SITUATION AND NEEDS ASSESSMENT OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN REFUGEE CAMPS IN TANZANIA, RWANDA AND BURUNDI

May 2010

Report of the assessment phase for the project
'Mental Health and Psychosocial Support Capacity Building for Implementing Partners of UNHCR Health Projects in Refugee Settings in Tanzania, Rwanda and Burundi'

Contact persons
- Marian Tankink, PhD, Medical Anthropologist, Researcher and Technical Advisor, HealthNet TPO, Amsterdam
- Peter Ventevogel, MD, Technical Advisor Mental Health, HealthNet TPO Amsterdam
- Louise Ntiranyibagira, B.A. Psychosocial Coordinator HealthNet TPO Burundi)
- Aline Ndayisaba, B.Sc. Psychology, Research Coordinator (HealthNet TPO Burundi)
- Herman Ndayisaba, B.A. Psychology, Country Director HealthNet TPO Burundi

Table of Contents

Abbreviations and acronyms

AHA	Africa Humanitarian Action
ARC	American Refugee Committee
AUDIT	Alcohol Use Disorders Identification Test
BID	Best Interest Determination
CBR	Community Based Rehabilitation
CBT	Cognitive Behavioural Therapy
CHV	Community Health Volunteers
CMD	Common Mental Diseases
DRC	Democratic Republic Congo
FGD	Focus groups discussions
HMIS	Health Management Information System
IASC	Inter Agency Standing Committee
IPT	Interpersonal Psychotherapy
INGO	International Non-Governmental Organization
IRC	International Rescue Committee
JRS	Jesuit Refugee Services
MH	Mental Health
MHPS	Mental Health and Psychosocial
MHPSS	Mental Health and Psychosocial Support
MHPSW	Mental Health and Psychosocial Wellbeing
MNS Disorders	Mental, Neurological and Substance Use Disorders
MoH	Ministry of Health
NGO	Non-Governmental Organization
NRC	Norwegian Refugee Council
PLWHA	People living with HIV/Aids
PNSM	Programme National de Santé Mentale
PS	Psychosocial Services
PSW	Psychosocial Worker
SBI	Structured Brief Intervention
SGBV	Sexual and gender-based violence
ToT	Training of Trainers
TRCS	Tanzania Red Cross Society
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Executive Summary

The violent upheavals over the last decades have led to large numbers of refugees living in camps in the African Great Lake area. The UNHCR and the staff of the implementing NGOs are confronted with refugees suffering from mental health problems and/or severe psychosocial stress. The UNHCR seeks ways to strengthen the competencies of the staff of implementing organizations in the fields of mental health and psychosocial assistance. This assessment is the start of a project with as main goal to develop, implement and evaluate a model of comprehensive services for mental health and psychosocial support within existing UNHCR-supported care structures for refugees.

The current report presents the results of an initial project assessment to address the need for mental health and psychosocial support to guide the UNHCR and their partners. This report focuses on the range of self-reported psychosocial or mental health problems among refugees associated with their current life in refugee camps. The report also describes the problems encountered by care providers and issues they consider important for good health care. This assessment is a situational analysis and not an in-depth needs analysis.

To address the needs of the refugees and the care providers, it is critical to look at psychological stress not only from the 'medical' perspective, but to take a broader perspective that includes social and ecological factors. A multidisciplinary approach is required to address the observed problems. The refugees in the camps are vulnerable: on a political, social and cultural level. This vulnerability is caused by their status as a refugee, by the situation in the refugee camps, and it is also related to humanitarian aid. However, not all problems are caused by the refugee situation. Psychosocial and mental problems can be pre-existing for refugees related to disaster, violence, loss of relatives, status, or belongings.

Social factors are known to be major determinants of mental disorders. Three key social determinants are risk factors for mental disorders: poverty, social exclusion and gender violence. Dependency is a central element in the worldview of the refugees, which results in the feeling that their future is blocked. They seem to develop apathy, but beneath this passivity there is a wish to be active agents in shaping their own future. Refugees want to work toward self-sufficiency, but care providers often believe that refugees are no longer able to organize their lives.

Changing gender roles, due to refugee status and of the structure of the camp (the lack of income-generating activities for men) cause significant stress in marriages. Respondents in all camps mentioned high levels of gender-based violence. Violence is not limited to refugee settings, but the specific dynamics of the refugee setting together with dysfunctional or broken extended family support systems increase the incidence of violence. Regarding sexual violence, refugees most frequently mentioned cases of prostitution, forced sex and unwanted early pregnancies. According to refugees these problems are related to the fact that girls and boys only have education up to grade ten.

There is established evidence that domestic violence has a significantly negative impact on women's mental health. Addressing gender violence requires that agencies work closely with refugee communities, rather than setting up parallel systems for them. Community-based psychosocial work can have a unifying effect by crossing the boundaries between various services.

There is limited space for refugees to express themselves and share their feelings in the refugee camps. Lacking a forum for expressing themselves points towards a key strength of group-based interventions. The refugees are very sensitive

to the kind of treatment they receive in the camps due to their status. They easily feel disrespected and often expressed negative opinions about NGO's and the UNHCR.

Regarding mental health, the stigma of epilepsy and mental disorders is high among refugees and health care providers. In general, only very severe mental disorders such as psychosis and depression were recognized in the camps. Worldwide the burden of depression and other common mental disorders is significant among refugees, but in this assessment health workers said that they did not often see people with depression. However, detection of depressive symptoms once a refugee seeks help is reasonably easy to elicit.

Our suggestions for possible interventions are meant to initiate a discussion in the upcoming workshop with the stakeholders. The purpose of the workshop is to develop guidelines for a package of interventions to improve mental health and psychosocial wellbeing in the camps. One of the core expertises of HealthNet TPO is in the field of mental health and psychosocial support and we focus on that, but we encourage the participants to think about interdisciplinary interventions. The proposed interventions are centred on the following suggested actions:

1. Foster mutual support and self-help among refugees.

a. Train NGO workers and or community volunteers in basic psychosocial support techniques, particularly problem solving counselling and mediation techniques for managing family and neighbour conflicts. Such techniques have been developed for use within African refugee settings (Baron, 2002) and are being used by HealthNet TPO psychosocial trainers in Burundi.
b. Improve the social fabric in the camps through community-oriented psychosocial techniques. There are several ways to do this. This can include elements of techniques such as 'sociotherapy' or 'narrative theatre, that have been tested in the Great Lake Area, but also other community-based techniques eg group discussions where local people reflect on ¨past ¨present and future and reflect on how people in the community can help one other and help other marginalized people. [1]
c. Take steps to improve the linkages between vertical services (such SGBV, child protection and CBR).
d. Explore options to provide more possibilities for refugees to generate income and earn a livelihood. Space to do this is often limited given the rules and regulation in the host countries, but when possible this should be advocated because it would perhaps be the most important factor to increase the psychosocial wellbeing among refugees.

2. Improve the capacity of the health services and community services to recognize and manage mentally distressed refugees/ refugees with common mental disorders.

a. Train health workers in the identification and management of people with CMD and unexplained medical complaints. The management should consist of several elements: Establish a mechanism to refer those with mild or moderate forms of common mental disorders to community-based social interventions, as described above.
b. Train health workers to manage those refugees with common mental disorders who present with predominantly unexplained somatic symptoms using the forthcoming 'intervention guide for priority mental, neurological and substance use

[1] Such techniques have been developed and tested in the Great Lake Area like sociotherapy (Richters, Dekker, & Scholte, 2008) and narrative theatre (Meyer-Weitz & Sliep, 2005; Sliep & Meyer-Weitz, 2003).

disorders' that has been developed by the World Health Organization and will soon be available for piloting (WHO, n.d.). This guide is intended for health workers (such as doctors, medical officers and nurses) who provide primary care services to persons with mental, neurological and substance use disorders.

c. Consider training psychosocial assistants in the use of a focused manual-based group treatment for common mental disorders.[2]
d. Train health workers to avoid prescribing unnecessary somatic drugs to people with common mental disorders.

3. Improve community awareness of alcohol and substance use disorders and management in the heal th and community services department

a. Use a screening method for alcohol abuse and introduce it in the training for general health workers and community services workers.
b. Introduce a form of Structured Brief Intervention (SBI) (eg ASSIST) as an intervention to be done by the psychiatric nurses in the camps who currently rarely see patients with alcohol use problems.
c. Interventions at the family / community level to address drinking as a "refugee culture "

4. Improve recognition and access to appropriate care for people with severe mental disorders and epilepsy.

a. Train designated persons within the general health care system to provide psychiatric services, using the WHO intervention guide (WHO, n.d.). In the camps this is currently being done to a limited extent, through the provision of care through separate mental staff
b. Train community health workers and other grassroots workers to raise awareness of severe mental disease and epilepsy in the refugee population.
c. Train health care staff in the use of the neuropsychiatric guidelines in the new HMIS system

5. Introduce an intervention for young children with emotional, behavioral and development disorders.

The MHPap of WHO recommend 'culture-sensitive parenting education'.

[2] In the Great Lake area, good results have been reported using group Interpersonal Psychotherapy (IPT) as in Uganda (Bolton et al., 2007; Verdeli et al., 2008).

Introduction

Violent upheavals during recent decades have led to large numbers of refugees in the Great Lake area of Africa. In UNHCR intervention sites, local NGO personnel are confronted with refugees suffering from mental health problems and/or severe psychosocial stress. These staff members often feel overwhelmed and insufficiently prepared to manage such issues. Therefore, the UNHCR seeks ways to strengthen the capacity of the implementing organizations' staff in the field of mental health and psychosocial assistance. Over the last few years humanitarian actors have increasingly paid attention to mental health and psychosocial support issues as demonstrated by the publication of the IASC guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings (IASC, 2007). The latest report is an initial assessment of a project that aimed to support UNHCR and partners to address the need for mental health and psychosocial support in the field.

The aim of the report is to show the range of self-reported psychosocial or mental health problems among refugees associated with their current life in refugee camps. Interventions for psychosocial distress and mental health cannot address all the problems. This report proposes an interdisciplinary approach to approach the needs of the refugees.

Objectives of the project

This assessment is part of a project to develop, implement and evaluate a model of comprehensive services for MHPSS within existing UNHCR-supported care structures for refugees. The project has four objectives:

1. To develop an intervention package for mental health and psychosocial support in refugee settings in the Great Lake area. Such an intervention package should be comprehensive to address the range of severe mental disorders, common mental disorders and psychosocial problems. In addition, it should be limited in scope and not include superfluous tasks as the care system is already burdened by many other priorities.

2. To strengthen the capacity of UNHCR staff and to implement partnerships in health and community services in refugee settings in Tanzania, Rwanda and Burundi through training and technical support to establish an integrated knowledge of the field of mental health and psychosocial support.

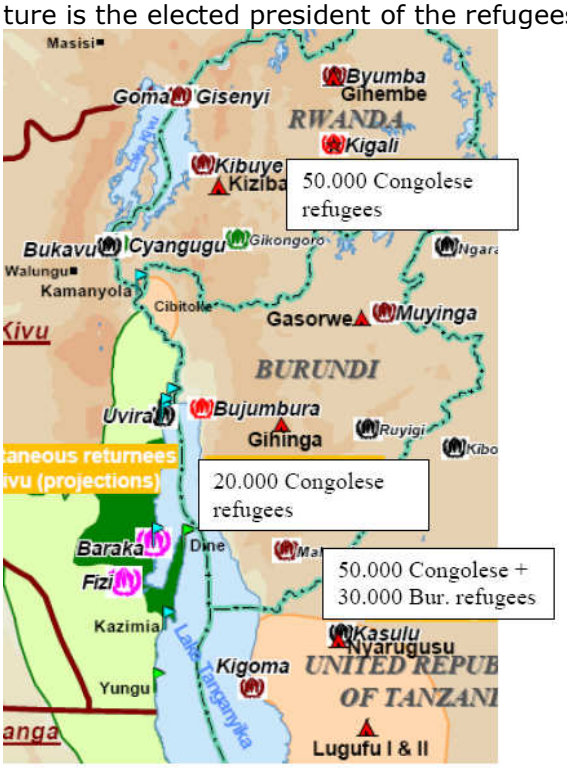
3. To evaluate the impact of the intervention package in the setting of all three countries, to formulate lessons learned, and to provide recommendations for scaling up MHPSS in refugee settings.

4. To ensure that returning Burundian refugees have continued access to MHPSS by including them in the existing systems developed in Burundi by HealthNet TPO. This intervention model, developed in Burundi, could serve as a framework for Congolese refugees who return to eastern Democratic Republic of Congo (DRC).

Refugee groups and camps

In the last decades there have been many refugee camps in Tanzania, Burundi and Rwanda. The population of these camps has fluctuated. For this assessment the UNHCR selected: Gasorwe camp in Burundi; Nyarugusu camp, Mtabila camp and Lugufu camp in Tanzania; and Kiziba camp and Gihembe camp in Rwanda.

Camp structure in all sites is more or less the same. There is a central location with community and health care buildings (in the large camps in Tanzania there are smaller annex buildings in the camp). The camps are divided into zones and the zones include blocks with block leaders. Every block includes approximately 60-100 houses and in some camps these blocks are called villages. At the head of this structure is the elected president of the refugees.



Map *1: refugee camps in Rwanda, Burundi and Tanzania*

Refugees in Burundi

The assessment was done in the Gasorwe camp in Burundi. There are two other camps: Musasa (Ngozi province) and Bwagiriza (in Ruyigi province). The high population density in Burundi and the lack of land is reflected in the construction of the camp. The houses in the camp appear small and dark, and are situated very close to each other in small compounds of about 12 houses. The refugees are restricted to leave the camp or to plant vegetables in small plots. These rules are designed to prevent conflict with the local population who are also very poor but cannot take advantage of the food transports that come to the camps or other humanitarian services. Attempts to make agreements with local farmers so that the refugees could work on their land were stymied by disagreements about the division of the harvest. The implementing partner organizations of the UNHCR in the Gasorwe camp are: Africa Humanitarian Action (AHA), Stop Sida, Norwegian Refugee Council (CNR) and HealthNet TPO.

Compound in Gasorwe camp

Refugees in Tanzania

Tanzania currently has three major refugee groups: 1) Burundian refugees who arrived after the 1972 violence, 2) Burundians who arrived after the start of their civil war in 1993, and 3) refugees from the Democratic Republic of Congo (DRC) mainly from South Kivu Province who arrived in the years 1996/7 when waves of violence affected eastern DRC.

The largest group of refugees are Burundians who came in 1972. Recently, with the return of peace and democracy in Burundi the Tanzanian authorities have encouraged the Burundians to repatriate. Since 2008 more than 50,000 refugees have returned to Burundi (Wolfcarius, 2009). The Tanzanian authorities have offered the Burundians who came in the 1970s the option to apply for naturalization. Since August 2009, approximately 29,000 Burundian refugees have been naturalized. The Tanzanian government aims to complete the naturalization process for an additional 133,000 applicants by the end of 2009.

Tanzania also hosts refugees who fled Burundi after the civil war of 1993. With the gradual restoration of peace in Burundi, 430,000 Burundian refugees have returned to their villages of origin. In early 2009, Mtabila camp held approximately 46,000 refugees and was the last camp for Burundians in Tanzania. At the time of this project assessment approximately 36,000 Burundian refugees were still living in Mtabila. The camp was included in the project assessment, but fewer data collection were undertaken compared to other refugee camps in the assessment, and a specific assessment will be conducted in December 2009. This Burundian refugee group is important for objective four (continued access to MHPSS by including refugees in the existing systems developed in Burundi by HealthNet TPO). Well-educated Burundian refugees who have worked as volunteers in support programs for refugees could act as liaisons and trainers/community supervisors to support refugees with psychosocial problems once they are back in Burundi. In this report we do not address this objective. The Tanzanian authorities put considerable pressure on the Burundian refugees to return. In 2008 Tanzanian authorities closed schools in Burundian refugee camps to encourage repatriation, but with intervention by the UNHCR they were reopened. (USCRI, 2009). Tanzanian authorities also closed the churches in the camp in order to prevent subversive refugees from using the church as a place to centralize their activities. The churches remain closed.

Nyarugusu camp

Most of the remaining refugees in Tanzania are Congolese who fled in 1997 from their homes on the other side of Lake Tanganyika (mainly in the province of Fizi). Tens of thousands of these refugees have repatriated voluntarily but the UNHCR stopped the repatriation of refugees to South Kivu due to the worsening security situation in eastern DRC. During the project assessment period, two camps with Congolese refugees were open: Lugufu (established in 1997, originally divided into two camps with almost 100,000 refugees, and when closed had 25,000 refugees) and Nyarugusu. An operation to move the refugees from Lugufu to Nyarugusu began during the project assessment period, which caused commotion among the refugees due to repatriation.

Space and land are not an issue for the Nyarugusu camp; the camp is quite large and is approximately seven kilometers long. Villages are composed of 60-100 loosely grouped houses. Between the villages there are buffer zones of 100 meters. Although refugees are not allowed to cultivate the land, small plots with vegetables exist inside and outside the camp. The UNHCR partner organizations in Nyarugusu are: Tanzanian Red Cross Society, World Vision, and the International Rescue Committee (IRC).

Refugees in Rwanda

In Rwanda there are approximately 59,000 refugees, the majority from the DRC and approximately 3000 from Burundi. The largest group of refugees came in the late nineties after the violent upheavals in eastern DRC. In particular, Tutsis from the DRC sought refuge in Rwanda after experiencing violence in the slipstream of military confrontations between various Congolese armed groups. The latest influx of refugees dates from 2006 when renewed fighting in the eastern DRC triggered a fresh wave of refugees who fled into Rwanda for safety (UNHCR, 2009).

The majority of refugees in Rwanda reside in camps. The project assessment was conducted in the two largest camps, Kiziba near Kibuye at Lake Kivu in the west of the country and Gihembe near Byumba in the north. Due to time, we could not visit a third smaller camp, Nyabiheke, near Gituza that houses refugees who have arrived in recent years. Small numbers of refugees reside in urban centres throughout Rwanda. The implementing partner organizations for UNCHR in the camp are AHA (public health & community services), American Refugee Committee (public health) and the Jesuit Refugee Service (JRS).

Kiziba camp

The lack of land is evident in the Rwandan camps as houses are constructed close to each other. However, the impression of the camp is quite different from camps in Burundi. In Rwanda the refugees are allowed to sell homemade products in the camp markets and have an open economy with the Rwandan people in the adjoining neighbourhoods. As refugees earn money by selling food or self made products, there is more interaction and trade with the local Rwandan population than is found in the camps in other countries.

Mental Health and Psychosocial wellbeing: concepts and theoretical approaches

Mental disorders and psychosocial problems

Mental health is not limited to the absence of mental disorders and includes a broad range of problems. People may feel emotionally upset and experience 'stress' but can still function well in their community and do not need treatment. Generally treatment is required for individuals with mental disorders. The contribution of mental disorders to the global burden of disease is significant, and growing (Prince et al., 2007). Data on the prevalence of *severe mental disorders* in the Great Lake area are not available. Several epidemiological surveys in post-conflict settings have estimated the prevalence of *common mental disorders* and psychosocial problems. The figures are usually high, but uncertain, and to a large extent may represent people with psychosocial distress but without diagnosed specific disorders. De Jong e.a. (2003) used a diagnostic tool for community surveys (CIDI) in four post-conflict settings and reported a range of prevalence rates for common mental disorders between 5% and 40%.

In this report we use the composite terms Mental Health and Psychosocial Wellbeing (MHPSW) and Mental Health and Psychosocial Support (MHPSS) of the IASC guidelines(IASC, 2007). We distinguish three broad categories of problems:

1. S*evere mental disorders* (such as psychosis, bipolar disorder, severe depression, substance dependence, epilepsy[3]*)*. People have typical symptoms and people with these disorders are often considered mentally ill by the environment.

2. *Common mental disorders* (such as mild to moderate depression, anxiety disorders, substance abuse problems and conversion disorders). People usually present to the health care system for a variety of reasons where their disorder is frequently not identified. The etiology of these problems is strongly connected to social factors.

3. *Psychosocial problems* (such as (gender) violence, substance use, the effects of war and repression and problems faced by adults, children and elderly, socio-economic difficulties, marginalization or exclusion of widows and orphans, people with living HIV, disabilities, etc.) Such problems can lead to any of the disorders listed under 1 and 2 above, but may also cause sleep problems, tiredness, emotional problems (crying, easily angered) and behavioral problems (Araya, Chotai, Komproe, & de Jong, 2007). The manifestation of psychosocial problems is generally characterized by social dysfunction of the individual and/or inter-personal problems in their family or social network, but may also lead to the expression of mental disorders in people who already have a pre-existing vulnerability. Individuals with unstable or small social networks are particularly at risk; for example, children and adolescents with disrupted nurturing and who have been traumatized by war and violence, as well as, women overburdened with family responsibilities or suffering from domestic and/or sexual violence and discrimination.

[3] Epilepsy is, of course, not a mental disorder, but following practice in many low-income countries and the WHO we include epilepsy within this assessment as a one element of Mental, Neurological and Substance use (MNS) disorders.

Towards a conceptualization of MHPSS problems in refugee settings

In this project assessment, we used a conceptual framework for analysis that was based on the ecological model (Bronfenbrenner, 2005; Tankink, 2009) (see Figure 1). This model allows for a definition of the impact of refugee status (in the specific contexts of the various camps) on the lives of the refugees on several levels and an understanding of the dynamics between those levels.

In this framework, health is defined on three ecological levels; for example, an individual with psychosocial stress would be the micro level, a disharmonic or dysfunctional family and other (social) networks would be the meso level and an unfavorable condition of a community (lack of resources and structures) would be the macro level. Detrimental conditions on the macro level, for instance, can affect relationships and social networks and can cause unfavorable conditions and psychosocial stress or even mental disorders on the individual level. The key concept of this framework is a variety of expressions for one concept: health. This framework challenges the user to define the disparate relationships between health and the factors that may influence health outcomes: risk factors (e.g. factors associated with specific health outcome), contextual factors (e.g. factors in the context associated with health outcome) and ecological factors (e.g. factors associated with aggregated health outcomes). In this study the focus was on the actual health status of refugees and the subjective experiences of the refugees or refugee communities. Refugees in the camps who were investigated were vulnerable on additional levels: not only on the political and social level, but also on the level of culture. For example, refugees' traditional notions do not give them the flexibility to adapt easily to the situation in refugee camps and to find new forms of support for their problems. An other example is that many refugees in the camps are from rural areas and have to live in huge and crowded refugee camps. Vulnerability can be caused by the situation in the camps and can be related to humanitarian aid. In other words, an individual is imbedded in the dynamic processes of context and time, relationships and personal interactions. Not all refugee problems, however, are caused by the refugee's situation. Psychosocial and mental problems can pre-exist the refugee's situation, induced by disaster or violence, loss of relatives, or loss of status and belongings.

Although the sources of the problems refugees experience are beyond the scope of this project, it is important to give attention to the entire cause-outcome sequences of the observed problems, because reducing psychological stress is not possible only from a single level. This point of view provides information for a multidisciplinary approach of the observed problems.

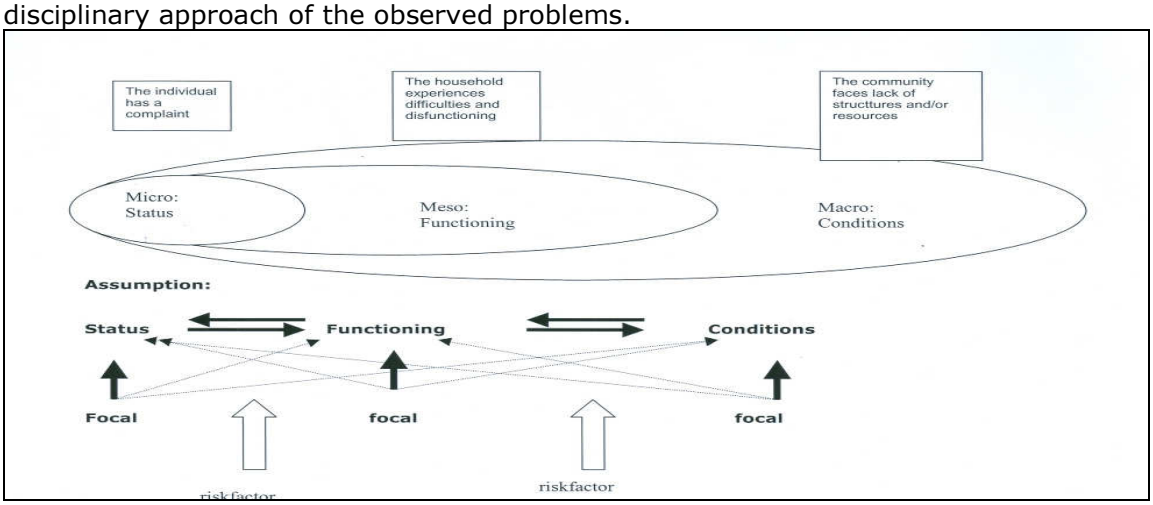


Figure 1: ecological model. Source: I. Komproe, HealthNet TPO, 2009.

Assessment methodology

Descriptive and qualitative methodology

The project assessment was explorative and descriptive. The goal of the assessment was to use the ecological model as a framework to improve our understanding of the MHPS problems the refugees face and how refugees and staff from health and community services in the camps currently cope with and respond to these problems. Such information will be used to strengthen MHPSS interventions in the three countries where we did the investigation. This assessment was conducted employing methods used in other assessments by HealthNet TPO (HealthNet TPO, 2007, 2008), as well as elements of a draft version of a new WHO Field Guide for Mental Health and Psychosocial Situation and Needs Assessments in Emergencies (IASC, 2007). We used a variety of assessment techniques to ensure that the perspectives and experiences of all subpopulations were documented.

Guiding principles for the assessment

In developing the methodology we were guided by the principles as described in the IASC guidelines on Mental Health and Psychosocial Support in Emergency settings (2007).[4]

a) Use a participatory approach, giving due attention to the views of the refugees themselves.
b) Involve a variety of stakeholders. The assessment included various stakeholders (UNHCR, implementing partners and refugees) with potentially diverse or conflicting views. In general, people always have conflicting ideas, roles and interests. That means that information is context-bound and dependent on the person, place, time and circumstances.
c) Strive to be inclusive. The assessment involved all sections of the affected population including children, youth, women, men, elderly people and various religious, cultural and socio-economic groups.
d) Use a multi-level perspective. Our assessment addressed all three levels of the ecological model and showed the dynamic interactions between those levels and the persons involved, including the wider socio-economic, political and cultural context of MHPS problems (Hardon et al., 1995).

The assessment thus considered:

a) Stakeholders' and beneficiaries' perspectives on psychosocial and mental health problems related to the refugees in Burundi, Rwanda, and Tanzania.
b) Existing support structures and services (individual coping, social support systems, community action, NGO and governmental capacities).
a) Clinical skills and competency of services providers.

Recruitment and training of assessment team

The HealthNet TPO Burundi research team selected a team of eight Burundian interviewers for this assessment project. Criteria for selection were: 1) previous experience in doing qualitative data collection, 2) having experience with mental health and psychosocial support projects, 3) experience working with refugees and 4) being able to speak French, Kirundi/Kinyarwanda and preferably Kiswahili. The team was balanced in respect to gender and ethnicity.

[4] Action sheet 2.1 on 'assessments of mental health and psychosocial issues'

Most of the interviewers were familiar with refugee settings (some had been refugees themselves, and all had worked in camps as data collectors or psychosocial assistants). The previous experiences of the Burundian interviewers were used in a free listing exercise to collect themes that might be relevant for this assessment project. Subsequently the identified themes were prioritized by the team of interviewers. The same procedure of free listing and prioritization of identified themes was also used in the focus group discussions with the refugees. At the end of day one we had four main topics: losses, interpersonal relations, violence, mental health and other findings.

On the second day of we formulated relevant probing questions for each of the four themes. The result of this exercise was a topic guide for focus group discussions and individual interviews (see Annex 2). During the data collection the assessors often came together to discuss new topics that came up and to evaluate whether the formulated question-grid had to be adapted.

Data collection techniques

a) Focus groups discussions (FGD)

Each of focus groups were led by two trained Burundian interviewers (one of whom acted as facilitator and the other as note taker. These interview couples were mixed in gender. Groups started with a grand round question, inviting the participants to describe and prioritize the main problems they faced as refugees. The facilitators of the FGDs decided if additional themes (other than those in the topic guidelines) needed to be discussed based on the problem prioritization of the refugee participants. We held FGDs with several groups from the refugee population: children (from 10 to 15 years), youth (16 to 22 years), adults and elderly. Males and females were in separate groups.

FGDs were conducted in the language of the refugees. Therefore, no interpreter was needed, with the exception of some FGDs in Tanzania that included Kibembe-speaking participants. A FGD ranged from 90 to 150 minutes. The interviewers strove to write down responses in the words of the participants but time constraints prevented us from reporting all responses fully 'ad verbatim'.

b) Key informant interviews

We held individual interviews with key informants among the refugees: care providers of the NGOs, members of the UNHCR and care providers from the refugee groups, as well as teachers, traditional healers and religious leaders in the camps. It was not feasible to conduct individual interviews with all members of the UNHCR or implementing NGOs, therefore, there were several group exchanges instead. The interviewer made notes during these group interviews.

c) Personal narratives

Personal narratives were collected from help seekers (for a psychosocial problem, a mental illness, or epilepsy) in order to gain insight into how the refugees experienced their illnesses or problems, which coping strategies they used, and how they perceived the health care and support in the camps. Health workers and staff from community services assisted us to establish contact with these refugees.

d) Skills assessment

A questionnaire was given to general health workers to assess their experience with/and knowledge of the common and severe mental disorders of refugees: how there are recognized and treated. The case descriptions for mental problems in the new UNCHR Health Management Information System (HMIS) were used to get a

quick overview of the health workers' ability to recognize these problems (see Annex 3).

e) Literature review

A basic literature review was conducted of existing published and unpublished literature on MHPSS in Burundi, Rwanda, and Tanzania and UNHCR policy for the camps included in the project assessment.

Overview of collected data

Data was collected from August 13-28 2009. In total we performed 30 focus group discussions in four camps, 51 interviews with key informants such as health workers, community workers (national staff and refugee staff), pastors, traditional healers, camp leaders, teachers and policemen. Fifteen personal or illness narratives were collected in the various camps, 28 other exchanges with service providers among those 19 needs and skills assessments were taken and we discussed our preliminary results with UNHCR and NGO staff involved in the three countries.

	Burundi	Tanzania			Rwanda		Total
	Gasorwe	Lugufu	Mtabila	Nyarugusu	Kiziba	Gihembe	
Focus groups	11	—	2	6	7	4	30
Key informant interviews	10	5	5	7	13	11	51
Personal narratives	2	—	—	7	1	5	15
Exchange with service providers	12	1	2	3	4	6	28

Table 1: number and kind of data collection

Data entry and data analysis

Respondents' answers were written down during the assessment and later entered in Word and translated into English. A computer program, Atlas.ti, was used in part to analyze the data.

Situation sketch and findings

The description of the data in this chapter must be considered as a 'snap-shot of the situation', which interprets the circumstances and situations associated with deteriorated mental health and psychosocial stress. The situation is complex and interventions aimed at reducing mental health problems and psychosocial stress are therefore limited. We focus on interventions to improve mental health and psychosocial support, but our approach provides important data for wider multidisciplinary approaches that go beyond the framework of MHPS wellbeing.

In all FGDs we started with free listing; the respondents were asked to mention the problems they face and to prioritize them. In the table below is an overview of the three most important problems the refugees mentioned. More detailed descriptions follow below in the text.

Respondents	**Living Condi-Tions**	**Health**	**Vio-lence**	**Educa-tion chil-dren**	**Losses**	**Inter-per-sonal**	**Other**
Gasorwe							
Elderly female	X	X		X		X	
Women	X	X	X			X	
Girls	X		X	X			
Elderly men	X	X				X	
Men	X		X	X		X	
Boys	X	X		X		X	
Nyarugusu							
Elderly female	X	X				X	
Women	X	X	X				
Girls	X	X	X	X			
Elderly man	X	X				X	
Men	X			X		X	
Boys	X		X	X			
Kiziba							
Elderly female	X	X			X		
Women	X	X		X			X
Girls	X		X	X			
Elderly men	X	X	X	X	X	X	
Men	X	X	X			X	X
Boys	X		X	X	X		X
Gihembe							
Women	X	X	X	X			
Girls	X	X	X	X			
Men	X	X		X			
Boys	X		X	X			

Table 2: Problem hierarchy

We started every interview with a problem hierarchy that showed many issues mentioned by the refugees could be grouped into four topics. The refugees frequently mentioned two topics: living conditions in the camp and the opportunity for education in the camp. According to the respondents in all camps, living conditions were

the source of many other problems. The problem heading 'interpersonal' included relations between the professional workers and the refugees; we will discuss that in a future section. We order the data according to the main themes we used in the interviews and start with the (1) living conditions, followed by (2) education (3) violence, (4) losses, (5) interpersonal relationships, (6) mental health and (7) skills of the health workers[5]. All these aspects will be discussed with attention to the specific context of the refugees and the health and community workers working among them. We will first consider the problems the refugees and the workers face, secondly how they cope with the problems they identified. As the findings in all the camps were similar, we will discuss them in general, but if there are particular differences between camps or countries we will discuss these in depth.

Living conditions

At first sight the living conditions identified as a problem by the refugees would not be considered as direct health problems or as psychosocial issues that were the focus of this assessment. However, these conditions were often seen by the refugees and caregivers as the roots of the refugee problems on the psychosocial level. Their living conditions can be considered as aspects of the macro level that influence the personal health and wellbeing of the refugees and in return, weak or bad health and psychosocial problems that can deteriorate living conditions. Two main issues were mentioned consistently: lack of food and poverty.

Lack of food

All refugees in all the camps requested that attention be given to their living conditions. It was remarkable that although the camps in the three counties are very different, all the refugees complained about a lack of food, the bad quality of the food and about the lack of diversity in the food supply (no vegetables, fruits, or meat). As can be seen under the heading of violence, the families considered food as a source of many of their problems. The refugees stated that although their food rations were too small, they had to sell their food in order to get extra vegetables, fruits and clothes.

In the Tanzanian camps the food supply was also considered too little and of poor quality, but in and around the camps a few refugees did have small garden plots. In Rwanda, particularly in the Gihembe camp, refugees who are from vulnerable groups[6] are allowed to have small home gardens for vegetables, and are taught income generating activities.

Poverty

Poverty was mentioned in all FGDs and was linked to the lack of opportunities to generate income. Women are responsible for the daily activities at home. Generally, male refugees do not have many meaningful activities during the day. This has serious consequences for gender relations. According to the cultures of the various refugee groups, the man is head of his household and he receives respect from his wife and children when he is able to take care of them. A man who is a refugee in a camp is unable to fulfil his role and this results in him losing his position as head of the family. The men consider that their wives are no longer not respectful toward them.

[5] Under the heading 'other' the groups in Kiziba mentioned the problems they face related to repatriation, particularly the fact that the local chiefs do not want them back in Congo.

[6] Vulnerable groups are widows, orphans, children, elderly, disabled, people living with HIV/Aids (PLWHA) and other chronically ill people.

'We are now married to the UNHCR', their wives say, because the UNHCR gives them food and building materials and other materials, if needed.
In Gasorwe, the staff of the UNHCR stated that the poverty caused problems, such as theft of UNHCR materials in an attempt to gain money. The poverty is so problematic because people do not see any possibility for it to be alleviated.

Education

This topic was beyond our assignment, but since it resulted in many psychosocial problems we will address it briefly. As is shown in Table 2, not only the boys and girls consider their lack of educational opportunities as a problem, but so did the adults. The same groups in all three countries identified education as a major problem. Educational possibilities in the home countries are also likely to be not good, but in contrast to the camps the children and youth in non refugee settlements in Africa are often involved in daily life activities such as keeping cattle, fetching water and firewood and assisting the parents in their jobs.

A significant problem was that children and youth felt restricted in their educational possibilities. The rules and regulation vary in the three countries, for example in Rwanda refugees do only have nine years of education, while in Burundi primary and secondary school is free for people till the age of 27, but in all settings refugees saw the limited options for education as a major barrier for the future of their children and youth. Often girls and boys who are about 15 years old have to leave school (unless they find a grant, which is very rare) and have no other activities during the day. The lack of good educational opportunities might be one of the reasons why the youth in the camps do not believe in a good future. The problems visible in the camps are that the youth have no daily activities, they are hanging around and as a consequence many boys start to use drugs and/or alcohol. Girls want to have nice things, such as body lotion or necklaces. These desires make the girls vulnerable for attention from sugar daddies or other kinds of sexual exploitation.

The schools themselves are also a subject of concern. The number of teachers in the camps is decreasing. According to the refugees, this is because the teachers earn a mere pittance. Other problems are that some camp libraries have no books and some teachers misbehave. Respondents reported cases of teachers who forced students to have sex with them in exchange for admission to the next class.

Violence

Refugees reported various forms of violence they faced in the camps and across all camps this was experienced as severe. For many refugees violence was the first problem they identified. They mentioned a variety of violent acts: domestic violence, fighting and burglaries caused by alcohol or drug abuse, sexual violence such as rape and (forced) prostitution, but also 'cultural accepted forms' of domestic and sexual violence, such as forced marriages, widows who are forced to marry the brothers of their late husbands (levirate marriage), seeing a woman as a possession of her husband's family, violence between ethnic groups, or witchcraft. There were no differences between the camps regarding the refugees' opinions about violence with the exception of ethnic violence. In Tanzania, violence between ethnic groups was not an issue because in the Mtabila camp, the population consists only of Hutu from Burundi and in Lugufu and Nyarugusu the refugees were mainly Bembe from Eastern DRC.

Domestic violence

Alcohol abuse by men was considered as a serious problem and mentioned as a frequent cause of domestic violence by all groups and individuals in all the camps. Men sell the family food ration in order to get money for alcohol and their wives and children suffer from hunger. This behaviour often causes fights between husbands and wives. A reason given for why many men drink was because they suffer from lack of employment and a meaningful way to spend their time and generate income.

Another root cause for domestic violence is the changes in gender relations in the refugee camps. While in the camps women get food from the UNHCR, men lose their social status because they are not able to take care of their families. As an old man in a FGD in Gasorwe stated: 'When we were in our country, the wives respected their husbands. Here in the camp, they see the husbands as just simple persons. Since they started earning money, they arrogantly tell their husbands that they are married to UNHCR. No respect at all. This is the main reason for the many cases of domestic violence, because once men are frustrated, they express this by beating their wives.' Also young men in Nyarugusu camp were complaining: 'There is an increase of violence situations due to changes in responsibilities. Men are totally humiliated, the culture has completely changed, women are arrogant now that they are allowed to run business activities and to earn money... In the camp, women were educated on human rights and the rights of women. This made them rebellious to men.' According to the men, most women do not care for their husbands anymore. Awareness campaigns make a lot of women realize that they do not need to accept the behaviour of their violent husbands.[7]

Some men want to go back to their country as an attempt to regain their position, but often the women do not want to join them, which can create additional tensions in the marriage. Not only the spouses suffer from violence, according the respondents, the children suffer also from the marital problems of their parents or are threatened with violence as well. In Gasorwe camp men stated that polygamy often goes hand in hand with quarrels that result in beating.

<u>Coping with domestic violence</u>

The refugees considered it the responsibility of the couple to find a solution for domestic violence. A cultural relevant way to solve domestic conflicts is via family mediation, but due to their flight from their home countries, families are separated and this traditional way of conflict solving in cases of domestic violence is no longer available for many refugees.[8]

The coping strategies of the women were diverse, but there were no clear distinctions in coping patterns between camps. The general pattern was that a woman did nothing or if there were relatives in the camp she would first go to them. If this did not result in a solution they asked other relatives to intervene. If this failed, the woman could go to the chief of their district and the chief could go to the committee of the camp or to a member of the committee. Every section in the all camps has its own committee that can help. The final step is to go to the police. Some women went to the health services or the social assistants or the Sexual & Gender-Based

[7] Intimate partner violence is, of course, not specific for refugee camps. It is engrained in society. Respondents mentioned that for the Congolese this got a boost during the Mobutu regime who insisted that all people should be independent and autonomous and could should not depend on the government and rule of law. This perspective needs to be taken into consideration.

[8] This is not to say that traditional conflict solving mechanisms are without problems or controversies: they often have a strong gender bias and women are often encouraged to endure violence to maintain a balance between families.

Violence (SGBV) unit in the camp. Other women asked for advice from neighbours or their pastor. Most women, however, would not make their problems public and kept quiet as they were too afraid of being denounced.

To divorce is culturally unacceptable in the camps: 'How can she pay back the cows that have been paid?', a respondent questioned. In most cases, however, women endured the maltreatments because they believed they had to accept their destiny and therefore it was better to keep the violence a secret. A woman in the Nyarugusu camp who suffered from domestic violence said: 'I have never seen a woman who wanted to divorce her husband. When there is a severe marital problem, the husband of the wife temporarily leaves the house, but divorce is not possible.' Another woman who wanted to divorce and went to the SGBV unit for help was told not to divorce, despite the cruelties she endured.

Two psychosocial workers in Mtabila camp stated that women are more conscious of their rights because of all the awareness programs; women are more empowered. 'Men complain that we are for the women, the SGBV units are perceived as for women. We have now a men's group with 25 men and discuss questions as what does it mean to be a father. They like it very much. They also train boys on how violence affects women.' In Nyarugusu camp there is a men's association, but they experience hostility and sometimes outright violence by other men in the camp. The members of the association are seen as a threat. Overall, men in the refugee camps thought that if jobs were available the incidence of domestic violence would decrease 'significantly.

Sexual violence

Christine and her stepmother

Christine is the daughter of her stepmother's late brother - her mother is missing. The stepmother who accompanied Christine gave birth to six children who all died due to illnesses and hunger because of the war.

Christine, who is 12 years old now, was raped at the age of nine by the stepmother's husband. This caused problems in the marriage and the stepmother decided to divorce. The husband, however, will only accept the divorce if the stepmother pays back her bride price. The stepmother is blamed for wanting a divorce and Christine for being raped. Due to her flight the stepmother has no relatives who can help her or who can give her husband her bride price back. After enduring public condemnation and exclusion, the stepmother moved with Christine to another part of the camp, but their history became public there as well and the taunting started again. No one helps Christine and the stepmother, not even the teacher at the primary school. Her husband has taken her food ration card and withholds their food. It seems that no one accused the husband of rape. The stepmother suffers from sleep problems.

Christine also has many problems including social problems because she is being humiliated by the constant taunt of being a prostitute. She has mental problems because she complains of difficulty sleeping and having nightmares and feels anxious when facing people. She often cries and is in a black mood. Christine also has physical problems, since at the time of her rape she was seriously wounded and bled copiously. Now her periods have started and are painful and irregular.

Refugees and care providers described various types of sexual violence, but the most frequently mentioned in all camps was the rape of a child or a girl by relatives, neighbours or other men and adolescents in the camp, and by men outside the camp. In Lugufu in 2008, 22 rape cases were reported to the workers of the SGBV unit. In Nyarugusu, 14 rape cases and six attempted-rape cases and sexual assaults were registered in 2008. In Gihembe, in 2008, 32 rape cases were reported. Given he taboos to report such cases these figures are most likely a severe underestimation. In all camps people expressed that

most refugees stay quiet. Having sex outside marriage is regarded as shameful and often the women or girls are blamed.

Most informants talked about girls who are very young becoming pregnant (early pregnancies). The fact that adolescents can only go to school until the age of 15, was regarded as a significant problem. The only available activity for teenagers, according the respondents, was loitering; boys tend to start using alcohol or drug or join gangs and some girls engage in sexual activities in exchange for small gifts. A pastor in Kiziba stated: 'The cause of all these problems is poverty. Girls need oil and soap so that they look beautiful.' Girls are more vulnerable for getting involved with 'sugar daddies' and as a result they risk to become infected with HIV and/or pregnant. Most girls are scared to tell their parents when they are pregnant and some seek an (illegal) abortion if they become pregnant, kill their newborn babies, leave them behind on the streets or dump them in the toilet pits. These stories were mainly heard in the camps in Rwanda. If it becomes public that a girl has had sex with a boy or has been raped by a man or if she has become pregnant due to rape, her family can force her to marry the perpetrator and sometimes she would be his second woman.

Families keep silent about forced marriages due to shame and in order to prevent social condemnation. In the Nyarugusu camp staff have registered seven forced marriages in 2007 and two in 2008. However, these numbers do not correspond with the number of early pregnancies that have been recorded: 114 in 2007 and 118 in 2008. It is likely that 'forced marriages' are seen as a solution for the problem of unmarried pregnancies; the families involved make the arrangements.

It is also unclear what exactly is meant by terms such as 'rape', 'force marriages', etc. Men in the refugee camps only talk about rape by strangers; for example, as occurring when women collect firewood, or of the rape of young girls. Women in the refugee camps, on the other hand, talk about men (neighbours, relatives and others) who enter their houses and force them to have sex.

Coping with sexual violence

'Relatives and neighbors try to help but in cases of rape this is not possible, because women keep silent, because people will not accept the woman anymore and will be afraid that she develops AIDS. AIDS is also shameful...', a pastor in Gasorwe told us. The cultural way of coping is to keep silent, and if the information becomes public, relatives will try to find a solution within the family or try to come to an agreement between the family of the victim and the perpetrator. As a result of a lack of relatives, sometimes neighbours fulfil the role of mediating or looking for a solution.

In Gihembe, as stated earlier, men talked a lot about children being raped and about the need of bringing the perpetrator to the police, while women talked about going to the health centre or the SGBV unit. Also for the girls, the police were only considered as a last resort. In Gihembe the SGBV unit organizes group meetings with women to support each other. In the case of women who experienced sexual violence, religion is seen as a critical source of support. If the pastor knows about the situation of the woman or girl he tries to support her, including on the material level. In the Rwandan camps people made a connection between rape and trauma; we did not see this in the camps in Burundi and Tanzania.

Other types of violence

Cultural practices and traditions can be perceived as harmful for people in refugee camps. Widows are forced to marry the brother of their late husbands and have no cultural options to refuse. The war in the countries of origin destroyed family ties and therefore the widows cannot find support for negotiating with their in-laws and/or

Disabled, people, children, orphans, single mothers, widows, elderly and people with chronic mental disorders of HIV/AIDS are particularly vulnerable for violence, not only physically but mainly psychological and social forms of violence such as taunting, and exclusion. A disabled man was just released from prison after being accused of having raped a girl. It turned out that he had not done anything but his in-laws did not like having a disabled relative. In an attempt to throw him out the family they had accused him of the crime.

paying back their bride price. The widows in the camps who refuse to marry their brother-in-laws suffer
the repercussions of their decision.
Support systems outside families appear to be difficult for refugees to establish. In fact all vulnerable people in the camps are likely to be exposed to violence.

Another form of violence often mentioned was witchcraft. Refugees described several examples of witchcraft. 'Even if someone dies of malaria, typhoid or diarrhoea then people say that it is witchcraft and will accuse a person.'

'If someone is allegedly accused of bewitching a person he is psychologically in problems', a woman in Gasorwe said, 'One day I was coming from another area where I had gone to look for some flour. As I prepared it for food, I saw a crowd of seven people coming to kill me, because they said I had killed the woman with whom I share a husband. She started with very high temperature. I was lucky the neighbours rescued me. The woman went to the doctor and got well, but I was feeling bad, psychologically'.

Adolescents face a striking problem due to the small houses they live in. According to a member of the SGBV unit in Kiziba, youngsters run away because they feel that they are the cause of conflict in the family. Their fathers want to have sex with their mothers while the youngsters sleep in the same room and can hear and see them. They hear their mothers disagree and that their parents quarrel because their mothers are ashamed.

The last aspect we want to mention are the tensions between the various tribes in the Gasorwe camp. Inter-tribal conflicts are considered as a problem that often results in violence.

Sexual and gender-based violence (SGBV) units

Considering the figures of the kinds of SGBV documented in the camps, there is little change over time in the number of reported cases. According to the staff from the SGBV units this is the result of the awareness programs. They stated that as a result of the awareness programs the number of real cases declined, but the number of women who are willing to report sexual or gender-based violence to the SGBV units or to the police has increased. However, the staffs of all camps in the three countries admit that due to the culture of keeping such cases secret, there is no clear view of the situation.

The programs of the SGBV units are similar across camps. SGBV units provide programs in the field of peace education, reproductive health, gender and human rights, and girls' education. However, there are some differences. In the Gihembe camp animators use drama to address the issue of taunting and excluding sexual violence victims. The Nyarugusu camp has a men's association whose aim is to increase awareness among men about the equal rights of men and women and to promote men and women to have equal say in the decision-making processes of families. At this moment the men's association's work is challenging because the members of the group face the negative attitudes of other men who complain that due to men's association, the women have too many rights. In the Mtabila camp there are also men's groups, but we did not hear about any problems those men's associations may have faced.

The staff of the SGBV units is a mix of professionals and volunteers, and most of them are refugees. The moment they come into contact with a refugee who has

experienced violence, they follow a protocol. First they accompany the refugee to the health centre for a medical examination and treatment, and for psychological assistance. They motivate the refugee to report the event to the police. The village leader, area leader and camp committee can support such a person, by taking the perpetrator to the police and to offer help, if necessary, with income-generating activities.

Many refugees who have experienced SGBV try to find support by praying. The church and their religion is a significant resource for coping. Sometimes these refugees find assistance from their neighbours but the stories of being taunted, excluded or not taken seriously anymore predominate.

The SGBV units offer practical support, legal aid, and counselling for individuals, couples and families. If we asked a battered woman to describe her counselling she said that she comes to the SGBV unit if she needs help mainly on an irregular basis and for her counselling was a synonym for practical support.

Camps with child protection units organized individual counselling for girls who had been raped (reported cases of boys being raped are very rare) and counselling for the family. The children also have group meetings to regain their self-esteem.

For many health care workers and community workers it is often difficult to raise the question with refugees of violence and if it is involved in their complaints, especially sexual violence. However, the camp authorities will give shelter to persons who are rejected by their relatives.

Losses

It is not news to state that the refugees in the camps in these three countries have suffered a great deal. People died in the war or during their flight from their homeland because of violence, hunger, and a lack of medical care. Many families are incomplete when they arrive in the camp. Furthermore, most of them have lost all their property, their jobs, cows, good salaries, their social position and respect. Refugees express that they feel very sad because of all the losses and some state that they occasionally have the feeling that they are becoming crazy because of their experiences. It is remarkable, however, that only in the Kiziba camp did refugees put losses in the top three of the problem hierarchy (in all camps the participants in the FGD's mentioned losses when free listing).

Women talked about their personal losses, which were often severe as in the case of a woman in the FGD in Gasorwe: 'Thank God that I am still alive, I could have become foolish because I give birth to eight children and I stay only with one, all died during the war. Can you imagine?'

Women in a FGD in Tanzania had the following expressions when we talked about the emotions connected to their losses: 'I am afraid, I feel a wound in my heart', I feel changes in my whole body', 'I feel it would be better for me to die and not to see Congo. I feel that nothing interests me', 'I have many thoughts and I have sleep difficulties', 'I feel sadness. I feel bad in my heart, I will never forget it.'

It appears that men were more focused on their material losses and the loss of their social position. Some men wanted to go back because in Congo they had had a good life, while others did not dare to go back. Congo was too connected with bad memories or they did not believe that peace would really be achieved. These issues gave them a lack of peace in their hearts, emotional instability, sleeping problems, sadness and hopelessness as well as physical complaints. In Rwanda people call themselves traumatized: 'We walk with deep pain, we are traumatized.' For most refugees the current situation in the camps continues to be difficult to manage.

The fact that they have lost hope that they will ever be able to go back to their homes is painful to live with: ‘’I feel worthless’, ‘I feel I have no life’; ‘I feel like getting mad’ are expressions that are often heard. ‘You see children suffering from Kwashiorkor here. This would never have happened if we were in Congo, we use to get enough food, *ndagala*, *sombe*, mixed food, we cultivated harvest.’ The poor situation in the camp, the lack of food and other necessities constantly reminds the refugees of their lives in Congo and it reminds them that they have lost their way of living.

Young girls and boys who were born in a refugee camp have never seen their country and experience this as a kind of loss. One of these girls uttered: ‘In my heart I wish to go back home, because they tell us that life was perfect back home. We had everything. I feel bad.’ However, these aspects are not the only losses for refugees. Due to the system of the refugee camps, refugees lose the ability to take care of themselves. The food, the school, the material to build a hut, health care, everything is organized by the UNHCR and is free. Young people especially do not learn to till the land, to take care of cattle, and to take care of their family if schools and health care are paid for. Refugees have learned to be helpless, powerless and dependent. This makes the already difficult life in the camp even more problematic and the refugees become frustrated and passive. The psychosocial problems they face cause them to become more and more ‘individualistic and traumatized.’

Coping with losses

The refugees try to support each other with all these losses. They try to maintain themselves by dancing and singing, but praying is the most important coping mechanism. ‘When they pray for you, you feel relief and believe in future happiness’, a women in a FGD stated. Sometimes a pastor or other church leader plays a role in this process, although some pastors said that for them it was difficult to give support because they are also refugees and ‘one of them’, with the same problems.

The refugees also come together and talk and try to advise each other, or go to friends for support. Some of them go to a care provider who knows how to listen. The most important coping strategy for the refugees was to have meaningful activities and especially for the men this was a problem. Most of the refugees have been in the camps for more than ten years and ‘they are exhausted’, according a UNHCR employee in Kiziba, because of the living conditions and lack of hope for a better life.

Interpersonal relationships

There is a Banyamulenge proverb that says: ‘*ntazibana zidakubitana amahembe*’ which means ‘there is no relationship which has no problems.’ Some people say that they have no major interpersonal problems, but ‘no one expects nice words from an empty stomach.’ In the camps refugees face so many problems that people feel stressed and tensions easily arise between people.

As mentioned earlier, in Burundi, relationships are tense between the various ethnic groups and every now and then there are fights so children cannot marry a person from another ethnic group. ‘Training or workshops related to peace and reconciliation could help us to improve our relations because we are the same’, a man stated in a FGD. These problems were not as common in the camps with Congolese refugees in Tanzania because the refugees were mainly from the same ethnic group, the Bembe.

Across all the refugee camps there was tension between people in general, but in cultures where it is not acceptable to talk about personal problems with people outside the family, interpersonal relationships can be strained. ‘We keep quiet and digest the suffering.’

Rules in the camp influence the interpersonal relations between the professionals and the refugees. Examples of such rules include the impossibility of cultivating vegetables and the fact that some refugees feel rebuffed because of the rules. However, the way people experience their relationship with the camp professionals differed across countries and camps. In Gasorwe both the refugees and the professionals spoke of their relationship in negative terms. In informal conversations refugees and aid workers complained about each other. The refugees felt that they were not taken seriously by the health care workers (reported in all camps) and this was supported by several stories and gossip about substandard care and drugs that were insufficient in quantity and low in quality. It was not clear whether this situation was a perception of the refugees or reality. In the Nyarugusu camp the interpersonal relations between the beneficiaries and the professionals in the camps was good. The refugees did not have significant problems with the way decisions were made and communicated by the board of the UNHCR and the Tanzanian government. However, refugees and the local professionals in the Lugufu camp, for instance, only understood that the camp would be closed one week before the refugees were transported to the Nyarugusu camp. Some health workers expressed that there is a relationship between how the humanitarian aid is provided and the way people feel, 'they can get depressed because of the way we provide assistance. If the relationship between the professionals and the refugees in the camp is not good, the professionals complain about the refugees who steal and refuse to do anything.

Tensions between the care providers and the refugees have significant implications for the health care and psychosocial support. Those tensions support rumours that the care providers do not do their work properly or provide no or wrong treatment that results in the refugees avoiding health care workers. In Gasorwe a story was circulating that there were no drugs in the health units and thus refugees went to an illegal drugstore in the camp and obtained all kinds of drugs without having had a medical examination. One woman almost died because of this practice.

Mental disorders

One of the themes in the FGDs was mental disorders. This topic was introduced with an open question, 'tell us about mental disorders in the camp', and when necessary conversation was prompted with some examples given by the interviewers. After a quick inventory of the various disorders the participants faced in the camp the focus shifted to possible sources for support and treatment.

The types of mental disorders that were spontaneously mentioned by the respondents corresponded roughly with the broad categories 'psychotic disorders', 'epilepsy' and 'mental retardation'. Other mental problems, such as depression and psychological trauma, were mentioned less frequently overall; however, the Tutsi refugees in Burundi and particularly Rwanda did mention them and had vernacular terms for these problems. Substance abuse was seen as a significant problem in the camps but respondents did not often spontaneously mention it as a mental problem.

Mental problems, as described by the refugees were abundant and quite diverse. Below are some typical examples of participants' responses:

> *Facilitator: "Let us talk about mental health, are there people suffering from mental illness here in the camp?"*
> *Girl 1: There are some people who run up and down, and others who lose their mind and fall down.*
> *Girl 2: "There are those whom talk to themselves, and take off their clothes"*

Girl 3: "Yes and there are those who do not speak and they are very shy. They are crazy."
(*FGD Gasorwe young girls*)

In some of the FGDs it became clear how many refugees were actually confronted in their daily lives with someone who suffers from a mental disorder. 'My brother-in-law is mentally ill and he wrongs me very much. At times he lies saying that I bewitched him, or saying that I committed adultery with him.' *(woman in FGD Gasorwe)*

The results of this section are ordered in broad categories of mental disorders. This ordering in large clusters results in some loss of specific cultural information, but given the exploratory nature of the study we feel this is justified. In Table 3 we provide a brief overview of the local words and idioms we encountered during the assessment. In the following paragraphs these idioms are mentioned and this table is mean to provide a quick overview of terms. Of course, the local terms are by no means synonyms for the medical constructions of mental and neurological disorders. But the local categories and idioms do overlap to some extent with medical terms.

	Bembe (camps in Tanzania)	Swahili (camps in Tanzania and Burundi)	Kirundi (camps in Tanzania and Burundi)	KinyaRwanda/ KinyaMulenge (camps in Burundi and Rwanda)
Severe mental disorders	*Mshile* ('crazy') *Mwenye kuchanga-nyikiwa* ('totally confused')	*Kicha, payu*	*Umusazi*	*Umusazi/ Abasazi*
Depression	*Mlwaci wa malenga* ('thinking too much')	*Upweke*	*Akabonge, agahinda*	*Agahinda / guta umutuwe*
Psychotrauma	-	*kupagawa*	*guhahamuka*	*Umuntu yarahahamutse/ Inahamuka/ guhahamuka*
Mental Retardation		*Kiwelewele, zuzu*	*igikehabwenge*	*Ibimara*
Epilepsy	*Efuele*	*kifafa*	*intandara*	*Ibicuri/ Igicuri*
Alcohol and substance use Disorders		*Mlevi*	*Imborerwa, umunywarumogi*	

Table 3: local words and idioms used by informants to indicate mental disorders and epilepsy.

Severe mental disorders

In all settings when asked about 'mental problems' respondents gave examples of people they had seen. The most prominent features that were mentioned were severe behavioural problems ('eating anything one can find on the ground', 'beating children', 'throwing stones to people', 'walking naked'), withdrawal and self-neglect ('they are dirty', they never wash themselves') problems with speech and language ('talking nonsense', 'talking senseless things', and talking a lot', 'saying things that no one can understand'). Specific symptoms of psychosis (delusions and hallucinations) were not frequently mentioned directly but were often acknowledged in an indirect way ('talking to oneself', 'saying things that are not true').

To the question of who assists people with severe mental disorders was often answered by 'no one'. Women in Kiziba said, for example, that some Christians assist people with mental disorders by providing them with material assistance. The health sector was also mentioned but often people were not optimistic about the assistance people with mental disorders could expect from this resource.

Epilepsy

All focus group participants mentioned epilepsy as a syndrome and had local words to describe it (See Table 3). Symptoms mentioned were invariable: falling unconsciously on the ground, moving with arms and legs, excess of saliva in the mouth, urine loss, and a duration of minutes to one quarter of an hour. The dangers of epilepsy were also mentioned in all settings: hurting oneself when falling, falling in the fire, or drowning.

The notion that epilepsy could be contagious was expressed in various settings. Stigma around epilepsy was considerable: 'There are many people with *igicuri* but they do not say it because of the fear to be rejected. Families who have epileptics have serious problems.

They are not accepted or nobody to marry in those families because epilepsy is contagious.' (*FGD Kiziba camp elderly women*)

Interview with the father of a girl with epilepsy and mental retardation

The daughter is a 24-year-old Bembe woman, who cannot speak. She is intellectually disabled and has severe chronic muscular contractures of her right arm and hand.

Q: Have you visited other persons to find help for your daughter?

R: We are members of the Free Methodist Church and we went to pray. We tried healers who gave her herbs and all kinds of things that made her vomit. Nothing helped. A healer gave her something to inhale. But it did not help.

Q: How is her life now?

R: Life is difficult. She is not always behaving well and the neighbours get inpatient with her and become angry with us. The children fight with her and throw stones. She has two babies, but she does not know how to care for the children. She cannot even breastfeed the baby. My wife is doing this instead even though she is old and does not have much milk. The people from the Nutrition section give some milk powder every month. The fathers of the children are not here. Both times she became pregnant after she was raped. She cannot talk and if a man wants to have sex she cannot do anything. The first man who raped her was known to us. He did nothing to help the child. When he saw she had become pregnant he ran away and we do not know where he is. The second one is an unknown rapist. We need to live in peace with the neighbours. This is not easy. If we talk to the neighbours they listen and say they understand but they do not change their behaviour towards our daughter. We are worried about the children. We are old (father is 46 and mother is 52) and we do not know who can care for the children if we die…

The Rwandan psychiatric nurse in Gihembe camp said: 'People in the camp think epilepsy is caused by poisoning. They find the diagnosis hard to accept particularly in forms of epilepsy that do not have the tonic-clonic manifestations.'

In all settings the focus group participants mentioned that there was no medication for epilepsy available in the camps. This is remarkable because in all settings, epilepsy was part of the treatment packages and the available statistics of the health information system showed that significant numbers of refugees are receiving treatment for epilepsy. For example, in Kiziba the women in the FGD insisted that the health centers had no medication for epilepsy while during the assessment period 55 people (0.28 % of the Kiziba camp population) were receiving treatment for epilepsy. There is a considerable treatment gap for epilepsy but it is not true that there is no treatment available, despite the fact that it is a widely held opinion in the Kiziba camp. The same paradox was found in the other camps, for example, in Nyarugusu camp refugees said that people with *efuele* sometimes seek help in the health centre and with traditional healers, but more often 'they are left in the families because epilepsy does not have a cure and it is contagious.' Epilepsy is well recognized by communities and health workers, but this is most likely only true for the typical 'grand mal' convulsions and not for many other types of epi-

leptic manifestations. In general when respondents mention that 'there is not treatment in the health centre' do they actually mean: there is not 'cure'. Often the notion of chronic diseases is difficult in African settings. When the treatment does not lead to disappearance of the symptoms people can consider it as a failed treatment.

Severe learning disabilities

Interview with the mother of a mentally retarded child: Gihembe camp
Jean is the fifth child in a family of seven children. His mother told us that she saw Jean's problem when he was two years old. He was able to speak but not understand. He is hyperactive, always moving, climbing trees, and other children throw stones at him. His mother tells us that she is in control of the situation. She doesn't know the origin of the problem. But, she says that she had pregnancies close to one another between the second child and the last one. She has seven children: She ends by asking if humanitarian NGOs could continue to help her child to become independent.

Most groups mentioned that they knew about people with severe learning disabilities in the camp. Some groups had words for this condition; for example, the women in Gihembe used the term *ibimara* to signify mentally retarded persons. As a characteristic they mentioned: 'they sneak out and go to Kigali, they leave the camp without permission, they talk nonsense as if they are crazy.' In the Nyarugusu camp the community services included a mental retardation intervention in the program for Community Based Rehabilitations.

Depression and other common mental disorders

People with a depression were described as 'people who cry all the time and there are people who feel that their head is heavy.' A patient described it as:

> I do not feel any happiness. I have no life. Nothing is giving me pleasure. I should take care for my wife and children, but what can I do? I have no interest in doing anything whatsoever. I will die in a bad state. And my family will die in a bad state as well. There is nothing I can do to support my family. I have bad thoughts.

Some informants in Rwanda used the word *guta umutwe* ('losing your head'), which has some similarities to depression:

> A person with *guta umutwe* becomes easily irritable and gets angry for small reasons. If such a woman starts a household chore she sometimes does not even finish it because her mind is not there. If they cook the meal is not properly cooked. She forgets things. Sometimes they wear clothes that do not actually fit well together. They are not well in their heart. They do not know what to say and how to talk. They have lost their joy in things. Nothing can make them happy. They sleep very badly and do not eat well because they do not have appetite. This is because of the difficulties in life that a person faces. (*Gihembe camp traditional birth attendant*)

Trauma

The refugees in Tanzania (the Burundians and the Congolese) did not mention psychotrauma, and had no words to indicate a specific syndrome related to being traumatized. This was very different in Rwanda and to some extent among the Banyamulenge in Burundi:

> *Guhahamuka* is, for example, when you think about how your children and husband are killed in front of your eyes, when you think about all that you have lost. Someone like that has a fear inside the heart because of all that he has seen. If one thinks about all that you are lost because then you lose your balance and get *guhahamuka*.

> But of course the difficulties in the camp here make the things worse. The problem comes back when one is in difficult circumstances; for example, when one is in extreme poverty. If you look at a person with *guhahamaka* you may think he has a low intelligence, but this is not true. He is intelligent but because of his problems he is bothered. (*interview traditional birth attendant Gihembe camp*)

While in the focus groups participants tended to focus on problems in the 'here and now'; however, in some of the individual interviews people talked about the psychological effects of violent events in the past. For the Congolese refugees in Rwanda and Burundi the memories of massacres were painfully present.

Respondents found it difficult to indicate what would help refugees with such complaints. Some of them talked with a psychosocial worker or a counsellor. This is what a survivor of the Gatumba massacre[9] says about his relationship with a psychosocial worker:

> He listens to me and makes meetings with me. But he cannot really help me. I have seen him three times now. It has helped me to change my way of thinking, but in the end nothing has changed, my situation is exactly as it was before because there are still people out there who are after me.

Psychotrauma has a role in the political discourse of the Tutsi refugees. Commemorations for the massacres are performed and these are important elements in the formation of a collective identity as victims. During our assessment in the Gasorwe camp in Burundi the fifth anniversary of the Gatumba massacre was observed. During this meeting several hundreds of people gathered to listen to speeches and testimonies. It was remarkable that no representatives from other ethnic groups were present, just Banyamulenge.

The notion of victimhood that is often connected to trauma was frequently expressed, but not always. A camp leader in Rwanda spoke at length to convince us that *guhahamuka* was not an issue among the Tutsi refugees in the camp. According to him, it was something that was often seen among Rwandans who had lost many family members during the genocide, but was not a relevant issue among the refugees in Rwanda who would 'not dwell on the past but think about the future.'

Alcohol and drugs

In all camps the use of alcohol and drugs were considered problematic, as discussed earlier. They were primarily seen as a behavioural problem and not as a 'disorder'. Use of drugs and alcohol was considered as a consequence of other problems: 'The consequence of these problems is that you can change and start a bad behaviour like taking drugs, believing that drugs may help you forget everything', said a young girl in Gihembe. Overconsumption of illegal alcohol is regarded as a huge problem. This was particularly so for the illegally brewed drinks such as *kanyanga* a traditionally brewed drink with a high alcohol percentage that is on the national illegal drug lists of all three countries. People do make a link between long-term use of alcohol and strange behaviour:

> People can get mad from *kanyanga.* It is used by men and women, although mainly man. People get mental problems if these the wrong brew, even so severe that they have to transfer to hospital. (*Interview Kiziba camp police, Rwanda*)

[9] In 2004 a refugee camp in Gatumba, at the border of Burundi and DRC was attacked by rebels and many refugees were massacred.

Mental health problems in the health care system

Mental health knowledge and skills among health care providers

In the camps individual interviews were held with service providers in the health care sector (three doctors, nine nurses and five community health workers) to get an overview of their knowledge and opinions regarding the treatment of MNS (mental, neurological and substance use) disorders and psychosocial problems. A questionnaire was distributed that had open questions and case vignettes. All respondents were non-specialist health workers; although, some had previous experience and training in mental health and psychosocial wellbeing. The three medical doctors had had some basic training in psychiatry during their medical education. One had received supplementary short courses on mental health organized by NGOs in the camps. Of the nine nurses, three had had some additional training in mental health. Most nurses said that psychiatry had been part of the nursing curriculum but four spontaneously indicated that this did not help them in their actual practice. Of the five community health workers, two had had short courses on mental health in the camp.

MHPSS problems seen in daily work

Medical doctors

The three medical doctors all described epilepsy, and chronic psychosis. One also described a depressive syndrome and bipolar disorder. Medical doctors identified (correctly) phenobarbital as a treatment for epilepsy and two of them would refer the person to specialized services. For mental disorders all three medical doctors would refer the refugee to the psychiatric nurse in the camp – if available – or refer the person to a designated psychiatric hospital (in Burundi and Rwanda this is the national mental hospital in the capital, and for Tanzania this is the hospital in Dodoma).

Nurses

All the nurses mentioned epilepsy as having the following main characteristics: falling down, tongue bite, urine loss, shaking of arms and legs. The description is similar to those given by the participants in the FGDs. As treatment six nurses described Phenobarbital as the medication to be given.

Six out of nine nurses also described psychosis, describing main characteristics using the same elements as the participants in the FGDs: aggression, bizarre behaviour, or talking nonsense. As treatment three nurses mentioned that such a person needs antipsychotic medication, and considered haloperidol or chlorpromazine as treatment, but said that these were not available in the camps. These drugs are however in the essential drug list and according the health care providing NGOs the drugs should be available in the health centres.

Brief case descriptions

Seven brief case descriptions from the new UNHCR Health Information System were presented to the community health workers. They were asked whether they had seen cases like these in the last two weeks, and what they thought the appropriate management would be.

Case description A (epilepsy):
A person who has at least two episodes of seizures not provoked by any apparent cause such as fever, infection, injury or alcohol withdrawal. These episodes are characterized by loss of

consciousness with shaking of the limbs and sometimes associated with physical injuries, bowel/bladder incontinence and tongue biting.

All health care respondents recognized this as epilepsy. Two nurses and one MD had seen people like this in the last two weeks. The nurses said they had referred them to the neuropsychiatric hospital. The doctor described the treatment as a combination of medication (phenobarbital) and behavioural education.

Case description B (alcohol and drugs):
A person with this disorder seeks to consume alcohol (or other addictive substances) on a daily basis and has difficulties controlling consumption. Personal relationships, work performance and physical health often deteriorate. The person continues consuming alcohol (or other addictive substances) despite these problems.

One nurse indicated that she had seen cases (two persons) in the last two weeks. Her approach was to talk to the person and advise him to stop drinking. Another nurse had also seen two cases of persons who were intoxicated by drugs. He had measured the serum glucose and referred the man to the hospital. A nurse in Tanzania mentioned he had seen five cases of people who had shown up drunk in the health centre. He advised them to stop drinking. Respondents indicated that using alcohol and drugs is widespread in the camp. The use of illegally brewed spirits (called *kanyaga*, *urumogi, simba waragi*) in particular caused problems. Refugees in the camps did not consider intoxication a medical problem (if they see it as a problem at all) and do not visit a health centre for this problem. One Tanzanian nurse in Nyarugusu said: 'I do not know any Congolese man who does not drink. But they do this secretly and will not visit the health centre.' Of the three medical doctors, one had seen people with alcohol problems in the last two weeks. His treatment consisted of counselling, performing physical examinations, prescribing Vitamin B6 and referring to a nutrition unit.

Case description C (mental retardation):
A person with very low intelligence causing problems in daily living. As a child, this person is slow in learning to speak. As an adult, the person can work if tasks are simple. Rarely will this person be able to live independently or look after oneself and/or children without support from others. When severe, the person may have difficulties speaking and understanding others and may require constant assistance.

Three nurses and one doctor had seen patients like this in the last two weeks. The management consisted of some emotional support for the family and the nurses would refer the person to the doctor. A nurse answered: 'I saw a mentally retarded person. He was 17 years old but based on his physical appearance you would think he was only seven and based on his intelligence you would think he was 2 years old. I talked to the family of the patient and referred them to the psychiatric unit in the hospital in Kibuye.'

Case description D (severe mental disorder: psychosis):
The person may hear or see things that are not there or strongly believe things that are not true. They may talk to themselves, their speech may be confused, or incoherent and their appearance unusual. They may neglect themselves. Alternatively they may go through periods of being extremely happy, irritable, energetic, talkative, and reckless. The person's behaviour is considered 'crazy'/highly bizarre by other people from the same culture.

One nurse and one medical doctor had seen such cases. They had referred the person to the psychiatric services in either the hospital or the national psychiatric hospital. This is remarkable because in all the camps psychiatric services are provided by

a nurse trained in psychiatry. However, it appeared that current health services personnel do not feel capable of managing refugees with severe mental disorders.

Case description E (severe emotional disorders: depression):
The person's daily normal functioning is markedly impaired for more than two weeks due to (a) overwhelming sadness/apathy and/or (b) exaggerated, uncontrollable anxiety/fear. Personal relationships, appetite, sleep and concentration are often affected. The person may be unable to initiate or maintain conversation. The person may complain of severe fatigue and be socially withdrawn, often staying in bed for much of the day. Suicidal thinking is common.

One nurse and one medical doctor saw such cases in the last two weeks. A nurse in Nyarugusu: 'I saw one last week. I talk to him and tried to find out why he was so sad. He did not want to talk much. I gave him diazepam and amitriptyline.' One MD had seen two people with suicidal ideas and severe depression whom he referred to the national psychiatric hospital.

Case description F (mild emotional stress):
Complaints related to emotions (e.g., depressed mood, anxiety), thoughts (e.g., ruminating, poor concentration) or behaviour (e.g., inactivity, aggression), but it is not severe: The person tends to be able to function in all or almost all day-to-day, normal activities.

In general the impression among respondents was that refugees with such problems would not visit the health system for this problem; therefore, such cases are rarely seen. A nurse in Kiziba had had a similar patient: 'I saw one case, an unmarried girl who was pregnant. She was desperate and wanted to abort and really had suicidal thoughts. I have counselled her and educated her about the consequences of abortion. I made her understand that she can better keep the baby and that she is not the only one, there are any unmarried mothers out there.'

A nurse in Nyarugusu: 'I saw a mother who complained she had too many worries. She did not sleep and had lost her appetite. She was very distressed. I tried to talk to her to know the cause of her problem. I explained to her that everyone has problems and that she should try to forget her problems. I gave her diazepam and paracetamol.'

The low rate of recognition of refugees who fit the profile of this vignette is remarkable because given the estimated prevalence figures of mild mental disorders and psychosocial problems one would expect that the health workers would have seen many of these cases. Probably they *have* seen them, but they did not recognize the refugees as having MHPSS problems.

Case description G (Unexplained somatic symptoms):
A person with a somatic/physical complaint that does not have an apparent organic cause

It appeared that this vignette was not well understood by the respondents. Contrary to our expectations, the respondents said they hardly ever saw a refugee who met the above criteria. One nurse said she had seen a child with injuries all over his body and since it was unclear what had caused these injuries he was referred to the MD. We have had no possibilities during the assessment to analyze the records on the health centres. It is however likely that in the case load of the health centres many cases of recurrent somatic complaints can be found.

Mental Health problems diagnosed in the health care system

	Nurses (n=9)	Medical Doctors (n=3)
No of patients last 2 weeks	2438	500
No of Epilepsy	5	2
No of Alcohol / drugs	9	3
No of Mental retardation	4	5
No of Severe mental disorders	1	2
No of Severe emotional disorders	1	2
No of Mild emotional distress	3	0
No of Unexplained somatic complaints	2	1
TOTAL MSN	25 (1%)	15 (3%)

Table 4: numbers of patients seen by general health workers in last two weeks based on case vignettes.

	Estimated prevalence	No. in treatment (in last 3 months) (% of population)			
		Burundi Gasorwe (n=9300)	Tanzania Nyarugusu	Rwanda Kiziba [10] (n = 20.000)	Rwanda Gihembe[11]
Epilepsy	1%		201	55 (0.28%)	46
Alcohol/drugs	?	1 (0.0%)	-	-	
Mental Retardation	1%	1 (0.0%)		-	2
Severe Mental Disorder	2%	16 (0.4%)*	8	14 (0.1%)	20
Severe Emotional Disorders	2-4%	12 (0.3%)*	15	39 (0.4%)	5
Others		2 (0.0%)	3	4 (0.0%)	13

Table 5: People with neuropsychiatric disorders in treatment by psychiatric nurse in camp

[10] In Kiziba the figures include 'sleeping cases' who are still registered but have dropped out of care. The psychiatric nurses estimated this is about half of the cases)

[11] In Gihembe the figures include 'sleeping cases' who are still registered but have dropped out of care. The psychiatric nurses estimated this is about half of the cases)

* For adult disorders (severe mental disorder, severe emotional disorder, alcohol/drugs we use a denominator of half the total number of refugees, based on the estimate that 50% are children). For epilepsy and mental retardation the total number of refugees is used.

Discussion

In this need assessment we have tried to find answers to the question of how to improve the mental health care and the wellbeing of the refugees in the UNHCR camps in the Great Lake area. We used a broad approach by focusing on the social constructions and problems the refugees' experience. This perspective gives insight into the risk factors and the coping strategies the refugees use.

Using the framework of the ecological model it became clear that the dynamic between processes and situations on the macro level, such as the ongoing conflict in Congo, the political decisions of the host country and the UNHCR, and the specific situation in the refugee camps causes the refugees to have psychological and social problems on the meso and micro level. We know that social factors are 'major determinants of mental disorders (Patel, 2007). According to Patel, three key social determinants are risk factors for mental disorders. The first is poverty, since mental disorders prevent people from being productive and hence they experience financial hardship. The other two are social exclusion and gender violence. In addition to the consequences of war or other disasters - loss of property, trauma and displacement are major risk factors for mental disorders (Patel, 2007). We will discuss these important aspects of our assessment, but it is important to bear in mind that the process has a looping effect: problems in people's health can result in problems in the community. For the same reason, problems in a community can result in mental health problems for the individual; the process is interrelated.

It is remarkable that the refugees and the stakeholders in the camps gave us the same picture and most problem issues were reported across all the camps we visited. It is noteworthy that we only heard about "losses" in the problem hierarchy of the refugees in the Kiziba camp. We do not know the reason behind this. However, all refugees expressed a loss of ownership; the capacity of a person to act and to make their own choices to improve their circumstances.

Disempowerment and loss of agency

An important aspect of psychosocial wellbeing is the feeling of 'ownership' of ones own situation and future. Many respondents emphasized how the context of a refugee camp (poor food distribution, inability to work or restricted options for schooling) significantly restrained their ability to find work and continue their education, and thus to improve their lives. This situation frequently led to demoralization and 'learned helplessness' on the part of the refugees. The latter term refers to a condition in which a person has learned to behave helplessly and dependently, even when opportunities to improve their circumstances exist. The phenomenon has been described using other terms, such as 'the refugee dependency syndrome' (Berckmoes, 2006).

Dependency is a central element in the worldview of refugees in Burundi, Tanzania and Rwanda, which results in the feeling that their future is blocked and it is expressed as a kind of loss of their future. The refugees feel as though they are in a state of stagnation because of the lack of opportunities to take action for themselves. They seem to develop apathy and sit and wait for assistance. Pavlish highlighted dependency in her qualitative study among Congolese refugee women in Rwanda (Pavlish, 2005b). Her work supports our conclusion that beneath the refugees' passivity there is a wish to have more agency. The refugees want to work toward self-sufficiency. However, refugee youth lack good education. In addition to the problems this creates in the refugee camps, it deprives the youth and their parents

of the hope of escaping their poverty. Foueré (2007, p. 21) in her research among Burundian refugees in Tanzania asserts that 'the organization and structure of the camps where refugees settled contributed to the weakening of transmission of traditional knowledge. Planned spatiality, democratic leadership, control over daily activities and more specifically over work, limitation of movement, dependence on food, provision of non food items and daily supervision of officers of the government of Tanzania resulted in the quasi total submission of parents to the camp structures'.

In an evaluation of the community service programmes in Nyarugusu and Lugufu camps Dick (2002) also noted how aid structures contributed to dependency of refugees. She however also notes a tension between the desire of UNHCR and donors to encourage refugees to become self-reliant and the expectations and concerns of refugees themselves, who often complain about direct assistance from UNHCR and NGOs which makes it difficult to facilitate community initiatives without encountering expectations for handouts (Dick, 2002). She argues that in programming refugees should be allowed more to participate in decision making and management and should be approached as people with skills and inherent capabilities, not as helpless victims (Dick, 2002, p. 41). An evaluation by the Norwegian Refugee Council of their programmes in the Burundian refugee camps also noted that "Refugee participation is low […]. The refugees are passive and request payment for any service rendered for their own benefit or that of their families." (Davies & Ngendakuriyo, 2008)

Health workers who participated in this assessment argued that the refugees were not able to organize their lives. They were worried about the Burundian refugees who are sent back to Burundi after so many years living in the refugee camps. Berckmoes had similar findings in her research. She found that it is difficult for people to take care of themselves if they are dependent on organizations (Berckmoes, 2006). This situation-dependent state of apathy would be authentic learned helplessness as the term presupposes a loss of initiative even when the situation would allow for actions. However, learned helplessness is not universal, as is demonstrated by refugees who 'reconfigure' the humanitarian aid they receive. For example, some refugees arrange cooperative groups, infiltrate local markets, and barter items of value (Pavlish, 2005a). But in general people are losing or are prevented from gaining the skills that are necessary for independent living. This situation causes people stress, diminishes their self-esteem and drastically influences gender relations.

Changing gender relations

Men in a dependent state have no possibilities to earn money for their family. This seriously affects them; they feel incompetent and ashamed, which leads to frustration and loneliness and having 'no peace in your heart'. They complain that they do not receive sufficient respect from their wives or children when they cannot 'be a man' and provide their families with necessities such as clothing and food. In research among Congolese refugees in Rwanda many men expressed shame due to their loss of stature in the eyes of their wives and children (Pavlish, 2007). Refugee men consider gender-awareness-raising programs as a threat to their gender role and position (Turner, 1999).

The changing role of men within the family system in refugee camps in the three countries we assessed was expressed by females in terms of 'we are married with the UNHCR' and by the men as 'men come after the women and the children' and predominates in the experiences of the refugees. Turner found the same in his studies in Tanzania; however, he points out that this should not always be taken at face value. He states that feelings of loss and uncertainty encountered by refugees are easily expressed in narratives where the lack of respect for adult men is seen as the

'symptom' while UNHCR's policy of equality is perceived as the 'cause' (Turner, 2004).

This aspect certainly plays a role, but there are also real changes in gender relations as a result of the disintegration of families due to flight and to the gender equality policies in the camps. These changes in gender relations, often in combination with feelings of being worthless can cause tensions and violence within families. It remains unclear to what extent the male respondents, when they complain about lack of respect by women and children, are in fact complaining about the loss of their former cultural privileges that legitimized gender inequality and abusive behaviour.

Gender-based violence

Gender-based violence is defined by the IASC (2005, p. 7) as 'an umbrella for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females'. Respondents in all camps mentioned high levels of gender-based violence. Violence is not unique for refugee settings, but the specific dynamics of the refugee setting (as noted above), dysfunctional or broken extended-family support systems, and the availability of agencies providing support and assistance to women who have undergone violence may have unintended consequences.[12]

We see the same increased vulnerability of women in the camps. If men feel threatened, the risk of violence increases. Women need the support and potential protection of their neighbours and community leaders, because many of them lack the natural protection of their extended families. Being aware of their rights as women is not the same have coping strategies or feeling the agency to stop the violence or ask for protection. It is therefore important that agencies work closely *with* refugee communities, rather than setting up parallel systems *for* them. Our finding that parallel systems fuel gender-based violence has also been described by other researchers (Pavlish, 2007).

Domestic violence

Refugee women are vulnerable to many forms of violence, domestic violence in particular, which is at its highest level in refugee communities (Sattopima, 2004). The artificial refugee environment, traditional gender roles (women are expected to be submissive, not talkative and respectful) and the treat on the changes of those roles expose women to a situation of abuse and violence. Refugees are forced to be idle in the camps, which adds more frustration and stress to their home live and men often resort to drinking. Only a very small number of refugees work with the NGOs as social workers, teachers, assistants for food distribution, health workers, or as local guards. Neither the professional organizations nor the refugees regard this NGO work as employment. The work is perceived as voluntary work and at the end of the month these refugees get pittance not a salary.

Polygamy is common among the Congolese refugees, and in the camps this is a source of conflict. The family is very important for Congolese and other refugee communities and therefore family stability requires more attention and protection, because if families are in confusion and in conflict this also affects the harmony of the entire camp.

[12] See also Horn (2010) who discussed similar finding in the Kakuma refugee camp in Kenya.

Alcohol and drugs abuse reinforce domestic violence. Men sell their basic food necessities for alcohol. They are the ones who make decisions for the family and traditionally the women's duty is to comply. So when a woman questions the behaviour of a man, according to local culture, she deserves to be beaten. There is established evidence that domestic violence has a significantly negative impact on women's mental health. It is a salient risk factor for depression (Patel, 2007) as are early marriages, widowhood and sexual violence.

Sexual violence

Sexual violence occurs on many levels: within families and perpetrated on children and women, by neighbours and by strangers, inside or outside the camps. Refugees talked about women who were raped while they were collecting wood or were outside the camp for any reason. However, girls most frequently mentioned cases of rape related to sexual exploitation, and unwanted teenage pregnancies. We did not hear cases of adult female refugees who were involved in transactional sex in and around the camps to obtain food or money for themselves or family members. In a survey in 2005, among Congolese refugees in the Nyarugusu camp, 18.8% of the women indicated they were involved in transactional sex, including sex with police and humanitarian workers, and 24.7%, of the men said they practiced transactional sex (Tanaka, Kunii, Hatano, & Wakai, 2008).

Rape and other forms of sexual violence perpetrated on women and girls by men in conflict areas is widely documented, and the African Great Lake area has witnessed the worst of it (UNOCHA, 2007). The refugees in all camps we visited perceived the level of sexual violence as very high. People spoke about it in many interviews. An NGO assessment among Burundian refugee women in Tanzania in the late 1990s estimated that approximately 26% of the women between the ages of 12-49 had experienced sexual violence since becoming a refugee (Nduna & Goodyear, 1997). In a 2005 household study in two refugee camps in Tanzania lower figures were found: Around 10% of the refugees in Lugufu camp reported to have had forced sex (about half of these said this happened in the last 12 months). A majority of them identified their partner as perpetrator (UNHCR, 2005a). Compared to women from the surrounding villages the refugee women in Lugufu (especially widowed, divorced and never-married women) were more vulnerable to transactional sex (Rowley et al., 2008). However, an small survey by World Vision amkong randomly selected children in refugee camps in Rwanda (Gihembe camp, n=30) and Tanzania (Lugufo, n =42) revealed much higher percentages: 20% of the respondents in Gihembe and 17% of those in Lugufu had been forced to have sex (Kamatsiko, 2006).
Women who have experienced forced sex are culturally encouraged to remain silent, particularly among Burundian and Banyamulenge groups. When speaking out about rape, the survivor and her family risk being ostracized by the community and the woman herself may be blamed (Nduna & Goodyear, 1997). Therefore, refugee women do not find it easy to talk about forced sex.
Performing research on sexual violence experiences is difficult not only because of the taboo, shame and risk for exclusion. The definition of words such as 'forced sex', 'sexual violence' or 'rape' can cause misunderstanding and 'category fallacy' (defined as using the same word does not mean that we talk about the same topic). In the local East Congolese languages there are few words for rape and other kinds of sexual violence. They use proverbs or the France word 'viol' (Ndaya, 2005). Furthermore, according to Ndaya, they know about the concept rape but consider it only in the context of a virgin; therefore, a married woman cannot be raped. That may be an explanation for the focus on rape of young girls and children in the respondents' discussions.

Violent cultural practices

Many refugees perceive cultural practices and traditions as harmful during their lives in the camps. Levirate marriage is problematic and a form of violence for many refugee women. This form of violence is directly connected to their special position as refugees. Because of the destruction of family ties, the widows cannot find support to negotiate with their family in-laws or pay back their bride price if they chose to divorce their husband. A woman who rejects her marriage provokes condemnation and risk for exclusion, because it is considered as bad behaviour by the larger community. Those women also risk significant trouble when they return to their home villages. Women cannot inherit land and property; they have no access to their husbands' land or cattle, and this causes the women to live in deep poverty (Newbury & Baldwin, 2001).

The last form of violence described in the camps is violence related to witchcraft. Refugees felt that they could be accused of witchcraft or be victimized by witchcraft at any time. Refugees who are accused of using witchcraft risk being beaten up or even killed.

Lack of social space to express suffering

We felt a strong motivation among the refugees to share many of their problems in the focus groups. People were eager to reveal their situation to us and to each other. Refugees, living in the artificial setting of a refugee camp, often have limited options to find support and an audience for their problems. Refugees, especially women, lack a cultural support system, which is normally provided by their extended family.

There is limited space for refugees to express themselves and share their feelings and experiences because of a lack of structure in which they are allowed to speak. Lacking a forum for expressing themselves, focus group participants identified the need to be heard. However, this finding also points towards the strength of group-based interventions. Pavlish (2005b) explicitly asked participants of a focus group what they found to be the most important thing they talked about. Invariably the answer was that it was the talking itself that was the most important aspect: having an opportunity to express their concerns and feel included, listened to, and strengthened. Trust and a level of social cohesion is necessary in order to express oneself.

Interpersonal relationships

All the aspects discussed above have repercussions for the interpersonal relationships of the refugees: stress, limited space, apathy, loss of hope, and agency. In the Gasorwe camp in Burundi, the various ethnic backgrounds are a source for conflict. However, we want to stress the relationship between the refugees and the professional workers of the UNHCR and the NGOs who provide services in the camps. The refugees are very sensitive to the kind of treatment they receive due to their position in the camps and easily feel disrespected. General negative opinions about NGOs or the UNHCR creates additional stress and agitation. It was remarkable to see that those irritations were often mutual.

Stigma and lack of information on mental disorders and epilepsy

The stigma of epilepsy and mental disorders is high, as described earlier. Epilepsy is considered to be an infectious disease or as a kind of spirit possession. Even some health care workers in the camps considered epilepsy as dangerous.

Refugees only recognized severe mental disorders such as psychosis and depression. They described people laughing at someone with psychosis or with acting out behaviour and in particular, women who were presumed to be depressed were told that they had failed in their role as a wife and mother. The lack of recognition of depression and unexplained medical complaints among the population has been reported elsewhere that psychosocial distress is culturally recognized (with local terms) but not considered to be illness (Hanlon, Whitley, Wondimagegn, Alem, & Prince, ; Ventevogel, 2007). It is not easy for care providers to recognize refugees with mental problems and especially refugees with mild mental disorders or with psychosocial stress. The health care workers lacked the knowledge and the skills to identify such problems.

Problems in service delivery

Improving the integration of services

In the camps there is a tendency for services aimed at specific groups sections (SGBV, HIV/Aids, CBR) to work in isolation. Community-based psychosocial work can have a unifying effect by crossing the boundaries between various service providers. As we have discussed, most refugee problems are interrelated and are difficult to isolate from the context of the camps. Therefore solutions to problems are often complicated and challenging to offer. Professionals working collaboratively provide more insight and increased opportunities for effective support.

Improving community support

A reasonable support system for refugees on the community level, or on the 'village level' is a condition that is needed for good health and good health care and a prerequisite for social and psychological wellbeing. The results of this assessment show that many of the problems we documented were directly related to the respondents' refugee status.

In some camps there are activities to improve the community support, to reduce stigma, and question culturally-accepted violent behaviour towards individuals. What is lacking are activities that strengthen personal connectedness in the 'villages' of the camps. This is especially important because refugees' original support system, the extended family, is often scattered by war and is not available in the camps. New support systems have to be developed. Refugees do not find their way to camp health care centres easily, due to their cultural habits for coping, which involve doing nothing and digesting their suffering. A stronger support system on community level and on the level of community services within the camps could help refugees and if necessary bring them into contact with the health or community support centres. In this effort churches are critical in refugee camps. However, church leaders in the camps often lack the knowledge and psychological strength to support their congregation.

Some initiatives that had been very promising in the past such as the child empowerment programme Child Voice Out as developed by World Vision in Tanzania have discontinued (Kamatsiko, 2006, p. 36).

Improving the psychosocial skills of staff

In all camps we noticed that staff providing psychosocial support tend to offer advice rather than to assist the person to make informed choices. This has been documented earlier in the Kibondo camp in Tanzania: a UNHRC report advised training SGBV counsellors in the difference between offering advice or counselling the survi-

vor about her options, particularly in relation to negotiating relations with husbands/partners (UNHCR, 2005b).

Improving the recognition of common mental disorders

Worldwide the burden of disease for depression and other common mental disorders is significant, but in this assessment, health workers said that they did not often see refugees with depression. They also had no figures regarding unexplained complains A recent review of affective disorders in Africa suggests that this may be due to symptom presentations that emphasize non-affective phenomena (largely somatic, based on interpersonal relationships, or spiritual in nature) (Tomlinson, Swartz, Kruger, & Gureje, 2007). However, detection of depressive symptoms, once they are investigated, are reasonably easy to elicit. Given the strong relationship between common mental disorders and contextual (social) etiological factors, the treatment response should avoid medicalizing social distress. The health workers need to be trained in recognizing mental disorder so the treatment of the patients improves.

Conclusion

We have tried to demonstrate the complex relationship between the context of the refugees and their wellbeing and mental health. Using an ecological framework shows that there are no simple interventions for the problems the refugees experience on the psychosocial level. The lack of ownership, the lack of educational opportunities, and the high level of refugee stress with attendant violence cannot be solved by simple interventions and indeed are problems that while being increasingly recognized by UNHCR are often beyond the capacity of UNHCR to change (Slaughter & Crisp, 2009).

We see that psychosocial stress has several effects. For example, men who fail to find a meaningful job, as a result of the policy on the macro level, start to misbehave on the meso level (such as drinking, fighting and beating) and have psychological problems on the individual level (e.g. lack of self-esteem, a high level of stress, depression, or addiction). Their problem manifests itself as a disharmonic or dysfunctional (social) network on the meso level resulting in psychosocial problems for other family members as well as for the direct environment including the camp.

We have shown a variety of expressions of the same concept: health and the distinct relationships between health and factors that may influence health outcomes. Because the focus of this study was on the actual health status and the subjective experiences of refugees or refugee communities, we now focus our interventions only on mental health and psychosocial support. We realize that by doing so, we do not offer adequate solutions for all the refugees' problems because the sources of their problems are beyond our assignment, scope and government policies. However, we do provide information for an interdisciplinary approach to these complex problems.

In the following paragraphs we propose and recommend issues for interventions to improve the mental health care and the psychosocial support of refugees living in camps in Burundi, Tanzania, and Rwanda.

Suggestions for interventions

In this section we provide suggestions for possible MHPSS interventions in refugee camps in the African Great Lake area. These suggestion were the basis of a workshop (mach 2010) in which stakeholders from UNHCR and the involved NGOs in refugee camps discussed a package of interventions to improve mental health and psychosocial wellbeing in the camps. The interventions in the field of mental health and psychosocial support can be centred around three key elements: 1) fostering mutual support and self-help among refugees, 2) improving the capacity of the health services and community services to recognize and manage people with common mental disorders, 3) Improve community awareness of alcohol and substance use disorders and management in the health and community services department and alcohol use disorders, and 4) improve recognition and access to appropriate care for people with severe mental disorders and epilepsy. These interventions are directed to levels 2 and 3 in the IASC MHPSS intervention pyramid (see Annex 4). The package will be implemented within a specific context and that is why it was necessary to determine priorities collaboratively with stakeholders during the needs assessment process. The report of the joint planning workshop can be consulted as a separate document (annex 5).

1. Foster mutual support and self-help among refugees.

Much of the psychosocial distress perceived by the refugees is strongly linked to the refugee-context: living in a camp where their usual social support mechanisms (such as extended family systems) have been distorted. It is important that psychosocial support is not a top down process (from aid worker to the beneficiary) but a horizontal process: between the refugees themselves. An important aspect of psychosocial wellbeing is 'agency', the capacity of a person to act and to make their own choices to improve their circumstances. The context of a refugee camp (with food distribution, inability to have a job, or to continue with education) significantly restrains the agency of refugees, and can lead to a situation of demoralization and 'learned helplessness'. Therefore an essential element in any strategy to improve the mental health and psychosocial wellbeing in the refugee population should be geared towards strengthening their sense of agency and social fabric.

<u>Suggested actions</u>

a. Train NGO workers and or community volunteers in basic psychosocial support techniques, particularly problem solving counselling and mediation techniques for managing family and neighbour conflicts. Such techniques have been developed for use within African refugee settings (Baron, 2002) and are being used by HealthNet TPO psychosocial trainers in Burundi.
b. Improve the social fabric in the camps through community-oriented psychosocial techniques. There are several ways to do this. This can include elements of techniques such as 'sociotherapy' or 'narrative theatre, that have been tested in the Great Lake Area, but also other community-based techniques eg group discussions where local people reflect on ¨past ¨present and future and reflect on how people in the community can help one other and help other marginalized people. [13]

[13] Such techniques have been developed and tested in the Great Lake Area like sociotherapy (Richters, Dekker, & Scholte, 2008) and narrative theatre (Meyer-Weitz & Sliep, 2005; Sliep & Meyer-Weitz, 2003).

c. Take steps to improve the linkages between vertical services (such SGBV, child protection and CBR).
d. Explore options to provide more possibilities for refugees to generate income and earn a livelihood. Space to do this is often limited given the rules and regulation in the host countries, but when possible this should be advocated because it would perhaps be the most important factor to increase the psychosocial wellbeing among refugees.

2. Improve the capacity of the health services and community services to recognize and manage mentally distressed refugees/ refugees with common mental disorders

We do not have prevalence rates of such disorders in the refugee population or among primary care visitors in refugee camps. We do know however that people with mild and moderate depressive disorders, anxiety disorders and unexplained somatic complaints form a disproportionate percentage of primary care patients everywhere in the world. This assessment indicates that health workers in the camps do not appear to recognize refugees with common mental problems. We base this observation on the diagnoses in the HMIS system and the health workers' level of recognition of the case vignettes. It is likely that, in the primary care centres, patients with CMD are present but not recognized and treated as such. Preferred treatment options include social interventions and brief solution-focused counselling techniques.

The role of the health care system is to identify refugees who are mentally distressed or have a CMD, prescribe medication as needed, and to strengthen the links with psychosocial and community support. Psychosocial interventions are a combined responsibility of health workers and non-health workers (such as social workers, psychosocial assistants, community workers etc).

<u>Suggested actions</u>

Train health workers in the identification and management of people with CMD and unexplained medical complaints. The management should consist of several elements:

a. Train health workers in the identification and management of people with CMD and unexplained medical complaints. The management should consist of several elements: Establish a mechanism to refer those with mild or moderate forms of common mental disorders to community-based social interventions, as described above.
b. Train health workers to manage those refugees with common mental disorders who present with predominantly unexplained somatic symptoms using the forthcoming 'intervention guide for priority mental, neurological and substance use disorders' that has been developed by the World Health Organization and will soon be available for piloting (WHO, n.d.). This guide is intended for health workers (such as doctors, medical officers and nurses) who provide primary care services to persons with mental, neurological and substance use disorders.
c. Consider training psychosocial assistants in the use of a focused manual-based group treatment for common mental disorders.[14]
d. Train health workers to avoid prescribing unnecessary somatic drugs to people with common mental disorders.

[14] In the Great Lake area, good results have been reported using group Interpersonal Psychotherapy (IPT) as in Uganda (Bolton et al., 2007; Verdeli et al., 2008).

3. Improve community awareness of alcohol and substance use disorders and management in the health and community services department

In all camps the use of alcohol and drugs is considered problematic and often is the cause of interpersonal violence. It is above all considered as a behavioural problem and not as a 'disorder'. Use of drugs and alcohol is primarily seen as a consequence of other problems. A recent review of effective interventions for alcohol use disorders in low income countries (Benegal, Chand, & Obot, 2009) suggests that the wide treatment gap can be narrowed by opportunistic screening and by structured brief intervention (SBI) in primary health care settings. SBI is a step-by-step intervention to help risky drinkers reduce or stop alcohol consumption. It starts with simple and structured advice, progresses to extended brief interventions, and ends with referral to a specialist.

Suggested actions

a. Use a screening method for alcohol abuse and introduce it in the training for general health workers and community services workers.
b. Introduce a form of Structured Brief Intervention (SBI) (eg ASSIST) as an intervention to be done by the psychiatric nurses in the camps who currently rarely see patients with alcohol use problems.
c. Interventions at the family / community level to address drinking as a "refugee culture "

4. Improve recognition and access to appropriate care for people with severe mental disorders and epilepsy.

Compared to other health sectors the mental health component in the general health care in the camps is relatively weak and marginalized (Jones et al., 2009). At least 2-4 % of the population in post conflict settings suffer from severe mental disorders or epilepsy (IASC, 2007; Silove et al., 2008). In low income countries there is a usually a wide treatment gap. The situation in the camps during this assessment was relatively good due to the accessibility of medical care. It should be possible in the camps to treat the majority of the people with severe mental disorders and epilepsy, but this is not the case. There continues to be significant stigma regarding these disorders and many refugees do not receive even minimal treatment.

Suggested actions

a. Train designated persons within the general health care system to provide psychiatric services, using the WHO intervention guide (WHO, n.d.). In the camps this is currently being done to a limited extent, through the provision of care through separate mental staff
b. Train community health workers and other grassroots workers to raise awareness of severe mental disease and epilepsy in the refugee population.
c. Train health care staff in the use of the neuropsychiatric guidelines in the new HMIS system

Basic knowledge for primary health-care workers to address mental health problems in emergency settings

- Communication skills
- Basic problem-solving skills
- Psychological first aid
- Recognition and front-line management of mild, moderate, and severe neuropsychiatric disorders in adults and children including:

a. Acute and chronic psychoses
b. Epilepsy
c. Alcohol and substance misuse
d. Mental retardation
e. Severe emotional disorders
f. Common mental disorders

- Simple cognitive-behavioural techniques
- Interpersonal psychotherapy group or individual approaches
- Proper use of essential psychotropic medication
- Appropriate lines of referral to social supports in the community and, if accessible, to secondary and tertiary services
- Time-management skills including service reorganization

Sources: (Jones et al., 2009)

Introduce interventions for young children with emotional, behavioral and development disorders.

To make an intervention package comprehensive some child focused interventions should be considered.

Suggested actions

'culture-sensitive parenting education'. This intervention is recommended by the WHO MhGap.

Annex 1: List of contact details

Burundi				
Name	**Function**	**Organization**	**E-mail**	**Phone**
Herman Ndayisaba	Country Representative	HealthNet TPO	her_ndayisaba@yahoo.fr	+257 79954444 +257 22242124
Dr Colette HOUETO	Medical Coordinator	UNHCR Burundi	HOUETO@unhcr.org…	
Lucia TEOLI	Program Coordinator	UNHCR Burundi		
Louise NTIRANYI-BAGIRA	Project coordinator	HealthNet TPO	ntiranyi-bagira2000@yahoo.fr	+257 22242124 +257 78 925 693 +257 79 925 693
NDAYISABA Aline	Research Coordinator	HealthNet TPO	Ndayisaba_aline@yahoo.fr	79924927
Sophie CAZADE	Country Director	Norwegian Refugee Council	Country.director@burundi.nrc.no	+257 22242386 +257 22216462 +257 79920421
Askale BINEGA	Country Representative	AHA Burundi	aha@cbinf.com	+257 249644
Dr François-Xavier RWITEYIMANZA	Medical Coordinator for refugee camps	AHA	rwitexa@yahoo.fr	
ABOGI Anthony	Head of Field Office Muyinga Ad Interim	UNHCR	Abogi@unhcr.org	
Fabien BARIKEKA	Coordinator Community Services	AHA		79993069
NIYONIZIGIYE George	Psychosocial Assistant	HealthNet TPO	niyonigeorges@yahoo.fr	79945787
NZEYIMANA Jean Claude	Psychosocial Assistant	HealthNet TPO	jeanclaudenzeyim@yahoo.fr	
NYAMWANA Dismas	Assistant Community Services Officer	UNHCR Muyinga	Nyamwana@unhrc.org	
Fatoumata DIALLO	Protection	UNCHR	diallof@unhcr.org	
Pierre MARA	Field officer	UNHCR	marap@unhcr.org	
Céline MARET		Norwegian Refugee Council (NRC)	cm.muyinga@nrc.org	
RWABAYINKOVU Emile	Office Manager	HealthNet TPO	Rwabayinkovu@yahoo.fr	78 926656
NYAKWENA Hilaire		Stop Sida		77754310
Rwanda				
Name	**Function**	**Organisation**	**E-mail**	**Phone**
GATERA Augustin	National Public Health Coordinator	UNHCR Rwanda	agustin_gatera@yahoo.fr & gatera@unhcr.org	+250 0788308301
Dr MULUGETA, Tenna	MedicaL Coordinator Kiziba Camp	AHA		
HealthNet TPO				
Name	**Function**	**Organisation**	**E-mail**	**Phone**
Dr Peter Ventevogel	Mental Health Advisor	HealthNet TPO	peterventevogel@healthnettpo.org	+257 79986908
Marian Tankink	Senior Advisor	Healthnet TPO	mtankink@healthnettpo.org	+31-2062500005

Tanzania				
Name	**Function**	**Organisation**	**E-mail**	**Phone**
Dr Sunday RWEBANGILA	Public Health Officer	UNHCR Tanzania (Kigoma)	rwebangi@unhrc.org	
Dr Kevin TSATSIYO	Health and Nutrition Coordinator	UNHCR Tanzania (Kasulu)	tsatsiyo@unhrc.org	
Viola MAKAME	Community Services Assistant	UNHCR Tanzania (Nyarugusu)	makame@unhcr.org	
Veronica MZYIA	Community Services Assistant Focal point PSS Tanzania	UNHCR Tanzania (Lugufu)	mzyia@unhcr.org	
Lucas MACHIBYA	Nutritionist	UNHCR Tanzania	machibya@unhcr.org	
Alfred WARYOSI	Health Manager	IRC		
Dr Amos SCULLE		Tanzanian Red Cross		
Ernest ATHUMANI	Health Coordinator	Tanzanian Red Cross (Lugufu)	athumanieg@yahoo.com	
Florence MSHANE	Health Coordinator	Tanzanian Red Cross		
Sospeter MUTIBA	Mental Health Officer	Tanzanian Red Cross (Nyarugusu)	smmusiba@yahoo.com	
Vincent MHANGWA	Community Services Coordinator	World Vision Tanzania (Lugufu)	mhangwavincent@yahoo.com	
KIMENYI S.		Tanzania Red Cross Kasulu		
Jonia KARUMUNA	SGBV Program	IRC	Jania.karumuna@tanzania.theirc.org	
Monica NYATEGA	Child Protection Supervisor	IRC	Monica.nyatega@tanzania.theirc.org	
Christine KIVUYO	SGBV Officer	IRC		
Zephrine BAGUMA	Community Services Coordinator Nyarugusu		Zephrinebaguma@yahoo.co.uk	
Raphael BUKURI	Child Protection Officer	IRC		
Edith PAGULA	Child Protection Officer	WV Tanzania	Pagula2004@yahoo.com	

Annex 2: Topic guide for focus group discussions

Bonjour,
Je m'appelle……..et moi je m'appelle…….
Nous sommes à deux. L'un va faciliter la discussion et l'autre va prendre notes des échanges

Nous travaillons pour l'ONG HealthNet TPO dans le département de la Recherche. Nous sommes venus ici pour échanger et écouter les problèmes que vous rencontrez ici au camp et surtout comment vous parvenez à trouver des solutions.
Nous n'offrons pas une assistance directe mais nous allons donner des conseils aux ONGs qui vous assistent dans les besoins de tous les jours. Nous allons parler spécifiquement sur une catégorie des problèmes qui peuvent vous affecter, c'est a dire des problèmes qui vous sentez dans vos cœurs et des problèmes qui affectent vos relations avec les autres dans le camp?
Nous vous garantissons toute notre confidentialité. Personne ne sera capable de savoir qui a dit quoi. Tout ce qui va être discuté va rester entre nous. Toute personne est invitée à participer dans notre discussion. Il n'y a pas de bonnes réponses ou de mauvaises réponses. Les informations reçues ont pour but d'améliorer votre situation dans le camp.
= Vous avez une question de clarification avant que nous commencions nos échanges?

1. Quels sont les problèmes que vous rencontrez ici au camp?

2. Parmi les problèmes énumérés, quels sont ceux qui vous touchent le plus et affectent vos cœurs et vos relations sociales dans le camp?

Thème : Santé Mentale

1. Relater les problèmes psychosociaux et les problèmes mentaux que vous rencontrez ici au camp

2. Y-a-t-il des gens qui ont des problèmes ou des troubles mentaux

(Si la question n'est pas clair donnez de 'probes' par ex;
Des personnes qui marchent nu, parlent à eux-mêmes
Ou des personnes qui s'isolent et sont très tristes,
Ou des personnes qui ont des problèmes liées á l'alcool ou la drogue
Ou des personnes ayant l'épilepsie
Ou des personnes avec le retard mental)

3. Qui dans la communauté aident les personnes ayant une maladie mentale?

4. Qu'est ce que les gens font pour résoudre ou surmonter ces problèmes?

5. On faites recours à qui? Quelle type d'assistance reçoivent ils?

Thème : Violences

1. Existent-ils des personnes qui vous connaissez et qui ont subit des violences dans votre camp?
Si oui, quelles sont les différentes formes de violence que les gens rencontrent dans la vie quotidienne?

2. Comment est-ce que vous évaluer la fréquence de ces violences?

3. En cas des violences quelconques, que font les gens pour trouver des solutions?

4. Qui autres dans la communauté aident ces personnes dans la résolution ou la prise en charge de ces problèmes?

5. Quels types d'assistance reçoivent-ils en cas des violences?

Thème: Les pertes

Vous êtes dans un pays d'accueil, probablement que vous avez laisser des éléments importants (les personnes chères, les propriétés, le statut social, l'emploi…) dans votre pays d'origine.

1. Quels sont les sentiments avez-vous vous comptez tenu de ce que vous avez perdu?

2. Que faites-vous pour faire face à ces pertes (éléments laissés derrière)?

3. A qui adressez-vous ou adressent les gens pour chercher l'assistance?

4. Qu'est-ce qui peut être fait par les intervenants pour vous aider a faire face à ces pertes

5. Quels sont les effets de cet aide?

Thème : Les relations interpersonnelles

1. Pouvez-vous nous décrire brièvement s'íl y a des problèmes ou des difficultés dans les relations qui existent entre les membres de la famille dans le camps. Si oui, quels problèmes ou difficultés
    a. Quand ces relations ne sont pas bonnes, à qui est-ce que vous vous confiez?
    b. Qu'est-ce que les gens font eux-mêmes pour remédier à cette situation ou problème?
    c. Qu'est-ce qui peut être fait par autrui pour améliorer ces relations?

2. Pouvez-vous nous décrire brièvement s'íl y a des problèmes ou des difficultés dans les relations qui existent entre les réfugiés dans le camps. Si oui, quels problèmes ou difficultés
    a. Quand ces relations ne sont pas bonnes, à qui est-ce que vous vous confiez?
    b. Qu'est-ce que les gens font eux-mêmes pour remédier à cette situation ou problème?
    c. Qu'est-ce qui peut être fait par autrui pour améliorer ces relations?
3. Pouvez-vous nous décrire brièvement s'íl y a des problèmes ou des difficultés dans les relations qui existent entre les réfugiés et les professionnels qui vous assistent? Si oui, quels problèmes ou difficultés
    a. Quand ces relations ne sont pas bonnes, à qui est-ce que vous vous confiez?
    b. Qu'est-ce que les gens font eux-mêmes pour remédier à cette situation ou problème?
    c. Qu'est-ce qui peut être fait par autrui pour améliorer ces relations?

= Y-a –t-il une situation ou un problème oublié que vous voudriez partager avec nous?

Annex 3: Skills assessment health care providers

My name is……. I am from HealthNet TPO and as you may know we do an assessment in the camp to improve the mental health and psychosocial situation of the people who are in the camp. We want to know how we can assist the health workers. I want to ask you some questions on mental health and psychosocial wellbeing. The answers will be used to make a training program for you, if necessary.
We will not use your name in the report, but only use what you say anonymously.
Date:
Name interviewer:
Name interviewed person: (Tell the person that we will not use this in the report)
Camp
Profession (for example nurse A2, medical officer, doctor)
Function:

Topic
Experience and training in mental health and psychosocial wellbeing.

1. In your daily work which people with mental problems do you see? Describe:
   A. Name/description?
   B. What are the symptoms?
   C. What is your current management?

Write what the person tells you. Ask him/her to be detailed: if the person mentions the use of a drug ask:

   a. Name
   b. Dosage
   c. Side effects
   d. Duration of treatment

   D. What do you do to help a person who comes to you with this problem?
   E. How can the management be improved?
   F. How many people with similar problems do you see per month?
2. **(ONLY FOR MEDICAL PERSONNEL)** What psychiatric drugs are available in the clinic and what psychiatric drugs do you miss?

In your daily work what sort of people with psycho-social problems do you see? Describe:

1. Name/description?
2. What are the symptoms?
3. What is your current management?
4. What do you do to help a person who comes to you with this problem?
5. How can the management be improved?
6. How many people with similar problems do you see per month?

I want to describe 7 case vignettes and want to hear your opinion about such patients.

(1)
A person who has at least two episodes of seizures not provoked by any apparent cause such as fever, infection, injury or alcohol withdrawal. These episodes are characterized by loss of consciousness with shaking of the limbs and sometimes associated with physical injuries, bowel/bladder incontinence and tongue biting.

(2)

A person with this disorder seeks to consume alcohol (or other addictive substances) on a daily basis and has difficulties controlling consumption. Personal relationships, work performance and physical health often deteriorate. The person continues consuming alcohol (or other addictive substances) despite these problems.

(3)
The person has very low intelligence causing problems in daily living. As a child, this person is slow in learning to speak. As an adult, the person can work if tasks are simple. Rarely will this person be able to live independently or look after oneself and/or children without support from others. When severe, the person may have difficulties speaking and understanding others and may require constant assistance.

(4)
The person may hear or see things that are not there or strongly believe things that are not true. They may talk to themselves, their speech may be confused, or incoherent and their appearance unusual. They may neglect themselves. Alternatively they may go through periods of being extremely happy, irritable, energetic, talkative, and reckless. The person's behaviour is considered 'crazy'/highly bizarre by other people from the same culture.

(5)
The person's daily normal functioning is markedly impaired for more than two weeks due to (a) overwhelming sadness/apathy and/or (b) exaggerated, uncontrollable anxiety/fear. Personal relationships, appetite, sleep and concentration are often affected. The person may be unable to initiate or maintain conversation. The person may complain of severe fatigue and be socially withdrawn, often staying in bed for much of the day. Suicidal thinking is common.

This category covers complaints related to emotions (e.g., depressed mood, anxiety), thoughts (e.g., ruminating, poor concentration) **or** behaviour (e.g., inactivity, aggression). The person tends to be able to function in all or almost all day-to-day, normal activities. The complaint may be a symptom of a less severe emotional disorder or may represent normal distress (i.e., no disorder).

Inclusion criteria: This category should only be applied if (a) if the person is requesting help for the complaint **and** (b) if the person is not positive for any of the above five categories.

(6. Other psychological complaint)
The category covers any somatic/physical complaint that does not have an apparent organic cause.

Inclusion criteria: This category should only be applied (a) after conducting necessary physical examinations. (b) if the person is not positive for any of the above six categories **and** (c) if the person is requesting help for the complaint.

(7. Medically unexplained somatic complaint)

Disorder	**Number last week**	**Number last 2 weeks**	**Prevalence last 3 weeks**
1. Epilepsy/seizure			
2. Alcohol or other substance use disorder			
3. Mental retardation/ intellectual disability			
4. Psychotic disorder			
5. Severe emotional disorder			
6. Other psychological complaint			
7. Medically unexplained somatic complaint			

For each category:

- What is your management in such cases?

Annex 4: The IASC guidelines on MHPSS in Emergency Settings

The IASC guidelines on Mental Health and Psychosocial Support in Emergency Settings recommend multilayered systems of support and distinguish four layers of MHPSS interventions (see figure).

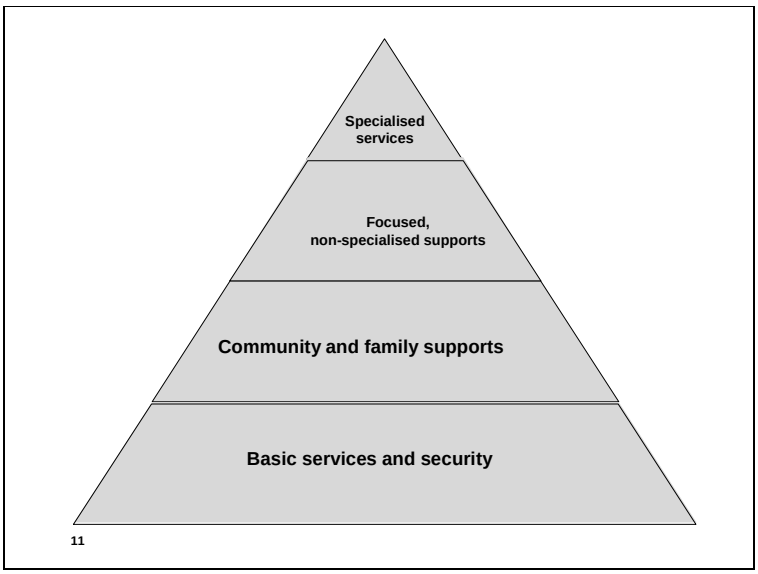


Figure: Intervention pyramid for mental health and psychosocial support (IASC, 2007)

Layer 1: Basic Services and Security
The most important interventions to improve mental health and psychosocial wellbeing for refugees have apparently nothing to do with psychosocial support and mental health care. The best guarantee for improved mental health status and psychosocial wellbeing is the normalization of living circumstances and the alleviation of problems due to poverty and insecure livelihoods.

Layer 2: Community and family-level support
The second layer represents services for people able to maintain good mental health and psychosocial wellbeing if they receive help in accessing key community and family supports.

Layer 3: Focused Non-Specialized Supports
The third layer represents support structures for people who require individual, family or group interventions by trained and supervised workers who are, however, not specialists in the domain of mental health and psychosocial support. Usually this involves a smaller number of people. The interventions in this layer can include the establishment of a system of caseworkers/ psychosocial workers who are able to give psychosocial support to families and individuals and assessment and referral of those with specialized mental health/psychological needs. This layer also includes the training of general health care workers to provide basic mental health services.

Layer 4: Specialized Services

The pyramid's top layer represents specialized interventions required for a small percentage of people with severe psychological complaints or mental disorders.

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