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Final report

Assessment of options for humanitarian child protection actors to assist children and adolescents who need specialized mental health services

April 2023

100408703-024 | UNICEF LTA Education FWC - P24 - R060 MHPSS

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Assessment of options for humanitarian child protection actors to assist children and adolescents who need specialized mental health services

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Data in this report includes data collected from selected contexts as part of the study and citations from secondary sources and as such may not be triangulated or verified.

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Issue and Revision Record

Revision	Date	Originator	Checker	Approver	Description
Final Report	March 2023	Lucy Palmer	Terri Collins	Khadijah Fancy	Final synthesis of earlier submissions

Document reference: 100408703-024 | UNICEF LTA Education FWC - P24 - R060 MHPSS

Information class: **Standard**

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Acknowledgements

The authors thank:

- the Global Child Protection Area of Responsibility for their valuable guidance during this assessment
- the various UNICEF field offices for their logistical support
- Education Cannot Wait for funding this important work.

We would like to thank the individual country researchers noted below for your excellent efforts in getting the fieldwork completed and the country reports drafted:

- Jinat Jahan in Bangladesh
- Juliette Ortiz in Colombia
- Luyeye Macky in Democratic Republic of Congo
- Sara Kamal in Kurdistan
- Elijah Khot in South Sudan

Above all, we would like to thank all the key informants we had the privilege to interview. This included the global stakeholders we interviewed as well as all the country and field level representatives who were interviewed by the country researchers. We are, indeed, grateful for the information, insights, and wisdom shared.

Introduction

According to the newly published World Mental Health report, on average 1 in 5 people in conflict-affected settings have a mental disorder. However, many health systems in fragile countries do not prioritize mental health care and it remains a neglected area. Around half the world's population lives in countries where there is just one psychiatrist to serve 200,000 or more people.[1]

Assessments typically identify clear gaps in the availability of mental health services beyond informal mechanisms of support, including a nearly complete lack of formal mental health services for people with serious mental health conditions. Whether pre-existing or emergency-induced, children with Mental, Neurological, and Substance Use (MNS) disorders and disabilities are often excluded, stigmatized, isolated, abused or neglected.[2]

The Global Child Protection Area of Responsibility (CP AoR), in collaboration with the IASC MHPSS Reference Group, contracted Mott MacDonald to assess options for humanitarian child protection actors to assist children and adolescents needing specialist ('Layer 4') mental health services. The assessment included case study explorations in five countries to inform learning and recommendations for child protection actors seeking to improve comprehensive MHPSS care for children and their families as part of humanitarian responses.

The five humanitarian settings for our case studies were:

- Bangladesh (Cox's Bazar)
- Colombia (Cazucá, between Bogotá and Soacha)
- DRC (Maluku within Tshangu district of Kinshasa)
- Iraq (Baharka Camp in Kurdistan)
- South Sudan (Malualagorbaar, near Bor Town in Jonglei State)

These site settings were all unique. While we have drawn out common emerging themes and findings, we acknowledge that some findings are site specific and may not be comparable even with alternative settings in the same country. Nevertheless, we have aimed to select a typical range of humanitarian settings from which valuable lessons can be learned.

As part of our data gathering, we also consulted a small number of global key informants and looked at key global documents to help us frame the country fieldwork.

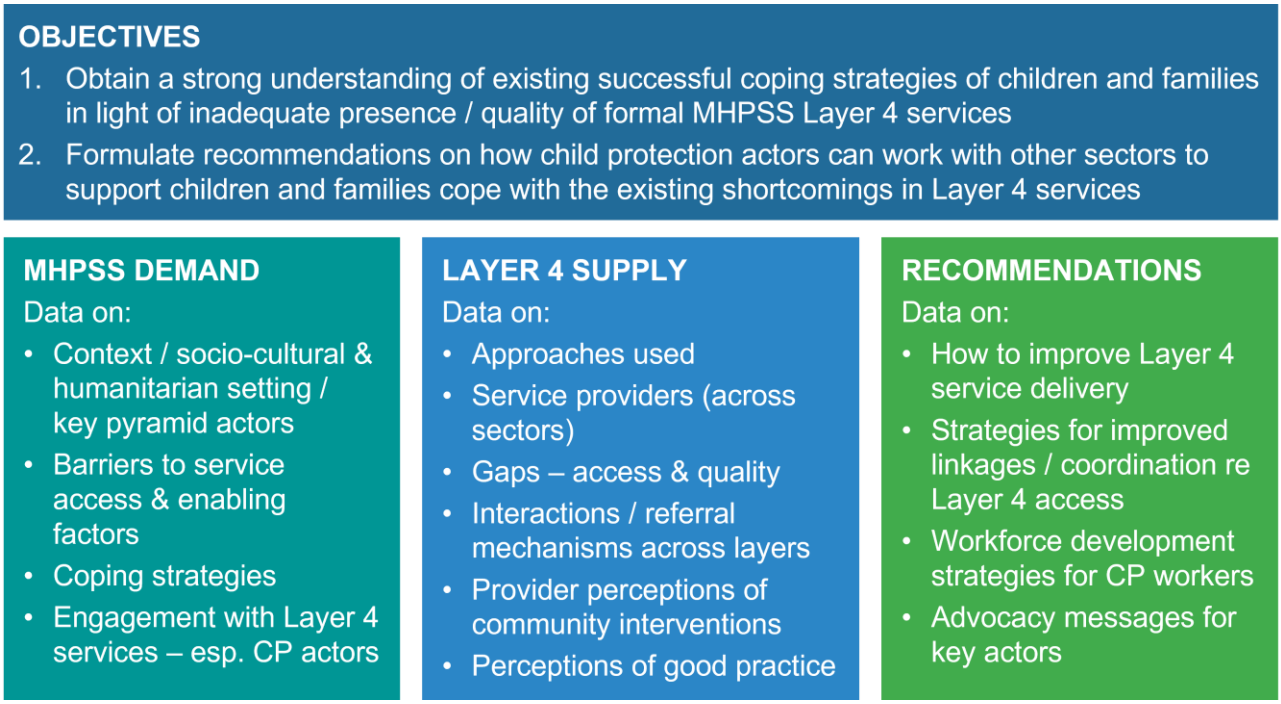
1 World mental health report: transforming mental health for all. Geneva: World Health Organization; 2022. Licence: CC BY-NC-SA 3.0 IGO

2 Community-based Mental Health and Psychosocial Support in Humanitarian Settings - Three-tiered support for children and families. Operational Guidance. UNICEF.

1. Methodology

For the purposes of designing our assessment framework, we categorized data around three broad thematic areas, namely: i) MHPSS needs; ii) Layer 4 (L4) interventions; and iii) recommendations.

Figure 1.1: Overview of key thematic areas for data collection



We used a multi-stage purposeful sampling to select countries, humanitarian sites, and stakeholders for interview, considering that inclusion/exclusion criteria needed to include practical considerations, such as time/resource constraints, safety concerns, feasibility, and efficiency.

The study design was customized to the requirements and approach described in the assignment's terms of reference (TOR) using a standardized qualitative methodology across the five countries. The study design was tailored to the time and resources available, including the fact that, for each selected country, data collection would be completed by a single experienced local consultant over a period of 16 days.

The country assessments studies were based on a non-experimental, descriptive study design, and a mixed, qualitative methodology. Following comprehensive country literature reviews, primary data collection referenced the IASC MHPSS pyramid to investigate access to and use of specialist Layer 4 mental health services by children and their families in the selected humanitarian settings.

Specific data collection methods included:

- A country literature review – focusing on a context analysis as well as an ethnographic literature review of conceptualization of MHPSS and coping mechanisms
- Rapid mapping of humanitarian sites including stakeholder mapping
- Key informant/stakeholder interviews – in person/online semi-structured interviews at national, sub-national and site levels
- Stakeholder meetings/focus group discussions (FGDs)
- Ongoing direct observation of the humanitarian setting to identify contextual factors influencing access to MHPSS services for children and their families

A Country Research Toolkit was developed with tools for each method.

Data in this report includes data collected from selected contexts as part of the study and citations from secondary sources and as such may not be triangulated or verified.

2. Conceptualization of Layer 4

The IASC pyramid categorizes MHPSS responses across four layers, from interventions for the general population to protect and maintain psycho-social wellbeing (Layers 1-3), up to specialist clinical services for those with severe MHPSS needs. Our high-level key informant interviews (Annex A) suggested there are mixed views on the usefulness of the IASC pyramid – while it is popular in some circles, there is potential for confusion about which services to include in each layer, and the relevance of the hierarchical pyramid for some insecure and resource-constrained humanitarian settings – especially for children and adolescents, and their families.

In recent years, there has been an emerging consensus that, for children and adolescents, Layer 4 services should not be limited to specialist clinical MHPSS providers (psychiatrists and clinical psychologists) but be extended to include child protection actors as part of a comprehensive approach to clinical service provision. Education services are usually assigned to L2; however, there is recognition that teachers have a key role to play across all layers, especially in identifying young people with significant mental health problems, referring them to relevant services, and in providing follow-up support. Similarly, some services/responses are relevant to all layers e.g., emotionally safe spaces; yet there can be an unhelpful tendency for organizations to work rigidly within specific layers or 'siloes,' rather than responding flexibly to the dynamic needs of young people and their families. For children and adolescents especially, it is often necessary to mobilize assistance across layers, with different combinations of support needed at different developmental stages or stages of illness.

It has been observed, then, that the IASC's pyramid has limitations as a conceptual framework for meeting the MHPSS needs of children and adolescents in emergency settings. For adolescents, referral options might at best lead to referral and treatment with psychotropic medication only which can interfere with socio-emotional aspects of development. SSRI (anti-depressants), for example, are known to decrease libido and sexual dysfunction. For children aged 5-10 years, there is no reference to distinct clinical packages at all. However, the need to increase the pool of professionals who can provide specialist care to children and adolescents is acknowledged. UNICEF is now working with WHO on a new primary health care package for children (which could be termed mhGAP ++) and which will include a psychological intervention for children.

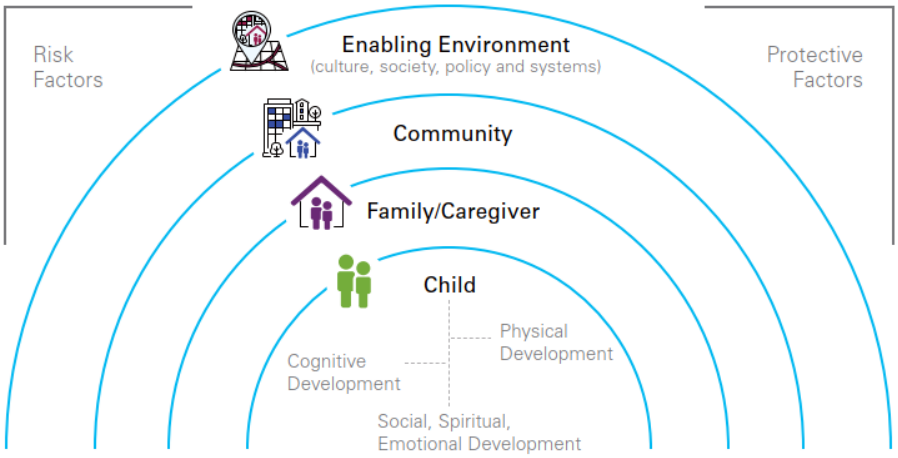
Another view gaining traction is that the starting point should be to ask: 'what does the child need?' or 'what does the caregiver need?' rather than what clinical, psychiatric, or psychological services should be provided. This, in turn, would mean that Layer 4 care are conceptualized more holistically to include specialized protection services (often provided by clinical social workers) that complement and extend medical services. Consequently, the fundamental question becomes whether a young person is getting the care they need – not what layer they are in, or what services are assigned to that layer.

The IASC thematic group is now working on development and field-testing of updated guidance that will address the distinctive mental health needs of young people – although it will take some time to ensure consistency with other IASC products. WHO has recently been mapping different versions of the pyramid to see what a more integrated pyramid could look like, while recognizing the need to tailor the tool to context. WHO advisors have also emphasized the need to be clear about the specific condition, complexity, and age cohort so that responses can be adjusted accordingly. There is emerging consensus that, for children and adolescents, a socio-ecological model might be more relevant that the pyramid approach.

The social ecological model (see Figure 2.1) has four layers, with the child at the center, and concentric circles consisting of family/caregiver, community and enabling environment (systems). It emphasizes the importance of networks and structures that surround children, safeguarding their wellbeing and optimal development.

UNICEF's newly published global multisectoral operational framework for mental health and psychosocial support of children, adolescents, and caregivers[4] contains comprehensive and practical guidance and examples to help its staff and partners develop programs across the layers of the social ecological model and the mental health continuum of prevention, promotion, and treatment. This updates and replaces the previous UNICEF guidance on community-based mental health and psychosocial support in humanitarian settings.

Figure 2.1: Socio-ecological model (UNICEF)[3]



The new framework defines Layer 4 as: ***"Services provided by mental health clinicians and social service professionals for children and families beyond the scope of general (non-specialized) social and primary health services."*** This includes interventions that are intended to manage mental health conditions for example individual, family or group psychotherapy for people with mental health conditions. The new guidance suggests that psychiatrists, psychiatric nurses, psychologists, clinical social workers, occupational therapists, primary care physicians and other professionals who are trained in clinical services, including pharmacological treatment and management of mental conditions, are best suited for delivering focused and clinical services at Layer 4. Among key informants interviewed, it was felt that there was enormous potential for the cadre of 'Clinical Social Worker' as a first line provider of holistic needs-based care.

Case Study: Save the Children International (SCI) involvement at Layer 4

SCI is developing a website as a live toolkit on how to integrate MHPSS into sector programming. As they collected data from country offices, they discovered that more were working at Layer 4 than they previously thought. Where there was no supervision system in place, they recognized there was potential to do harm. But they also recognized that simply following protocol and referring cases to specialized psychiatric services, could also cause harm if these services were sub-optimal, for example providers over-prescribing medication without adequate consideration of side effects or counselling. This generated a discussion that had not previously happened. Some teams genuinely thought they were helping the child by referring. There was also fear within the non-specialist community of legal consequences of overstepping limits. SCI is now developing its position paper on involvement at Layer 4, which will allow country teams more autonomy to make their own decisions, based on country context and what alternatives are in place.

Tools to support the process are under piloting. For example, SCI has one protocol called the Suicide Risk Management protocol. This covers questions to ask yourself and the adolescent, and how to help the adolescent find the right support. Importantly, this is not just about referral to other services. It is about understanding what is around the child and their environment - using the social ecological model. It requires follow up and showing the child or adolescent that there is a trusted adult around them who is not going to let them down or judge them.

[3] United Nations Children's Fund, 'Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings,' UNICEF, New York, 2022.

[4] United Nations Children's Fund, 'Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings,' UNICEF, New York, 2022.

3. Needs of children, adolescents, and their families

3.1 Vulnerability and risks for children and adolescents

From our five country case studies, we found that children and adolescents (C&A) in the selected humanitarian settings have elevated levels of mental health and psycho-support needs that are not being adequately met through existing services. Some have been exposed to extremely traumatic events. 40% of Rohingya adolescents in Bangladesh have experienced being in combat or torture. Negative coping mechanisms such as substance abuse occur within this group, increasing the risk of further abuse, exploitation, and gender-based violence. Similarly, in the Kurdistan Region of Iraq, many young people have been forced to flee from their homes and studies, and those living in IDP camps, such as Baharka Camp, face particular mental health stresses. In South Sudan, an estimated one million displaced children are suffering from severe emotional distress and are vulnerable to harmful practices, such as physical/sexual assault, child marriage and child labor.

A range of mental illnesses have been identified among C&A in humanitarian settings, such as depression, hopelessness, aggression, anti-social behavior, anxiety, sleep disturbance and developmental delays. Other broader needs arise from poverty, persistent discrimination, extended disruption to education, concerns about violence and abuse, and pressures to join armed groups. An alarming number of children do not live with their parents, so lack a first layer of protection. Among IDPs in Maluku, DRC, a sizeable proportion of children are orphans, street children, or are separated from their families. Many are reported to be especially vulnerable to abuse, physical and gender-based violence, as well as alcohol and substance abuse. In Maluku, mental health problems are said to be common among IDP parents, while mental health problems in young people are often attributed to witchcraft which increases vulnerability to abuse. For young people with MHPSS problems, there are risks of harm from family rejection or disengagement, stigmatization, and isolation.

Some respondents observed that in the absence of specialist psychological interventions for C&A, providers sometimes resort to medication as this involves shorter consultation times and can be seen as a quick fix to manage symptoms. However, there was generally a lack of knowledge or critical engagement on how psychotropic interventions might interfere with social-emotional aspects of child development and so endanger developmental progression.

For different conditions, there appear to be various levels of stigma and willingness for parents to come forward. Across the board, deeply rooted stigma prevented people from acknowledging or talking about mental health problems that children, or parents themselves, were experiencing. For example, in Baharka Camp, Kurdistan, parents sometimes keep children hidden or chained due to issues of stigma; while in Cazucá, Colombia stigma was commonly given as a reason for not seeking healthcare support. In Kurdistan, there was some suggestion that the community experience of COVID-19 had made it easier to talk about mental health symptoms, so there were now opportunities to help destigmatize the topic.

In humanitarian settings, we found that families and parents often have little knowledge of what is happening to a child with mental health problems, and may not recognize signs of distress such as withdrawal, not playing, bed-wetting etc. Among most respondents, there was recognition that parents and caregivers need specialist support and resource materials to manage and care for young people with significant mental health problems - even when Layer 4 services are available. However, in Cox's Bazar, Bangladesh it was observed that many parents are illiterate and need more than the information given in leaflets. Meanwhile, in Cazucá, Colombia it was observed that widespread poverty means that parents are overloaded with work and expenses and have little time to care for their children's mental wellbeing. We note, however, that WHO's

Minimum Service Package (MSP) contains a parenting component/caregiver skills training and there are now significant efforts to focus on trainings for caregivers.[5]

We found that families with lived experience can play a key role in supporting others experiencing mental health conditions, advocating for their rights and perspectives, promoting their social inclusion. Youth and family activist groups have had some success in identifying their own needs and reducing stigma through bringing together those with lived experience, e.g., in Maluku, DRC, the local 'Youth Movement' uses a process of engaging key stakeholders in a community forum (the Children Parliament) to address child protection matters.

3.2 Terminology and cultural differences

Crucial to understanding MHPSS needs in humanitarian settings is an appreciation of the local vocabulary and conceptualization of mental health disorders – these can differ considerably from those used in western medicine. For example, among Rohingya refugees in Cox's Bazar, Bangladesh there is a considerable vocabulary for emotional and behavioral problems, with problems often attributed to malevolent spirits – jinn – or the 'evil eye.' Among Iraqi Kurds, idioms of psychological distress frequently refer to bodily symptoms and crushing sensations. Among IDPs in South Sudan, 'overthinking' or 'thinking too much' is regarded as an idiom of distress. In Colombia, Indigenous communities talk about living in balance – with relations, nature, and the dead; being out of balance is seen as one of the causes for mental health issues such as anxiety, depression, and psychosis. Consequently, familiarity with local terminology and cultural concepts of distress and mental illness may be a key factor in providing culturally sensitive and contextually relevant MHPSS services to these populations. Some key informants also suggested that these issues explained why parents and families may seek assistance from a traditional or religious healer in preference to/alongside the services of an urban, high-status medical doctor/psychiatrist.

Some INGOS and NGOs have worked with health providers on their normal dialogue and discourse with families to help them to ask common questions in a different way. Once a degree of comfort with these conversations is achieved, both health workers and clients/families can feel more confident about engaging in a conversation about mental health challenges.

Shifting to a more culturally nuanced approach also necessitates thinking about alternative actors. Traditional and religious healers often work in mental health and so are one part of the eco-system of practitioners and often trusted due to the spiritual and cultural belief of communities.

[5] Sengupta, Koyeli & Shah, Henal & Ghosh, Subharati & Sanghvi, Disha & Mahadik, Sanchita & Dani, Allauki & Deshmukh, Oshin & Pacione, Laura & Dixon, Pamela & Salomone, Erica & Servili, Chiara. (2021). World Health Organization-Caregiver Skills Training (WHO-CST) Program: Feasibility of Delivery by Non-Specialist Providers in Real-world Urban Settings in India. Journal of Autism and Developmental Disorders. 10.1007/s10803-021-05367-0.

4. Barriers at Layer 4

4.1 Lack of formal services

Across the board, our five case studies spotlighted the real-world challenges for children, adolescents and their families needing to access specialist Layer 4 mental health services in humanitarian settings. In most cases, Layer 4 services are either not available or difficult/costly to access. Where services are offered, there is little evidence of continuity or consistency of care, coherent case management across services, or efforts to tailor the care package to the specific needs of the young person and their families. There is sometimes a tendency to suggest that frontline workers should just make a referral for Layer 4; however, several child protection actors suggested that, when services are not available, accessible, or linked to local service providers this can lead to the phenomenon of 'empty referrals' where the referring provider has no confidence in the referral and no knowledge about the outcome.

There were some stark differences between our country case studies, for example, in:

- Malualagorbaar, South Sudan: Layer 4 services are not available at the IDP camp site, although services are available at the hospital in Juba and more recently at the Jonglei State Hospital but travel to access these services can be costly.
- Maluku, DRC: Services are generally available through the public and private sectors, as well as by Roman Catholic organizations in large urban centers, however there is a shortage of specialist providers. In Maluku itself, there are no services because of a lack of psychologists and psychiatrists able to provide care to children. We were told, for example, that in DRC, only about 1% of cases would be accessing specialist care – and then for only about 1% of the time.
- Baharka Camp, Kurdistan, Iraq: Specialist services are not available in the camp but are available in Erbil city through the public and private sector, although it is costly to travel to reach these services; NGOs in Erbil city offer a variety of approaches including some good practice examples. However, these services generally target children under 15 years.
- Cazucá, Colombia: Services are available by referral but there is a lack of psychologists and psychiatrists able to cater to children's needs. Layer 3 psycho-social support services are more prevalent compared to specialist Layer 4 services, but time and resource constraints are a key barrier for parents/families.
- Cox's Bazar, Bangladesh: Each camp has a MHPSS focal point to whom providers or case managers are expected to refer. Typically, this focal point then refers to a psychologist who might in turn refer to one of 4 psychiatrists who rotate to different camps. However, the chain of referrals for MHPSS cases, especially children, are often not practical, affordable, manageable, or realistic for most families.

It is notable that, where Layer 4 services do exist, be it through the public, private or NGO sectors, there are often issues of predictability and sustainability of service provision. Respondents suggested this could either be to pressures on government budgets and service restructuring, or changes in donor funding to NGOs. For example, in Malualagorbaar, South Sudan over 12 humanitarian organizations used to provide services covering child protection, nutrition, MHPSS, healthcare, gender-based violence and education; all have now pulled out due to lack of funding. A Child-Friendly Space that was constructed to support these services is no longer functioning.

4.2 Quality of care

In the most marginalized settings, quality of care is generally reported to be low. Although there are pockets of good practice, these are not widespread or accessible to all, especially for displaced populations. For example, at the renowned faith based Panzi Hospital in DRC there is good, targeted care for women, including young women, who are victims of GBV; however, these services are only available in South Kivu Province. More generally, key informants were skeptical about the quality of MHPSS services offered in humanitarian settings.

> ***"If we're talking about fully ethical services that 'do no harm,' then these are rare."***
>
> Global key informant

Where psychiatrists are present, their training can be of variable standards, even in high income countries or mature health systems. WHO is currently working to update curricula and approaches, but the current focus is on post-Soviet settings (including Ukraine). Global key informants observed that professional standards, the credibility of qualifications, and even the type of facility are all important considerations in assessing quality of mental health services. It was acknowledged that psychiatric hospitals have been sites of grave human rights abuses, in the past and in the present. Indeed, some case study respondents referred to mental health institutions as places of last resort that are associated with fear and abandonment.

Limited dose and frequency: Contact time with specialist providers is generally insufficient and complementary/supplementary approaches are also needed. For example, in Cazucá, Colombia, when successful referrals are made, the norm is a 45-minute consultation once a month. Siloed thinking was often blamed, with services only provided by highly qualified clinical psychologists and psychiatrists, ignoring the potential of more available and accessible cadres such as therapists, counsellors, social workers, and pedagogical specialists. The result was that the clinical specialists only then had time for the most extreme cases.

Theoretical rather than practical skills-building: There is generally more focus on short classroom training of providers in MHPSS packages than in building practical skills dealing with children. In Kurdistan, for example, several officers we spoke to had received MHPSS training but were not providing any services. In Cox's Bazar, many organizations provided their own training in a range of approaches (counselling for individuals, groups or families, basic psychosocial support, individual or group psychological debriefing, psychological first aid (phone counselling and protection awareness sessions etc.) but there was a dearth of examples of this training being put into practice to conduct sessions with families.

It was also reported that inclusion of MHPSS services was at times donor driven. New MHPSS 'boilerplate' texts could be generic, and approaches not well-researched or tailored to the local context. Respondents reported that quality of services was poor because a 2–3-day training for providers was not sufficient to build skills to provide the level of care families needed.

Lack of focus on children: There were almost no child MHPSS specialists at the sites. There are few widely available clinical packages for children aged 5-10. For example, the mhGAP Humanitarian Intervention Guide has ten modules, just one of which is for children. In implementing the Guide, communities need to select modules to focus on and, we were told, hardly ever pick child mental health as a key focus.

Lack of continuum of care: Most countries reported that information hardly ever flowed from the referral level down to primary care tier. For example, in Baharka Camp, in the Kurdistan Region of Iraq, services are fragmented, and referral systems are disjointed; there is little provision for integrated care, or continuity of care over the longer term; while NGOs based in Erbil city offer a variety of approaches, there appears to be little in the way of a standardized or coordinated approach.

4.3 Stigma

As mentioned in section 3.2, the issue of social stigma, along with lack of parental knowledge and information, were repeatedly mentioned as key barriers preventing parents and families from seeking mental health care services. In extreme cases this can lead to the child's isolation and abuse. In almost all settings it was reported that, even when a child is brought to a primary health care provider, their basic training does not equip them to provide the child with appropriate treatment and care, and there is often little understanding of referral options.

> ***"Depending on the family, there are still those who conceal their children's mental health concerns due to stigma, but the majority of them look for assistance to help their child get better."***
>
> NGO representative, Kurdistan

In Cazucá, Colombia, it was reported that adolescents often prefer to talk to NGO workers than health professionals because of the stigma associated with attending mental health consultations. Indeed, some respondents suggested adolescents sometimes reject referral to a mental health professional arguing they do not need that type of care because they 'are not crazy' ('yo no estoy loco').

4.4 Packages for low resource settings (and limitations)

The barriers to accessing MHPSS care in low resource and humanitarian setting have been well documented. Indeed, organizations such as WHO and IASC are making concerted efforts to introduce 'low-intensity' MHPSS packages specifically for low resource settings. These aim to tailor MHPSS services to what is feasible and possible in these settings; this often entails providing psychological or psychiatric services through non-specialists under the leadership of a qualified mental health professionals. For example, as part of the ongoing mental health GAP Action Program, WHO and the United Nations High Commissioner for Refugees (UNHCR) produced the Mental Health Gap Action Program Humanitarian Intervention Guide (mhGAP-HIG) in 2015 to address persistent capacity gaps in emergency settings. Other examples of these adapted approaches include WHO's Psychological First Aid (PFA), Problem Management Plus (PM+), and Group Interpersonal Therapy (IPT) for Depression; along with the MHPSS Minimum Service Package (MSP).

Global key informants suggest that, while these adapted approaches are much needed and make excellent contributions, it has been challenging to integrate them into routine service provision at scale at country level; hence, they have not yet been rolled out to their full potential. Human resource capacity was often cited as a key challenge for programs trying to bridge gaps using mhGAP or MSP; meanwhile, adding additional skills and competency packages runs the risk of overloading workforces. Often health workers are reluctant to get involved because they are unfamiliar with mental health conditions or are fearful of causing more harm. Building non-specialist capacity with adequate supervision can also be expensive and take time; indeed, the lack of available supervision for non-specialist practitioners was often cited as the main obstacle when rolling the mhGAP approach in low resource settings.

Some key informants observed a tendency to overly focus on interventions that are easy to roll out, such as PFA which can be rolled out in 8 sessions or less; this is sometimes a consequence of funding and reporting cycles demanded by external donors. High-level key informants reported that in low-income settings there is a particular shortage of specialist mental health supervisors to oversee the treatment and care for children and adolescents. Some key informants suggested remote supervision can be problematic when there is little understanding of the child's physical state, living conditions, cultural setting and options for local support. Examples were given of incorrect prescription doses, along with a disproportionate emphasis on the adolescent mental health disorders found in affluent, Western settings.

4.5 Unsustainability

While international NGOs can bring good approaches, these initiatives are often short-term, fragmented or disconnected from the wider health system; consequently, overall coverage can be insignificant relative to the needs of the population. This means that, in low resource settings, most people continue to access services through the public health system.

There are, however, some examples of good practice. One global key informant cited the example of Ethiopia where there has been more sustainable scale-up of mental health services due to the federal government's continued investment of resources, along with a successful long-term training partnership with Kings College London. This model approach involved training different cadres of service providers in mental health care; trained officers were then stationed in strategic spots e.g., refugee camps, where they could support others through training, supervision, and ongoing mentorship.

Among senior key informants, there was consensus that in low resource and humanitarian settings, the starting point should be local sources of care that can be sustained within country health systems to provide continuity of care. Organizations providing MHPSS services and child protection have pulled out of Malualagorbaar in South Sudan due to lack of funding after the area was de-prioritized by the South Sudan Humanitarian Funds. Previously, over twelve different humanitarian organizations were conducting activities

in child protection, nutrition, MHPSS, health, gender-based violence and education. It was argued that vertical or siloed approaches need to be re-thought, especially for mental health care that often requires longer term inputs, rather than 'quick fixes. For example, while the in-service training courses provided by international development partners can be helpful in the short-term, a more sustainable approach would be to build capacity for delivery of a revised pre-service curriculum by existing training institutions. This, in turn, could consider the potential contribution of informal, traditional and religious providers at community level.

5. Pathways to care and coping strategies

5.1 Pathways to care

Our five country case studies confirmed that children and adolescents have minimal agency to seek care for themselves. The primary decision-makers for treatment seeking are usually parents or families of the child; indeed, child protection actors in the DRC emphasized that, under the 2009 Child Protection Act, children under 18 years cannot be referred for treatment without parental/guardian consent (unless there are exceptional circumstances). For children who do not live with their parents there is often no way to access treatment.

Religious and traditional healers are the most common first port of call for families across most of our study settings. Mental health problems in young people often manifest as behavioral concerns and may be understood in many different ways across cultures, including as possession by a jinn or demon in Bangladesh or as 'witchcraft' in DRC. Some NGOs and child protection actors emphasized the challenge of identifying children with mental health conditions and stressed the importance of educating parents and caregivers to help them recognize when additional assistance might be needed.

Notwithstanding this, traditional and religious healers are local, available, and trusted, and are often the first layer a family might consult about their problem.

In the South Sudan study setting of Malualagorbaar, the population is strongly Christian, and people try prayers in churches before seeking care in hospitals for mental health needs, including for difficult cases. They tend not to go to traditional healers as they see this to be in conflict with their Christian beliefs. However, in other parts of Jonglei State there are traditional healers who are actively approached by communities.

> ***"Sometimes people do not access services due to traditional belief for instant fixes, in case of seizures, people will request the child to be taken to church first for prayers because they believe that God can heal all these illnesses and they later ignore the importance of hospitals and specialized MHPSS treatments available."***
>
> MHPSS Officer, South Sudan

In Cox's Bazar, Rohingya parents take children to traditional healers 'Kabiraj' for 'Jharfuk' though may give up if there is no improvement or if repeated visits become too expensive. Religious leaders 'Huzur,' 'Imam,' or 'Mawlobi' are also consulted. Some traditional healers (Hujurs) provide services on a voluntary and donations basis, not demanding a specific payment for their services.

In Baharka Camp, Kurdistan, if a child or adolescent shows signs of a mental health problem, a family's first source of advice is often a traditional healer, especially for severe conditions such as psychosis. Several respondents mentioned that families may take a child to both health care providers and religious/traditional healers at the same time. It was also reported that families might return to their original homes to find a trusted traditional healer though they might be secretive about their use of informal services when dealing with the formal system. One factor may be the negative perception of the informal sector expressed by some health care providers:

> ***"The religious healers are abusing the patient."***
>
> Health Care Worker 1

> ***"Religious healers cannot help children who have had depression or sexual abuse, and I refuse to treat children who are currently being harmed or threatened until I am certain that they are safe."***
>
> Health Care Worker 2

Some organizations reported that religious healers were beginning to refer cases to them:

> ***"When spiritual healers are unable to help, many times the patients turn to mental care. Recently, I heard that one of the spiritual healers advised a client to visit a mental professional, and that's important…If they had the necessary knowledge, herbalists and religious healers would recommend patients to the appropriate services, but they don't since they don't know."***
>
> NGO Health Care Worker, Baharka Camp

Other pathways to care differed significantly by setting. In Cox's Bazar, child protection actors were found to make referrals to Layer 4 services. In Kurdistan, it was reported that some families ask for assistance from the school's teachers and meet with the psychosocial counsellor if one exists or visit a private mental clinic if they can afford. Similarly in DRC, schools are sometimes involved in helping families in the initial care seeking decision process.

In Colombia, children and adolescents normally access MHPSS services through referrals. Pathways are quite long, especially for families living in the Soacha part of Cazucá, because they need first to see a general practitioner, then a psychologist and only then a psychiatrist which can be prohibitively expensive in time and expense. To alleviate this, in Bogotá's part of Cazucá, a group of psychologists goes to the houses of families living in Cazucá and other nearby settlements.

In Colombia, an example of good practice is that the lead organization for child welfare, ICBF, operates a kindergarten which identifies and refers children to specialized services in cases of autism, intrafamily violence and sexual abuse. An integrated team (auxiliary nurse, pedagogic coordinator, and psychosocial therapist) schedule observational visits to the families and analyze the behavior of the family and also refer GBV cases to the Women's Secretariat in Bogotá.

5.2 Coping strategies

When there is a concern, the first step is generally to ask the advice of other parents, an elder or a community healer.

Traditional medicine: There was a general understanding that medicine from formal health services could be combined with the healing practices of priests/traditional healers. The therapies provided by religious healers 'Hafez' or 'Qari' in Cox's Bazar included holy water to drink for treatment, reading the Quran, reciting prayers for troubled children, talking to the child, 'giving quality time to make the child happy.'

> ***"People go mostly to 'Molla' or 'Munshi' for blowing and pouring water as they believe they are near to Allah and Quran's verse has the power to reduce their pain or suffering."***
>
> Key informant, Cox's Bazar

In Kurdistan, traditional healers provide herbal medicine which can at times cause severe stomach problems. In DRC, traditional medicine is given to induce vomiting to 'drive out the spirit' which may allow a family to accept the child back into their care in the belief the evil spirit has gone.

Alongside allopathic medicines, parents also use traditional medicine made from herbs and roots. Cox's Bazar residents complained that there is not enough vegetation in their area to make traditional remedies as the camp site is barren.

Communal coping strategies such as social support through connecting with elders, relatives, community members, and religious institutions were mentioned as coping strategies. In South Sudan, activities mentioned to support recovery included attending Sunday school church services, community gatherings, local marriage celebrations, and engaging in traditional activities of dancing and wrestling. Provision of play materials in child friendly spaces and storytelling on safety, resilience and recovery were also reported to help children. In Colombia, some NGOs provide leisure activities in arts, music and sports and act as informal therapists 'by accident' just by listening to troubled children. This channel of support can be more acceptable to adolescents who refuse to be referred to formal mental health services.

Peer-to-peer support: Some adolescents and their families have contacted each other and provide themselves peer-to-peer support. In Colombia, Coorporación Infancia y Desarrollo (CID) organizes support groups in different regions of Colombia (not Cazucá) to provide spaces for support and compassion.

Do nothing: Across the settings there were reports that families at times did nothing to address their children's MH challenges, sometimes because of the struggle just to survive and earn money for food, and sometimes when other routes had failed, and a child had not recovered.

5.3 Recognition of joint referral pathways

There is growing acknowledgement that informal, traditional, and religious providers play a significant role as the first source that families consult. UNICEF's Community-based MHPSS guidance states ***"most MHPSS assistance is provided by traditional healers."***[6]

The 2022 World Mental Health Report states:

> ***"In most countries, faith-based leaders and traditional and complementary practitioners are widely consulted. Their beliefs and practices vary widely across settings, as does their effectiveness. Traditional healers sometimes apply highly harmful practices. But they are often the first point of contact for people with mental health conditions, who see their input as meaningful and likely to be helpful.[7] And there are likely many occasions where fruitful collaboration between health services and local healers is possible."***

In practice, however, there is wide divergence in the propensity of formal Layer 4 service providers to engage with the traditional sector. In many settings, there is no relationship or connection between the formal and informal sectors and often the default of formal health providers is to diminish the influence of traditional healers given the secular and evidence-based nature of medical training.

> The Lancet Global Commission on Mental Health states:
>
> ***"Global mental health practitioners have shown that integrating understanding of local explanatory models of illness experiences is possible while respecting the complementary role of western biomedical and local traditional approaches to treatment."*** [8]

At the same time, there are other settings which take a more integrated, culturally respectful, and pragmatic approach. A recent webinar on decolonization in MHPSS reflected that mental health professionals are often urban, higher socio-economic status professionals who do not relate to communities as peers. A purely bio-medical approach to MHPSS overlooks the fact that mental health conditions have non-physical as well as physical causes; and can reinforce power dynamics while ignoring cultural factors and barriers. The concept of 'cultural competence' is now gaining some currency. This implies first listening to the community to devise therapies that are more meaningful, and which might entail combining or adapting therapies. For example, instead of patients coming to a clinic they might attend therapeutic sessions in outdoor settings, or a session that is facilitated by a trusted advocate. Interestingly, in Colombia informal or alternative health providers are considered mental health providers if they have attended a training to provide MHPSS services.

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6 United Nations Children's Fund. Operational guidelines on community based mental health and psychosocial support in humanitarian settings: Three-tiered support for children and families (field test version). New York, UNICEF, 2018.

7 441 Van der Watt ASJ, van de Water T, Nortje G, Oladeji BD, Seedat S, Gureje O, et al. The perceived effectiveness of traditional and faith healing in the treatment of mental illness: a systematic review of qualitative studies. Soc Psychiatry Psychiatr Epidemiol. 2018;53(6):555–566. doi:10.1007/s00127-018-1519-9.

8 The Lancet Commission on global mental health and sustainable development Lancet 2018; 392: 1553–98; Bolton P, Bass J, Neugebauer R, et al. Group interpersonal psychotherapy for depression in rural Uganda: a randomized controlled trial. JAMA 2003; 289: 3117–24.

> ***"People forget that the reason people go to traditional healers isn't just because they are the only health worker or source of what they perceive as health advice around. It's also because they're trusted. A lot of formal health services often aren't trusted not because people don't have faith in conventional and modern medicine, but because the quality of care and services are often not very good, and people are not treated very well. So, on a very human basic level there's a lot of reasons why people would continue to go to take the views and support of a traditional healer."***
>
> Global key informant

There are examples of efforts being made to work in collaboration with traditional healers, for example bringing groups together for regular meetings with a health post for a designated area. This is a way to engage and maintain relationships with traditional healers and to provide more consistent and sustainable approaches. It was reported by a global informant that Nepal is an example where this approach was taken, being small but ethnically diverse where reliance on traditional healers varied across the country. Both INGOs and government were reported to work collaboratively with traditional healers.

6. Multisector MHPSS support

6.1 Role of Child Protection

Across the five case studies, it was evident that there is a strong, two-way relationship between protection risks and MHPSS. Young people with MHPSS challenges face a range of risks and vulnerabilities associated with their condition, for example, being subjected to violence within families and schools, or being socially marginalized. Other challenges arise from neglect, other forms of abuse, extreme poverty or simply lack of understanding about their condition. For example, one NGO respondent in Kurdistan told us of a case of a child who was chained naked inside a family's tent because the parents did not know how to care for the child.

We found that the existence and effectiveness of formal child protection structures differs between settings; however, it was notable that child protection structures are often under-funded, under-staffed and inadequate to fulfil obligations – especially at field level.

In South Sudan, for example, the Ministry of Gender, Child and Social Welfare, with support from the Child Protection Sub-Cluster, has developed official child protection case management standard operating procedures (SOPs). However, the implementation of these SOPs is lagging across the country due to lack of capacity and trained personnel, high staff turnover and the ongoing conflict. Moreover, most child protection systems in South Sudan are designed, funded, and implemented by weakly coordinated humanitarian NGOs and agencies with a temporary mandate.

In Colombia, there is a formal child protection agency called the Instituto Colombiano de Bienestar Familiar (ICBF). This agency has authority to take action in cases of child abuse within families. However, it was reported that the agency's child protection actors are not familiar with or trained in MHPSS. There is also a negative a perception among communities that referral to ICBF will separate children from their parents, hence an unwillingness by some community leaders to refer cases.

Although public sector structures exist to a varying extent in each case study country, there was a general perception that NGOs have stronger coordination and referral systems than government structures. Across settings, child protection and NGO actors reported that they try to tackle young people's wider needs, especially in cases where there is a mental health issue and little family or socio-economic support. For separated children with mental health problems, referral to an orphanage might be the only option for providing shelter and assistance.

Case workers in Kurdistan were able to list a few examples where MHPSS services were combined with wider services that children need; however, the examples provided tended to be short term, often pilot activities, and not established as long-term practices in the camp. The community-based Public Aid Organization (PAO) is working with children in Baharka camp to address extreme needs but without adequate resources. There is frustration that basic needs cannot be met:

> ***"While UNICEF spends a lot of money on its partners to provide psychosocial support in the camps, if a child lacks access to food and shelter, we cannot provide MHPSS."***
>
> Camp key informant

In Maluku, DRC the local Child Protection Office can, in exceptional cases, make referrals for MHPSS services following formal procedures that involve working with a local 'Youth Movement' and 'Children's Parliament.' If they identify a case, they begin by inviting parents or guardians, then seek clearance from the Local Authority. Some child protection officers ('social educators') are able to provide educational talk therapy, health education and life skills education. It was reported that, when child protection officers refer children for specialist services, they rarely receive information or feedback and there is minimal coordination between services:

> ***"What comes next we don't know because there is no counter reference mechanism."***
>
> Social Educator/Case Manager, DRC

In most settings, we encountered good examples of child protection actors working with communities to assist children and families with mental health needs to the best of their abilities. In South Sudan, community-based protection officers, community mobilizers and social workers are effectively providing psychological first aid and counselling for children with distress, depression, and other mental health problems, despite not having been formally trained in providing these services.[9]

In Cox's Bazar, Bangladesh, recruitment of community psychosocial volunteers and lay counsellors from the Rohingya community has been a successful approach in bridging cultural gaps. Volunteers facilitate peer support groups, community psychoeducational workshops and individual psychosocial sessions.

Key informants at the global level spoke of the necessity of integrating MHPSS and child protection. Indeed, child protection actors are regarded as absolutely central to UNICEF's new framework for community based MHPSS. Several suggested that, in practical terms, better integration could be supported by developing education and career pathways along a spectrum of 'public mental health' services, with a cadre of 'Clinical Social Workers' deployed to coordinate a continuum of care approach, including for C&A with specialist needs.

It was also argued that there is scope for greater collaboration between schools and protection services so they can leverage multiple types of support and make them accessible to large numbers, with a less stigmatizing approach. This allows specialists to focus on and provide support for more complex conditions (co-morbidities etc.) or those requiring specialist medication.

Innovative technology is helping to facilitate better referral linkages and support between specialist and non-specialist cadres of providers. SCI has set up telephone support line for non-specialist health workers who need support. While not 'the ideal' in terms of support beyond Layer 3, this solution does at least enable better informed support so that a frontline health worker can provide a more advanced level of service in a safer way. During a recent series of workshops focusing on skills improvement and enabling systems, the telephone support line gained traction as one of the few options available.

6.2 Role of Education sector

Teachers and educators are a key resource for identifying at-risk cases for support and referral as they are usually the first point of contact outside of the family for children and adolescents. There is scope to build the capacity of teachers to respond to the support needs of at-risk children. In most settings we studied, schools, especially kindergartens, were recognized as having an important potential role in case identification, referral, and ongoing support. While schools were seen as an underutilized channel, there were also concerns that they have insufficient capacity to manage children with 'special needs,' Schools are currently unable to get more involved in MHPSS because they lack the training, infrastructure and/or resources to assist young people with specific mental health challenges.

There were some examples of collaboration between schools and parents to help identify children experiencing mental health problems and make joint decisions. In Cox's Bazar, Bangladesh, education actors believe that that MSPSS could be better integrated with education and that more work is needed on feedback mechanisms following referrals. In Colombia it was felt schools need more help is determining who to refer. In Maluku, DRC, schools are sometimes involved in decision-making and may advise families on options for care and support.

> ***"Parents are sometimes happy as the school can identify that a child is experiencing some mental health problems, and this helps them take a decision."***
>
> Community Educator

[9] Jeffries, R. et. al. (2021) The health response to the Rohingya refugee crisis post August 2017: Reflections from two years of health sector coordination in Cox's Bazar, Bangladesh. PLoS ONE 16(6): e0253013

A global level key informant spoke of the potential for clusters of support in education settings. To avoid overloading teachers, it may be preferable for them to make referrals to a school psychologist, counsellor etc. as simply training teachers can have limited value if they cannot refer. Training also needs to be targeted appropriately, for example generic training of teachers about suicide etc. can simply scare them.

A key opportunity is the existence of cadres of school social workers or counsellors who are an untapped resource who could be better supported to do more. In DRC, a new Directorate has recently been established to deal with 'socio-emotional' welfare of children in schools and is planning to put counsellors in place at national, provincial, and sub-provincial levels. In Iraq, some schools have a school social worker, however it was reported that they are usually assigned to other roles. Frontline workers may need support to manage their own stress (with female teachers often carrying a high burden).

6.3 Nutrition actors

INGOs, such as SCI and Action Contre la Faim (ACF), are combining maternal mental health with infant feeding, so using a hybrid approach with nutrition as an entry point for better awareness, skills and confidence in relation to common mental health anxiety and depression. By identifying maternal mental health issues, this approach mothers to access support which also helps alleviate issues that become barriers to infant feeding. It was reported, for example, that when ACF worked in nutrition and health in Kurdistan, there was always a group of psychologists.

SCI is compiling operational guidance on integration and mainstreaming of MHPSS across sectors as a practical guide to help countries and programs to gradually mainstream and integrate MHPSS into health, education, and child protection. Their website is undergoing piloting and will be an internal resource for the time being.

6.4 Coordinated and community case management

In general, respondents suggested there are insufficient functional linkages between mental health services and social services, with a pronounced lack of information flowing back to community or child protection actors.

The MHPSS Working Group is developing a strategy to standardize reporting, especially for data sharing. A separate Working Group for Children and Adolescents was created to work on program design and advocacy but has not been operational since the COVID-19 pandemic. Digital tools exist for coordination, such as the Health Resources and Services Availability Monitoring System (HeRAMS) and the World Health Data Hub (WHDH); however, neither of these systems plays a particularly functional role in helping refer families for services.

As indicated above, a key challenge for child protection actors is that community interventions that could provide MHPSS benefits are not well coordinated:

> ***"Each person does what he thinks to be good without considering the actions of others."***
>
> Community Educator, DRC

> ***"We notice that community interventions are sometimes scattered, interventions are not organized, and it is very difficult to have a control on all cases."***
>
> Community Educator

Community-based interventions are limited but can include counselling by community members and community-based protection and social workers. There are child friendly spaces in the camp, and religious, cultural, and sports activities. Community members often encourage children to engage in these activities to recover from mental health conditions and build resilience. However, it is widely reported that, in humanitarian settings, there is inadequate training and resource materials on MHPSS strategies for children and adolescents.

In our case study settings, child protection officers and other local actors, often had clear insights on what was feasible within the context of local humanitarian settings; some were also making efforts to action these. For example, in:

- South Sudan: Respondents suggested that mechanisms such as community-based child protection networks, could be empowered as an MHPSS resource and could refer cases to agencies on the ground.
- DRC: Following the creation of a new division for the promotion of mental health in the National Mental Health Program, efforts were being made to create a network of different child protection actors and train them to identify specific child protection problems, including those linked to mental health. UNICEF DRC also successfully introduced community psychosocial agents to expand service provision and budget gaps of trust during the Ebola response (see case study in box below).
- Colombia: In Bogotá, the Secretary of Health had developed a public health program in which different health providers (nurses, psychologists, nutritionists, and physicians) visited various parts of the city - including Cazucá - to evaluate the health of key population groups. These 'Public Health Brigades' also received referrals from community leaders, teachers, and others to provide care to families or children in need of MHPSS care.

Case Study: Community psychosocial agents to bridge MHPSS gaps

In DRC UNICEF addressed lack of medical and psychosocial support for children affected by Ebola by incorporating MHPSS-specific interventions into the care model for Ebola outbreak response from the outset. The strategy included focusing on stigma reduction by speaking about MHPSS needs at the household level with both children and family members to help address any stigmatization regarding MHPSS and Ebola treatment in general.

Local providers in the region, including social workers, nurses, and religious leaders, were also offered psychosocial training, both due to the dearth of mental health professionals but also to address the apparent lack of trust between MHPSS professionals and community members. Ebola survivors provided various forms of support to those currently infected by Ebola. Additionally, a diverse team of MHPSS professionals, including psychologists, nurses, social workers, religious and community leaders etc., provided Ebola-specific support at treatment centers for their larger community. At the peak of the epidemic more than 1,000 of these psychosocial agents and psychologists provided support to people infected and affected by Ebola.

7. Conclusion

Psychiatrists have limited time to provide holistic care services and we know that children with mental health needs are often out of school, on the streets and at significant risk of harm or abuse – in other words have multiple needs. Children and adolescents also spend a far greater proportion of time with their families, teachers, and peers than they do with specialist health professionals. The best care even for specialist MHPSS needs, therefore, will always require an integrated and multisectoral team approach, including not only a psychiatrist and psychologist but also education, child protection and community-based actors.

Given the dynamic nature of needs, there is also a need to work across all layers of the pyramid with differentiated responses depending on the condition. Even beyond MHPSS, better translation and integration of basic children's rights into services is a fundamental need. Violence against children is accepted in many settings, contributing to future inter-generational cycles of mental health issues, and should be addressed in its own right.

There is a clear need for stronger collaboration between the sectors who engage at the frontline with children and adolescents and their families. Case managers can facilitate connections to social workers and child protection services. From a global perspective, however, there seems to be little in terms of best practice. One global informant remarked, ***"the global conversation on this is just starting."*** The appointment of a lay point person, based on models such as 'patient navigators' can help families move through systems with continuity of support.

A referral system needs to find people at the point when they are reaching out for care and so should not start at the formal health system. Religious and traditional healers are often the first point of contact that a family go to, but there has been some understandable hesitation to engage with such cadres. Ignoring the informal sector brings its own risks, however, as families continue to consult them, at times secretly, and abusive practices might go unchecked. At the same time, opportunities might be lost to introduce culturally relevant and benign approaches, or for traditional providers to refer appropriately.

Joint referral pathways are needed with more dialogue between cadres and types of providers to strengthen referrals and to safeguard young people. The 2022 UNICEF framework suggests: ***"Because some local practices can cause harm, MHPSS workers must examine and support local practices and resources only if they fit with international standards of human rights."*** [10] By engaging respectfully, options for meaningful care in the community can increase and capacity can be built of traditional healers on how and when to refer for conditions they see. It is argued we have done this in maternal health and if anything, it could be more helpful for MHPSS given they are a point people turn to for reassurance and advice.

The ideal is a comprehensive approach based on the socio-ecological model which connects dots and brings an understanding of a person's economic, social, and cultural situation into a practical and realistic treatment plan. Skills are needed across different sectors at all levels to detect mental health problems, respond appropriately and normalize mental health care and support.

Cross-disciplinary training on 'common childhood problems' could be a way forward so that actors can learn something outside their own discipline and be able to refer appropriately. There has been too much focus on short, one-off, theoretical classroom training on the relevant basic MHPSS packages – often low-hanging fruit to complete an intervention within externally funded programs. A different approach is needed to build true capacity which requires ongoing support, feedback loops and a more practical, problem-solving mindset. Continuous quality improvement clusters to drive health worker performance is a useful parallel. CQI is proven to work by empowering clusters or teams of providers at a local level to bring their contextual experience to address a specific issue; they need access to regular and rapid data to show what is working.

[10] United Nations Children's Fund, 'Global Multisectoral Operational Framework for Mental Health and Psychosocial Support of Children, Adolescents and Caregivers Across Settings,' UNICEF, New York, 2022.

For MHPSS, the equivalent would be community-based multi-disciplinary (multi-cadre) teams empowered to problem-solve, with access to data to make a realistic assessment of referral options and what alternatives exist for children. This would also provide more of a mandate for child protection actors and others to get involved. The cluster approach with a focus on feedback loops, will also act as a check and safeguarding on alternative providers involved as part of complementary approaches.

8. Recommendations

Recommendations primarily targeted to child protection actors

These recommendations are primarily targeted at child protection actors as measures to be implemented or advocated to other sectors.

1. Operationalize Nurturing Care Framework guidance to prevent (or avoid exacerbating) MHPSS needs of children and adolescents) in humanitarian settings:
   - Educate parents and carers on importance of play, communication, and avoidance of violence against children.
   - Replicate models such as Humanitarian Play Lab (HPL) BRAC model.
   - Work across sectors to connect families of children with MHPSS needs with actors attending to families' basic needs such as housing, food, clothing.
2. Reduce stigma for families around MHPSS:
   - Use locally and culturally appropriate language that is non-stigmatising.
   - Launch media/social media campaigns to talk openly about MHPSS challenges.
   - Organize self-help groups for families with similar experiences.
3. Advocate to health actors and others to make Layer 4 MHPSS interventions far more localized, tailored to context and sustainable:
   - Involve local actors/providers who families normally turn to (*see also recommendation 5*).
   - Incorporate local language/cultural idioms of distress when communicating about MHPSS.
   - Empower families as part of a stepped approach, first to get more involved and then to enhance their own agency for example to establish peer support/self-help groups (for both parents and children/adolescents), to act as volunteers and to advocate for better services and access.
   - Identify services with longer term continuity (as opposed to quick fixes).
4. Build capacity of locally available cadres (including child protection actors, reproductive health workforce, nutrition actors, etc.) who regularly encounter families and children to identify MHPSS cases and make meaningful referrals:
   - Make child development screening tools for early detection of developmental delays available to child protection actors to use in the community.
   - Agree on responsibilities for using child development screening tools to assess child development.
5. Include first-line providers (e.g., traditional, religious healers, etc.) as a part of local problem-solving focused, team- and community-based MHPSS.
   - Include traditional/informal providers in 4Ws mapping exercises as complementary services.
   - Help the traditional/informal sector to organize itself (this might be coordinated for example through the MHPSS Technical Working Groups).
   - Organize workshops and ongoing mentoring e.g., by clinical or educational psychologists to build capacity for effective and safe approaches.
   - Create digitally enabled communities of practices mixing informal with formal providers to share understanding of what good practice looks like from a variety of cadres.
   - Engage positively with this sector to lift secrecy, reduce stigma, and root out abusive practices (*see also recommendation 10*).
   - Set up protocols to ensure no harm is done to patients when accepting help from formal and informal service providers.
6. Support and empower child protection actors hitherto working only up to layer three to see where they can add value at Layer 4 based on assessment of alternatives available, rather than making 'empty referrals' (paper referrals which are known to be unlikely to lead to effective care):

- Step up support to community-based child protection structures to intervene in MHPSS cases and address child protection issues.
- Extend use of case management approaches drawing on good practices (such as brigades in Colombia).
- Build capacity of different types of youth workers (e.g., those working through youth clubs, sports, music, etc.) who have an interest in youth welfare and who may be better placed to engage with adolescents and their families than officials.

7. Advocate for strengthened government child protection institutions and field force to address MHPSS challenges:
   - Advocate for greater regulation of treatment of children and adolescents with psychotropic medication without effective supervision or supporting therapy.
   - Advocate for introduction of formal qualification and cadre of 'Clinical Social Workers.'
8. Use education sector more strategically for children with MHPSS needs:
   - Where they exist, build on cadres such as school social workers or school counsellors, advocating for resources to allow greater time spent attending to pastoral needs/supporting student welfare.
   - Actively mentor and support school counsellors by connecting them with a clinical or educational psychologist, using digital as well as in person channels of support.
   - Build capacity of teachers to play a bridging role between families and MHPSS services.
   - Advocate to keep children with mild to moderate MHPSS needs in schools wherever possible, supported by peer-to-peer options such as young mentors who run girls' clubs.
9. Advocate for continued roll out of Minimum Service Package and mhGAP more suitable for use with children and adolescents with more concentrated and ongoing supervision of frontline providers:
   - Extend capacity of competent supervisors by employing digital channels such as tele-supervision, helplines etc.
   - Advocate to reduce fragmented training/interventions developed and led by numerous individual organizations.
   - Ensure data is collected on user experience and quality of care to avoid tokenistic and unsustainable MHPSS provision.
10. Advocate to encourage collaboration between sectors in multi-disciplinary teams:
    - Strengthen the role of CP actors in the MHPSS Technical Working Group (TWGs).
    - Sensitize the formal health sector to potential benefits and harm reduction of engaging with complementary approaches that families are already using.
    - Advocate for a 2-way flow of information from referral level back to primary care and community level, to empower and build capacity of local child protection actors and improve effectiveness of referrals.

Recommendation for UNICEF/CP AoR

11. Fund a multi-site implementation research study of a shared care model involving formal and informal providers, to build understanding of how existing and local trusted sources of support can be better utilized in care pathways.

CAMBRIDGE EDUCATION

Child Protection Area of Responsibility
Global Protection Cluster

EDUCATION CANNOT WAIT

Final report | Annexes

Assessment of options for humanitarian child protection actors to assist children and adolescents who need specialized mental health services

April 2023

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Annexes

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Final report | Annex A: Global key informants

Assessment of options for humanitarian child protection actors to assist children and adolescents who need specialized mental health services

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Annex A: Global key informants

Inka Weissbecker, Technical Officer, Department of Mental Health and Substance Abuse, World Health Organization

Leslie Snider, ex-MHPSS Collaborative

Ashley Nemiro, MHPSS Collaborative

Andrew Clarke, Senior Health Advisor, Save the Children International

Anne Filorizzo Pla, MHPSS Lead (acting)| SCI MHPSS TWG co lead, Save the Children International

Zeinab Hijazi, Senior Mental Health Technical Advisor (Global Lead on Mental Health), UNICEF

Julian Eaton, CBM Global Disability

Koen Sevenants, UNICEF, CP AoR

Suzan Song, Psychiatrist

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Final report | Annex B: Bangladesh country report

Field research in Bangladesh to assess services available in Cox's Bazar camp to assist children and adolescents who need specialized mental health services

April 2023

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Annex B contents

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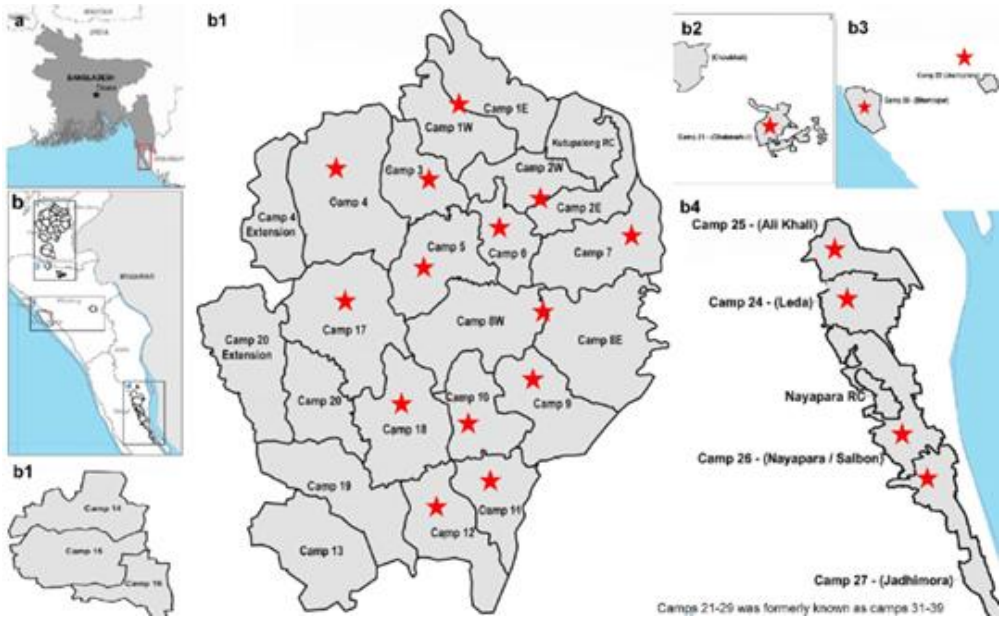
B-1. The humanitarian setting

In August 2017, almost a million Rohingya people fled to Bangladesh to escape violence and persecution in Myanmar; 55 percent of them were children.[1] The influx of Rohingya Muslims refugees introduced more complexity to the existing challenges in the country, especially at Ukhiya and Teknaf Upazilas in Cox's Bazar and Bhasan Char in Bhola district.

Figure 1.1: Location of Cox's Bazaar



Refugees are currently living in 34 highly-extremely congested camps settings in Bangladesh. Their living conditions are very poor. The children are growing up without proper education, and lack access to protection, food, water, shelter, and health services. An estimated 12 per cent of the Rohingya refugees in camps in Cox's Bazar District are living with disabilities.[2] The Rohingya became the demographic majority in areas where the camps are located. Some refugees have been reported to enter into fake marriages to secure Bangladeshi citizenship. Rohingya women are also reported to be engaged in the sex trade and some girl children are victims of trafficking.

This rapid assessment case study is based on interviews with 19 key informants and stakeholders involved in MHPSS services in Cox's Bazaar, as well as a desk review of the literature base, including site data and project reports.

[1] Kamruzzaman, M. (2022, December 31). '2023 should be Rohingya Home Year,' demand Rohingya refugees. Retrieved January 23, 2023, from www.aa.com.tr: https://www.aa.com.tr/en/politics/-2023-should-be-rohingya-home-year-demand-rohingya-refugees/2776859#:~:text=DHAKA%2C%20Bangladesh,country%20of%20Myanmar's%20Rakhine%20State

[2] UNHCR, t. U. (2022, December 03). *Being Disabled in the World's Largest Refugee Camp*. Retrieved January 23, 2023, from www.unhcr.org: https://www.unhcr.org/news/videos/2022/12/638b2d634/being-disabled-in-the-worlds-largest-refugee-camp.html

B-2. Setting the scene

B-2.1 Review of the literature base

Cox's Bazar is the most researched of the five locations in this study, with existing literature on MHPSS and alternative religious or cultural approaches to providing children with Layer 4 needs psychosocial support.

Studies among Rohingya refugees in Cox's Bazar indicate that many experienced unprecedented traumatic events in Myanmar and during their journey to Bangladesh, and this compounds the daily stressors they continue to experience - such as, high rates of sexual and gender-based violence, lack of privacy and safe spaces, and risks associated with monsoon and cyclone seasons.[3]

A study of pathways to accessing tertiary level mental health care services in Bangladesh found that 84% of patients consulted other carers first – of these, 44% first visited an individual private practitioner, while 22% first visited a native or religious healer, and 12% first visited a rural medical practitioner. The remaining 16% of the patients came directly for specialist psychiatric care.[4]

Barriers to accessing mental health care include language and cultural barriers, as well as lack of appropriate information. Psychiatrists or other providers do not always speak Rohingya or Chittagonian, most spoken by children, and there is a lack of MHPSS terminology in these and other local languages.[5] One way the stigma of PSS was addressed was by calling MHPSS workers 'doctors of the heart' (diller daktar), a more culturally accepted term.[6] It has been noted that, while the Rohingya language has a considerable vocabulary for emotional and behavioural problems, there is limited correspondence between these Rohingya terms and western concepts of mental disorders such as depression or PTSD. This hampers the provision of culturally sensitive and contextually relevant MHPSS services to these refugees.[7]

An ethnographic study of mental health beliefs among semi-rural villagers near Dhaka found villagers distinguished several types of mental illness, ranging from emotional and behavioural conditions to congenital illnesses and conditions associated with alcohol and substance abuse. Supernatural causation and local cures were mentioned, and mental health care services were sometimes accessed from the city if the illness persisted. There were significant gender issues in explanations for and experiences of mental illness, with women talking most openly about protracted anxiety and distress. It was observed that men (especially young men) frequently took refuge in substance abuse – including the proprietary sedatives that were easily obtained.

Thoughts about suicide are reportedly common among Rohingya in Myanmar and Bangladesh and are linked to a strong sense of hopelessness regarding their situation, the lack of prospects for the future and the loss of identity.[8] As suicide is strongly condemned in Islam, Rohingya will often conceal these ideas out of shame and fear for being judged – this a particular concern among Rohingya women.[9]

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3 Riley, A. et. al. (2017) Daily stressors, trauma exposure, and mental health among stateless Rohingya refugees in Bangladesh. Transcult Psychiatry. 2017 Jun; 54(3):304-331. Available from: http://www.ncbi.nlm.nih.gov/pubmed/28540768

4 Giasuddin, N.A. et. al. (2012). Pathways to psychiatric care in Bangladesh. Soc Psychiatry Psychiatr Epidemiol 47, 129-136 (2012)

5 Child-centred, cross-sectoral mental health and psychosocial support interventions in the Rohingya response: a field report by Save the Children Aladin Borja Jr., Ruma Khondaker, Jessica Durant & Beatriz Ochoa

6 ICRC, 2020, Living through war

7 Ibid

8 Thawnghmung, A.M. (2016) The politics of indigeneity in Myanmar: competing narratives in Rakhine state. Asian Ethnicity 17, 527–547

9 Nordby, L. (2018). Gender-Based Violence in the Refugee Camps in Cox Bazar: A Case Study of Rohingya Women's and Girls' Exposure to Gender-Based Violence. Sweden: Uppsala University

Understanding Rohingya traditional help-seeking behaviour and involving traditional healers in interventions is important in the provision of culturally relevant psychological treatment and psychosocial support.[10] Examples of Rohingya healers are (1) the spiritual healer (bouid-dou) who can also serve as a fortune teller (goi-noi-ya); (2) the religious scholar (fóu-yirr); (3) the Quran reciter (mou-loi/habés, moulvi/mullah) and (4) the unlicensed practitioner using western medication (daac-torr).[11] Healers are consulted for many different problems, including mental health conditions, seizures, developmental delay and autism.[12] Such problems are often attributed to malevolent spirits – jinn – or the 'evil eye.'

B-2.2 The wider context of mental health care

MHPSS Layer 4 services are provided by several organizations, most prominently UNHCR and BRAC through their health centers across Cox's Bazar.[13] UNHCR offers specialized services by psychiatrists and mhGAP trained doctors. Individual psychosocial support is provided through psychologists and para-counsellors, people from the refugee community who are trained to provide individual level MHPSS support.[14]

Child protection in Bangladesh is the responsibility of the Government, with the Children Act 2013 providing the framework for child protection systems.[15] The Child Protection Sub-sector in Cox's Bazar works with the District Social Services (DSS) to strengthen the CP system and link it to the national protection system. The CP Sub-Sector in the UN humanitarian response plan for Rohingya refugees works with partner organisations to strengthen capacity of case managers, provide service delivery in the camps, and strengthen referral pathways and entry points to specialized services for children.

In Cox's Bazar, the IOM and UNHCR-led MHPSS Working Group has supported the health sector in coordinating specialised MHPSS partner agencies. Integration of mental health into primary health care services has been identified as an important strategy, along with recruitment of community psychosocial volunteers and lay counsellors from the Rohingya community and involvement of traditional healers and religious leaders in planning, implementation, and evaluation of MHPSS initiatives.[16]

In theory, all MHPSS support provided at the camp level should be coordinated by the MHPSS Working Group. The working group of this area is taking a strategy to standardise reporting, especially for data sharing. SCI and IOM both have needs assessment tools and encourage partner organisations to make use of their tools.

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10 Chen, D.H. (2018). In Rohingya camps, traditional healers fill a gap in helping refugees overcome trauma. Available at https://www.irinnews.org/feature/2018/07/30/rohingya-camps-traditional-healers-fill-gap-helping-refugees-overcome-trauma

11 Tay, A.K. et. al. (2019). Op. cit.

12 Mollik, A.H. et. al. (2011). Towards integration of unconventional medicines in the public health service: the experience of Rohingya refugees' In Bangladesh. Journal of Epidemiology & Community Health 65, A449-A449

13 Map BRAC and UNHCR Rohingya Refugee MHPSS Response factsheet 2020

14 UNHCR Rohingya Refugee MHPSS Response factsheet 2020

15 CP Cox's Bazar Child Protection sub-sector, strategy 2021

16 Jeffries, R. et. al. (2021) The health response to the Rohingya refugee crisis post August 2017: Reflections from two years of health sector coordination in Cox's Bazar, Bangladesh. PLoS ONE 16(6): e0253013

B-3. Findings

B-3.1 Mental health needs of children and adolescents

Many children and adolescents of the Rohingya Refugees Community experience poor mental health. Rohingya adolescents are exposed to extremely traumatic events at high rates: nearly 50% experience being close to death and over 40% experience being in combat or torture. Many young Rohingya refugees have no work, no jobs, and no opportunity for income. Community members report that the food crisis and lack of proper care is leading to psychological problems. Diverse types of mental illness among Rohingya refugee camp children were identified by community members as hopelessness, aggression, anti-social behaviour, sleep disturbance, developmental delays, and low IQ.

Negative coping mechanisms persist, disproportionally affecting Rohingya women, girls, and boys, who face risks of abuse, exploitation, and gender-based violence. Camp workers consider that children are frustrated and afraid, many growing up with negligence, without proper care, and without any goals in life. An alarming number of children do not live with their parents, so they lack a first layer of protection to look out for their mental health. An education sector informant reported that circumstances associated with family stress, such as persistent poverty, may elevate the risk of serious mental health problems. Young children who experience recurrent abuse or chronic neglect, domestic violence, or parental mental health or substance abuse problems are particularly vulnerable.

B-3.2 Mental health care providers

Community members and organisations interviewed considered Layer 4 services in the camp to be very limited. There are 4 psychiatrists working at Cox’s Bazaar who rotate to different camps. Some doctors have recently been appointed who have mhGAP training. Clinical psychologists studying at the University of Dhaka do placements in the camp but there are no child MHPSS specialists. In the view of the health team, only students who are specialised in Educational Psychology and Schools Psychology are well-suited to work with children; but this is not considered when recruiting for camp positions.

There are supply issues with medication and it is rare for people (especially children) to be prescribed psychotropic medication for mental health disorders.

Many different organisations provide MHPSS services following their own guidelines with various interventions to bridge the IASC MHPSS Guidelines and mhGAP. While organisations provide their own training in various counselling approaches, Psychological First Aid (PFA), protection awareness sessions, there are very few examples of training being put into practice for supporting families.

For camp workers, a 5-day training is conducted following the UNICEF MHPSS Age-Appropriate Module. Children and adolescents are particularly prioritised, and all sectors are encouraged to incorporate MHPSS approaches to support children and family’s mental health and well-being. There were posters available about this training and camp workers were aware of it, but none interviewed had attended this training.

NGO staff noted that their organisations may have added the component of MHPSS to their work, but this was often done to meet a donor requirement in a superficial way and the staff themselves had not received training or guidance to implement MHPSS interventions. They felt MHPSS ‘boilerplate’ texts were generic and that approaches were insufficiently researched or tailored to the local context. Some interventions are short-lived. There was one example of a meditation group doing family sessions at the time of this research, but the group of volunteers doing this were visiting for 3 weeks only and this was not a permanent service for the camp.

B-3.3 Pathways to care and coping strategies

Child protection actors were found to make referrals to Layer 4 services. Children are referred to psychologists and if necessary, then further referred by the psychologist to a psychiatrist.

Parents take children to traditional healers 'Kabiraj' for 'Jharfuk' but may give up if there is no improvement and consider their condition ‘permanent’ and assume a passive and depressed attitude. Respondents say there are limitations to visiting a 'Kaviraj' as each visit involves expensive fees and families are too poor to afford frequent visits. Families can however discuss workarounds with the ‘Kaviraj’ who also accept ‘in-kind’ payments, some of which can result in abuse or exploitation. Some traditional healers (Hujurs) on the other hand provide services on a voluntary and donations basis.

Community members also rely on religious practices and visit the religious leader 'Huzur' or 'Imam' or 'Mawlobi' and collect water from him to drink for treatment. 'Hafez' or 'Qari' reads the Quran and prays for troubled children to Allah SWT. They talk to the child and people report they give quality time to make the child happy. People go mostly to 'Molla' or 'Munshi' for blowing and pouring water as they believe they are near to Allah and Quran’s verse has the power to reduce their pain or suffering.

Parents take children to traditional practitioners 'Vaidya' for cases with severe and visible disability. It was reported that for mental health disorders like depression or anxiety parents are less likely to take action than for a disability or severe condition. Many parents lack a basic understanding of their child’s condition as well as lack tools to help manage conditions to make it less disabling. Some think their child is possessed by a Jinn or demon or is a bad child.

Families adopt various other strategies. Some turn to Save the Children to provide MHPSS services. Some call a National Child Helpline 1098 for advice however they often do not receive practical advice as recommended services are not available in their location. Parents also use regular over the counter medication for children and herbal medicine / traditional medicine made from the roots of trees and plants. Camp residents complained that there is not enough vegetation in their area to make traditional remedies as the camp site is barren.

B-3.4 The role of the education sector

An education sector informant reported that teachers give a special focus to children who are avoidant or have inappropriate behaviour and try to motivate them; if they think the case is serious, they refer to MHPSS focal point. As teachers are not specialists, however, they are limited in identifying cases in the school setting.

Norwegian Refugee Council (NRC) is implementing a Better Learning Program (BLP) and is training teachers on MHPSS to improve awareness at school level. Teachers can engage by talking to a troubled child in private if they notice signs of mental problems and will also speak with a child’s friends. New teachers are also made aware of issues with individual children. NRC places emphasis on sports along with education ***“because one who is not good mentally will not like his studies.”*** There are some extra-curricular activities in the community associated with educational institutions. Some students have volunteered to teach parents of deaf students how to sign, and other students have taken an initiative to plant trees.

Education actors believe that if MSPSS is integrated with education it will bring good results and that more work is needed on integration and feedback mechanisms following referrals.

B-3.5 Case management for coordinated support

Each camp has one MHPSS focal point to whom camp workers are expected to refer when they see a psychological issue. Typically, the case managers refer to MHPSS camp focal point who then refers the case to a psychologist or psychiatrist.

WHO and health sector partners have joined forces and developed SOPs to strengthen referral pathways in Cox's Bazar. However, participants at all levels felt that referrals for MHPSS cases, especially children, were still not practical, affordable, manageable, or realistic for families, one respondent referring to 'empty referrals.'

The MHPSS Working Group is developing a strategy to standardise reporting, especially for data sharing. A separate working group for children and adolescents was created to work on programme design and advocacy, but this stopped during COVID. Digital tools exist for coordination such as Health Resources and Services Availability Monitoring System (HeRAMS) World Health Data Hub (WHDH). Neither of these systems play a particularly functional role however in helping refer families for services.

Case workers were able to list a few examples where MHPSS services were combined with wider services that children need - education, health, and child protection. The examples provided were short term, often pilot activities, and not established as long-term practices in the camp to date:

- Gender based violence was given as an example where girls received a holistic package of support including MHPSS. Caritas offered free travel and medical fees for victims of GBV to receive full medical and psychological support in a project that ran from February 2019 to March 2022. This GBV program had full-time MHPSS officers and included 4 highly qualified child phycologists and one child-specialised psychiatrist.
- When ACF worked in nutrition and health there was always a group of psychologists.
- Norwegian Refugee Council (NRC) is now training teachers on MHPSS to improve awareness at school level.

SCI and IOM both have needs assessment tools and encourage partner organisations to make use of their tools.

There were also examples of missed opportunities to address mental health needs within the mainstream health system. For example, one case was given by the caseworker where the child received medical care for cuts she made attempting to commit suicide, but the suicide itself was not addressed by the medical team, only the cuts were treated.

NGOs provide basic safe spaces for children for example BRAC has introduced some play-based therapeutic activities for children. IOM has opened some interventions in Rohingya camps focusing on adolescents, specifically to address drug and alcohol abuse.

B-3.6 Common barriers and gaps in MHPSS services

Specialized professionals (psychologists and psychiatrists) are not available in each block and each camp. Families are restricted in their movements and traveling between camps or blocks to access services is very expensive. It is not uncommon for a referral to be made and never followed up because travel costs are too high, families do not trust the process, or families are not able to invest the time and energy to go to a specialist.

One issue for the health team was that psychologists were recruited but quickly lured into doing managerial activities and switching to permanent management roles. A risk across the camps was that workers were burning out fast and psychologists and psychiatrists did not stay to work in the camp for the long term. Families considered this lack of consistency a barrier to bringing their child for treatment; children with autism, for example, struggled to adjust to a new specialist every time. Providers not understanding the Rohingya language was also an obstacle.

For the small number of cases where successful referrals are made, the health team raised concerns that many of the MHPSS clinical staff are students, and their clinical practices are not supervised well. NGO participants were concerned that staff are engaged to work in MHPSS positions without enough training and background. They feel that the quality of MHPSS services to the community is poor because a 2-3-day training is not sufficient for anyone to provide the needed level of care. Families were often told 'what is wrong,' but not 'what to do about it.'

Another gap in quality of service is that all interventions are done with adults in mind. While some methods could be also appropriate for adolescents, there is little capacity building for suitable services for children up to 10 years of age.

One of the main challenges to providing Layer 4 MHPSS in Cox's Bazar is the stigma attached to mental health difficulties some of which is perpetuated even by health care professionals.

B-3.7 Opportunities for integrated support

Integration of mental health into primary health care services has been identified as an important strategy, along with recruitment of community psychosocial volunteers and lay counsellors from the Rohingya community and involvement of traditional healers and religious leaders in planning, implementation, and evaluation of MHPSS initiatives.

In some cases, para counsellors from the refugee community have been trained in specific modules to provide individual level MHPSS support within their own communities circumventing language and cultural barriers

A model that received widespread praise is the Humanitarian Play Lab (HPL) developed by BRAC which is providing play-based learning to children in emergency situations to help mitigate the detrimental long-term effects of displacement and trauma. Its slogan is 'Play to Heal, Play to Learn.' The team has data to track core child indicators and can show that Play Labs improved children's developmental outcomes. Play Labs have equipped parents with knowledge and resources to support their children's development, developed a cadre of Play Leaders build their knowledge and skills in early childhood development, and reduced gaps between children's outcomes.

B-4. Summary of key findings

- Cox's Bazar houses over 1 million Rohingya refugees, over half children, who fled to Bangladesh to escape violence and persecution in Myanmar. There are 34 separate camps.
- Rohingya children and adolescents have high rates of exposure to extremely traumatic events. An alarming number of children do not live with their parents and are extremely vulnerable.
- Specialised Layer 4 services consist of four psychiatrists at Cox's Bazaar who rotate to different camps. Some doctors have mhGAP training, while student clinical psychologists undertake placements in the camp. Referrals for MHPSS cases, especially children, were often not practical, affordable, manageable, or realistic for families.
- NGOs provide different MHPSS and counselling services – however these are often inadequately tailored to context and workers are not trained in sufficient depth. Families are often told 'what is wrong,' but not 'what to do about it.' There are good examples of NGOs providing safe spaces and play-based therapeutic activities for children.
- Religious and traditional healers are the first port of call for most families having a child with mental illness. Some report that these healers spend quality time with children.
- Education actors believe that that MSPSS could be better integrated with education and that more work is needed on feedback mechanisms following referrals.
- Opportunities identified by the community include recruitment of community psychosocial volunteers and lay counsellors from the Rohingya community and involvement of traditional healers and religious leaders in planning, implementation, and evaluation of MHPSS initiatives.

CAMBRIDGE EDUCATION

Child Protection Area of Responsibility
Global Protection Cluster

EDUCATION CANNOT WAIT

Final report | Annex C: Colombia country report

Field research in Colombia to assess services available in the Cazucá immigrant community to assist children and adolescents who need specialized mental health services

April 2023

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Annex C contents

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C-1. The humanitarian setting

The setting for this study is the humanitarian site of Cazucá, which is located between Bogotá, the capital city of Colombia, and Soacha, a municipality that shares borders with Bogotá. Since the 1960's Cazucá has been a site occupied by displaced populations and ex-combatants from paramilitary and guerrilla groups. The part of Cazucá that is in Soacha presents significant security concerns regarding poor housing conditions and exposure to violence.

Figure 1.1: Location of Cazucá in Bogotá and Soacha[1]

Current estimates indicate that 69,325 people live in Cazucá with around 80% displaced from different rural regions of Colombia. There are no current figures for the proportion of Venezuelan migrants living in Cazucá. An initial demographic assessment showed that around 33% of Colombian IDPs were children and young adults, with the majority not able to return to school following displacement. Women are frequently employed as domestic workers or become street vendors while men are mostly employed as building workers and wardens.

The sprawling nature of Bogotá city means both IDPs and Venezuelan migrants become highly dispersed and difficult to target. Both groups face financial and logistical barriers to accessing mental health services; in addition, it is difficult for Venezuelan migrants to access local health insurance schemes for accessing these services.

This rapid assessment case study is based on interviews with 15 key informants in Cazucá, who were asked about the challenges and strategies developed by families to access to mental health services, as well as a desk review of the literature base, including site data and project reports.

[1] Taken from https://semanarural.com/web/articulo/fotorreportaje-la-soacha-negra-resistencia-afro-en-cazuca/231 and Google Maps

C-2. Setting the scene

C-2.1 Review of the literature base

Colombia is reported to have one of the largest populations of conflict-affected IDPs in the world.[2] Gender-based violence is reported to be a particular problem for female IDPs - in armed conflict zones, young girls are often forcibly recruited or kidnapped by armed groups and forced to work as fighters, informants, guides, messengers and conjugal partners to the group leaders, or sex slaves.[3] Meanwhile, survey data shows a significant association between substance misuse, depression, and psychiatric illnesses among men - especially young men.[4]

A significant proportion of IDPs in cities are indigenous people, such as the Emberá people. Armed conflict in rural areas of Colombia forces these indigenous people to abandon their ancestral territories and cultural practices, with detrimental consequences for their mental health.[5]

Studies on mental health needs of Colombian IDPs have shown high prevalence of exposure to traumatic events and common mental disorders, such as depression, anxiety, PTSD, and substance use disorders.[6] A study in deprived areas of Bogotá, found that preschool IDP children presented worse mental health than non-displaced peers, especially when their families and caregivers were experiencing mental health challenges.[7]

Barriers to accessing MHPSS services for highly dispersed IDPs in this urban setting include logistical barriers, lack of transportation or childcare options, mistrust, stigma, and the low priority given to mental health by IDPs.[8]

A study of coping strategies among adults (including IDPs) exposed to the armed conflict in Colombia found religion to be one of the most common coping strategies among this population.[9]

A study conducted through the Colombian Red Cross emphasised the importance of tailoring MHPSS services to the backgrounds of migrants – in this case focusing on the different approaches needed for Colombian IDPs and Venezuelan refugees. Adult Colombian IDPs tend to have lower levels of education and are often unemployed or restricted to work in the informal sector. In contrast, Venezuelan migrants have higher levels of education but also tended to work informally; they also reported common threats of violence, sex work, theft, extortion, xenophobia, sleeping on the street, recruitment by armed groups and drug gangs. Overall, there was little literature offering explanatory models of mental health and psychosocial problems and help-seeking patterns for both study populations.[10]

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2 Shultz, J.M. et. al. (2014a). Internally displaced 'victims of armed conflict' in Colombia: the trajectory and trauma signature of forced migration. Current Psychiatry Reports, 16, 475

3 Chaskel, R. et. al. (2015). Mental health in Colombia. BJPsych. International, 12(4), 95-97

4 Ibid

5 Eslava, L.F. et. al. Internal forced displacement and mental health in Colombian indigenous peoples. The Emberá case in Bogotá. Revista Tesis Psicológica, 14(2), 42-65

6 Shultz, J.M. et. al. (2014a). Internally displaced 'victims of armed conflict' in Colombia: the trajectory and trauma signature of forced migration. Current Psychiatry Reports, 16, 475

7 Flink, I.J.E. (2013). Mental health of internally displaced preschool children: a cross-sectional study conducted in Bogotá, Colombia. Soc Psychiatry Psychiatr Epidemiol 48, 917-926 (2013)

8 Shultz, J.M. et. al. (2014a). Op. cit.

9 Hewitt-Ramirez, N. et. al. Afectaciones psicológicas, estrategias de afrontamiento y niveles de resiliencia de adultos expuestos al conflicto armado en Colombia. Rev Colomb Psiquiatr. 2016;25(1):125-40

10 Perera, C. et. al. (2020). No implementation without cultural adaptation: a process for culturally adapting low-intensity psychological interventions in humanitarian settings. Confl Health 14, 46 (2020)

C-2.2 The wider context of mental health care

The Colombian Ministry of Health and Social Protection is responsible for providing Layer 4 services to displaced communities and people affected by emergencies and disaster. The policy was developed in 2011 but is still being implemented. According to policy services are available to displaced children, but people need to seek Layer 3 or 4 services themselves or alternatives. Informal or alternative health providers, such as faith and religious leaders, are considered mental health providers as long as they have attended a training to provide MHPSS services.

Child protection at the national level is the responsibility of the Government. In addition, child protection is coordinated through the OCHA Sub-cluster for child protection and the Interagency Group of Mixed Migratory Flows (GIFMM-R4V) led by UNHCR/IOM. According to the OCHA Child Protection sub-cluster the two organisations present in Cundinamarca as part of the child protection network are Fundación Plan and World Vision.

Child protection activities for IDP and refugees in Colombia is run through variety of actors, including UNICEF, IOM, and international and national NGOs. To mitigate child protection risks, UNICEF is working with Instituto Colombiano de Bienestar Familiar (ICBF) and the Colombian Red Cross to enhance psychosocial support and case management for children.[11]

Organizations that have provided mental health support for displaced children are UNICEF, IOM, HIAS and Action Against Hunger.

Within Cazucá, the following foundations provide MHPSS services: Fundación tiempo de juego, Centro de Desarrollo Familiar, Fundación Verdaderos Héroes, Fundación alas cinco, and Coorporación Infancia y Desarrollo (CID, this is a UNICEF implementing partner in Colombia). Governmental programs include PAPSIVI (managed by the Ministry of Health), and the sub-network of health of Bogotá's Secretary of Health.

[11] UNICEF 2021 Country Activity Report

C-3. Findings

C-3.1 Mental health needs of children and adolescents

In Cazucá children spend a great amount of their spare time alone. Many parents are absent with poverty forcing them to work long hours.

Tragically, an 11-year-old child took his life three weeks before our fieldwork.

> ***"Because all the pressure his parents were going through, their expenses and everything, he committed suicide. He was traumatized because they left their home in the rural area and came to suffer to Soacha. […] Back in their home they had everything, and here they have practically nothing. He left a note explaining that he did it because his mother was suffering."***
>
> ***"Sometimes one, as a father, neglects what children are going through. […] One sees things too late, because one is worried about bringing them food, but they need love, support, understanding, but sometimes the lack of time does not permit us to provide such things."***

Although some foundations offer children cultural and sports activities, they do not have enough resources to provide activities to children living in the most recently built shanty towns.

C-3.2 Mental health care providers

Colombia lacks for financial and human resources to provide Layer 4 services. One interviewee commented that Colombia was well advanced in providing child protection services, but behind in providing mental health services. She indicated this happened because there are not enough financial and human resources: in Colombia ***"there are areas where a psychiatrist will only be available for half a day during the whole week"***.

Children referred to mental health services (psychology or psychiatry) will typically receive a 45-minute consultation with a mental health professional once a month. Another way to access mental health services in Bogotá is through the sub-network of health department. A psychologist from this sub-network will visit selected families to engage in family therapy and will develop seven family sessions.

The quality of the mental health care is considered was reported to be inadequate as consultations last a maximum of 45 minutes and only in severe cases will be scheduled more than once a month. Moreover, mental health practitioners are not well trained to provide mental health care to children, nor to provide layer four MHPSS services.

C-3.3 Pathways to care and coping strategies

Children and adolescents normally access MHPSS services through referrals. Referral pathways to mental health consultations are quite long -especially for families living in the Soacha's area of Cazucá. Because they need to get referred by a general practitioner to get to a psychologist or a psychiatrist, children and their families will need to attend to at least one medical appointment before accessing to a mental health consultation. For some families, getting to one consultation will be too expensive because of the time taken from work and the travel expenses. It will also be time consuming to attend to any other health consultations. To alleviate this, in Bogotá's part of Cazucá, a group of psychologists goes to the houses of families living in Cazucá and other nearby settlements. Soacha could replicate this strategy so that families can access more easily to health care.

Frequently, schoolteachers and community leaders refer children to a non-specialist medical practitioner within the health care system.

Common coping strategies are:

Approaching NGO's workforce for support: A coordinator at a local NGO providing leisure activities for children and adolescents (arts, music, and sports) indicated how she has been serving as therapist for some of the adolescents who are supported by her NGO. She did not intend to become a therapist - and she does not consider herself to be one, but she listens to those children who behave in ways that need to be addressed. Some of these adolescents have not accepted referrals to mental health services because they do not perceive themselves to have a mental health problem.

Peer-to-peer support: following the above point, some of the adolescents supported by the NGO have contacted each other and provide themselves peer-to-peer support. In a similar way, CID (Coorporación Infancia y Desarrollo) has been organizing support groups in different regions of Colombia (not Cazucá) to provide people in need of mental health care a space to find support and compassion. These support groups are intended to cover the lack of mental health specialists available in many cities and municipalities of Colombia.

Community leaders: a community leader working nearby Cazucá's part located in Bogotá, indicated that parents (both mothers and fathers) approach to him to receive advice on raising their children. If he considers it necessary, he refers them to a psychologist from the public sector.

Not doing anything: Another community leader indicated that some families do not address the mental health problems of their children because they have too many other problems to care about. She also indicated that she did not trust Colombia's most important child protection institution, ICBF because ***"they come to take your children"***.

Music, arts, and spare time: different foundations, including Fundación Tiempo de Juego, offer children activities in which to spend their spare time so that they get to socialize with other children. With these activities, some children are given the chance to stay less time alone in their houses when their parents are out working.

C-3.4 The role of the education sector

School teachers seem to play an active role in referring cases for MHPSS care. Among the interviewees it was perceived as a good practice that education in emergencies is being provided to different populations in Colombia. Also, it is viewed positively that the Education Sector oversees training teachers and community leaders on MHPSS and humanitarian emergencies. However, there was also concern that it is not clear how teachers (and community leaders) decide to refer a child for MHPSS services which should be clarified as there could be children in need who are not receiving care.

One reported case was of teachers at a kindergarten who noticed that a two-year old child still did not pronounce any words and was isolated from other children. They discussed this with his mother and suggested that her child might be in the autism spectrum and should be taken for assessment. Though it was hard for her to hear this news, she has since been taking her child for neuropediatric consultations and myofunctional therapy. She is also receiving support from the kindergarten staff, who are keeping record of his progress.

C-3.5 Case management for coordinated support

CP actors are not familiar with MHPSS services: most of the child protection workforce in charge of providing care to children are not trained in MHPSS.

Some foundations refer to Instituto Colombiano de Bienestar Familiar (ICBF) when they suspect that children are being abused in their homes. Some families reject being referred to ICBF because they believe they will be separated from their children.

Most community leaders interviewed were negative about referring cases of abuse to ICBF. They said that alerting ICBF to family misconduct could cause serious repercussions with the community. One said: ***"it becomes an explosive bomb […] this happened to one of my colleagues and the family broke her home's windows"***.

This attitude could imply misconduct by ICBF staff or misinterpretation of what the institution does in cases of suspected child abuse. It was reported by some interviewees that some ICBF staff have used xenophobic language.

C-3.6 Common barriers and gaps in MHPSS services

Though guidelines exist, Layer 4 services are not accessible: though rules and guidelines for child protection actors to refer children to specialized health care exist in Ministry of Health guidelines, referrals do not occur because of a lack of psychologists and psychiatrists, especially in remote areas, with a specific lack of providers able to provide care to children. The few qualified providers dealing with children work outside the health insurance companies and are unaffordable to poor populations. In most of the cases, through Colombia's health system those needing mental health care can only access once a month to a 45-minute psychological or psychiatric consultation.

Lack of confidence in referrals

One respondent related that while working in remote and rural territories she has referred children to specialized mental health services without being totally sure that they are going to be cared for. Moreover, she stated that very few mental health providers know how to work with children because most are trained to work with adults only.

Stigmatization of mental health consultations: many informants indicated that some adolescents reject being referred to mental health professionals arguing that they do not need that type of care because they 'are not crazy' ('yo no estoy loco').

Colombia's health system is accessible for people who are insured: Those who are not -which are mainly migrants, can only access to emergency care. This means that people without insurance can only access mental health care if they are experiencing a crisis requiring emergency services.

In humanitarian contexts Layer 3 services are available, while Layer 4 services are not: MHPSS services for children and adolescents are available through support groups. In Colombia, neither the government, nor the NGOs and foundations provide Layer 4 services because the lack of human and financial resources. In Bogotá, a lot of work has been done so that migrants can access to health care services, while in Soacha not much has been done.

C-3.7 Opportunities for integrated support

In Bogotá, the Secretary of Health has developed a Public Health program in which 'brigades' of different health providers (nurses, psychologists, nutritionists, and physicians) visit different parts of the city, including Cazucá, to evaluate the health of different populations. During these brigades, they also receive referrals from community leaders, teachers, and others to provide care to families or children in need of care.

Cauzcá in Bogotá - referrals for Layer 4 services: ICBF runs its own kindergartens which can activate referrals to specialized services for children diagnosed with autism, are victims of intrafamily violence or sexual abuse. For detecting these cases, an integrated team (consisting of auxiliary nurse, pedagogic coordinator, and a psychosocial therapist) schedule observational visits to the families of the children and analyse the behaviour of the family. If they identify that a woman is experiencing violence, they refer her to the Women's Secretariat in Bogotá.

During a workshop organized in Bogotá on MHPSS services, leaders from Catatumbo - a municipality seriously affected by Colombia's armed conflict - asked for workshops on how to better work with adolescents.

C-4. Summary of key findings

- Cazucá is located between Bogotá and Soacha and houses around 70,000 people around 80% displaced from rural areas of Colombia plus Venezuelan refugees. In Cazucá children spend a great amount of their spare time alone as parents are absent working long hours.
- Specialist mental health services are available by referral, but Layer 4 services are often not accessible because of a lack of psychologists and psychiatrists able to provide care to children. When successful referrals are made, the norm is a 45-minute consultation once a month.
- Psychosocial work / Layer 3 services in Colombia are more prevalent compared to specialized Layer 4 mental health care services.
- Informal or alternative health providers, such as faith and religious leaders, are considered mental health providers as long as they have attended a training to provide MHPSS services.
- Adolescents often prefer talking with workers of NGOs than going to health professionals because they stigmatize attending mental health consultations.
- Schools, especially kindergartens, are recognised as having an important role in case identification, referral, and ongoing support; however, they need further support in clarifying who they should refer.
- Social protection actors play a valuable role in case management. Some foundations refer to Instituto Colombiano de Bienestar Familiar (ICBF) when they suspect child abuse though communities have a negative view believing ICBF will separate parents from their children.

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CAMBRIDGE EDUCATION

Child Protection Area of Responsibility
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Final report | Annex D: DRC country report

Field research in DRC to assess services available in Maluku IDP community to assist children and adolescents who need specialized mental health services

April 2023

100408703-024 | UNICEF LTA Education FWC - P24 - R060 MHPSS

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Annex D contents

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D-1. The humanitarian setting

The Democratic Republic of Congo (DRC) has more than eighty-nine million inhabitants, of which around five million are categorized as Internally Displaced People (IDPs).[1] Much of this is due to chronic instability and conflict, especially in the east of the country since the 1990s.

Maluku, the humanitarian setting for this study, is a municipality in the Tshangu district of Kinshasa, and covers both peri-urban and rural areas.

Figure 1.1: Location of Maluku in the DRC

Maluku is regarded as a multi-cultural area due to population movements across the Congo River. Around half the population is under 15 years old.[2] For several decades, Maluku has been receiving IDPs fleeing conflict in North and South Kivu to the east, and inter-communal violence in Mai-Ndombe Province to the north. Maluku is not a single camp, rather IDPs live alongside local communities. The local Social Affairs Service reported that, at the time of this study, there were over 250 registered IDP households (around 1,300 people) in the area. Most IDP households in the area are dependent on subsistence agriculture; there are also reported to be high levels of extreme poverty and family separation.

This rapid assessment case study is based on interviews with eighteen key informants and stakeholders involved in MHPSS services for IDPs in Maluku, as well as a desk review of the literature base, site data and project reports.

[1] UNHCR. (2020). 5.2M people internally displaced in the DR Congo: UNHCR | CGTN Africa

[2] Source: Dr Congo Population 2023 (Live) (worldpopulationreview.com)

D-2. Setting the scene

D-2.1 Review of the literature base

In DRC, especially among IDPs from Eastern DRC, mental health disorders are broadly understood in terms of two distinctive cultural concepts of 'madness' and 'sadness.' Causes of mental illness are considered to range from: bad spirits, spells and sorcery, to cerebral malaria, substance abuse, grief, rejection in love, worry and sexual abuse.[3] Childhood epilepsy can be associated with stigma and misconceptions that it is contagious, or due to possession by evil spirits.[4] Responses to mental illness often require a visit to a traditional, religious, or herbal healer, with recourse to ancestors. This may be combined with advice, comfort, and practical support, as well as visits to a medical facility.[5] Children with disabilities or mental health disorders may be accused of witchcraft, with some being driven from their homes and on to the street where they may be at increased risk of ritualistic child sexual abuse or cult-based child marriage.[6] Studies on protection services emphasize the need to consider gender and the distinctive needs of children and adolescents. They also emphasize the need to combine individual care with the need to tackle social and structural determinants of poverty, insecurity, stigma, and marginalization.[7]

Young people face child protection issues with implications for their mental health

Violence against children in the Democratic Republic of Congo (DRC) is widespread in all settings, including families, schools, and communities. Nearly one in three women is affected by child marriage, often linked to early pregnancy. Indeed, one in four girls has begun her reproductive life before the age of 18 years, making the DRC one of the countries in the world with the highest number of children affected by early pregnancy.

In addition, only 40% of children under the age of five are registered with the Civil Registry, and only 13% have a birth certificate. This is due to a registration system that struggles to reach newborns, which is exacerbated in conflict areas.

Across the country, eight out of ten children under 14 years are regularly subjected to physical punishment, and 15 percent of children aged 5 to 17 years are engaged in child labor. An estimated 10,000 children are still associated with armed groups and forced labor.[8]

D-2.2 The wider context of mental health care

There are around sixty psychiatrists in the country, mostly located in Kinshasa city – where there are six hospitals offering specialist mental health services. There are two university institutions: the CNPP–Mont Amba in Kinshasa and the Department of Neuropsychiatry of Sendwe Hospital in Lubumbashi. There is one State Hospital, operated by the Roman Catholic Brothers of Charity (the CNPP–Katwambi) in Lubumbashi. In addition, there are mental health centers, 90% of which are run by Roman Catholic organizations. There are also some private clinics run by Congolese neuropsychiatrists in Kinshasa.

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3 Ventevogel, P. et al. (2013). Madness or sadness? Local concepts of mental illness in four conflict-affected African communities. Confl Health 7, 3 (2013).

4 O'Neill, S. et al. (2019). Stigma and epilepsy in onchocerciasis-endemic regions in Africa: a review and recommendations from the onchocerciasis-associated epilepsy working group. Infect Dis Poverty 8, 34 (2019).

5 Priest, R.J. et al. (2020). Christian Pastors and Alleged Child Witches in Kinshasa, DRC. On Knowing Humanity Journal 4 (1), January 2020.

6 Kasherwa, A.C. and Twikirize, J. M. (2018). Ritualistic child sexual abuse in post-conflict Eastern DRC: Factors associated with the phenomenon and implications for social work, Child Abuse & Neglect, Volume 81, 2018, pp. 74-81,

7 For example: See for example, Cherewick, M.L. (2016). Trauma, Coping and Resilience Among Conflict-Affected Youth in Eastern Democratic Republic of Congo. PhD dissertation, Johns Hopkins University. Available at: CHEREWICK-DISSERTATION-2016.pdf (jhu.edu)

8 Source: Child protection | UNICEF

Some humanitarian organizations and NGOs offer MHPSS services. This includes the Danish Refugee Council, Care International, IRC, MSF, UNICEF, and the Red Cross; however, these often focus on victims of gender-based violence (GBV) and other forms of violence and mostly work in the Eastern Regions and central Kasaï Province.

The DRC has ratified the international legal instruments concerning the rights and protection of people who are mentally ill, but these have not yet been translated into domestic law. The Ministry of Health is responsible for the organization, management, and planning of mental health sectors. Successive national health planning documents indicate that mental health should be integrated into primary care in line with policies on health decentralization. However, key informants suggest that, to date, progress has been slow and budget allocations for this exercise have not been forthcoming.

Several Government ministries have mandates relevant to the protection of children separated from their families, the principal one being the Ministry of Social Affairs, Humanitarian Action and National Solidarity (MINAS). MINAS is responsible for initiating, coordinating, and implementing policies for the social protection of vulnerable groups, including orphans and vulnerable children (OVC). At the provincial level, MINAS provides services through the Division of Social Affairs (DIVAS) or the Urban Division of Social Affairs (DUAS). The country's legal framework for the protection of children was substantially strengthened with the adoption of the Child Protection Law in 2009.[9]

[9] Source: Save the Children Fund: https://resourcecentre.savethechildren.net/pdf/drc_report_kinship_care_drc_report_0811131.pdf/

D-3. Findings

D-3.1 Mental health needs of children and adolescents

Key informants suggest that children and adolescents in the Maluku area face many problems associated with severe poverty, but for children and adolescents in IDP communities this can be compounded by family separation, loss of one or both parents, as well as experiences of traumatic events and conflict.

The Maluku Child Protection Office reported that two years ago it registered around fifteen serious MHPSS cases requiring specialist care services, as well as a large number of abandoned children in the community. Some children who have lost parents and exhibit mental health symptoms have been ostracized and treated as a 'witch.' It was reported that young people with mental problems are often rejected by their families, become victims of physical violence, and may resort to alcohol or substance abuse. Women and girls face specific risks and vulnerabilities, including sexual abuse and violence; some young girls who have become pregnant are then abandoned by their families.

D-3.2 Pathways to care and coping strategies

In Maluku, families / appointed guardians of young people with mental health conditions usually identify the issue and refer themselves to a preferred practitioner. In most cases, the first point of contact is a traditional healer, pastor, or priest.

> ***"From my experience, I can say that when a child has a mental problem, it is a troublesome problem in the large family. Most of time the family thinks this as roots from a spirituality problem, or it may be a curse. The first reaction to resolve the problem is to see a priest or a pastor."***
>
> Primary School Teacher

Some respondents suggested this was due to lack of other accessible services in the area:

> ***"The informal mechanism is not controlled. Each family tries to find his way out to resolve the problem and seek healing of the child. Some may go to find pastors or a priest, others go to the traditional healer. This is due to their conviction, but also due to the lack of special services."***
>
> INGO Representative

It was also observed that parents and guardians may seek assistance from a health provider at the same time, especially if the mental health condition is thought to have a medical cause.

However, some community members made the link between medical treatment and institutional care, suggesting that the best care for severe mental health issues was in Kinshasa, where the individual could be admitted to an institution. This was especially recommended for cases where care was beyond the means of the family or community.

D-3.3 The role of the education sector

Schools are sometimes involved in decision-making and may advise families on options for care and support.

> ***"Parents are sometimes happy as the school can identify that a child is experiencing some mental health problems, and this helps them take a decision."***
>
> Community Educator

There were some examples of collaboration between schools and parents to help identify children experiencing mental health problems and make joint decisions. However, it was generally emphasized that schools are unable to get involved in MHPSS activities because they lack the training, infrastructure and / or resources to assist young people with specific mental health challenges.

From a key informant interview at the Ministry of Education, we learnt that a Directorate of Orientation has recently been established to deal with 'socio-emotional' welfare of children in schools. The directorate is now planning to put counsellors in place at national, provincial, and sub-provincial levels.

D-3.4 Case management for coordinated support

Child protection officers reported that parental / guardian consent is required for a child to be referred to a medical service.

Nevertheless, identification of young people in need of mental health services was seen as challenging.

> ***"The community is very large, and we need more technical capacity to be able to identify cases, not to wait for families to shout."***
>
> Child Protection Actor

In child protection cases, referral decisions are made as part of a formal collective decision involving a committee of social educators / officers. In this region, a 'youth movement' has a process for engaging decision-makers in a community forum. Here, a 'children parliament' takes on child protection matters. When they identify a case, they begin by inviting parents or the guardian. If a decision is made to refer the child for services, such as specialist health care, then clearance is needed from the local authority. However, case managers suggested that one problem is that they do not receive information or feedback from specialist services:

> ***"What comes next we don't know because there is no counter reference mechanism."***
>
> Social Educator / Case Manager

Child Protection and NGO actors reported that they do try to tackle young people's wider needs, especially in cases where there is a mental health issue and little family or socio-economic support. In Maluku, this is most commonly the case for street children, some of whom have mental health problems; however, in these cases, referral to an orphanage is often the only option for providing shelter and assistance.

A key challenge for Child Protection actors is that community interventions that could provide MHPSS benefits are not well coordinated:

> ***"Each person does what he thinks to be good without considering the actions of others."***
>
> Community Educator

> ***"We notice that community interventions are sometimes scattered, interventions are not organized and it is very difficult to have a control on all cases."***
>
> Community Educator

D-3.5 Common barriers and gaps in MHPSS services

Key informants and stakeholders report that the main barriers to uptake of mental health services by children and adolescents in Maluku are:

- Lack of government budget allocations for mental health services, leading to failure to implement MHPSS approaches
- The low coverage of health care services in general, especially in rural areas
- Lack of accessible specialist mental health care services and a shortage of specialist mental health care providers
- Weak mechanisms for identifying children and adolescents in need of mental health care services

- The high out-of-pocket expenses for families, and the lack of financial support for families to meet the cost of attending services at specialist referral centers
- Lack of trained MHPSS personnel at community level across all sectors, and little coordination and referral between sources of support
- Few strategies available to child protection actors for dealing with issues of family disengagement / rejection, or social stigmatization and isolation

D-3.6 Opportunities for integrated support

Discussions with key informants and child protection actors at national and local levels did, however, elicit a number of opportunities at the national and local levels, including:

National level:

- Creation of the new division in the National Ministry of Health is an important opportunity for leadership and momentum in implementing the national mental health program
- National policies / guidance has recently been developed to support children suffering from autism
- There may be new opportunities associated with the Ministry of Education's new Orientation Directorate which is placing school counsellors at national, provincial, and sub-provincial levels.

Local level:

- There have recently been efforts to create a network between different child protection actors in Maluku and train them to be able to identify any child protection problems including those linked to mental health.
- There have recently been efforts to reintegrate children with specific problems, e.g., those not able to return to school, by placing them in vocational centers and providing basic health services
- In recent years, some Community Educators have been trained in educational talk therapy, health education and life education.

D-4. Summary of key findings

- Maluku Municipality is situated to the east of the DRC capital, Kinshasa. It is a diverse community that includes around 250 IDP households distributed across peri-urban and rural areas.
- Children and adolescents make up almost half the local population. Among IDPs, a sizable proportion are orphans, street children, or are separated from their families. Young IDPs in Maluku are especially vulnerable to abuse, physical and gender-based violence, as well as alcohol and substance abuse. Mental health problems in young people are often attributed to witchcraft.
- Priests, pastors or traditional healers are the first port of call for families and young people with a mental health problem. However, this can depend on the cultural beliefs about the cause of the condition.
- Specialist Layer 4 mental health services are available through the public and private sectors, as well as by Roman Catholic organizations, in large urban centers. There is, however, a shortage of specialist providers. In Maluku, primary health care staff have little training in mental health care; however, Community (Social) Educators under the child protection office have been trained to provide basic 'talk therapy,' as well as health and life-skills education.
- Referrals for mental health services can be made by a medical practitioner or the Child Protection Office but, in most cases, financial and logistical constraints limit uptake of these services by parents and families in Maluku.
- Recent legislation means that parental consent is required for a child to be referred for mental health care and other MPSS services. In child protection cases, the local Child Protection Office can make a referral, but formal procedures must be followed. These can involve working with the local 'Youth Movement' and 'Children's Parliament' to seek local authority clearance.
- Schools may be involved in case identification and parental guidance; however, they have limited capacity for these activities. The education sector is planning to make counselling services available to children through the school system.
- Widespread poverty means that young people with mental health challenges can face multiple needs. It is, therefore, challenging for the local child protection offices to prioritize MHPSS needs and coordinate sectors to address them.

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Final report | Annex E: Iraq country report

Field research in Iraq to assess services available in Baharka camp to assist children and adolescents who need specialized mental health services

April 2023

100408703-024 | UNICEF LTA Education FWC - P24 - R060 MHPSS

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Annex E contents

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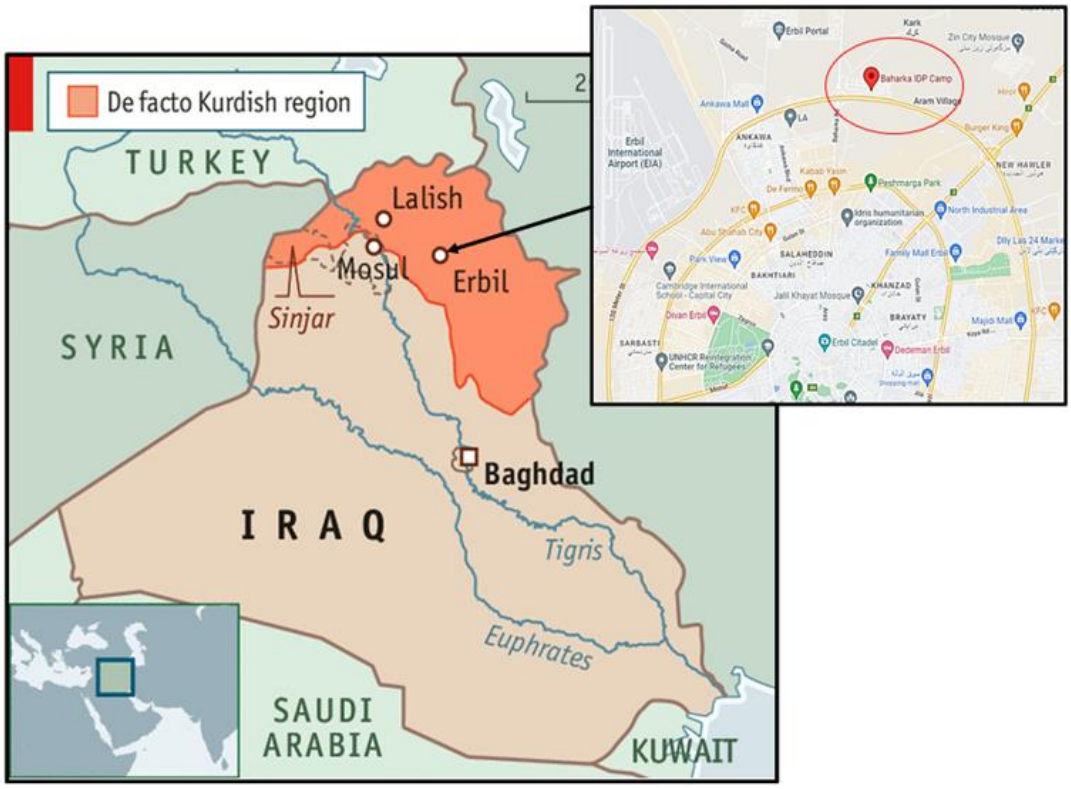
E-1. The humanitarian setting

The country of Iraq has been characterized by intensified regional tensions and political unrest for over five decades. The Republic of Iraq is now divided in two main regions and has two governments: the Central Government of Iraq, with the capital in Baghdad; and the Kurdistan Regional Government (KRG), with the capital in Erbil. The Kurdistan Region in Iraq (KRI) is an autonomous region, with its own language and ethnicity. It is home to 90% of the country's IDPs and refugees, as well as refugees from Syria, Turkey, Iran, and Palestine.[1]

The setting for this study is Baharka Camp on the northern edge of Erbil. Established in 2014, it is a permanent IDP camp managed by the Barzani Charity Foundation.

Figure 1.1: Location of Baharka Camp in the Kurdistan Region of Iraq



In Baharka Camp, the majority (90%) of the resident IDPs are from the border areas of Mosul and Hamdaniyah Districts; there are also 12 Palestinian families. Camp records indicate that, at the time of this study, the population of Baharka Camp was around 4,500 people living in 925 households, mostly accommodated in tents and caravans. There are roughly equal percentages of men and women. However, 50% of the population is below the age of 18 years – this includes many children and adolescents who are orphaned or separated from their families.

This rapid assessment case study is based on interviews with fifteen key informants and stakeholders involved in MHPSS services in Baharka Camp, as well as a desk review of the literature base, including site data and project reports.

[1] Source: About 900,000 IDPs, refugees still live in the Kurdistan Region (kirkuknow.com)

E-2. Setting the scene

E-2.1 Review of the literature base

Studies suggest that, among Kurdish refugees in Iraq, there are disproportionately high levels of mental health distress among children and adolescents; however, a strong group identity and supportive family relationships have also been found to be protective in these groups.[2]

Among Iraqi Kurds, idioms of psychological distress frequently refer to bodily symptoms and crushing sensations.[3] Some studies suggest that suicide, including self-immolation, tends to be higher among refugees and IDPs in Iraq – especially among young women and victims of gender-based violence.[4] However, those who attempt suicide, or lose someone to suicide, can experience additional stigmatization or marginalization.[5] Coping mechanisms for mental health conditions often involve guidance from a faith leader and access to religious spaces and resources. This can be especially difficult for women in camps and shelters, due to logistical barriers, lack of privacy and lack of a dedicated prayer space in crowded accommodation.[6]

Young people in Iraq face specific mental health challenges

Iraq has one of the highest youth populations in the world; nearly 50 percent of the population is under 19-years-of-age. Many Iraqi youths have been forced to flee from their homes and are living in camps or in host communities.[7] Studies suggest young people living IDP camps in Kurdistan face particular mental health stresses, including feelings of hopelessness and persistent discrimination, extended disruption to education, heightened concerns about violence and abuse, and pressures to join armed groups.[8] Young female IDPs feel pressures to marry early or enter into forced marriage, with studies suggesting this has detrimental effects on their mental wellbeing and vulnerability to violence and abuse.[9] Female youth living with disabilities face heightened social exclusion, harassment, and difficulties accessing school, and often feel they are a burden on their families.[10]

E-2.2 The wider context of mental health care

WHO data suggests that, across the board in Iraq, there is a shortage of trained mental health professionals, with only 0.11 psychologists and 0.34 psychiatrists available per 100,000 population in the mental health sector; the figure for social workers was even lower at 0.089 per 100,000 population.[11]

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2 Bolton, P. (2013). Mental health in Iraq: issues and challenges. The Lancet. Comment. Vol. 381, Issue 9870, pp. 879-881, March 16, 2013

3 Bolton, P. et. al. (2013). The mental health and psychosocial problems of survivors of torture and genocide in Kurdistan, Northern Iraq: A brief qualitative study. Available at: The mental health and psychosocial problems of survivors of torture and genocide in Kurdistan, Northern Iraq: A brief qualitative study | Academic Commons (columbia.edu)

4 Mirlashari, J. et. al. (2017). Living with burn scars caused by self-immolation among women in Iraqi Kurdistan: A qualitative study. Burns, Volume 43, Issue 2, 2017, pages 417-423

5 Marzouk H.A. (2021). International Organization for Migration Iraq Mental and Psychosocial Support Programme Suicide Prevention Activities. Intervention 2021;19:255-60

6 Rutledge, K. et. al. (2021). Faith and MHPSS among displaced Muslim women. Available at: Faith-and-MHPSS-among-displaced-Muslim-women.pdf (researchgate.net)

7 Save the Children. Uncertain Futures: The impact of displacement on Syrian refugee and Iraqi internally displaced youth in Iraq. Available at: Uncertain Futures: The impact of displacement on Syrian refugee and Iraqi internally displaced youth in Iraq | Save the Children's Resource Centre

8 Ibid

9 Howe. K. et. al. (2020). The Cost of Being Female: Mental Health and Psychosocial Support (MHPSS) of Displaced Female Youth in South Sudan and the Kurdistan Region of Iraq. Available at: MHPSS_11.7.22.pdf (tufts.edu)

10 Ibid

11 WHO (2017). Global Health Observatory Data Repository

The KRG Ministry of Health is responsible for planning, overseeing, and resourcing mental health care in the region. Within Erbil District, the Children's Unit of the Mental Health Hospital is operational but is not able to meet all demands. Across Erbil District, international organizations such as the International Organization for Migration (IOM), Médecins Sans Frontières (MSF) and International Medical Corps offer specialist psychosocial support, outreach, case management and psychiatric consultations, often in collaboration with government health facilities;[12] however, these specialist services do not extend directly to Baharka Camp.

The General Directorate of Labor & Social Affairs in Erbil is responsible for child protection in the Erbil Governorate. It has responsibility for child protection referral pathways in Baharka Camp, including case management, referral to specialized services and structured psychosocial support. There are several local and international NGOs working on child protection in the region, including Triangle (government capacity training), World Vision, and SEED Foundation Kurdistan.

[12] See, for example, https://internationalmedicalcorps.org/country/iraq/

E-3. Findings

E-3.1 Mental health needs of children and adolescents

The Erbil Governorate estimates that 12.7% of the children aged 4-17 years suffer from anxiety and 4.2% suffer from have depression in the Erbil District. Other studies suggest that 2.3% of in-camp IDP households have children showing symptoms of psychological distress.[13] In our study, the most frequently mentioned mental health conditions were post-traumatic stress disorder (PTSD), bed-wetting, behavioral disorders, trauma, anxiety, attention deficit hyperactivity disorder (ADHD), autism and speech difficulties. Intellectual disorders, phobia, fear, shock, emotional issues, rudeness, anger, and depression were also mentioned, particularly among children and adolescents confined to the camp. There were also cases reported of epilepsy, Downs Syndrome, and 'psychiatric conditions.'

E-3.2 Mental health care providers

There is one public health clinic in Baharka Camp with primary health care staff and a general practitioner, but these staff are not trained in providing specialist Layer 4 MHPSS services. Children with serious mental health problems may be referred to mental health services in Erbil; however, it was observed that most primary health care staff lack the information and training needed to make appropriate referrals.

In Baharka Camp, NGOs are the main sources of MHPSS services for young people. For example:

- The Zhyan Foundation runs awareness sessions in schools, kindergartens and through mukhtars (community leaders).
- The INGO War Child has a combined cadre of 'Child Protection and Education Officer' and focuses on children and care givers.
- The local NGO, Wchan, is reported to offer good quality MHPSS services from its center in Erbil; two psychologists visit the camps and jails daily and offer therapy services. Psychological support services are offered at the community-based Helena Center at no cost.
- The Iraqi Red Crescent offers support services for children with autism spectrum disorder (ASD), including small financial incentives for families to come forward.
- One NGO operates a hotline for children to offer informal support and referral to service providers for follow-up – although community awareness of this hotline was reported to be limited.
- Other local and international NGOs provide educational sessions for parents, along with some efforts to address children's physical needs.

Notably, some NGOs reported that they had been trained in approaches such as mhGAP, Psychological First Aid (PFA), and Problem Management Plus (PM+), but they were not currently providing services based directly on these approaches. Indeed, we noted that across the NGO sector, there were a range of approaches being used.

E-3.3 Pathways to care and coping strategies

Parents and families are considered to be the primary decision makers for children and adolescents with a mental health problem. If a child or adolescent shows signs of a mental health problem, a family's first source of advice is often a trusted traditional healer, especially for specific conditions such as psychosis. In some cases, families secretly return to their original homes to find a trusted traditional healer.

Several respondents mentioned that families may take a child to both health care providers and religious/traditional healers, but they tend to be secretive about visits to the latter. One factor in this may have been the negative perception of the informal sector expressed by some health care providers:

[13] REACH Multi-Cluster Needs Assessment, 2021

> ***"The religious healers are abusing the patient"***
>
> Health Care Worker 1

> ***"Religious healers cannot help children who have had depression or sexual abuse, and I refuse to treat children who are currently being harmed or threatened until I am certain that they are safe."***
>
> Health Care Worker 2

Some key informants suggested that families only take a child to a health professional if informal methods fail:

> ***"In one case, a child was receiving medication and developed severe diarrhea which the parents initially attributed to the medication. However, the parent later acknowledged that the child had also been given herbal medicine from a religious healer."***
>
> Health Care Worker 3

However, it was also suggested that there is a trend towards use of mainstream health care services:

> ***"In the past, the majority of parents would take their children to religious healers or give them herbal remedies. When their children didn't get better, they would bring them to us out of shame or sometimes because they were unaware that the service was available. Today, things are better, but we still need to improve things."***
>
> NGO Representative

Additionally, some organizations reported that religious healers were beginning to refer cases to them. One provider explained there could be more referrals between sectors if there was more awareness of available services:

> ***"When spiritual healers are unable to help, many times the patients turn to mental care. Recently, I heard that one of the spiritual healers advised a client to visit a mental professional, and that's important…If they had the necessary knowledge, herbalists and religious healers would recommend patients to the appropriate services, but they don't since they don't know."***
>
> NGO Health Care Worker

In Baharka Camp, NGOs were widely seen as a providing an important pathway to care – often because their services are free. Sometimes cases are referred to them and several use primary assessment tools to assess eligibility for further MHPSS support services.

While a few respondents suggested that institutions were needed to 'keep children away from the community,' most stakeholder interviewed emphasized the importance of keeping families at the heart of MHPSS services. Several shared 'good news stories' of children who recovered well when families were involved in decision-making and follow-up care after professional treatment and appropriate medication had been prescribed. One respondent described a case of a child with a severe mental health problem who had been kept isolated. The child was referred to an MSF psychiatrist who gave medicine, psychological assistance, and education to the parents. The parents were involved in making decisions at each stage and the child has now improved considerably.

Respondents suggested that if Layer 4 MHPSS services are not available, and if traditional/ religious healers and neighbors are unable to give advice, then families eventually stop looking for assistance and take no further action – this is especially the case if the family lives far away from services and could not afford transportation costs:

> ***"If a family is unable to obtain assistance, they will stay quiet and continue to raise the child according to their beliefs about how it should be done. For instance, in one case, the parents claimed that they were aware that their child had autism but could not afford to send him to a private center, as a result, they would raise the child in their own way."***
>
> Case Worker.

E-3.4 The role of the education sector

There was general acknowledgement that schools could play an important role in identifying and referring children:

> ***"the behavior of students at school can tell us a lot"***
>
> Baharka Educator

While schools were seen as an underutilized channel, there were also concerns that they have insufficient capacity to manage children with 'special needs.' It was suggested that there is a shortage of teachers because they are not willing to teach in the camp. One respondent reported a student saying, ***"Because we are living in the camp the world is not paying attention to us."***

Although it was acknowledged that some schools have a School Social Worker, it was reported that they are usually assigned to other roles.

E-3.5 Case management for coordinated support

Several public sector respondents suggested that NGOs have stronger coordination and referral systems than government.

> ***"We lack a referral pathway, there is poor coordination between service providers, and if there are specialists, they are difficult to reach."***
>
> Camp key informant 1

> ***"The referral system is ineffective; although there are standard forms, they are not used, and those making referrals are unsure of whether they have sent a case to the appropriate party or location."***
>
> Camp key informant 2

Another constraint identified was that MHPSS services are not all present in one location. Some organizations on provide support for children up to 15 years; services for older adolescents are not accessible because they are too far away.

The community-based Public Aid Organization (PAO) is working with children in the camp to address those with extensive needs, but their resources are considered to be inadequate. Indeed, there was some frustration that basic needs cannot be met:

> ***"While UNICEF spends a lot of money on its partners to provide PSS in the camps, if a child lacks access to food and shelter, we cannot provide MHPSS."***
>
> Camp key informant 3

For case management (including the provision of clothing, money, and medicine), some cases are referred to the SEED Foundation. In terms of legal services for children, frontline providers refer to ASUDA Foundation or the Democracy and Human Rights Development (DHRD) Centre.

E-3.6 Common barriers and gaps in MHPSS services

Over the course of this study, the issue of social stigma, along with lack of parental knowledge and information, were repeatedly mentioned as key barriers preventing parents and families from seeking mental health care services. In extreme cases this could lead to the child's isolation and abuse:

> ***"Depending on the family, there are still those who conceal their children's mental health concerns due to stigma, but the majority of them look for assistance to help their child get better."***
>
> NGO Representative

One NGO respondent also mentioned the case of a child who was chained naked inside a family's tent because the parents did not know how to care for the child.

Other key barriers and gaps identified included:

- Lack of specialist service providers – the shortage of psychologists and psychiatrists with no MHPSS services available in primary healthcare centers.
- Fragmented MHPSS and child protection services, with little emphasis on service integration, a continuum of care for the child, and continuity of care over the longer term.
- Lack focus on children - even if primary health care workers are trained in mhGAP, they do not receive any specific training in child and adolescent mental health.
- Mental health issues among parents themselves in this humanitarian setting.
- Practical challenges, such as family separation, lack of identification documents, restrictions on mobility or underlying disabilities.
- Poverty - extreme hardship and lack of financial resources to travel for a child's treatment and care, or purchase medicines.

E-3.7 Opportunities for integrated support

Respondents interviewed identified a number of opportunities for child protection actors to enhance MHPSS services for children and adolescents within the institutions, networks, and resources available in Baharka Camp. These included:

- A focus on extending MHPSS education activities to parents of children with mental health conditions so they understand what is happening and to improve their coping strategies at home. Facilitate peer-networks/self-help parent groups for families dealing with the same mental illnesses.
- Tackling stigma - working with government and NGO partners to use local/social media for awareness-raising in the community, including protecting children from harm, the role of parents, schools, and what to do when a child has a problem.
- Advocacy to restore the psychiatric and psychological outreach services that were formerly provided by the Children's Unit of the Mental Health Hospital. This should include a resumption of follow-up support by social workers, and improved information sharing through referral systems.
- Advocacy for social protection/financial assistance for the poorest families so this does not worsen and cause an escalation of severe mental health issues.
- Closer collaboration with the education sector. For example, the INGO War Child has a combined cadre of 'Child Protection and Education Officer' and focuses on children and caregivers. It uses a module called 'DEALS' which is endorsed by Ministry of Education and is used by other organizations across the country.
- Collaborative working and information sharing with the informal sector. Here the experience of the War Child NGO in other cities could be instructive. War Child has established community Child Protection Committees that include mukhtars, religious leaders, and elder women as volunteers to assist more coordinated identification and follow-up of young people with serious MHPSS needs.

E-4. Summary of key findings

- Baharka Camp is a permanent IDP camp to the north of the city of Erbil in the Kurdistan Region of Iraq. Children and adolescents form a large proportion of the camp population - many are unaccompanied or orphaned. Young people in the camp face distinctive mental health challenges; often parents and other family members have mental health problems too.
- Specialist mental health services are available in the city through the public sector, but these services are limited in number. The most accessible mental health services are provided by national and international NGOs – this sometimes includes targeted specialist services.
- NGO mental health services and activities are mostly offered through outreach visits and target younger children. Specialist services for adolescents usually require travel to city-based centers.
- Continuum of care is rare. In general, services are fragmented, referral systems are disjointed and there is little provision for integrated care, or continuity of care over the longer term. NGOs bring a variety of approaches and there appears to be little standardization or coordination.
- Religious and traditional healers are the first port of call for most families having a child with mental illness. Fear of stigma is a key barrier to use of mainstream health services – although these services are often combined with informal care. Health care workers tend to have negative perceptions of informal services.
- Schools are recognised as having an important role in case identification, referral, and ongoing support; however, they appear to have inadequate capacity for this role.
- Social protection actors play a valuable role in case management. Extreme poverty, child abuse and neglect are key concerns. Effective coordination across role-players is a challenge; however, several NGOs have experience of best practice approaches that could be extended.

CAMBRIDGE EDUCATION

Child Protection Area of Responsibility
Global Protection Cluster

EDUCATION CANNOT WAIT

Final report | Annex F: South Sudan country report

Field research in South Sudan to assess services available in Malualagorbaar IDP Camp, Jonglei State to assist children and adolescents who need specialized mental health services

April 2023

100408703-024 | UNICEF LTA Education FWC - P24 - R060 MHPSS

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Annex F contents

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F-1. The humanitarian setting

South Sudan has around 1.5 million inhabitants, of which over 2.2 million are internally displaced persons (IDPs).[1] This assessment was done in the Malualagorbaar IDP site, which is located about fifteen kilometers to the southeast of Bor Town along the Juba – Bor highway in Jonglei State.

The IDP site was established in 2020 due to floods that affected the northern areas of Bor South County in Jonglei State. Other IDP in Malualagorbaar came from Twic East County and Duk County also in Jonglei State. In 2022, around 12.000 IDPs live in Malualagorbaar, of which more than half are minors.

At one point, there were more than twelve different humanitarian organizations conducting activities in Malualagorbaar, but currently many of the agencies have pulled out due to lack of funds. The IDPs depend on food distribution from humanitarian agencies and there are little to no other socioeconomic activities sustaining life for the residents. Access to mental health and psychosocial support (MHPSS) depends on humanitarian organizations, as the majority of the IDP population cannot afford treatment.

This rapid assessment case study is based on interviews with eighteen key informants and stakeholders involved in MHPSS services for IDPs in Bor Town, as well as a desk review of the literature base, site data and project reports.

Figure 1.1: Malualagorbaar IDP, Bor County, Jonglei State in South Sudan

[1] UNHCR. (2020). Country - South Sudan (unhcr.org)

F-2. Setting the scene

F-2.1 Review of the literature base

In South Sudan, mental health problems are broadly seen viewed as 'madness' (severe mental disturbances associated with aggressive and bizarre behavior) or 'sadness' (difficulties associated with psychosocial causes such as loss, bereavement, and deprivation).[2] Among IDPs in South Sudan, 'overthinking' or 'thinking too much' is also regarded as an idiom of distress – although this idiom also captures aspects of beyond psychiatric diagnoses, such as depression, anxiety, and PTSD.[3] It is also observed that the sense of self among South Sudanese populations is inextricably linked to the body. For example, South Sudanese sometimes use bodily metaphors, such as 'heart pain,' 'bad heart' to describe psychological distress.

Causes for mental illness among IDPs in South Sudan are considered to include life and family situation; the consequences of war; loss of loved ones; witchcraft or spirit possession; health problems (e.g., cerebral malaria) and, rarely, inherited conditions.[4] Mental health problems are exacerbated by lack of quick interventions and the population preference for religious and traditional remedies. Sometimes lack of awareness raising on the impacts of mental health problems, availability of MHPSS services, training of key stakeholders and strategic approaches have been noted as major contributors to mental health problems.

Communal coping strategies[5] are consistently mentioned as coping and help-seeking strategies – including among displaced youth.[6] Responses to mental illness fall into five categories:

- Social support
- Practical support (basic need for food, shelter, employment, etc.)
- Prayer and traditional treatments
- Medical care by a doctor or hospital
- 'Government solutions' (includes imprisonment or after abandonment by family/community)[7]

Specialist MHPSS publications emphasize that displaced women and girls in South Sudan need dedicated support. They have often lost their spouse or guardian, and many have experienced physical and/or sexual assault during the conflict or following displacement. Many camps and IDPs are crowded and do not allow for privacy or traditional 'safe gathering points' for women and girls, which increases their vulnerability and feelings of insecurity and distress.[8]

A report of the MHPSS Technical Working Group in South Sudan indicates that children in IDP camps are also in need of targeted support. An estimated one million children are suffering from severe emotional distress. Children in IDP camps are reported to be especially vulnerable to harmful practices, such as child marriage and child labor, while people with epilepsy and disabilities are highlighted as having specific psycho-emotional needs that need to be addressed.[9]

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2 Adaku, A. et al. (2016) Mental health and psychosocial support for South Sudanese refugees in northern Uganda: a needs and resource assessment. Confl Health 10, 18 (2016).

3 Goodman, J.H. (2004). Coping with trauma and hardship among unaccompanied refugee youths from Sudan. Qual Health Res. 2004; 14(9):1177–96.

4 Schafe, A. (2014). The influences of basic needs, social support and migration on mental health in South Sudan. Doctoral thesis (Clinical Psychology), Swinburne University of Technology. Available at: The influences of basic needs, social support and migration on mental health in South Sudan (swinburne.edu.au)

5 E.g., social support through connecting with elders, relatives, community members, religious institutions

6 Goodman, J.H. (2004). Op. cit.

7 Schafe, A. (2014). Op. cit.

8 HealthtNetTPO & UNICEF South Sudan. (2016). Promoting Positive Environments for Women and Girls: Guidelines for Women and Girls Friendly Spaces in South Sudan. Available at: Guidelines for Women and Girls Friendly Spaces in South Sudan (mhpss.net)

9 MHPSS Network South Sudan. (2018). South Sudan: Who is Where, When, Doing What (4ws) In Mental Health and Psychosocial Support 2018. Available at: https://app.mhpss.net/?get=167/mhpss-4w-southsudan-2018.pdf

F-2.2 The wider context of mental health care

The Juba Teaching Hospital in Juba is the only hospital in South Sudan that provides in and outpatient mental health services with a limited number of inpatient places.[10] It is not a service targeted specifically at children. WHO found that per one hundred persons there were fewer than 0,03 psychiatrists and 0,26 psychologists.[11]

More than 20 NGOs and several international agencies provide MHPSS services in South Sudan, some of which are also present in Malualagorbaar. The includes the International Committee of the Red Cross, HealthNet TPO, International Organization for Migration, Care International, Medair, and UNICEF. These interventions most often fall under Layer 1 to Layer 3 in the IASC pyramid and range from child-friendly spaces to non-clinical case management for more severe cases. Many of the MHPSS services target children specifically.[12] However, there is no specialized services referral pathway that can improve access to Layer 4 services (if available) for children that encounter these organizations.

The IDP in Malualagobaar received support from NGOs and international agencies in the past, however many projects have ended and as of now there is no support for education, WASH, MHPSS and child protection. According to previous service provider mappings, organizations that work in child protection and provide MHPSS services in Malualagorbaar include Community In Need Aid (CINA), Save the Children, War Child and UNICEF. HealthLink, Care International and CIDO provided gender-based violence related support, while WHO, Care International, MDM and Livewell provided health and nutrition services. Norwegian Refugee Council, RC and Save the Children supported education at the site.

The Ministry of Gender, Child and Social Welfare, with support from the CP sub-cluster, developed the official child protection case management standard operating procedures in South Sudan. It outlines the official procedures for recognizing needs, prioritization of cases and referring urgent cases or children in need of specialized services.[13] However, the implementation of this framework is lagging across the country due to lack of capacity and trained personnel, high staff turnover, the large number of organizations taking up MHPSS uncoordinated, and the ongoing conflict.[14] Most of the CP systems in South Sudan are designed, funded, and implemented by humanitarian NGOs and agencies with a temporary.

10 Mental Health in South Sudan: A case for community-based support, Goldsmith & Cockcroft-McKay

11 Stories of Change in Four countries WHO, mhGAP 2021

12 Mental Health in South Sudan: A case for community-based support, Goldsmith & Cockcroft-McKay

13 Child Protection Case Management Standard Operating Procedures, Ministry of Gender, Child and Social Welfare

14 And then they left: Challenges to child protection systems strengthening in South Sudan Mark Canavera

F-3. Findings

F-3.1 Mental health needs of children and adolescents

A few organizations have previously been implementing child protection projects. Notably, SCI was doing MHPSS for children through a child friendly space, War Child Holland was supporting child protection and CINA was doing PSS for adults. These projects have all been completed and ended. The area was not prioritized in the last year resources allocation strategy of the South Sudan Humanitarian Funds (SSHF) and the organizations have not yet been able to secure new funding to support children in Jonglei State and there is no clear path for MHPSS interventions specifically for Malualagorbaar IDP site.

According to the community leaders and camp management committee members who were interviewed, there is no recent child protection assessment that was done. The community members are requesting for support through humanitarian agencies in order to help rescue the MHPSS situation of children.

Risks to children in the community included:

- Lack of basic food, shelter, and care
- Unsafe situations for children who have moved to the IDP camp without their parents or family
- Specific risks for girls in cases of early and forced marriage
- Lack of education for children – especially adolescents getting involved with unhealthy habits because they do not have school

F-3.2 Referral pathways to mental health services

MHPSS is a new subject to this community and there are not many approaches used to manage mental health problems. The first point of contact for most respondents in this specific IDP setting was the church. The community in Malualagorbaar is Christian and they rely on the church for support with mental health. The church is managing issues for children through prayers and singing songs to relieve the problem in case 'it may be devil spirit possessing a child.' The church typically does not refer a child further to a medical facility.

The community is not opposed to treatment done in the hospital, and does accept the medical interventions, however the services are not available in the camp. This could be one of the reasons why the church does not refer families to a medical point.

The community does not refer to traditional healers as they see this to be in conflict with their Christian beliefs. However, in other parts of Bor state there are traditional healers who are actively approached by communities. In an isolated case, the pastor reported that a child from Malualagorbaar was sent to a traditional healer further up north.

For example:

> ***"Sometimes people do not access services due to traditional belief for instant fixes, in case of seizures, people will request the child to be taken to church first for prayers because they believe that God can heal all these illnesses and they later ignore the importance of hospitals and specialized MHPSS treatments available."***
>
> MHPSS Officer, Care International

F-3.3 Community based interventions

The community has limited coping strategies which include lack of playing materials in the child friendly space. In the IDP camp, child friendly activities include attending Sunday school church services, and other reactional activities in the community such as community gathering, local marriage celebrations, and traditional activities like dancing and wrestling by the host communities.

The community practices games like football, Chess, and dominos. They believe that these activities help children to easily recover from post-traumatic stress disorders and the community members encourage children to engage in these activities to recover and build resilience. Community recreational activities like traditional dances, wrestling are major stress relievers by the community members. Church services like singing songs, bible stories, preaching and choir dancing like are groups that help engagement of children to focus and forget traumatic events.

There are no adequate measures taken to manage Layer 4 MHPSS issues in the community because of lack of knowledge. Some traditional practices do take place, such as tepid sponging for fever, covering with blanket when they fall down, body cutting by traditional healers, pouring water on heads and prayers by the religious leaders. This community does not practice witchcraft; as a Christian community they prefer to try prayers in churches before resorting to hospitals, including for difficult cases. These are traditional and religious methods while widespread are not comprehensive, so there is scope for non-harmful practices to be complemented by contemporary approaches to MHPSS care.

F-3.4 Provision of services through health services

Though there are not trained people on counselling, the respondents have reported that they do psychological first aid and counselling. This is done by community-based protection members, community mobilizers and social workers who try to assure children in distress, with depression and other mental health problems of safety, care, and healing. There is a need to expand on these activities by training these actors and other key stakeholders on counselling in order to achieve better results on children with mental health and psychosocial support issues.

The main coping strategy reported was seeking medical support and get the children treated. However, this strategy is not comprehensive. As there are no Layer 4 MHPSS services at the IDP site, families/children seek medication outside the IDP camp. There were no services at the closest hospital, Jonglei State hospital, but recently an MHPSS department has been established there. However, there is a need to bring these services closer to the IDP community by equipping the PHCC or construct a MHPSS Clinic.

F-3.5 Barriers to mental health services

Key informants and stakeholders report that the main barriers to uptake of mental health services by children and adolescents in the Malualagorbaal IDP camo are:

- The socioeconomic status of most families and a lack of financial assistance made it hard to access high-level medical services in Bor, in Juba or outside of South Sudan, particularly for the most severe cases of mental health conditions like epilepsy or schizophrenia.
- Lack of knowledge of the impacts of severe mental health disorders on patients and misconceptions about how to interpret abnormal behavior among the community, causing them to not recognize when an individual needs to be taken to a hospital for treatment.

  > ***"It is perceived that the mental problem that some children have is something they are born with and may be a curse."***
  >
  > MHPSS Officer, Care International

- Distance from the IDP site to health facilities that provide Layer 4 mental health services, as there is only Primary Health Care Unit (PHCU) at the site which is not well equipped or stocked with medication. The recently established MHPSS department in the State hospital fifteen kilometers from the camp site was not known to the community and is hard to reach due to medical conditions and road safety concerns.
- Lack of training and awareness raising among the community and care providers, including how to identify a child with mental health problems. Parents have inadequate information about MHPSS services, means cases of children and adolescents needing specialist MHPSS support are likely to be missed.
- While child protection actors were active in the camp, including with a child friendly space, there is now no active Child Protection agency permanently active in the camp and community-based networks are the only source of child protection assistance.

There are critical gaps in Layer 4 MHPSS services in the IDP camp. There is a lack of awareness and information regarding the availability of specialist MHPSS and there are no Layer 4 MHPSS services in the IDP camp. Hardy any personnel trained in even basic MHPSS services, like counselling and awareness raising, are at the IDP site. Only one clinical officer who is the in charge of the PHCC was trained last year in July.

F-4. Summary of key findings

- The Malualagorbaar IDP camp is situated to the southeast of Bor Town, the headquarters of Jonglei State, about 15 kilometers on Juba - Bor highway. The community is around twelve thousand people, of which over half are children.
- Flooding is the primary reason for displacement of the population in Malualagorbaar. IDPs fled from Bor South County, Twic East County and Duk County due to floods in 2020.
- Organisations providing MHPSS services and child protection have pulled out of Malualagorbaal due to lack of funding after the area was de-prioritized by the South Sudan Humanitarian Funds. Previously, over twelve different humanitarian organizations conducted activities in child protection, nutrition, MHPSS, health, gender-based violence and education in Malualagorbaar.
- Displaced children, as well as girls and women, are in need of dedicated MHPSS support according to the MHPSS Technical Working Group in South Sudan. An estimated one million displaced children are suffering from severe emotional distress and are vulnerable to harmful practices, such as physical/sexual assault, child marriage and child labor.
- Specialist Layer 4 mental health are not available at the IDP camp site. The hospital in Juba provides mental health services and recently the closer-by Jonglei State Hospital opened a mental health department. However, the financial costs and distance to the hospitals is still too great for most residents of the Malualagorbaar site.
- Informal or traditional services: The community in Malualagorbaar is Christian and people try prayers in churches before resorting to hospitals for mental health needs, including for difficult cases. They tend not to go to traditional healers as they see this to be in conflict with their Christian beliefs. However, in other parts of Jonglei State there are traditional healers who are actively approached by communities. Some traditional practices do take place, such as covering with blankets, body cutting by traditional healers, pouring water on heads and prayers by the religious leaders.
- Community-based interventions are limited but include counselling by community members and community-based protection and social workers, however they lack sufficient training and material about MHPSS services. There are child friendly spaces in the camp, and religious, cultural, and sports activities. Community members encourage children to engage in these activities to recover from mental health conditions and build resilience.
- Families: Parents have inadequate information, including how to identify a child with mental health problems and how to support them, meaning children are not being helped when they need.

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