

# A Kenyan case study: implementation of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

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*This case study describes the use of the IASC Guidelines on Mental Health and Psychosocial Support in Kenya. The fieldwork was carried out 14–25 July 2008, and involved discussions with representatives of humanitarian organisations, UN agencies and government departments in Nairobi, Eldoret and Nakuru. It describes the ways in which the guidelines have been disseminated in Kenya, how they have 'added value' in that context, as well as the factors that have hindered the full implementation of the guidelines in Kenya.*

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January 2008 saw widespread post election violence in Kenya, resulting in the displacement of an estimated 500 000 people. Although Kenya had seen violence after previous elections, it had never experienced anything on this scale, and the whole country, including humanitarian agencies, was unprepared to respond to such an emergency.

The mental health and psychosocial support (MHPSS) offered to internally displaced Kenyans during the crisis was co-ordinated by the government, with the Kenya Red Cross taking the lead role in the field. Initially, large numbers of individuals and

small organisations arrived in the internally displaced persons (IDP) camps and started providing 'counselling' services which varied considerably in quality. There was little monitoring or coordination of services. The government of Kenya gave the Ministry of Health (Division of Mental Health) the task of coordinating the MHPSS response. In conjunction with Internal Organization for Migration (IOM) and UNICEF, they established a psychosocial sub-cluster, from which a smaller Psychosocial Technical Working Group (TWG) was created to coordinate MHPSS provision to those affected by the post election violence.

The *IASC Guidelines on Mental Health and Psychosocial Support* were not well known in Kenya when the post election violence began. Also, Kenya had not been the focus of a formal IASC case study. However, a series of workshops and training events introducing the guidelines began in late January and continued throughout the year. These were effective in terms of raising awareness of the guidelines in the urban area of Nairobi, but those who were working in the field had less access to the information.

Therefore, a Kenya specific guidance document was produced, based on the guidelines and tailored to the specific issues affecting the MHPSS response in Kenya (i.e., the large number of untrained and unsupervised volunteers providing MHPSS to IDPs).

These ‘*Kenya national guidelines*’ (KNG), were then disseminated by email to all those attending psychosocial sub-cluster meetings. Again, this was successful to some extent, but those working in the field, and those not affiliated with organizations participating in psychosocial sub-cluster meetings, were unable to readily access the KNG.

In general, the *the IASC Guidelines on Mental Health and Psychosocial Support* and the KNG were used at policy level in Kenya, but those responsible for planning and implementing programmes outside Nairobi tended not to use either set of guidelines. This was due, partly, to lack of awareness, but also because they became aware of these guidelines during the crisis. Therefore, when they were already engaged in responding to the needs of the displaced and did not have the time to read the guidelines, or reflect on their practice. Also, the guidelines were said, by some, to be overwhelming (in content, organisation and language), especially in an emergency situation where people have very little time to read and reflect, and receive many manuals and guidance documents. The IASC Checklist for Field Use was not available at the time of the emergency in Kenya, but would have been a very useful resource.

The nature of the emergency in Kenya hindered the implementation of the guidelines. The country as a whole, including humanitarian organisations, was unprepared for post election violence on the scale that it occurred. Furthermore, there was great confusion during the early part of the crisis, which made it difficult to plan and implement programmes in accordance with the guidelines. International non-governmental organizations (INGOs) were slow to get funding and implement programmes, compared to local non-governmental organizations (NGOs).

There was an influx of unsupervised and uncoordinated volunteers who, from very early on in the crisis, began providing counselling services and emotional support for those affected by the violence. The quality of the services was extremely variable, and the reliance on volunteers had its own challenges (e.g. inconsistent services). There was no *Code of Conduct* or training for the volunteers, or others working with IDPs, which contributed to the high levels of sexual exploitation and abuse reported in the IDP camps. The Kenyan experience highlights the need for volunteers to be part of a well coordinated, structured service, with supervision and training.

The lack of MHPSS awareness and capacity in Kenya also limited the extent to which services were developed according to the guidelines. In general, psychosocial wellbeing has been understood in Kenya from a medical, psychiatric perspective, with ‘*counselling*’ as the only alternative. This form of ‘*counselling*’ is frequently seen as an activity that can be carried out by well-intentioned people with minimal training.

This narrow perspective on MHPSS issues meant that there was a lack of capacity in Kenya to respond to the needs of the displaced population, and little understanding of the priorities or services required at different stages of the emergency. On the other hand, the government and others recognised their lack of capacity in this area, and therefore warmly received the guidelines as a document that would help them to respond effectively to the crisis. There was an openness in Kenya to a more holistic understanding of psychosocial needs, despite the dominance of a medical model there. However, INGOs such as UNICEF and IOM, who were able to draw on international psychosocial resources and technical advice, had to work very intensively

to develop the capacity and understanding of MHPSS issues, and the guidelines, in Kenya. This delayed the implementation of programmes, while the post election violence continued, and smaller agencies, religious groups and independent volunteers continued to provide uncoordinated MHPSS services of varying quality. The guidelines assume that everyone is working in a situation with a similar understanding of what MHPSS involves. This was not the case in Kenya.

A further concern expressed by some was that the guidelines could exacerbate delays in implementing services, as agencies become *'paralysed'* by their concern to get their programmes exactly right before implementation. A contributor to this case study suggested that the guidelines could include a useful highlight of the benefits of small, simple interventions, along with examples of effective, integrated and multi-sectoral programmes.

Coordination of MHPSS services was particularly challenging in Kenya. The Division of Mental Health had only five members of staff, and limited experience of implementing MHPSS services in an emergency setting. At the same time, the Ministry of Special Programmes was given responsibility for planning and coordinating MHPSS services for those affected by post election violence, but was unaware of the work of the psychosocial sub-cluster, the guidelines or the Kenya National Guidelines. The two Ministries were working independently, with no knowledge of each other's work until July 2008.

The location of the psychosocial sub-cluster within the health cluster meant that physical health was often prioritised over MHPSS issues. It was suggested by some that the psychosocial sub-cluster would have been better placed within the protection cluster, since

many more agencies were involved and it would be easier to ensure that MHPSS issues are integrated into their programmes.

The integration of MHPSS services into other sectors was a particular challenge in Kenya. This was due to the general lack of awareness in Kenya of the ways in which a psychosocial approach can inform other sectors, and the psychosocial sub-cluster lacked the capacity and resources to advocate for this inclusion. The Kenyan experience highlights the need for psychosocial sub-clusters/working groups to have a strong voice and to be in a position to advocate for using the guidelines.

One very positive point learnt from the Kenyan experience was the value of the presence of a MHPSS expert in the country, to advocate for the guidelines and to steer the development of local guidance. In emergency-preparation situations, and in chronic situations of extreme stress, it would be valuable to encourage a very participatory process of engagement with the guidelines that combined training with the collaborative development of a locally adapted version of the guidelines. This would help local actors to understand them, promote ownership and increase the likelihood of their sustained implementation.

The widespread activity of volunteers, who were neither regulated nor dependent on the approval of any coordinating bodies, created their own challenges in Kenya. This highlights the importance of both regulation and support as strategies for implementing the principles of the guidelines. In this emergency, and in most emergency settings, it was simply not possible to regulate in the early stages. Policy makers welcomed and used the guidelines as it contributed to their task, but many practitioners and volunteers felt that they were already too busy and/or too knowledgeable

to invest time in looking at them during the crisis. The IASC Checklist for Field Use, had it been available at that time, would have helped to address this issue. Crucially, however, more investment is needed in looking at how the guidelines could be presented and adapted in ways that provide immediately recognisable help to people working in the midst of an emergency. This could

make a significant impact on the quality of psychosocial support provided.

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