The CENTER for VICTIMS of TORTURE

Who is Where, When, doing What in Mental Health and Psychosocial Support in Dadaab?

4W Mapping of MHPSS Services and Supports

Contents:

Who is Where, When, doing What (4Ws)
Mental Health and Psychosocial Support

Introduction

In recent years, Kenya has become an epicenter for refugees, asylum-seekers, internally displaced persons (IDPs), and stateless people. As of January 2013, an estimated 979,070 people are residing in various refugee camps across the country[1], making the work of humanitarian agencies crucial and necessary for their well being. Much of the population in the camps was displaced by drought, famine, and/or insecurity. In addition to the immediate impacts of such human suffering, long-term impacts such as the mental health and psychosocial well-being of the affected populations, also requires attention.

In cases of such emergencies, humanitarian actors often encounter many challenges with coordination. In response to address such challenges, the Inter-Agency Standing Committee (IASC) established a Task Force on Mental Health and Psychosocial Support (MHPSS) in 2005. The IASC Task Force developed a 4Ws map tool to better understand in knowing *Who is Where, When, doing What (4Ws*). The tool was meant to not only provide a clear picture of what is happening regarding MHPSS in emergency or post-emergency settings, but to also foster collaboration, coordination, referrals, and accountability for all involved agencies. The tool is part of the World Health Organization's (WHO) "Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Crises."

International Medical Corps (IMC), in coordination with the WHO and the National Center for Security and Crisis Management in Jordan, first piloted the 4Ws tool in Jordan in 2009. The tool has since been used in Nepal and in Haiti. The lessons learned from these pilot exercises were then incorporated into the tool's revisions in 2010 and 2011.

The mapping also provides an opportunity for reflections on current patterns of practice while drawing important lessons for future practice. The information provided by the mapping can [also] feed into national plan for emergency preparedness, identifying gaps in services, geographic and target group coverage, human resources, and technical expertise.

Timeframe

In 2012, The Center for Victims of Torture (CVT) undertook the 4Ws mapping process for Dadaab, one of the largest refugees camps in the world. CVT sent the 4W Data Collection Spreadsheet application (available at www.mhpss.net) to all participating agencies providing mental health and psychosocial support. No previous mapping processes or reports had been published on Dadaab, and similar reports that IMC had prepared for Jordan and Libya were used as guidance in preparing this report.

Objectives

a.) Utilize the 4Ws mapping tool to identify gaps in MHPSS activities in various refugee camps. (Camps include Ifo, Ifo II, Dagahaley, Hagadera, and Kambi Oos.).
b.) Present the findings to participating agencies.
c.) Foster collaboration, coordination, and referrals of services across various camps, while also adopting greater accountability on behalf of all involved agencies.
d.) Recommend changes in the mapping tool based on field experience and analysis.

4Ws Mapping Process

CVT, via psychotherapist/trainer Patricia Giffoni, took the initiative to lead the mapping exercise in part due to Ms. Giffoni's strong professional motivation to look to the bigger picture, and to contribute to making coordination work possible in order to insure better and more organized services for clients. It was also Ms. Giffoni's and CVT's belief that in the context of the coordination, the recurrent shortage and fragmentation of mental health programs in emergencies could be mitigated. UNHCR at first expressed their concerns about the resources needed, but later came on board, agreeing that perhaps the different agencies could contribute in different ways to the mapping. UNHCR also believed that they could give some responsibility to a consultant that that may potentially be hired (this did not happen due to increased insecurity in Dadaab). Other partners later joined and welcomed the idea of conducting the mapping. Through several follow up meetings of the Dadaab Mental Health Working Group (MHWG), CVT introduced and trained the MHWG members on the 4W tool. CVT was also able to negotiate collaboration with IOM for data entry support. UNHCR provided overall coordination and support at leadership level.

CVT proposed that the mapping should proceed in the following way:

1. Adapt the mapping tool to the Dadaab geographical area.

2. 2. CVT conducts a daylong workshop with the partners to define the services provided by each agency, in association with the IASC guidelines pyramid of services. (For service quality control, appropriate referral, and data consistency. There is tendency for the different agencies to defines their MHPSS services in different ways, leading to a confusion on what is psychotherapy, counseling, PFA, and psychological support.) The same workshop will be conducted with IRC for the GBV WG. This is to avoid the following limitations:
    a. *The data collection relies largely on self-report. Some actors may decide to participate.*
    b. *The possibility of self-enhancing data.*

c. The method assesses the absence and presence of services and support, but it does not discern between quality of services and support.

3. Following completion of the workshop, the matrix is sent to the partners.

4. With the support of the two IOM staff, coordinated by CVT, data entry and data quality control is completed.

5. CVT works through its volunteer system to identify someone to complete analysis in order to produce graphs and charts from the data, according to the *Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes* and to sample reports already done.

6. If possible, UNHCR finds a consultant to write the report and make the possible contribution of the Interagency Standing Committee. If unattainable, CVT is responsible for this step.

7. A final two-day workshop (included in the UNHCR consultancy) is held for presenting the MH mapping and strategy.

The tool, as discussed above, was then sent to the various organizations psychosocial representatives within all of the Dadaab camps. The package of information consisted of:

- One-page introduction of the 4Ws exercise; and
- An excel file with three active sheets: (1) for filling out information about the organization; (2) for filling out details of the activities; and (3) a list of the 11 MHPSS activities and their corresponding sub-activities.

Of the agencies that were asked to participate, 29 agencies provided data regarding their activities. Supplementary interviews were conducted with 14 agencies (see attached list) to obtain more information on the duration of the assignment to substantively discuss issues connected to MHPSS in relation to the 4Ws exercise. A brief on the major issues addressed in the interviews are summarized in the findings section below.

Observations on the Tool

Certain activities and sub-activities presented challenges to the agencies filling out the information forms, and further training from a CVT psychotherapist/trainer was required. **Utilization of tools was limited to national and international IGOs. (Waiting on Patrizia to give some feedback on this, will insert when that happens)**

Challenges and Limitations

While it was easy to connect with the NGOs given the concentration in Dadaab and the existence of the MHWG, getting the partners to complete the surveys accurately and timely was a challenge. CVT's lead person assigned to this task undertook explaining the process through several meetings before participants were able to accurately identify the categories. Additionally, there was tardiness in the completion and return of completed materials. This may have been due to the fact that many of those responsible had several other duties to perform in conjunction with this project. Additionally, it could also have been due to the fact that there was no immediate impetus to rush toward completion of the tools. In the end, UNHCR had to use its position to push for deadlines on completion, along with follow-up phone calls and emails to attempt compliance.

Another challenge was the generally high turnover of employees in Dadaab. During the period in which the tool was distributed, there were several personnel changes, including those who were responsible for completing the 4Ws form in their various organizations.

FINDINGS

National NGOs	International NGOs	Governmental Bodies	Independent/Private Actors

Findings drawn from activity details data

1. WHO

Participating Actors:

Table 1: the table above displays the active international and national NGO's involved in providing services in various camps of Dadaab. Currently, neither governmental bodies nor independent/private actors are involved, or perhaps have chosen not to participate in the mapping process. The information on participating actors and where they are working (see next page) is critical in mobilizing coordinated efforts.

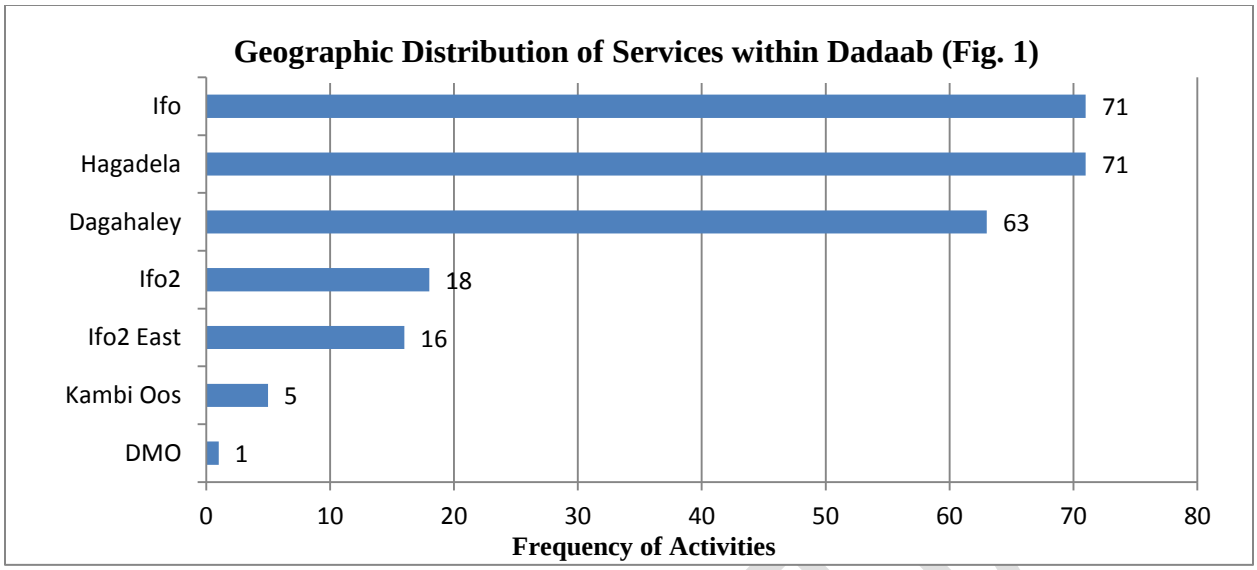
Refugee Consortium of Kenya	International Organization for Migration (IOM)		
National Consortium of Churches in Kenya	CARE International Kenya (UK based)		
	Save the Children		
	Médecins Sans Frontières (MSF-CH)		
	International Rescue Committee (IRC)		
	German International Cooperation		
	Lutheran Federal Cooperation		
	Handicap International		
	Kenya Red Cross		
	Center for Victims of Torture (CVT)		

2. WHEN. We need this data, per Libya report, it should be about when services started, if that's the intent of this report.

3. WHERE

The geographic distribution (concentration of various MHPSS services and supports within various camps in Dadaab)

As shown in **Figure (1)**, the frequency of activities reflects the amount of mental health and/or psychosocial services present within various camps in Dadaab. The figure illustrates that Ifo and Hagadela have the highest concentration of services, whereas DMO has the least.



According to previous reports, this type of centralization of resources was also evident in Jordan and Libya. Agencies are urged to investigate and to extend their resources out to other camps based on the camp's needs. It is of paramount importance for NGOs to collaborate between each other in order to extend their resources and inform appropriate planning of activities in line with established concentrations of target groups.

MHPSS Coverage Throughout Dadaab

Figure 2: approximate locations of each of the camps in Dadaab

Refugee Camp	Actors
Ifo	CIK, Save the Children, Refugee Consortium of Kenya, German International Cooperation, LWF, Handicap International, CVT
Ifo II	Refugee Consortium of Kenya, IOM
Dagahaley	CIK, Save the Children, Refugee Consortium of Kenya, LWF, MSF
Kambi Oos	Refugee Consortium of Kenya, LWF
Hagadera	Save the Children, Refugee Consortium of Kenya, LWF, Handicap International, IRC

Table 2: Type of national and international actors in each of the refugee camps

As **Table 2 and Figure 1** indicate, there seems to be a positive correlation between the frequency of activities at each of the camps and the number of actors involved. It's important to note that the data in Table 2 might fluctuate depending on identified needs, organizational capacities, and availability of funding.

4. WHAT

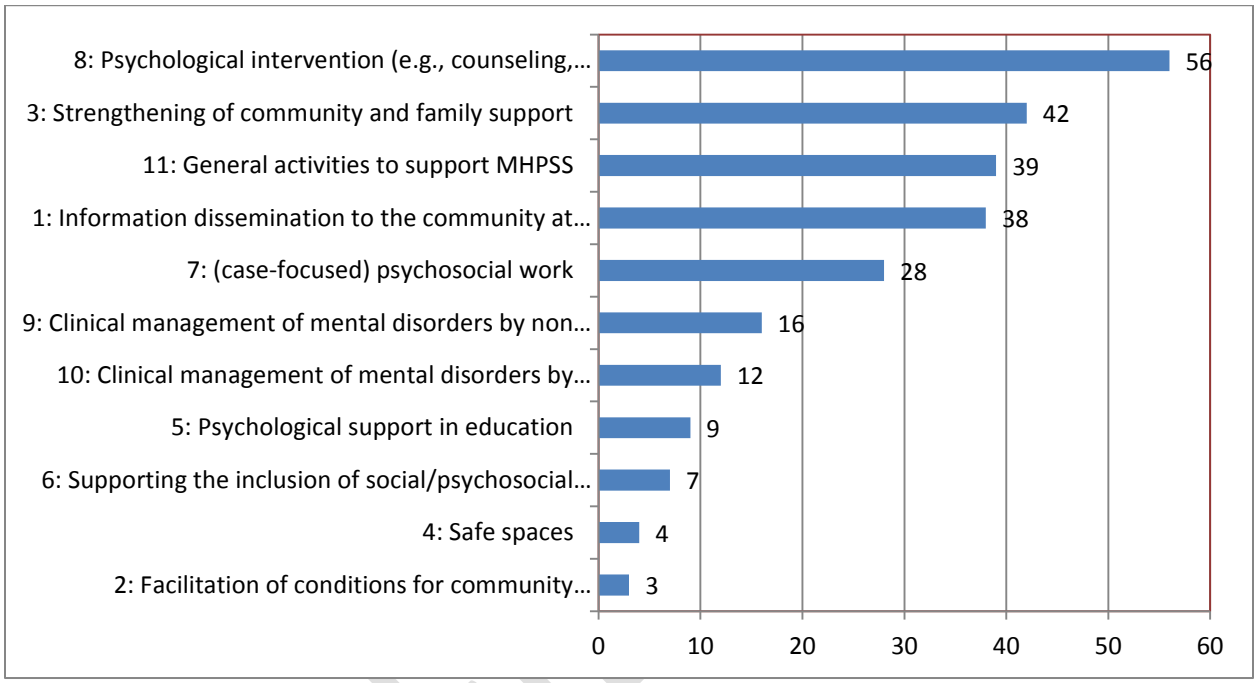
The **Table 3** below displays frequently provided mental health and psychosocial service in emergency settings. These were the same activities that IASC previously captured in its 4W's Data Collection Spreadsheet. Though the list is not exhaustive, it does provide a useful guide for reference. Activity 11, which states "General activities to support MHPSS," includes activities covering assessment, training, research, and supervision.

Activity Code	Description of 4Ws Activity Codes (Table 2)
Activity 1	**Information dissemination to the community at large**
Activity 2	**Facilitation of conditions for community mobilization, community organization, community ownership or community control over emergency relief in general**
Activity 3	**Strengthening of community and family support**
Activity 4	**Safe spaces**
Activity 5	**Psychological support in education**
Activity 6	**Supporting the inclusion of social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation**
Activity 7*	**(case-focused) psychosocial work**
Activity 8*	**Psychological intervention (e.g., counseling, psychotherapy)**
Activity 9*	**Clinical management of mental disorders by non-specialized health care providers (e.g. PHC, post-surgery wards)**
Activity 10*	**Clinical management of mental disorders by specialized mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/ general health facilities/ mental health facilities)**
Activity 11	**General activities to support MHPSS**

**** Of note: some activities under Activity 7 or 8 may also be coded under Activity 9 and 10 when these occur in health care settings. Categories 7-11 are thus not mutually exclusive.***

Concentration by Activity Type

The **Figure 3** below displays the frequency or number of specific types of activities in Dadaab. It indicates that there are a high number of psychological interventions available. The data also shows that there are very few efforts devoted to facilitating conditions for community mobilization, its organization, and ownership/control over emergency relief in general.



The above data regarding frequency of specific types of activities can be grouped into community-focused, case-focused, or as general activities. Activities 1-6 from Table 3 are considered community-focused activities; activities 7-10 are case-focused activities; and activity 11 accounts for all general activities, which involve all training activities implemented by MHPSS actors.

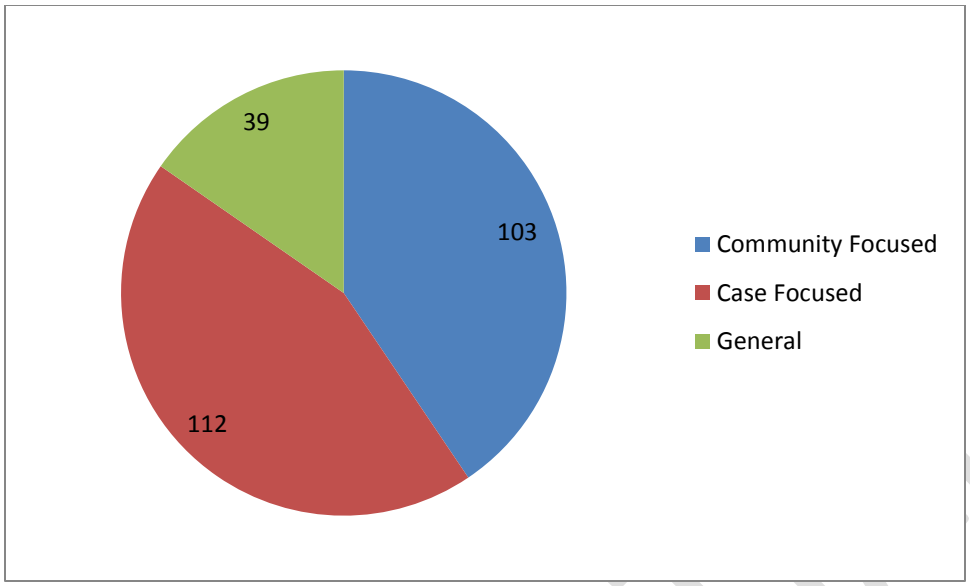
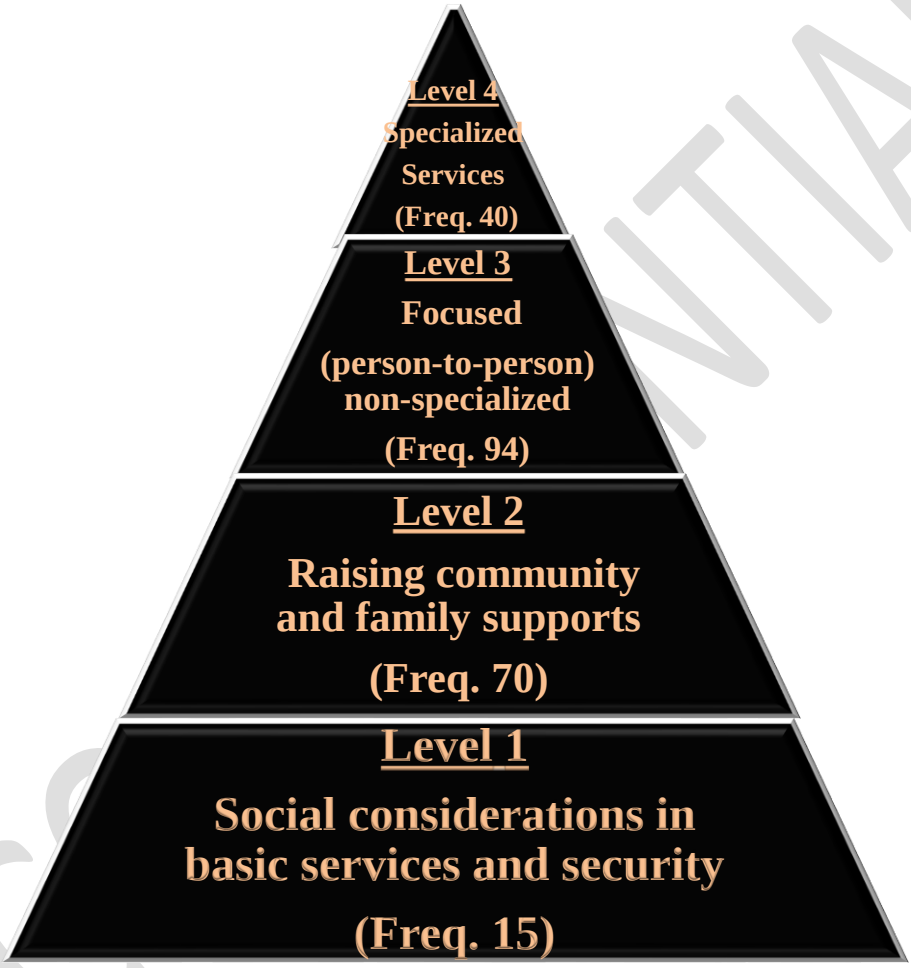


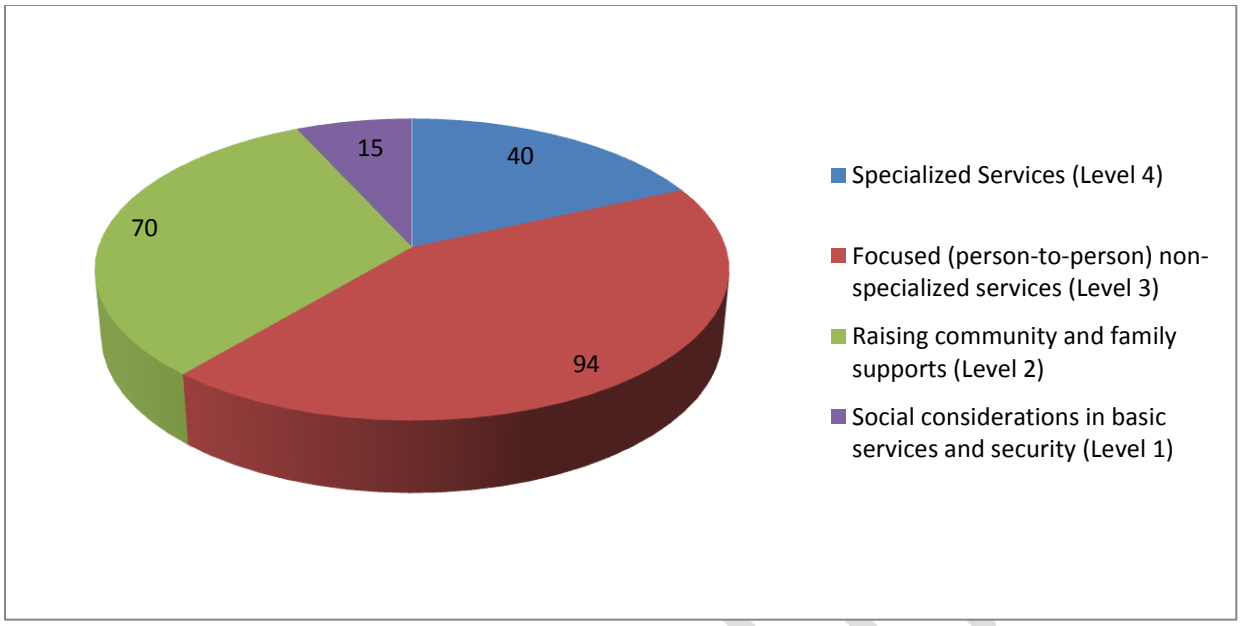
Figure 4: The pie chart indicates that NGOs are spending 44% of their activities on case-focused interventions (Activities 7-10 in Figure 3) such as psychosocial work, psychological intervention, and clinical management of mental disorders by specialized and non-specialized health care providers. 41% of their efforts are spent on "community-focused" activities (Activities 1-6 in Table 3) such as information dissemination, community mobilization, community support, safe spaces, psychological support in education, and inclusion of social and psychosocial support. 15% of NGOs' efforts are devoted to training activities (Activity 11 in Table 3).

IASC's MHPSS guidelines recommend that during an emergency or post-emergency setting, a major part of the MHPSS support should be devoted to community rather focusing on case management. However, the observation above indicates that 44% of MHPSS support is focused on case management rather than on community management (41%).

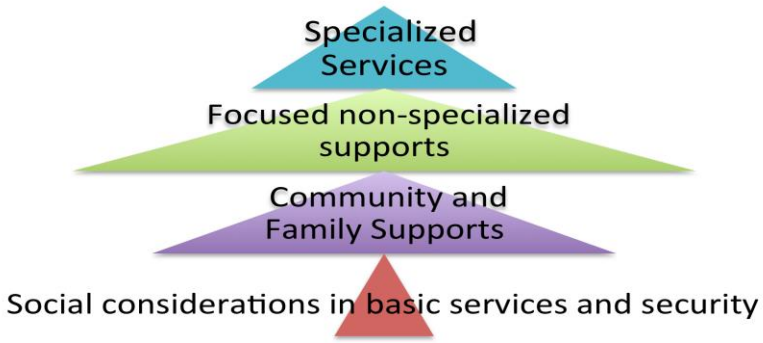
Intervention concentration according to level base on the IASC Guidelines pyramid

Individuals that require mental health and psychosocial services are typically affected in different ways. For instance, a Somali refugee who was tortured may require a different type of MHPSS support than another refugee who was not tortured. Recognizing the various kinds of supports following an emergency, IASC created a pyramid layer system of complementary supports that illustrates different layers of support, and the likely scale of demand for each of those layers.





Actual Distribution of Activities in ISAC Pyramid



Recommendations:

There is a danger that base services may be overlooked and underrepresented due to perceived lack of need. Certain groups may be jumping to specialized services that are more specific, based on reports from refuges upon sessions. The data indicates a possible need for communication on the importance of base services- it is likely that the base services occur in conjunction with the specialized services.

Annex 1:

Name of implementing agency	Address of implementing agency	Name of focal point in implementing agency	Telephone number of the focal point in implementing agency	Email address of the focal point in implementing agency
IOM	Dadaab	Abubakar/Khadija	720736432	iabubakar@iom.int
CARE International Kenya (CIK)	Po Box 43864,00100, Nairobi	Wilson Kisiero	727475593	kisiero@ddb.care.or.ke
Save the Children (UK)	Dadaab	Kefah Maranga	722822632	k.maranga@scuk.or.ke
MSF-CH	Dadaab	Mogaka Birongo	0722624026	sbirongo@gmail.com
International Rescue Committee (IRC)	Box 62727, Nairobi	Mental Health Dept. IRC. Hagadera Hospital	0721336231	john.kivelenge@rescue.org
Refugeee Consortium of Kenya	None	Elizabeth Wangare	0700369703	wangare@rckkenya.org
German International Coorperation	p.o.box 628 Garissa	Abdikadir Sheikh Ahmed	0720971693	sheikh.ahmed@giz.de
Lutheran World Federation (LWF)	P.O. Box 48 Dadaab	Nancy Auma	0717837311	nancy-auma@lwfkenya.org
Handicap International	P.O.Box 76375,Yaya,Nairobi	Lucy Murage/Lucy Njeri	720283813	hi.psychosocial.ddb02@gmail.comlcymurage@yahoo.com
NCCK	PO. Box 2 - Dadaab	Henrietta Namusonge/Caroline Chelimo	0721657381 - 0719323498	hnamusonge@ncck.org cchelimo@ncck.org
Kenya Red Cross Society (KRCS)		Tamima salah	0721585683	tamimasalah@yahoo.com
Center for Victims of Torture (CVT)		Patrizia Giffoni	(254)706312678	pgiffoni.cvt@gmail.com