only available for children under 5, low quality supplementary food)
Food preparation (e.g. Sorghum available but nothing to grind it (only few grinding machines are available), would need seeds for vegetables (before rainy season), no place to dig and plant)
Shelter (e.g. tents are hot and wearing out, grass houses would be better but they have to pay to cut the grass or the host community chases them off the land)
Weather (e.g. heat (different from what they are used to, tents are hot inside), changes in weather)
Insects (e.g. too many flies, not enough mosquito nets)

</td><td>

Education (e.g. Education for children is not up to date, both children and adults need education, not enough teachers, teachers are not qualified enough)
Economic (e.g. no employment available)
WASH (e.g. It takes time to get to water points, water tables are low, not enough soap available (only 2 pieces per person per month))
NFIs (e.g. no flashlights (only torch at night, can be dangerous and burn tent), no clothes (some people have to walk around without clothes), no utensils for cooking, no saucepans and cups for tea, lack of clothes (often people can not go out, they have to wait for someone else to come back to wear their clothes), host community does not allow to collect firewood)

Psychosocial Related Concerns

Child Development (e.g. Delayed development among children, some do not walk as fast)
Community participation (e.g. many refugees are skilled and educated but they are idle)
Problems with the host community (e.g. no good cooperation with the host community, refugees are blamed for robberies by host community)

</td></tr>
<tr><td colspan="2">Vulnerable groups

People with disabilities (e.g. visually impaired, amputated)
People who have been sick for 3 months, have gone to hospital and not getting better
Separated children
People who have no relatives or others to support them
Women who do not have husbands

</td></tr>
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4.2. Prevalence of mental neurological and behavioral problems and psychological distress

No data on mental health problems is currently available in Maban. Data from a previous study conducted by IMC in Darfur showed that major depressive disorders was reported by 31% (Kim et al, 2007) and another study conducted in Juba suggests that over one third (36%) of respondents met symptom criteria for PTSD (Bayard et al, 2009). The World Health Organization (WHO) estimates that rates of common mental disorders such as anxiety disorders and depression double in the context of humanitarian emergencies from a baseline of about 10% to 20% while people with severe mental disorders (2-3%) are especially vulnerable in such contexts and need access to care. This has important public health implications as mental health problems interfere with a person's functioning and daily living which typically impacts the whole family. Estimated numbers of mental health problems based on the lower ranges of WHO estimates are presented below for all camps.

Table 2. Estimated of Prevalence of Mental Disorders in the Camps

	Gendrassa	Batil	Doro	Jemmam	Total
Total Population	*15,839*	*37,896*	*46,024*	*15,729*	***115,488***
WHO Population estimates of common mental disorders (15% estimate)	2,375	5,684	6,903	2,363	**17,323**
WHO Population estimates of severe mental disorders (2% estimate)	316	758	920	314	**1994**
Population estimate of psychotic disorders only (1%)	158	379	460	157	**997**
Actual # of identified psychotic disorders (based on estimated numbers from PHCUs, PHCCs and hospitals)	3	2	24	No Data	**29**

Key informant interviews with service providers who have been engaged in psychosocial support and counseling in the camps suggest that common problems include depression, "thinking a lot", loss of appetite, adjustment disorder, loss and grief, bereavement, somatic complaints, general body pain and trauma/PTSD. Violence and protection issues are also common. Severe mental health and neurological problems reported include psychotic disorders, epilepsy, bipolar disorder, conversion disorders (e.g. Pseudo-seizures, selective mutism, paralysis), It was also noted by non-service provider key informants, that drinking too much alcohol was a problem in Doro leading to violence and injuries and that ration cards were being used to buy alcohol.

4.3. Frequency of mental health problems identified in general health clinics

IMC collected estimated data on the approximate number of mental health cases seen per month at health facilities in each camp. Medically unexplained somatic complaints/depression were most common and providers could not distinguish between both. Other mental disorders were detected only rarely and there was a wide variation across camps (which could be due to different diagnostic skills of healthcare providers) and over time. General health staff at PHCU clinics reported that they do not see people with psychotic disorders at health facilities but that they do see them in the market and around the clinic.

It should be noted that studies from other countries estimate that the prevalence of mental health problems among patients seeking care at health clinics is higher than among the general population (at about 30-40%).

Figure 1. Frequency of priority mental health conditions identified at selected health facilities.

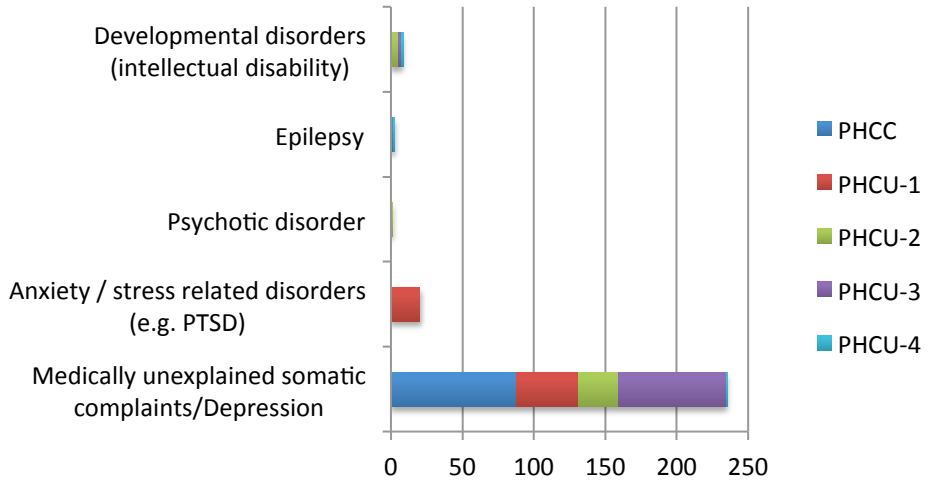
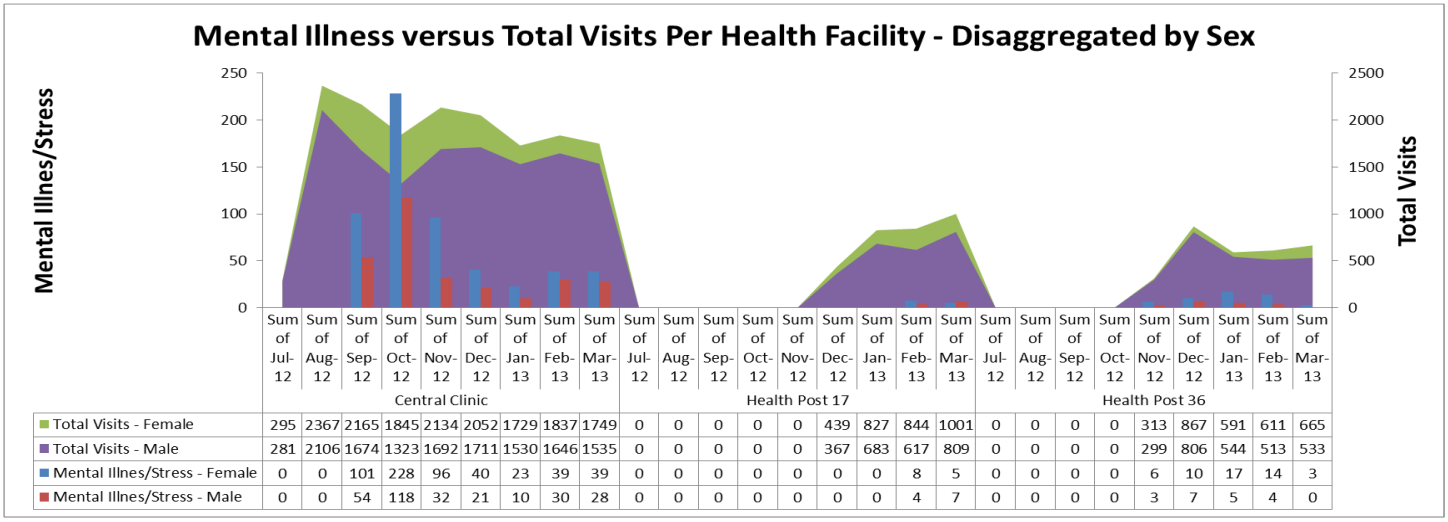


Table 3. Approximate number of cases identified per month at camp health facilities

Type of health facility	PHCC	PHCU-1	PHCU-2	PHCU-3	PHCU-4	Total
Total # of patients seen per month	1,250	1875	1,375	1,750	1,750	8,000
Medically unexplained somatic complaints/Depression	87.5	44	28	75	1	235.5
Anxiety / stress related dx (e.g. PTSD)	0	20	0	0	0	20
Psychotic disorder	0.3	0	0.5	0	0	0.8
Epilepsy	1.6	0.2	0	0.25	0.5	2.55
Developmental disorders (intellectual disability)	0.5	0	5	2	1	8.5
Bipolar disorder	0	0.25	0.25	0	0	0.5
Behavioral disorders (ADHD, conduct)	0	0	0	0	0	0
Dementia	0	0	0	0	0.25	0.25
Alcohol and drug use disorders	0	1	0	0	0	1
Total	89.9	65.45	33.75	77.25	2.75	269.1
Total proportion identified with mental health problems	7%	3.50%	2.40%	4.40%	> 1%	

Figure 2. Frequency of mental illness/stress in IMC PHCU and 2 PHCC clinics (Gendrassa) over the past 9 months



	Central Clinic									Health Post 17									Health Post 36								
	Sum of Jul-12	Sum of Aug-12	Sum of Sep-12	Sum of Oct-12	Sum of Nov-12	Sum of Dec-12	Sum of Jan-13	Sum of Feb-13	Sum of Mar-13	Sum of Jul-12	Sum of Aug-12	Sum of Sep-12	Sum of Oct-12	Sum of Nov-12	Sum of Dec-12	Sum of Jan-13	Sum of Feb-13	Sum of Mar-13	Sum of Jul-12	Sum of Aug-12	Sum of Sep-12	Sum of Oct-12	Sum of Nov-12	Sum of Dec-12	Sum of Jan-13	Sum of Feb-13	Sum of Mar-13
Total Visits - Female	295	2367	2165	1845	2134	2052	1729	1837	1749	0	0	0	0	0	439	827	844	1001	0	0	0	0	313	867	591	611	665
Total Visits - Male	281	2106	1674	1323	1692	1711	1530	1646	1535	0	0	0	0	0	367	683	617	809	0	0	0	0	299	806	544	513	533
Mental Illnes/Stress - Female	0	0	101	228	96	40	23	39	39	0	0	0	0	0	0	0	8	5	0	0	0	0	6	10	17	14	3
Mental Illnes/Stress - Male	0	0	54	118	32	21	10	30	28	0	0	0	0	0	0	0	4	7	0	0	0	0	3	7	5	4	0

4.4. Local concepts of mental illness and expressions of distress

Key informants including health service providers and psychologists as well as the general camp population were asked about local concepts of mental illness including perceived causes, consequences and ways of help seeking.

Psychologist key informants reported that non-specific somatic complaints and somatic problems in reaction to stress are common. One man reportedly saw his house burn and developed weakness in his body. Depression usually occurs with somatic complaints and people tend to speak about stress in physical ways. Indeed, a local counselor may open a consultation by saying “how is the body”.

Community members reported MHPSS related problems such as loss, anxiety and psychotic disorders among the camp population (see summary in table 4 below). They also reported specific cases such as a man becoming very aggressive after not succeeding to get married, a person getting scared suddenly and shouting/running off and one person who does not talk (possibly psychotic disorder and selective mutism respectively).

One local health care provider reported that traditional healers do not differentiate between diseases and treat everything (e.g. by putting herbs on skin). People often only come to the hospital after visiting traditional healers and when their condition has worsened.

Table 4. Summary of mental health problems including perceived symptoms, causes and help-seeking or coping

MHPSS Problem	Signs/Symptoms	Perceived Cause	Ways of help-seeking and coping
Jin (possibly psychosis)	Talking alone, saying something that people do not expect them to say, getting worried and almost mad, going and shouting as if something surprised him, person cannot be understood by people, feeling like they need to get something but cannot, fighting, being in the street, not being able to think properly	Mental or physical sickness	Nothing can be done, some people can recover, some go to the hospital. People from the community talk to the family about the situation. Some people are tied up at home. Sometimes people in the community help them (e.g. give them food)
Thinking a lot (possibly depression)	People think about what they had before and what they worked hard for (e.g. land, business, cattle that died or was left behind), they sit with their head down and are worried, they cannot complete daily tasks	Loss of belongings, bombs falling	There is no help, people do not have a chance to gain anything back.

4.5. Coping and community support

General refugee community members were asked about ways in which people cope and support each other. Results are summarized below.

Support of people in need

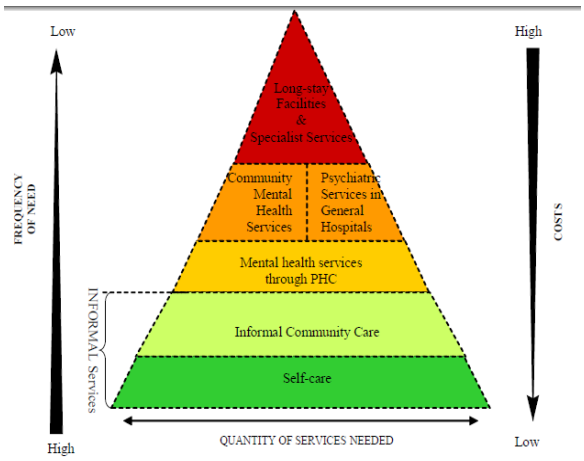
- Coming together to help each other
- If someone does not have something, neighbors will share what they have or take up a collection
- Giving sick people water and porridge
- When someone in the community dies, neighbors cook for their family

Music and art

- Dance, music and drama groups
- People coming together and playing guitar, drums

4.6. Mental Health Services in Maban

4.6.1. Health Facility Availability and Staffing



According to the WHO optimal mix of services, health systems should provide multi-layered services to support the mental health and psychosocial well-being of the community (see pyramid). Significant gaps exist in South Sudan, the whole Maban region and in the refugee camps.

Inpatient Psychiatric Facilities

There is no inpatient psychiatric capacity in the Maban region. The nearest and only referral mental health inpatient facility is at Juba teaching hospital which is about two hours by WFP plane and not accessible to the population in Maban. Juba teaching hospital only has a small psychiatric unit and one psychiatrist who recently arrived and has been trained outside the country. Three psychiatric assistants, six nurses, one clinical psychologist and two counselors are staffing the psychiatric IPD and OPD. Patients who are deemed agitated or aggressive are transferred to the Juba prison where they are kept for up to one month.

Psychiatric Services in General hospitals

The local government referral hospital is Bunj Hospital, which can be reached by the host and the camp population. Bunj Hospital has a maternity ward (deliveries), surgery, diagnostic services, stabilization center (for malnutrition with complications such as TB) and an Inpatient TB ward with separate tent space for males and females (patients stay one month with their families). Patients in the OPD primarily consist of the host population while patients in the IPD are split half and half between the host and refugee population. There is no staff specialized in mental health. Staff report that about 3 patients with severe mental illness (possibly psychotic disorder and bipolar disorder) have been admitted this year and have stayed for a few days but staff has not been able to make a diagnosis or prescribe appropriate medication.

Mental Health Services through General Health Clinics (PHCC and PHCU)

PHCCs and PHCUs in the camp and host community do not include mental health. Mental health services attached to healthcare facilities are provided by MSF Holland (Batil, Jemmam, Gendrassa) and MSF –Belgium (Doro). MSF staffing included psychologists as well as lay counselors and community outreach volunteers (more detail below).

4.6.1. Health Facility Staffing

General health care in all camps is provided through PHCCs and PHCUs. Health facility staffing is shown below.

Table 5. Staffing at surveyed health facilities

Camp	Type	Doctors	Clinical Officers	Nurses	Midwives	CHWs	Psycholo-gist	Psychia trists	Local MH Counselors/ Outreach workers
Gendrassa	PHCC	1	5	3	2	5			
Gendrassa	2 PHCUs	0	3	2	1	60			
Batil	2 PHCUs	0	5	4	1	3			
Batil	PHCC	1	5	4			1		5 community mental health workers
Doro	PHCC	2	6	2			1		5 counselors, 7 outreach workers
Doro	3 PHCUs		6		6	44			
Jammam	PHCC	1	2	3	4	1	1		4 community social workers
Total		**5**	**32**	**18**	**14**	**113**	**3**	**0**	
Bunj PHC	Gov PHC		1	1		6			
Bunj Hospital	Regional Hospital	2		1	3				

Specialized mental health services are provided by MSF Holland and MSF-Belgium. MSF-H currently has one psychologist in Batil (who spends one afternoon per week in Gendrassa), and one psychologist in Jemmam while MSF-B has one psychologist in Doro. MSF programs are supported by national mental health workers engaged in counseling and/or outreach (see table above) who have various backgrounds including teaching and health, and one of them (in Doro) has a BA in psychology. MSF-H used to have psychiatrist previously who also provided care for people with severe and chronic mental disorders requiring psychotropic medication. Currently MSF GPs diagnoses psychiatric cases and have links with a psychiatrist in Amsterdam to consult.

4.6.2. Psychotropic medications

WHO essential medications for managing mental and neurological disorders are listed below, with psychotropic medications recommended for the Interagency Emergency Health Kit (IEHK) underlined. Medicines and medical supplies

in the IEHK are designed to meet the expected primary health care needs of people exposed to major humanitarian emergencies. At the PHCU level, only injectable diazepam for managing convulsions is available while anti-psychotic medication is available at the regional hospital. INGOs, especially MSF-H and MSF-B who have been providing mental health services in the camps, have all medications available.

Table 6. Availability of psychotropic medication

Psychotropic medication on WHO essential drug list (WHO psychotropic medications recommended for Interagency emergency health kit underlined[2])	**PHCU**	**PHCC/INGO Hospital**	**Bunj Hospital**
Generic antidepressant medication (amitriptyline, fluoxetine)	None	Some facilities (MSF-H/B)	None
Generic anti-anxiety medication (diazepam tab and inj)	None	Some facilities (MSF-H/B)	None
Generic anti-psychotic medication (haloperidol tab and inj, chlorpromazine, Thioridazine)	None	Yes	Yes
Generic anti-epileptic medication (phenobarbital, carbamazepine, diazepam inj, valproic acid)	Yes (diazepam inj)	Yes	Yes
Generic bipolar disorder medication (valproic acid, carbamazepine)	None	Some facilities (MSF-H/B)	None
Generic antiparkinsonian medicine for the management of side effects from antipsychotic medication (biperiden)	None	Some facilities (MSF-B)	None

4.6.3. Basic Laboratory Services

Laboratory services to support initiation and monitoring of some psychotropic medications are largely available at the regional hospital (Bunj).

Table 7. Availability of laboratory services to support initiation and monitoring of psychotropic medications

Laboratory Service	**Location**
Complete blood count	Regional hospital and select INGO hospitals
Liver function test	No
Thyroid function test	No
Rapid Blood sugar test	Regional hospital and select INGO hospitals
Toxicology screening test (Urine Analysis)	Regional hospital
Creatine clearance test (BUN)	Regional hospital

4.6.4. Mental health training and capacity

None of the health staff at health facilities has received training and supervision in mental health BPHS priority conditions in line with WHO mhGAP Intervention guidelines and none of the staff had heard of those guidelines before.

Doctors: The majority of doctors are expats who provide services for varying and often limited periods of time. A few of them have received previous training in mental health and have completed clinical placements. None of the doctors interviewed were familiar with the WHO mhGAP.

Clinical Officers nurses and midwifes: Several Clinical Officers in camp clinics and Bunj hospital have completed their studies in neighboring countries such as Uganda, Ethiopia and Kenya. Several of them have received theoretical training on mental health and some have also completed clinical placements of one to three months in psychiatric facilities (e.g. Butabika mental hospital in Uganda, psychiatric unit at Juba teaching hospital).

[2] van Ommeren M, Barbui C, de Jong K, Dua T, Jones L, et al. (2011) If You Could Only Choose Five Psychotropic Medicines: Updating the Interagency Emergency Health Kit. PLoS Med 8(5): e1001030. doi:10.1371/journal.pmed.1001030

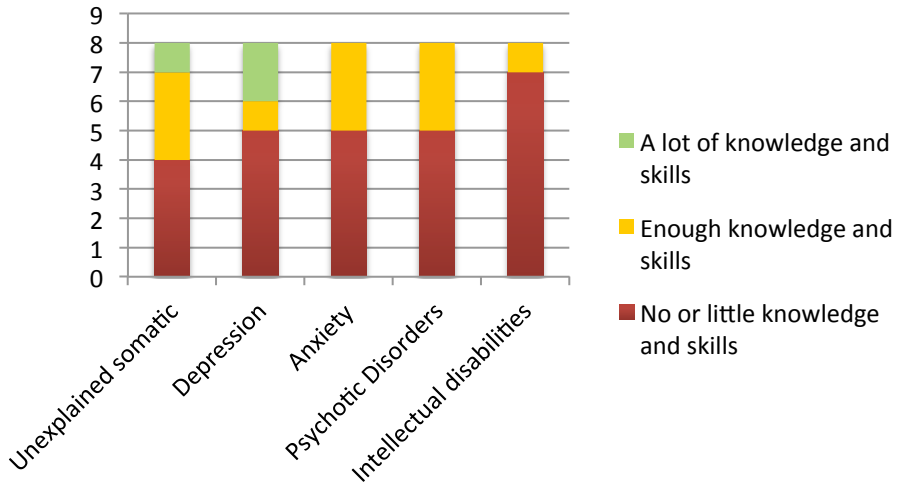
In Service Training

MSF-B in Doro has conducted in-service training for PHCC and PHCU staff in basic mental health case detection and referral (using 5 screening questions) last summer, followed by two afternoon refresher trainings. Additional refresher training is planned as well. However, training has been limited to identification and there has been no training in managing mental health cases for general health staff.

Perceived Competencies

IMC administered a questionnaire on perceived competencies among general health staff in IMC PHCC/PHCUs (5 Clinical officers, two nurses, one midwife, see Figure 3). Except for unexplained somatic complaints, most general health staff felt they had little knowledge or skills in managing people presenting with mental health priority conditions. Perceived knowledge and skills gaps were especially high regarding intellectual disabilities.

Figure 3. Perceived knowledge and skills among general health staff in managing mental health priority conditions



In discussions, general health staff noted that training in mental health would be needed, especially in helping people deal with stress and loss.

4.6.5. Current practice in identification and management of mental and neurological conditions

General health care level

IMC administered a questionnaire on current practices in identifying and addressing priority mental and neurological problems among general health staff in IMC PHCC/PHCU facilities (5 Clinical Officers, two nurses, one midwife. Data show that staff is making efforts to address mental health problems encountered in clinical practice, especially non-specific somatic complaints (see Figures 4 and 5 on next page).

Figure 4. Current self reported identification of mental health and neurological problems among IMC PHCC/PHCU staff

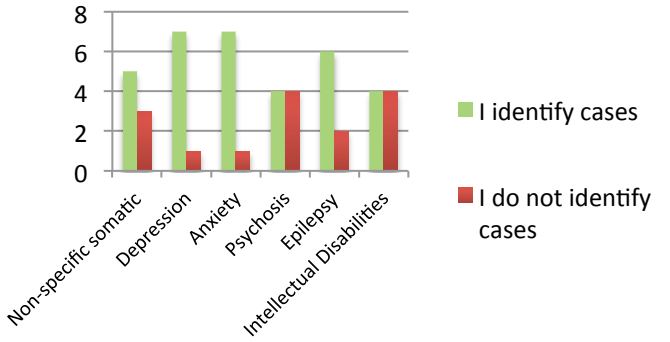
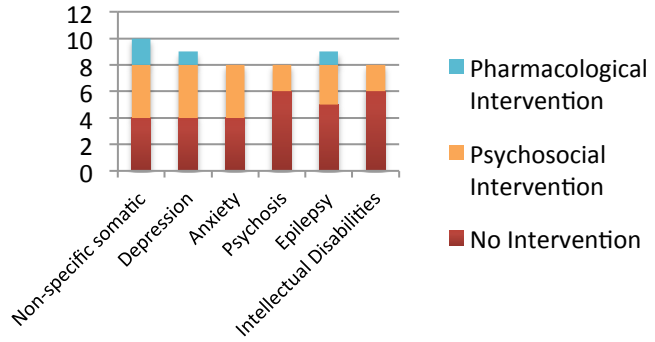


Figure 5. Current intervention practices among IMC PHCC/PHCU staff



Staff at general health facilities in the camps and the referral hospital were asked how they currently identified and managed mental health cases.

Table 8. Current reported ways of managing mental health problems at health facilities among general health care providers (PHCU, PHCC, hospital)

Mental health related problem	**Reported Signs**	**Psychosocial Intervention**	**Pharmacological Intervention**
Unexplained somatic complaints and depression with somatic elements	Somatic complaints such as not being able to sleep, dizziness, headache, general body pain, leg pain, patients say they have fever (but do not), joint pain (many come two days later with another problem)	Giving advice (e.g. explaining that medication is not the solution, that there is no physical problem), talking about stressors (e.g. lost property)	Antihistamine (for sleep/side effect), pain medication (e.g. paracetamol), folic acid (if indicated)
Depression	Insomnia, loss of appetite, signs of stress	General counseling	Drugs with sedatives
Insomnia	Being unable to sleep	Asking about current stressors (e.g. problems with husband), providing re-assurance, advising to "take it easy"	None
Psychotic disorders	Talking alone, shouting, running off	PHCC/PHCU: Talking to them, giving needed items such as mosquito net, piece of clothing (and refer)	Regional hospital: inpatient admission, giving drugs to calm down
Epilepsy	Convulsions	None	Pharmacological treatment with anti-epileptics (hospital level)
Developmental disorders	Slow development	Giving nutrition advice	N/A

General health staff are already identifying and managing some mental health cases. Pharmacological management for mental health problems was often not consistent with global guidelines. Some psychosocial management such as addressing current psychosocial stressors is consistent with mhGAP. However, staff could benefit from learning about the range of psychosocial (and pharmacological if appropriate) brief interventions in the mhGAP guide (especially for non-specific somatic complaints, depression and intellectual disabilities).

General health staff with previous mental health training reported using their skills when counseling patients but also noted that patients with mental disorders are often not identified or not accessing health facilities. They noted that community awareness raising and a referral system would be needed.

Specialized mental health care

Expat psychologists working for MSF-H (Jammam and Batil) are providing direct mental health services though translators with support from local MH workers while MSF-B (Doro) has local counselors provide most mental health care with support and supervision from the MSF psychologist. Currently used **interventions** for common mental health related problems and psychological distress include supportive listening, addressing immediate practical issues and current stressors, basic problem solving, identifying resources and psycho-education on the impact of trauma, narrative approaches and grief counseling. Interventions used for non-specific somatic complaints (e.g. dizzyness, headache, burning in feet and legs, medication-seeking) include psycho-education on links between body and mind, which is reported to be often of limited effectiveness. MSF-B is reporting positive effects and local acceptance of relaxation exercises. Trauma focused interventions were reported to not be suitable for most refugees, many of which "do not want to talk about the past" and do not come for repeated session over longer time periods. Psychologists reported that most people with mental health problems only come once or twice to access services. Follow-up of patients with psychotropic medications has been reported to be challenging with the whereabouts of various patients unknown.

Activities of national mental health staff

Activities of local MSF **mental health outreach workers** include disseminating messages about mental health, following up with patients, and linking with community leaders. MSF-B (Doro) community outreach workers also provide basic community sessions with children, engage children in drawing (e.g. draw something you are scared of, draw a safe place and subsequent discussion about protecting self). MSF-H (Jemman) outreach workers run two groups in the clinic, one children's group and one women's group. They also use a drum band, dancing and singing to spread messages about mental health.

Activities of **national staff counselors** include running various supportive groups (e.g. groups for caretakers, inpatients, mothers at the ITFC, training about attachment for mothers of malnourished children), group counseling sessions, psycho-education in patient waiting areas (e.g. mothers and babies at ITFC) and activities (e.g. activities for older siblings in ITFC). It was also reported that a GBV supportive group was tried but discontinued. MSF-B (Doro) local counselors provide individual sessions, use basic assessment screening of symptom clusters and traumatic experiences, record patient complaints in their own words, and explore resources and supports and goals.

Training for MSF-B and MSF-H national staff has included community awareness, communication skills, psych-education, consequences of trauma, Psychological First Aid (PFA), psychosocial support, support groups and relaxation exercises

4.6.6. Mental Health as part of the Health Information System (HIS)

HIS reporting to UNHCR occurs at all camp health facilities. UNHCR has one category for mental health and neurological conditions, which is broken down into seven sub-categories and which are used globally by UNHCR and other agencies. Some health facilities including IMC are currently reporting under one category of "mental illness or distress" while most other facilities also have this category but do not report on it. MSF specialized mental health services have their own 5 categories, which are based on mental health symptoms (rather than UNHCR diagnostic categories).

4.7. Current Mental Health Referral Pathways

Referral from general health care to mental health services

General health clinics within the camp report referring people with severe mental health problems to MSF. Referral sources for specialized mental health care (MSF-B and H) also include different health facility departments (OPD, ITFC, ANC). Some psychologists report that health staff often refer anyone with pain, even if they do not have mental health or stress related problems.

Referral from general health care to other services

Referrals are made by general health care providers for GBV (IRC-Jemmam, DRC in Batil), general protection (DRC), child protection (safe in Doro) and UNHCR. Only very few health care providers reported having referral links with other agencies. Children with intellectual disabilities and people in need of physical rehabilitation are at times referred to Handicap International (Doro, Genrdassa and Batil). One provider also reported referring to ARC (Jammam) for psychosocial support.

Referral links with community leaders and healers

Several health facilities reported linking to Sheiks. MSF-B Doro reported that their CHWs are working with sheikhs when screening new arrivals for different health problems including mental health. A few local health care providers who have lived and worked in this area for some time reported having connections to traditional healers. One meeting to address hepatitis E had been held with one traditional healer and several INGOs in the past.

4.8. Anticipated challenges in mental health PHC integration

General health care staff at health facilities was asked about anticipated needs and challenges for mental health PHC integration. Results are summarized below.

Psychotropic Medication:
- Availability of psychotropic medication
- Availability of better drugs (that are not part of WHO essential drug list)

Laboratory services
- Availability of lab services (check for complications, right dose)

Case Finding:
- Currently no good case finding (e.g. would expect more cases of PTSD and psychotic disorders)
- No instruments to do assessments

Overall system/law
- Need to find out how to work within law of South Sudan (e.g. involuntary admission, protection), no structures in place

Staffing/time
- Staffing might not be enough for the amount of people in the camp
- Mental patients difficult to manage

Community beliefs and practices
- People go to traditional healer instead
- Community believes in injectable drugs (and syrups for children), not in tablets
- It will take time to change attitudes
- Expectations need to be managed (might be high)

Staff well being
- Staff well being /MHPSS services for staff are needed

Follow up at community level
- Needed to make sure no danger
- Needed to make sure that family and community accepts them
- Stigma attached to mental illness, need to ensure community acceptance
- MH patients need social structure (medication alone is not enough)
- Needed to ensure drug compliance
- Need to make sure person comes back
- Need transportation to do outreach

Comprehensive services
- Need to train all staff including nurses and CHWs
- Training of individuals whose contracts are short

Inpatient services
- Patients may need inpatient admission
- Admitted patients are unstable and can run away

Referral
- Referral forms are needed for partners
- Need to establish referral mechanism with community
- Need to identify people within community
- There could be referral links to schools and teachers could be trained to identify and refer

5. Summary and Recommendations

In sum, this situational analysis provided important guidance for project implementation and expansion including local concepts of mental illness, coping and help seeking behaviors and available mental health services. Even though MSF has been covering MH services in Batil, Doro, Gendrassa (partially), significant service gaps and opportunities remain.

There is no psychiatric capacity to address severe mental disorders and manage medication. Communities are not accessing health facilities for mental health- based on HIS numbers, it is estimated that only under 5% of people with psychotic disorders have access to treatment (which is often no appropriate given lack of staff training) and that over two thirds of people who come with mental health problems to general health clinics are not identified.

IMC plans to complement existing activities and services by working in Gendrassa and Kaya to:

- Provide comprehensive mental health services which include strong community links as well as clinical psychiatric care
- Train selected national health staff in identification and management of priority mental health conditions in line with South Sudan BPHS guidelines
- Train selected refugee volunteers in community outreach and basic mental health support

Activities including psychiatric care and training of general health staff could also be scaled up to other camps if funding and resources can be secured. Detailed recommendations are outlined below.

5.1. Mental Health Training

→ **Provide basic training in identification of priority mental health conditions to all health facility service providers (PHCUs, PHCCs)**

Staff at health facilities is currently identifying up to 7% of patients with stress or mental health related somatic complaints and only a very small number of people with other mental health and neurological problems. Staff (doctors, clinical officers, nurses, midwifes) could benefit from learning a few basic screening questions for mental health related problems. This would also facilitate better-targeted referrals for mental health problems and more accurate reporting for UNHCR HIS mental health categories. IMC could coordinate with MSF-Belgium, who have already conducted similar basic training on this in Doro with the addition of UNHCR specific categories and case definitions.

→ **Provide basic training and supervision in the management of mental health priority conditions to select health facility staff**

Several national staff at health facilities already has some mental health training and is identifying and managing some metal health problems. Especially national staff such as Clinical Officers could benefit from capacity building in mental health. MSF has not and is not planning to build the capacity of national health providers in management of mental health problems. IMC should select staff such as Clinical Officers and provide basic training and supervision in management (psychosocial and pharmacological) of BPHS priority conditions in line with the WHO mhGAP Intervention Guide. A psychiatrist trainer would be needed for a minimum of 6 months (depending on number of trainees) to conduct this training. IMC should focus on health facility staff in IMC clinics first and could consider expansion to other health facility staff as a second step if resources are available. IMC should also consider including health facility staff from the regional hospital (Bunj) in the training.

→ **Include the additional WHO mhGAP condition of "Medically unexplained complaints" in the curriculum**

The current BPHS for South Sudan includes depression, anxiety, epilepsy, psychosis, and developmental disorders. However, the current situational analysis found that somatic complaints related to psychological distress and mental health problems are common and make up the majority of cases identified at the health facility level. IMC should therefore add the management (non-pharmacological) of medically unexplained complaints to the curriculum according to mhGAP. IMC should also coordinate and communicate with other national and global stakeholders and national authorities in developing the curriculum and share experiences and results.

→ **Provide basic training in identification, psychosocial interventions and basic IMC mental health case management to local community mental health workers**

Local community mental health workers (from refugee and host communities) have the capacity to play an important role in community outreach, following up with patients (e.g. ensuring medication compliance), psycho-education and mental health promotion and messaging. They can also assist in providing several of the recommended psychosocial interventions in the WHO mhGAP and can engage in basic mental health case management functions such as helping

link people to service providers and community supports. IMC could draw on IMCs current successful experiences in engaging CHWs and exchange experiences with MSF, especially in Doro. In the longer term, community lay workers could also be trained in evidence-based interventions such as CBT and IPT to treat mental disorders. Studies have found that lay CHWs can successfully apply such interventions in low resource settings (and MSF has not provided such training). A psychologist or clinical social worker with relevant training would be most suitable to build capacity of community workers.

5.2. Mental Health Service Provision

→ **Provide clinical and community mental health services for people with severe mental disorders**

Since a psychiatrist is no longer available at MSF, expat GPs have taken up pharmacological management of mental disorders. It would be valuable if IMC would fill this gap and provide psychiatric expertise and services for people suffering from severe disorders while at the same time training general clinic staff and community workers. Interventions should also address access to other services and supports (e.g. medical, protection), promote social inclusion and facilitate patients taking on daily tasks and family roles as they recover. Patients with acute mental health symptoms (e.g. acute psychosis) should be managed within their family environment and visited by a health service provider on a daily basis for at least the first 1-2 weeks as appropriate. Short-term hospitalization (at Bunj or a camp hospital) is a secondary but less desirable option. IMC could consider building the capacity of Bunj hospital to provide appropriate management for such cases in the longer term. Aggressive or agitated patients should not be referred or transferred to Juba teaching hospital as long as no appropriate care is available and patients are imprisoned.

→ **Ensure inclusion of psychotropic medication in mental health programming**

IMC will need to procure psychotropic medications when starting mental health services in the camps as needed medications are currently only available from MSF. IMC is already in the process of submitting a list to UNHCR. It would also be useful to advocate and support the inclusion of select psychotropic medications at the regional hospital (Bunj) if staff training is provided.

→ **Consider providing basic IMC mental health case management services**

Psychologists reported that persons with mental health problems also present with various basic needs and concerns, which is also reflected in results of key informant and FGDs. While MSF engages in basic problem solving, IMCs mental health case management model is more comprehensive and may add value. IMCs model works with clients to develop a care plan which takes multiple and complex needs into account and helps clients and families take small steps to achieve realistic goals. This approach is also strength based and helps affected persons identify and make use of their resources and supports- at the individual, family and community levels. Refugee workers also play and important role in engaging those individuals (e.g. in structured activities) and in following up to provide support.

5.3. Referral

→ **Build cross referral networks with various other formal and informal service providers**

Referral networks for people with mental illness should be broadened from general health facilities an some community leaders to also include a higher number of implementing agencies and facilities and community providers. Community leaders also play important roles in the camps. The community structure among refugees is structured around sheiks who are village leaders and typically responsible for about 500 to 700 people. They can play an especially important role in identifying people with severe mental disorders in their communities. Other agencies and implementing partners in the camps provide important services, which are also relevant for people with mental disorders and their families (e.g. protection, shelter, rehabilitation, etc.) and links to such services such be strengthened. In some cases, IMC mental health staff should advocate for access to specific services and supports for clients with mental health problems, which constitute a vulnerable population. It would be advisable to create a network of referral links, which makes use of both formal and informal services and supports. IMC could consider strengthening mental health case coordination by supporting the development and use of common referral forms and the mapping of MHPSS and protection services and support using a version of the WHO MHPSS 4Ws mapping tool.

→ **Improve case identification and access for people with severe mental disorders such as psychosis and neurological disorders (epilepsy)**

Identified cases of severe mental disorders and epilepsy are extremely low across all health facilities, suggesting that approximately over 90% of people with such disorders are not accessing care. Persons with severe or chronic mental illness and their families may seek out traditional healers instead and may also not expect health facilities to be helpful based on past experiences or word of mouth. Potentially effective strategies include engaging community leaders such as sheiks, and building links with traditional healers. This should be done in a sensitive and respectful way as to not encourage harmful practices (e.g. burning) but allowing for clients and their families to choose what is most helpful to them (e.g. rituals) in addition to clinical mental health care. IMC should also work through CHWs and mental health community outreach workers on awareness raising. In the longer term, it can also be valuable to engage people who are recovering from severe mental illness and their families, who can be powerful advocates in showing that those with severe mental illness can improve and take on family and community roles with appropriate care.

5.4. Mental Health Promotion

→ **Engage people in the camp (especially those experiencing psychological distress and mental health problems) in meaningful structured psychosocial activities**

Community discussions showed that loss of resources and belongings are a significant stressor for many refugees, which can increase the risk for common mental disorders such as depression (possibly referring to the local concept of "thinking too much"). Research suggests that it is important to create opportunities for resource gain and social support in such contexts. Global IASC guidelines also emphasize the importance of community control and participation. IMC should consider structured social, educational and recreational activities for youth and adults in the camp (noting that CFSs are already provided by Safe the Children). These activities should be chosen by the affected population and could also include vocational or livelihood components in consultation with IMCs food security/livelihoods advisor. Other IMC psychosocial programs for refugees have included activities led by refugee instructors such as cooking together, weaving baskets and mats, sharing daycare responsibilities, sports activities, music and dance. Those activities should include and prioritize people experiencing mental health problems and psychological distress. More information would be needed on what other actors in the camps are doing in this area but IMC could consider such programs for potential future projects.

→ **Engage refugees and people from the host community in joint purposeful activities**

Tensions with the host community contribute to limited access to resources (e.g. grass, firewood) and psychological distress. Research suggests that resource conflicts and tensions can be addressed by having people from different groups work on common goals that can benefit all (e.g. building something that benefits both communities). Other IMC psychosocial programs have engaged refugee and host population youth for example in working together on joint community projects and learning about life skills. Such activities could be considered for future projects as well, in coordination with other actors in this area (e.g. ARC, InterSOS).