HEART
HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Health and Nutrition for Displaced Populations

Date: 20 December 2013

Query:
1) Produce a report focused on evidence of the most appropriate ways to support health and nutrition outcomes for management of protracted population displacement.
2) Highlight information on psychosocial social impacts of protracted displacement (including gender).

Content

1. Overview

Sections 2-6 of this report provide resources to answer part 1 of the query on supporting health and nutrition outcomes. Sections 7-9 provide resources for part 2 of the query on psychosocial impacts.

PART 1: Health and nutrition management of protracted population displacement

Resources identified in the rapid literature search for this query include: programme evaluations with useful lessons; integration of services as a recommended strategy for protracted situations; health insurance as a funding option; operational guides; and two disease specific case studies. It was not always possible to directly link health and nutrition outcomes with different management types. Literature and guidelines for managing protracted displacement emphasise the need to consider local context and adapt plans to fit.

A synthesis of food assistance programme evaluations finds unacceptably high numbers of refugees were food-insecure, women more so than men (WFP, 2013). Rates of chronic malnutrition reached or exceeded the high severity threshold in all four country contexts evaluated. Malnutrition rates were mixed but were better than among host populations suggesting that food assistance had a positive impact. Inadequate programmes suffered from funding shortfalls, pipeline breaks and irregular updating of refugee registers.

Long-term support for protracted refugees fits uneasily with conventional donor funding modalities (WFP, 2013). This results in serious funding shortfalls and inadequate support for progress towards self-reliance. Host governments not permitting formal integration was common in influencing results. World Food Programme-controlled factors influencing results include: inaccurate household records; infrequent and poorly timed distributions of non-food items; inadequate monitoring of distributions; and missed opportunities for synergies with development or livelihoods and social protection programmes among the host population.

A review of nutrition indicators evaluating performance of nutrition programmes in more than 90 camps in 18 countries found supplementary and therapeutic feeding programmes exceeded nearly all standards (Doocy, 2011). Suggested programme priorities should focus on camps and countries with large refugee populations and high feeding programme enrolment rates to have the greatest impact in terms of absolute reductions in the incidence and prevalence of malnutrition.

A feeding programme in Thailand used funds to subcontract the Burmese Border Consortium to organise food and fuel needs for Burmese refugees (Shuftan, 2004). Procurement and logistics were evaluated and found to be largely successful. Entrusting the refugees themselves to receive and handle goods in the camps has worked well.

Evaluation of managing health in a protracted refugee situation in Kakuma, Kenya, shows the advantages of specialisation in delivering healthcare (Jamal, 2000). Reproductive health is managed by a national NGO. The advantages of being Kenyan are staying power; knowing their specialisation with the ability to pursue it vigorously; and ability to sell themselves around their specialisation and reputation attracting independent donor dollars.

A district in Uganda used a planning mechanism called ‘Quality Design’ to bring user expectations together with technical standards for service integration (Rowley, 2006). This was successful in creating one immunisation system for both refugees and hosts. However, the rest of the self-reliance strategy failed. The Emergency Plan in the US reports success in integrating HIV/AIDS services in Uganda, Kenya and Tanzania but does not report specific evidence of outcomes.

Some disease specific case studies are included in this response as they do report on outcomes. Mintetti et al. (2010) describe results and experiences over 20 years of a TB programme on the Thai-Burmese border. Findings suggest that treatment outcomes depend on the programme's capacity to respond to specific patients' constraints. High-risk groups, such as migrant populations, need a patient-centred approach, and specific, innovative strategies have to be developed based on the needs of the most vulnerable and marginalised populations. A UNHCR field report (2011) describes successful outcomes from eye care services for refugees in Yemen.

Insurance schemes are becoming more cost-effective and beneficial health insurance schemes for refugees are becoming available according to the UNHCR Guidance Note on insurance for refugees (2012). Some case studies are provided from both middle- and low-income settings.

PART 2: Psychosocial impacts of displacement (including gender)

Experience of conflict and displacement inherently involves exposure to a range of stressors and has the potential to negatively impact the mental health and well-being of everyone affected (UNHCR, 2013). Furthermore, efforts to promote self-reliance and livelihoods may be undermined if individuals and families are less likely to engage in such activities due to unmet mental health and psychosocial needs. Therefore, it is evident that symptoms of mental health and psychosocial problems can significantly impact individual, family and communal well-being (UNHCR, 2013).

Although protracted displacement increases the risk of mental health disorders, it is striking that more people do not develop them (Siriwadhana and Stewart, 2013). Factors preventing adverse mental health outcomes are likely to be individualised and include an individual's natural response to stress, and social support networks available (Siriwadhana and Stewart, 2013). Among those that do develop mental health disorders, post-traumatic stress disorder (PTSD), Somatoform disorder, major depressive disorder and generalised anxiety disorder have all been reported with prevalences higher than in non-displaced populations (Husain et al., 2011; Siriwadhana et al., 2013; Taha et al., 2013).

The term MHPSS – mental health and psychosocial support – is used to describe the range of activities that are used to treat mental disorders and to improve the well-being of individuals and communities in their conflict or disaster affected environments. This range of activities includes approaches designed to address the psychological and social impacts of conflict and displacement (UNHCR, 2013). The UNHCR and Wietse (2011) have published recommendations and guidelines to operationalise MHPSS interventions in those experiencing protracted displacement.

Displacement often increases individual insecurity, particularly for women, and the process of displacement can create new conditions for vulnerability and exacerbate existing conditions such that an increase in gender based violence (GBV) is seen (Seelinger and Freccero, 2013). Experience of gender based violence (GBV) has been significantly associated with increased risk of poor mental health outcomes (Anastario et al., 2009), and for that reason studies assessing the prevalence of GBV have been included in this report. Although there are few studies assessing the specific psychosocial effects of GBV in situations of protracted displacement, it is hoped that the studies included are informative enough to allow inferences to be drawn regarding the likely psychosocial effects of GBV in specific contexts.

Finally, children experience stressors associated with displacement differently to adults. Meyer (2013) investigated the range of stressors experienced by children in refugee camps in Thailand. There is also evidence to suggest that interventions designed to improve psychosocial outcomes in children have a beneficial effect on their mothers (Morris et al., 2012).

When reading this section of the report, the following definitions are useful (UNHCR, 2013):
Mental health: a state of well-being in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community.

Psychosocial: The term psychosocial is often used in the field of humanitarian response to "emphasise the close connection between psychological aspects of experience and wider social aspects of experience, inclusive of human capacity, social ecology, and culture and values."

Psychosocial interventions are designed to address the psychological effects of conflict, including the effects on behaviour, emotion, thoughts, memory and functioning, and social effects, including changes in relationships, social support and economic status.

MHPSS: Any type of local or outside support that aims to protect or promote psychosocial well-being and/ or prevent or treat mental disorder.

PART 1

2. Programme evaluations and reviews

Evaluation Brief: Synthesis of the Series of Joint UNHCR-WFP Impact Evaluations of Food Assistance to Refugees in Protracted Situations
WFP, 2013
http://documents.wfp.org/stellent/groups/public/documents/reports/wfp254898.pdf
Full synthesis report:
http://documents.wfp.org/stellent/groups/public/documents/reports/wfp254851.pdf
Summary report:
http://documents.wfp.org/stellent/groups/public/documents/eb/wfpdoc062402.pdf

This is a synthesis of the main findings and common lessons emerging from a series of mixed-method impact evaluations assessing the contribution of food assistance to durable solutions in protracted refugee situations. The evaluations were conducted jointly by the World Food Programme (WFP) and the Office of the United Nations High Commissioner for Refugees (UNHCR) through 2011 and 2012 in Bangladesh, Chad, Ethiopia and Rwanda.

Food security and nutrition findings include:

- Unacceptably high numbers of refugee households remained food-insecure, especially in the second half of the period between food distributions.
- Women were more food-insecure than men, often because they had more dependants.
- Rates of chronic malnutrition reached or exceeded the high severity threshold in all four contexts, and anaemia prevalence was high, but similar to national rates.

Global acute malnutrition rates ranged from acceptable to serious, and were higher in Bangladesh. Trends were mixed, but rates were better among refugees than among the host population in all four country contexts, suggesting that food assistance had a positive impact. Severe acute malnutrition rates were also mixed.

In some programmes, funding shortfalls, pipeline breaks and irregular updating of refugee registers resulted in general food distribution rations being less than the 2,100 kcal per day standard and deficient in proteins and micronutrients.

Two common key contextual factors stood out in influencing results: donor funding policies and host government policies. Long-term support for protracted refugees fits uneasily with conventional donor funding modalities, which differentiate between humanitarian and development assistance.

This resulted in serious funding shortfalls and inadequate support for progress towards self-reliance. Mobility and access to job markets are essential for prospects for self-reliance. In all four contexts, host governments did not permit formal integration of refugees, insufficient land was made available and mobility was restricted.

The most prominent factors influencing the results that were within WFP's control were inaccurate refugee household records and infrequent revalidation; insufficiently frequent and poorly timed distributions of non-food items; inadequate monitoring of food distributions; poor follow-up to joint assessment missions and weak joint plans of action; and missed opportunities for synergies with development or livelihoods and social protection programmes among the host population.

The synthesis makes five strategic recommendations for various parties:

Recommendation 1

Under the auspices of the WFP/UNHCR High-Level Meeting, a working group from both agencies should develop a joint corporate strategy and operational framework for refugees in protracted displacement and for the role that food assistance can play. The strategy should:

a) recognise that encampment brings risks to the prospects for self-reliance and that the current approach to food assistance is insufficient
b) outline plausible pathways to self-reliance and durable solutions for refugees in protracted displacement, and the role that food assistance – including complements to general food distribution (GFD) such as cash, vouchers or food for work – can play
c) develop a more holistic approach and the partnerships necessary to achieve it
d) establish management mechanisms for implementing the strategy, incorporating more systematic use of the Joint Assessment Missions (JAM)s, both in specific countries and in synthesis for corporate learning.

Recommendation 2

All actors should recognise that improving the lives of refugees in protracted displacement is not the business of WFP and UNHCR alone but must involve coordinated change in the approaches currently followed by United Nations country teams, particularly development-oriented agencies, host States, donors and implementing partners, as well as UNHCR and WFP. The Inter-Agency Standing Committee (IASC) Task Force on Accountability to Affected Populations should be encouraged to take a lead role in building this recognition and the resulting actions.

Recommendation 3

United Nations country teams should:

a) engage and advocate with host governments for refugees' rights to mobility, to practice livelihoods, to protection and to some form of acknowledged integration when repatriation remains elusive;
b) engage with host governments to improve selection of camp sites for those in or likely to be in prolonged displacement with the goal of enabling refugees to make a meaningful contribution to national and local economic development and to minimise conflict over natural resources and accompanying negative implications for the environment, economy and protection
c) monitor the prospects for repatriation and seek to increase spontaneous return
d) encourage donors to be more flexible (see recommendation
e) insist on greater involvement of United Nations agencies specialised in protection, development and gender issues
f) engage with refugees' host and original States to advance political solutions to protracted displacement

Recommendation 4

Donors should overcome or remove barriers to conventional funding restrictions, based on dichotomies between emergency and development situations

Recommendation 5

WFP and UNHCR country teams should systematically develop consensual programme strategies for the transition to self-reliance, based on contextualised knowledge of refugees' specific needs and prospects for long-term durable solutions – repatriation, local integration or resettlement. These strategies should transform the existing planning architecture based on joint plans of action to provide a strategic management tool for the country level, which: a) draws in new partnerships and b) provides a reference point for operation design and approval.

Performance of UNHCR nutrition programs in post-emergency refugee camps

Doocy, S. et al. (2011) Conflict and Health 5 (23)
http://www.conflictandhealth.com/content/5/1/23

This paper reviews nutrition indicators and examines their application for monitoring and evaluating the performance of UNHCR nutrition programs in more than 90 refugee camps in 18 countries.

Feeding programme admission criteria are defined by nutritional status. Children under five with moderate acute malnutrition (MAM), defined by weight-for-height of 70% to 80% of the National Center for Health Statistics/WHO median are enrolled in supplementary feeding programmes (SFP) that provide additional weekly rations until weight increases to 90% of the NCHS/WHO median at two consecutive weekly weighings. Children under five with severe acute malnutrition (SAM), defined as weight-for-height < 70% of the NCHS/WHO median or oedema, are admitted to in-patient or daily therapeutic feeding programmes (TFP) for stabilisation.

SFP performance consistently exceeded all UNHCR standards with the exception of length of enrolment. TFP performance met UNHCR standards with the exception of daily weight gain. In terms of programme priorities, a focus on camps and countries with large refugee populations and high feeding program enrollment rates would have the greatest impact in terms of absolute reductions in the incidence and prevalence of malnutrition.

Minimum standards and essential needs in a protracted refugee situation. A review of the UNHCR programme in Kakuma, Kenya
Jamal, A. (2000) UNHCR Evaluation and Policy Unit
http://www.unhcr.org/3ae6bd4c0.html

The purpose of this report is to analyse the way in which UNHCR manages protracted refugee situations and, on the basis of this analysis, to suggest an appropriate UNHCR response to such situations. It uses Kakuma camp, north-western Kenya, as a case study through which to undertake its analysis.

The refugees receive, on average, 2,100 kcal of food daily, in line with WFP/UNHCR minimum standards (2,100 kcal/person/day) and superior to the Kenyan national average (1,970 kcal/person/day). While calorie content may be sufficient, the refugees are not entirely satisfied with the package, and find themselves compelled to sell a portion of their ration in exchange for other vital foodstuffs. As it stands, the camp is entirely dependent upon mass food distributions. The fact that some refugees consider it necessary to trade part of their ration, at an energy loss, for nutrients indicates that the food basket is not well calibrated. In particular, the general ration is 'grossly deficient' in vitamins A, B2, C, niacin and iron. Mass food distribution is an inherently short-term affair; one does not usually expect to have to continue such distributions for years. Perhaps, stepping back from emergency management mode, other distribution systems might be considered, such as ration shops in which refugees could 'purchase' food with their ration cards, and have the flexibility to select those items they require.

There is one hospital and five health posts. The health centre structures are lightweight, there are no x-ray machines, the lab is inadequate and the focus is on primary, rather than preventive, health. This is neither economical nor beneficial to the refugees. Constant referrals of patients for x-rays, and dispatch of their blood and other samples to Nairobi, is not cheap, and in the long run exceeds the costs of purchasing an x-ray machine or upgrading the lab. By constructing a permanent structure and incorporating the centre into national health plans, UNHCR would demonstrate a positive spin-off of the refugee presence and would be more likely to attract development funds.

One part of the health sector – reproductive health – furnishes a positive example of the advantages of specialisation. Reproductive health is managed by a national NGO, the National Council of Churches of Kenya (NCCK). The advantages of having them take on this sector are that they are Kenyan, and thus have staying power; they know their specialisation and pursue it vigorously; and they are able to sell themselves around their specialisation and reputation, and attract independent donor dollars.

Evaluation of ECHO-funded Nutrition and Food Aid Activities for Burmese Refugees in Thailand
Shuftan, C. et al. (2004) European Commission Humanitarian Aid Office (ECHO)
http://www.alnap.org/pool/files/erd-3218-full.pdf

ECHO has been funding the Dutch NGO Interchurch Organisation for Development Cooperation (ICCO) which, in turn subcontracts the Burmese Border Consortium (BBC), an organisation active in feeding refugees there since 1984 -with ECHO support since 1995. For the period evaluated (2000-2003), ECHO has financed the basic food ration and cooking fuel needs of three camps in Tak province. The evaluation focused on the effectiveness and impact of procurement and logistical operations, as well as on the nutritional aspects of the ECHO-funded operations.

Key findings on procurement and logistics of the food and fuel provided:

- Refugees take primary responsibility of all distribution operations in the camp and BBC has capacitated them for this job. However, suggestions are made for improving this system.
- Population figures from a BBC system, used to calculate deliveries of commodities, were found to be correct.
- Procurement and tendering processes were found to be well documented and transparent.
- The quantitative computation of logistical data in the camps and in BBC's Tak province field office was found in need of improvement. Examples are given.
- The transport of commodities is judged to be efficient.
- Entrusting the refugees themselves to receive and handle goods in the camps has worked well.

Key findings on nutrition:

- The provision of full rations for camp dwellers (covering close to 100% of needs) is justified since their capacity to contribute to their own food security remains extremely limited. But in the rations provided, both the proportion of protein and fat are lower than recommended; they are also deficient in micronutrients.
- Data clearly show the project's positive impact on mortality and on acute malnutrition. However, vitamin and mineral deficiencies persist and chronic malnutrition remains a considerable problem.
- The basic ration now under review is to be more balanced; it adds a blended food (wheat-soy blend).

Key findings on supplementary feeding programmes (SFPs):

- The actual foods used by the different health NGOs in the SFPs are found not to be the appropriate ones.
- Impact for malnourished children is substandard but pregnant and lactating women have less vitamin b deficiency.
- It is recommended that the SFPs of health NGOs focus more on reporting actual (anthropometric) nutritional impact.
- Reliable monthly growth monitoring for <3s (preferably community-based) and the monthly calculation of low birth weight rates need to be set up by health NGOs.

Key finding in other areas:

- Little is known about the overall micronutrient status of the camp populations so it is difficult to estimate the impact of any activity aimed at reducing micronutrient deficiencies.
- Growth monitoring of infants must be continued after their mothers are discharged from the postnatal SFP (i.e., 6-9 months).
- Women's organisations of the minority ethnic groups are important in implementing gender policy and the BBC should continue to work with them closely.
- The specific problems of the elderly are not being addressed either while those of the handicapped are addressed by new funding of ECHO going to Handicap International (HI).

3. Integration of services

Protracted Refugee Situations: Parallel Health Systems and Planning for the Integration of Services
Rowley E, Burnham G, Drabe R (2006) Journal of Refugee Studies; 19 (2)
http://www.jhsph.edu/sebin/g/l/JRS_Uganda_Paper.pdf

This paper outlines three typical health service delivery models:

1) **Host country Government takes responsibility:** promising in terms of long-term viability but unlikely to evolve.
2) **Donor support to local health systems at the national level:** desirable but for many countries it may be difficult to absorb additional funding for refugee services even if it is made available directly to the government.
3) **Donor-funded NGOs:** this option, to support international, regional, or sometimes local NGOs to undertake the refugee health services delivery function, is most common.

Each of these have long-term implications in terms of ownership, planning and decision-making procedures, staffing, funding, and other management sustainability issues. The impact of which is stronger in protracted situations.

For the third option, NGOs are often perceived to be more effective in directly accountable, quick response, quality service delivery. Unfortunately, when short-term emergencies develop into long-term refugee situations, it is the most problematic strategy. Uganda's civil war and ensuing political crises in the years preceding the initial influx of Sudanese refugees in the late 1980s precipitated the establishment of parallel refugee services through donor-funded non-governmental agencies. While necessary at the time, this has proven an unsustainable approach.

The existence of parallel systems over a period of many years can cause management anomalies that eventually become very difficult to address, particularly in the areas of funding mechanisms, planning and budgeting, administration, implementation of service delivery, health service delivery policy, reporting, and monitoring and evaluation. It has the potential to undermine equity, quality, and sustainability. For example, the per capita health budget for district services in Adjumani is US$3.24 compared to US$9.32 for refugee services.

UNHCR and the Government of Uganda agreed to the Self-Reliance Strategy in 1999 and introduced it at the district level in the early part of that year. The difficult implementation and funding responsibilities were left to the district authorities to work out. Little specific guidance was provided in translating these concepts into reality at the district and community levels. Confusion and miscommunication between key parties on the ground, including UNHCR, NGO implementing partners, and the district authorities, slowed progress. Funding arrangements were the major problem.

Unfortunately the SRS never shifted from conceptual to practical and could not take on a functional form. At the policy level, the manner in which it was conceived and designed at the national level with minimal planning input from the districts, despite the decentralisation process that was well underway in Uganda at the time, created inadequate clarity about leadership and ownership of the process. There was a perception among many within the districts that UNHCR was trying to 'off-load' its responsibilities onto the government without addressing funding questions, and without adequate implementation planning. The vision of incorporating refugee health services within the district system was stymied by a focus on integration as an administrative handover without adequately planning for the ways and means by which to address differences between systems in terms of inputs and management processes.

The Adjumani district used an alternative planning mechanism called 'Quality Design'. The approach brings user expectations together with technical standards to design a new process rather than strengthening existing processes. One of the most important components is the establishment of effective teams. In this case it was important to bring together parties that had previously been suspicious about the idea of integration. As a team, the key stakeholders could create a common vision for the integration. The establishment of the District Director for Health Services as the chair of the District Integrated Health Coordination Committee clearly identified his leadership role. Acting on behalf of the team, he could make progress more quickly than if he had acted on his own. This contrasted to the handover approach which did not rely on a team mandated by a wider stakeholder group.

Data played an important role in the entire process and had been absent in the handover approach. Data helped members of the District Integrated Health Coordinating Committee understand how the present system was functioning. The flowcharting of activities with data about the individual steps within sub-systems, such as immunisation, gave members an understanding of where refugee health services and those of the district were managed in either a common or divergent manner.

As a result of the quality design process, Adjumani District today has one immunisation system. Although jointly managed by the district health services and an NGO, it is run according to district policies. The district health services manage a single system for cylinder supplies and cold chain equipment maintenance. Despite these outcomes in the area of immunisation the authors found that, overall, the SRS has failed.

Effects of a refugee-assistance programme on host population in Guinea as measured by obstetric interventions
Van Damme, W. (2000) The Lancet 351 (9116)
http://www.sciencedirect.com/science/article/pii/S0140673697103488

Since 1990, 500,000 people have fled from Liberia and Sierra Leone to Guinea, west Africa, where the government allowed them to settle freely, and provided medical assistance. This paper assessed whether the host population gained better access to hospital care and found in areas with high numbers of refugees, the refugee-assistance programme improved the health system and transport infrastructure. The presence of refugees also led to economic changes and a "refugee-induced demand". The non-directive refugee policy in Guinea made such changes possible and may be a cost-effective alternative to camps.

IDPs in protracted displacement: Is local integration a solution?
Report from the Second Expert Seminar on Protracted Internal Displacement, 19-20 January 2011, Geneva
Brookings, IDMC, and NRC (2011)

http://www.internal-displacement.org/8025708F004BE3B1/(httpInfoFiles)/8B818794423653F3C12578A900363BF4/$file/protracted-displacement_jun2011_en.pdf

The Access to Basic Services Working Group discussed local integration as a process, rather than an end result. The discussion was deemed to be not just about services, but rights, as education and health are "the key to everything". The group considered protracted displacement as a type of "permanent impermanence".

The group's departure point was that IDPs should have the same access to basic services as local citizens. However, participants wondered whether education and health care could be provided to IDPs as full services from the beginning of displacement. Also, they questioned when a situation becomes protracted and when services should be shifted or more permanent structures built. Finally, the group discussed the tension between the IDP category and status as a local citizen accessing services. The group considered how the IDP label may actually make it more difficult to access services, and how it might be worth separating IDP status from the rights to access basic services, which should apply to all residents equally. While shifting IDPs from a status-based to a needs-based access to services may be desirable, some IDPs may wish to maintain IDP status, as it has become an important part of their identity. For others, the retention of this status may lead to social stigma.

The group's overall conclusion was that most of the questions discussed were highly contextual. However, their recommendations centred upon the need for flexibility – a theme running throughout the seminar – to ensure that people have access to services as rights during different stages of displacement.

The President's Emergency Plan for AIDS Relief
Report on Refugees and Internally Displaced Persons
Office of the United States Global AIDS Coordinator (2006) U.S. Department of State
http://www.state.gov/documents/organization/63694.pdf

The U.S. Government Bureau of Population, Refugees, and Migration (PRM) supports basic health services in refugee camps through its substantial support to UNHCR, ICRC, and other international organisations and NGOs. Expanding HIV/AIDS activities within existing health infrastructures help reach more refugees and displaced persons sooner. For example, the Emergency Plan is supporting the integration of prevention of mother to child transmission (PMTCT) services into routine maternal and child health services in several refugee camps in Uganda.

Members of the local host community should also benefit from HIV/AIDS-related services provided for concentrations of refugee and displaced populations, just as services in host communities should be available to refugees and IDPs. This reciprocity increases programme reach, fosters good will between the affected populations and host communities, and avoids unnecessary duplication. In some cases, such services provided in refugee camps are currently available for the local non-refugee population as well. The Emergency Plan works with partners to share lessons learned from effective integration of refugee and host government HIV/AIDS services in Uganda, Kenya, and Tanzania. At Kyangwali and Palorinya settlements in Uganda, both refugees and the local populations are accessing counselling and testing, PMTCT, and other programmes jointly supported by the government and UNHCR. In Northern Kenya, refugee health services are integrated within national district hospitals and clinics, providing access to both the surrounding population and refugees.

4. Health insurance

A Guidance Note on Health Insurance Schemes for Refugees and other Persons of Concern to UNHCR
UNHCR, 2012
http://www.unhcr.org/4f7d4cb1342.html

UNHCR's public health and HIV section in the division of programme support and management has analysed different health financing options for refugees. Insurance schemes have sometimes not been adopted for refugees as they were either not available or not sufficiently advantageous. This situation is beginning to change as more cost-effective and beneficial health insurance schemes for refugees are becoming available.

This document provides guidance on introducing, negotiating and implementing health insurance schemes. It then describes some schemes that were assessed, some were rejected and others were implemented. Cambodia and Costa Rica are among the successful case studies.

In Phnom Penn, Cambodia, a voluntary community-based health insurance scheme which targets the "near-poor" (workers in the formal and informal sectors) has been developed by an NGO. By becoming members, health benefits for refugees and asylum seekers are being enhanced while the cost for UNHCR is expected to be significantly reduced. External financial support covers scheme administrative cost, and the collection of premiums meets the medical expenses. Costs were reduced by changing the physicians prescribing practices over many years. UNHCR is planning to introduce a cost sharing system for the monthly payment of the premiums. The agency has also begun to support various income generating activities that will help refugees be able to pay for their premiums.

In Costa Rica, there is a national health insurance scheme to cover for health needs outside of the National Health Service. It is mandatory for nationals and refugees. Monthly contributions are shared between employers, employees and the state. The state is also supposed to cover the costs of those with no capacity to pay but no refugees have so far been able to benefit from this scheme). Those refugees with capacity to pay do register and contribute from their own resources, but many cannot afford to do so. UNHCR does cover some vulnerable refugees on an ad hoc basis, but this is limited due to the cost, and only asylum seekers and refugees with chronic illnesses currently benefit from this opportunity.

An analysis was undertaken on insurance schemes in several countries in West Africa. One of the main obstacles to introducing a scheme was that UNHCR rarely had a sufficient budget to cover essential primary healthcare (PHC) and emergency health care costs of refugees, yet alone engage in a health insurance scheme. UNHCR in Gambia and Benin, for example, had less than a tenth of the budget needed to pay for the schemes during their initial phases.

The overall strategy was that UNHCR's contribution would decrease by 20% per year while that of the refugees' would increase by the same percentage, so that after 5 years, refugees would meet the total cost of the health insurance schemes. However, in practice, nearly all refugees in Ghana, Togo and Burkina Faso found it difficult to increase their payments; thus, UNHCR continued to pay nearly the entire premium for the refugees. Due to limited funds and differing contexts, UNHCR employs different scenarios in different countries. For example, in some countries, only vulnerable groups have been enrolled, and the criteria differ according to context.

Expanding health insurance coverage in vulnerable groups: a systematic review of options
Meng, Q. (2010) Health Policy and Planning 2010; 1-12
http://www.who.int/alliance-hpsr/projects/alliancehpsr_insurancevulnerablepopmeng.pdf

Vulnerable groups are often not covered by health insurance schemes. Strategies to extend coverage in these groups will help to address inequity. We used the existing literature to summarise the options for expanding health insurance coverage, describe which countries have tried these strategies, and identify and describe evaluation studies.

This study included any report of a policy or strategy to expand health insurance coverage and any evaluation and economic modelling studies. Vulnerable populations were defined as children, the elderly, women, low-income individuals rural population, racial or ethnic minorities, immigrants, and those with disability or chronic diseases. 86 documents were included.

Descriptions about the USA dominated, with only five from Africa, six from Asia and two from South America. Six main categories were identified:

1) changing eligibility criteria of health insurance;
2) increasing public awareness;
3) making the premium more affordable;
4) innovative enrolment strategies;
5) improving health care delivery;
6) improving management and organisation of the insurance schemes.

All six categories were found in the literature about schemes in the USA, and schemes often included components from each category. Strategies in developing countries were much more limited in their scope. All studies found that the expansion strategies were effective, as assessed by the author(s).

In countries expanding coverage, the categories identified from the literature can help policy makers consider their options, implement strategies where it is common sense to do so and establish appropriate implementation monitoring.

5. Best practice/strategy/operational guides

Strategies to support the HIV-related needs of refugees and host populations. UNAIDS/UNHCR (2005)
http://www.unaids.org/en/media/unaids/contentassets/dataimport/publications/irc-pub06/jc1157-refugees_en.pdf

Case studies relevant to protracted situations include:

- An integrated approach to HIV awareness in Tanzania. A local organisation formed by refugees, linked up with the Tanzanian Service Health and Development for People Living with HIV/AIDS—a group within the local host population—to provide HIV awareness and education to both refugees and the surrounding community.
- Integrated approaches in Uganda with a few examples of shared testing, counselling and mother-to-child transmission prevention sites.

Acute Malnutrition in Protracted Refugee Situations: A Global Strategy UNHCR/WFP
Corbett, M. & Oman, A. (2006) UNHCR/WFP
http://www.unhcr.org/469b6b0c2.html

This report represents the global aspect of an assessment of the nutrition situation in protracted refugee populations in Kenya and Ethiopia. Based on this, a number of strategies are recommended to respond to identified issue areas. Priority strategies are highlighted in a number of areas.

Management of malnutrition:

- Improve UNHCR/WFP technical capacity at country and regional level through hiring of nutritionists and improved coordination with technical unit at headquarters.
- Develop regular and consistent nutrition surveillance/surveys and monitoring through developing in-country nutrition surveillance capacity.
- Standardised information and training around infant and young child feeding practices by initiating a trainer of trainers program for refugee health providers.
- Improve the nutrition interventions for the treatment of moderate and severe malnutrition in the refugee camps by implementing guidelines and promoting community-based care practices.

Health services and environmental health access:

- Strengthen the preventative care component of health care by improving resources, training and technical support.
- Improve technical capacity of JAMs by including senior nutrition, health and water/sanitation staff and overcome gaps in data collection.
- Develop a strategy for the prevention and treatment of malaria in refugee settings by providing 80% bed net coverage, spraying and new line drugs.
- Reduce alarming anaemia rates by systematising iron and folate supplementation and improving the diet with iron and vitamin C.
- Improve water and sanitation quality and quantity to meet minimum standards.
- Mainstream HIV/AIDs and nutrition support for PLWHA in all protracted refugee situations by introducing camps to basic standards and guidelines.

Food Security:

- Improve ration adequacy (micro and macronutrients, demographic considerations, quantity and quality, and milling) by increasing and diversifying the general ration with fortified blended foods, complimentary foods, double fortified salt and fortified flour.
- Improve ration acceptability by providing priority foods by ensuring refugees receive culturally appropriate and accepted commodities, and conducting information campaigns on use and value of new commodities.
- Improve ration management (late arrival of food, pipeline problems, distribution) by employing strategies to ensure a regular food ration.

UNHCR's Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern
UNHCR, 2008
http://www.unhcr.org/4b4c4fca9.html

This guidance concludes that in all persons of concern (PoC) situations, those benefiting from referral health care programmes must be clearly defined and agreed upon with appropriate Government authorities. PHC should remain the entry point for all medical referral. Whenever feasible, the use and support of existing national health systems for PoCs are recommended. Prognosis of emergency and elective referrals is the most important criteria from the medical perspective. For the most part, cases presented for health referral should be those where the life or basic functions of the PoCs are at stake. However, cost of treatment will affect the possibility for referral as budgets are nearly always limited. In operations where decisions on referral cases and their management become complex, costly or controversial, it is recommended to create a referral committee. Medical resettlement, although not applicable at a large scale, remains an opportunity for cases with a reasonable prognosis. The referral committee may also be best placed to identify those relatively rare cases that are appropriate for medical resettlement to a third country.

A written agreement with hospital care service provider(s) is necessary to clarify expectations, specify which services will be paid for, ensure quality of care, and define the types and guarantee of payments. Legal contracts are recommended with all institutions

where UNHCR pays for services. The quality control of sub-contracted hospital care remains UNHCR's concern and must be included and monitored within the written agreement. Due to the nature of administrative procedures that accompany referral care clearance and payment, special attention to medical file confidentiality is needed throughout the process.

A functioning and regular monitoring system for referral care is a prerequisite for evidence-based decision making. Referral information systems should record information at the point of referral as well as from the referral care provider. Referral health care needs are constantly evolving due to increasing urbanisation, ageing refugee populations with a concomitant disease epidemiological shift from infectious to chronic diseases, and the increasing technical sophistication of hospital care. Referral care represents an important humanitarian component of protection and assistance programmes where UNHCR allocates substantial financial and human resources. Such essential programmes need to be carefully monitored and evaluated to ensure that accessible and quality services are available to the largest number of PoCs at a reasonable cost.

UNHCR Operational Guidance on the Use of Special Nutritional Products to Reduce Micronutrient Deficiencies and Malnutrition in Refugee Populations
UNHCR, 2011
http://www.unhcr.org/4f1fc3de9.html

This note builds on existing frameworks and standard feeding guideline for the six stages involved in food supplementation product programmes:

1) defining the nutritional needs of children under five within the population of interest
2) selection of a potential food supplementation product intervention for the nutritional problem(s) identified in stage one
3) identify any risks and precautions that need to be considered before commencing an FSP intervention
4) test the acceptability of the selected FSP to potential beneficiaries and their adherence to the recommended dosage
5) identifying the key components that need to be in place or developed to ensure that the intervention is implemented effectively
6) strong M&E should accompany any FSP intervention

Ensuring Access to Health Care Operational Guidance on Refugee Protection and Solutions in Urban Areas
UNHCR, 2011
http://www.unhcr.org/4e26c9c69.html

Practical guidance for non-camp settings.

6. Disease specific case studies

Tuberculosis treatment in a refugee and migrant population: 20 years of experience on the Thai-Burmese border
Minetti, A. et al. (2010) International Journal of Lung Disease
http://www.ncbi.nlm.nih.gov/pubmed/21144245

This paper describes results and experiences over 20 years at a TB programme in refugee camps on the Thai-Burmese border in Tak Province, Thailand. Findings suggest that treatment outcomes depend on the programme's capacity to respond to specific patients' constraints. High-risk groups, such as migrant populations, need a patient-centred approach, and specific, innovative strategies have to be developed based on the needs of the most vulnerable and marginalised populations.

Eye Care Service Delivery in Kharaz Camp and Aden Urban Refugee Programme in Yemen
UNHCR, 2011, UNHCR Field Brief
http://www.unhcr.org/4b4dcd3e9.html

During an assessment mission, refugees in Kharaz camp and Basateen urban areas in Aden, reported eye related problems as a major health concern. UNHCR and its health partner, Charitable Society for Social Welfare, initiated a community eye care project in Kharaz camp during 2009 and introduced the project to Basateen urban refugee area in 2010. The project is implemented by Ras Morbat, a specialist eye care charity working in Aden. The intervention aims to reduce and prevent avoidable blindness and low vision among refugees and the surrounding community through the provision of community eye care at the refugee health centers in Kharaz and Basateen, and selected referrals to the Ras Morbat eye clinic in Aden. The interventions focus on infectious and allergic related eye problems, cataracts, glaucoma, refractive errors, low vision, and childhood blindness.

Outcomes were successful. From November 2010 till April 2011, a total of 2,496 refugees have been screened for visual acuity and eye problems. Of those, 700 have been examined by the specialised ophthalmologist. Moreover, 541 refugees have received glasses, 315 refugees have been provided with essential medication for eye problems, and 56 people have had cataract surgery in the Ras Morbat clinic in Aden.

This field brief concludes that reaching out and establishing linkages with existing available resources for specialised health problems in the country shows that provision of eye care in both urban and refugee camp based operations is feasible and achievable.

PART 2

7. General psychosocial impacts of forced displacement

a) Type and prevalence of mental health disorders

Forced migration and mental health: prolonged internal displacement, return migration and resilience
Siriwadhana, C., and Stewart, R., (2013), *Int. Health;* 5 (1): 19-23.
http://inthealth.oxfordjournals.org/content/5/1/19.short

This review explores the evidence regarding prolonged internal displacement and mental health. Forced internal displacement has been rising steadily, mainly due to conflict. Many internally displaced people (IDP) experience prolonged displacement. Global research evidence suggests that many of these IDP are at high risk for developing mental disorders, adding weight to the global burden of disease.

Even after displacement, IDP continue to face substantial stressors, such as problems with food, shelter, education, healthcare, finances, employment and discrimination which may become perpetuating factors for mental disorders. It is highly likely that the risk of developing mental disorders such as depression, anxiety, post-traumatic stress disorder (PTSD) and psychoses are greater among displaced populations than that of stable populations.

A study conducted in northern Uganda found that social determinants play an important role in health outcomes among IDP. Traumatic events, overcrowding in displacement and poverty were found to affect the mental health of IDP while political, environmental and socio-cultural determinants were found to have associations with development of psychopathology. However, a striking feature of forced and traumatised migratory populations is the fact that many, possibly the majority, do not develop mental disorders, despite the higher than average risk.

Factors preventing the development of mental disorders among IDP encompassed within 'resilience' as a concept are likely to be many and varied including an individual's pattern of responding to stress (possibly influenced by earlier exposures or quality of key relationships) and the level of social support around the stressful period.

The public health impact of internal displacement is not clearly understood. The authors contend that epidemiological and interventional research in IDP mental health needs to look beyond medicalised models and encompass broader social and cultural aspects. The resilience factor should be integrated and explored more in mental health research among IDP and a clearly focused multidisciplinary approach is advocated.

Prolonged Internal Displacement and Common Mental Disorders in Sri Lanka: The COMRAID Study
Siriwardhana, S., Adikari, A., Pannala, G., Siribaddana, S., Abas, M., Sumathipala, A., Stewart, R. (2013). PLoS ONE 8(5): e64742.
http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0064742

There is a lack of evidence regarding the mental health issues of internally displaced persons, particularly where displacement is prolonged. Where studies have been performed, they have focused on a limited numbers of disorders, such as post-traumatic stress disorder (PTSD), anxiety and depression. The COMRAID (Common Mental Disorders and Resilience Among Internally Displaced in Sri Lanka) study was carried out in year 2011 as a comprehensive evaluation of Muslims in North-Western Sri Lanka who had been displaced since 1990 due to conflict, to investigate the prevalence and correlates of common mental disorders.

A cross-sectional survey was carried out among a randomly selected sample of internally displaced people who had migrated within last 20 years or were born in displacement. The total sample consisted of 450 adults aged 18–65 years selected from 141 settlements. Common mental disorders (CMDs) and PTSD prevalences were measured using the Patient Health Questionnaire and CIDI sub-scale respectively.

The prevalence of any common mental disorder among the study population was 18.8% (95% confidence interval [CI] 15.2–22.5). Somatoform disorder (14%; 95%CI 10.7–17.9) was the most common sub-category followed by other depressive syndromes (7.3%; 95%CI 5.3–10.3), major depression (5.1%; 95%CI 3.2–7.7), and anxiety disorder (1.3%; 95%CI 0.4–2.9). PTSD prevalence was 2.8% (95%CI 1.2–4.3). Current smoking was reported by 20.7% (95%CI 16.8–25.5), any current alcohol intake by 1.8% (95%CI 0.7–3.5), and drug use by 0.9% (95%CI 0.2–2.9). The following factors were significantly associated with CMDs: unemployment (odds ratio 2.8; 95%CI 1.6–4.9), widowed or divorced status (4.9; 2.3–10.1) and food insecurity (1.7; 1.0–2.9).

Considering prevalences of mental disorder, the prevalences of somatoform disorder (14.0%) and major depression (5.1%) were considerably higher than national estimates (4.2% and 2.6% respectively). However, the prevalence of CMD appears to be relatively low in the Sri Lankan sample (18.8%) compared to that observed in other international studies of IDP populations (Colombia 27.2%; Ethiopia 27.8%; Palestine 40.3%; Cambodia 57.7%; Algeria 62.3%). PTSD prevalence (2.8%) in the COMRAID sample was also lower when compared to a previous Sri Lanka study (7.0%) and international data (Guatemala; 11.8%, Afghanistan; 20.4%). This may be attributable to the longer duration of displacement and time since the traumatic experience of forced migration, as well as by the inclusion of generations born in displacement. In interpreting these findings, the living conditions in displacement, compared in context to many other developing countries affected by conflict (especially African countries) have to be carefully considered. These IDP did not face continuous conflict-related

trauma after displacement as the resettlement area was not significantly affected by the conflict.

However, the current CMD prevalence (especially high levels of somatoform disorder) may well reflect experiences of living in prolonged displacement, and it is worth questioning the extent to which well-recognised economic challenges in these circumstances are compounded by a sense of being cut-off from original homes and livelihoods, especially among older IDP. Although unadjusted findings showed associations between being displaced as an adult and mental ill health, these associations were non-significant when considered with other covariates. As adults, IDP would have had firmly developed sense of belonging, established livelihoods and social structures in place. The sudden loss of all these and the ability to understand the trauma of forced displacement may predispose the adult IDP to develop increased risk for mental illnesses. However, the finding that other factors became more salient after adjustment – for example, unemployment, food insecurity and divorced/widowed status – suggests that at least some of the age-related risk may be accounted for by accumulated post-migration stressors rather than the original migration itself.

This is the first study investigating the mental health impact of prolonged forced displacement in post-conflict Sri Lanka. The authors' findings add new insight in to mental health issues faced by internally displaced persons in Sri Lanka and globally, highlighting the need to explore broader mental health issues of vulnerable populations affected by forced displacement.

Prevalence of War-Related Mental Health Conditions and Association With Displacement Status in Post-war Jaffna District, Sri Lanka
Husain, F., Anderson, M., Lopes Cardozo, B., Becknell, K., Blanton, C., Araki, D., Kottegoda Vithana, E. (2011). JAMA; 306: (5), 522-531.
http://jama.jamanetwork.com/article.aspx?articleid=1104178

This study estimated the prevalence of the most common war-related mental health conditions, symptoms of post-traumatic stress disorder (PTSD), anxiety, and depression, and assessed the association between displacement status and these conditions in post-war Jaffna District, Sri Lanka. Between July and September 2009, a cross-sectional multi-stage cluster sample survey was conducted among 1,517 Jaffna District households including 2 IDP camps. The response rate was 92% (1,448 respondents, 1,409 eligible respondents). Two percent of participants (n = 80) were currently displaced, 29.5% (n = 539) were recently resettled, and 68.5% (n = 790) were long-term residents.

The overall prevalences of symptoms of PTSD, anxiety, and depression were 7.0% (95% confidence interval [CI], 5.1%-9.7%), 32.6% (95% CI, 28.5%-36.9%), and 22.2% (95% CI, 18.2%-26.5%), respectively. Currently displaced participants were more likely to report symptoms of PTSD (odds ratio [OR] 2.71; 95% CI, 1.28-5.73), anxiety (OR 2.91; 95% CI, 1.89-4.48), and depression (OR 4.55; 95% CI, 2.47-8.39) compared with long-term residents. Recently resettled residents were more likely to report symptoms of PTSD (OR 1.96; 95% CI, 1.11-3.47) compared with long-term residents. However, displacement was no longer associated with mental health symptoms after controlling for trauma exposure.

Among residents of Jaffna District in Sri Lanka, prevalence of symptoms of war-related mental health conditions was substantial and significantly associated with displacement status and underlying trauma exposure.

The mental health of internally displaced persons: an epidemiological study of adults in two settlements in Central Sudan

Taha, T., Salah, M., Abdelrahman, A., Lien, L., Henning Eide, A., Martinez, P., Hauff, E. (2013) Int J Soc Psychiatry 59: 782
http://isp.sagepub.com/content/59/8/782.long

This cross-sectional study assessed the prevalence of mental disorders of IDP in Sudan, and to determined and compared the association between mental disorders and socio-demographic variables between the rural and urban long-term IDP populations. Data were collected during face-to-face interviews using structured questionnaires to assess socio-demographic factors and the Mini International Neuropsychiatric Interview (MINI) to determine psychiatric diagnoses.

A total of 1,876 adults were enrolled from both study areas. The overall prevalence of having any mental health disorder in the IDP population was 52.9%. The most common disorders were major depressive disorder (24.3%), generalised anxiety disorder (23.6%), social phobia (14.2%) and post-traumatic stress disorder (12.3%). Years of displacement and education were associated with different mental disorders between the two areas, and there were no gender differences in prevalence of mental disorders in either area.

High prevalence rates of mental disorders in both urban and rural IDP populations in Sudan were found, indicating a need to explore the circumstances for these high rates and to develop appropriate responses.

Predisplacement and Postdisplacement Factors Associated With Mental Health of Refugees and Internally Displaced Persons: A Meta-analysis
Porter, M. & Haslam, N. (2005) JAMA 294 (5)
http://jama.jamanetwork.com/article.aspx?articleid=201335

The objective of this report was to meta-analytically establish the extent of compromised mental health among refugees (including internally displaced persons, asylum seekers, and stateless persons) using a worldwide study sample. Potential moderators of mental health outcomes were examined, including enduring contextual variables (e.g. post-displacement accommodation and economic opportunity) and refugee characteristics.

Effect size estimates for the refugee to non-refugee comparisons were averaged across psychopathology measures within studies and weighted by sample size. The weighted mean effect size was 0.41 (SD, 0.02; range, −1.36 to 2.91 [SE, 0.01]), indicating that refugees had moderately poorer outcomes. Post-displacement conditions moderated mental health outcomes. Worse outcomes were observed for refugees living in institutional accommodation, experiencing restricted economic opportunity, displaced internally within their own country, repatriated to a country they had previously fled, or whose initiating conflict was unresolved. Refugees who were older, more educated, and female and who had higher pre-displacement socio-economic status and rural residence also had worse outcomes. Methodological differences between studies affected effect sizes.

The report concludes that the socio-political context of the refugee experience is associated with refugee mental health. Humanitarian efforts that improve these conditions are likely to have positive impacts.

A Study of the Emotional and Psychological Well-being of Refugees in Kakuma Refugee Camp, Kenya
Rebecca Horn, (2009), International Journal of Migration, Health and Social Care; 5: (4), 20-32.
http://www.emeraldinsight.com/journals.htm?articleid=1929619&show=abstract

This study explores the emotional problems affecting refugees in Kakuma refugee camp (northern Kenya). The freelisting technique was used to interview 52 community members

and 32 ‘key informants’. The emotional problems most frequently identified were hopelessness, fear, sadness, anger/aggression and worry. Both current stressors and previous losses were said to affect emotional well-being. While psychosocial interventions are important, programmes addressing refugees' practical needs (particularly safety and material needs) will therefore have a positive impact on psychosocial well-being. These findings also suggest that some anti-social behaviours which contribute to problems within and between communities in Kakuma are due in part to emotional problems; if so, addressing emotional problems would be a worthwhile use of resources.

b) Models of interventions and operational guidance

Mental health and psychosocial support in humanitarian settings: linking practice and research
Wietse A Tol. W.A., Barbui, C., Galappatti, A., Silove, D., Betancourt, T.S., Souza, R., Golaz, A., van Ommeren, M. (2011), The Lancet, 378: (9802), 1581–1591.
http://www.sciencedirect.com/science/article/pii/S0140673611610945

This review links practice, funding, and evidence for interventions for mental health and psychosocial wellbeing in humanitarian settings. We studied practice by reviewing reports of mental health and psychosocial support activities (2007–10); funding by analysis of the financial tracking service and the creditor reporting system (2007–09); and interventions by systematic review and meta-analysis.

In 160 reports, the five most commonly reported activities were basic counselling for individuals (39%); facilitation of community support of vulnerable individuals (23%); provision of child-friendly spaces (21%); support of community-initiated social support (21%); and basic counselling for groups and families (20%). Most interventions took place and were funded outside national mental health and protection systems. 32 controlled studies of interventions were identified, 13 of which were RCTs that met the criteria for meta-analysis. Two studies showed promising effects for strengthening community and family supports. Psychosocial wellbeing was not included as an outcome in the meta-analysis, because its definition varied across studies. In adults with symptoms of PTSD, meta-analysis of seven RCTs showed beneficial effects for several interventions (psychotherapy and psychosocial supports) compared with usual care or waiting list (standardised mean difference [SMD] −0·38, 95% CI −0·55 to −0·20). In children, meta-analysis of four RCTs failed to show an effect for symptoms of PTSD (–0·36, −0·83 to 0·10), but showed a beneficial effect of interventions (group psychotherapy, school-based support, and other psychosocial support) for internalising symptoms (six RCTs; SMD −0·24, −0·40 to −0·09). Overall, research and evidence focuses on interventions that are infrequently implemented, whereas the most commonly used interventions have had little rigorous scrutiny.

Recommendations for mental health and psychosocial support (MHPSS) in humanitarian settings:

- Strengthen the evidence for MHPSS in humanitarian settings
- Broaden outcomes aside from post-traumatic stress disorder and internalising symptoms
- Stimulate collaboration between researchers and practitioners
- Reduce the gap between science and practice
- Prioritise research in to the most commonly implemented MHPSS, especially those in the bottom half of the intervention pyramid
- Dependent on assessed needs, make empirically supported MHPSS widely available
- Adapt the RCT design where necessary, and apply innovative research designs when randomised controlled trials are not feasible
- Ensure and assess interventions for people with severe mental disorders

- Sustain MHPSS through their integration with national and local health, education, and social systems
- Add a code for MHPSS to existing financial tracking databases and increase funding to match needs

Refugee Mental Health and Psychosocial Support: in Kharaz Camp and Aden Urban Refugee Programme, Yemen
UNHCR, (2011) UNHCR Field Brief
http://www.unhcr.org/4b4dce289.html

Mental health intervention in Kharaz refugee camp and Basateen-Aden urban refugee programme are supported by a visiting psychiatrist and clinical psychologist from the Al-Salam psychiatric Hospital on a bi-monthly basis. The visiting psychiatrist attends new cases that are screened by the clinical officers and medical doctor in the previous period to establish a proper diagnosis and if applicable a treatment plan. Furthermore, she attends the patients that require additional follow up.

To enhance and improve diagnosis and referral to the visiting psychiatrist, the primary health care staff in Basateen and Kharaz refugee camp have been trained on improved diagnosis and management of patients with mental illnesses. While there is no dedicated psychiatric nurse or full time clinical officer for mental health, the current public health staff are able to adequately respond to or refer patients.

In both Basateen and Kharaz refugee camp, there are two psychosocial counsellors who receive and counsel refugees in the drop-in centre, where refugees can come without a previous appointment or are referred to by the psychologist / psychiatrist. The counsellor conducts a thorough assessment to identify the special needs of the refugee as well as his/her social situation. For persons with severe mental disorders, when the person cannot function independently without support, the psychosocial counsellor supports the person's basic needs such as food, clothing and lodging. The psychosocial support aims at assessing and fostering the ability and the resilience of the person and their families to better adapt to their situation.

The psychosocial counsellor provides information on available activities in the camp or in Basateen, as well as clarification of what steps the person should take towards rehabilitation and how to build self-confidence so that a better solution may be reached.

The standard operating procedure for Mental Health and Psychosocial Support is established by a two–way referral system:

- The psychosocial counsellors refer those who need medical services and psychiatric consultations to the health centre and psychiatrist.
- The psychiatrist and clinical psychologist refer patients to community services at INTERSOS for psychosocial support if needed.

The psychosocial counsellors aims to build a social support system for the individual, with family and the neighbours support. The psychosocial counsellors conduct outreach visits to families and provide them with tools to deal with the difficulties that the person is facing.

The funding is provided through the regular budget for primary health care and community services and includes provision of drugs for mental health disorders on the Yemeni essential drug list, the capacity building and training of health staff, the refugee community health workers for mental health, psychosocial counsellors and mobilisers, and the monthly visit of a psychiatrist and clinical psychologist to the health centres.

Challenges of the programme are the excessive khat consumption and the subsequent poor adherence to medication, leading to incidence of violent and aggressive behaviour.

Furthermore the current programme is still very much focused on treatment and needs to develop more to include traditional and culturally sensitive healing mechanisms.

The experience in Yemen shows that with support from and regular visits by a psychiatrist and psychologist an improved response to mental health is feasible. Through improved referral and collaboration between the health and community sector, each sector can contribute to improved mental health and psychosocial support for refugees in both camp and urban based settings.

Operational Guidance Mental Health & Psychosocial Support Programming for Refugee Operations
UNHCR, (2013), Geneva.
http://reliefweb.int/sites/reliefweb.int/files/resources/UNHCR-OpG_MHPSPfROp3-SP_2013-10.pdf

This operational guidance on Mental Health and Psychosocial Support (MHPSS) provides a practical orientation and tools for UNHCR country operations. It covers specific points of good practice to consider when developing MHPSS programming and offers advice on priority issues and practical difficulties, while also providing some background information and definitions. The guidance is meant for operations in both camp and non-camp settings, and in both rural and urban settings in low and middle-income countries with a UNHCR presence, and should be adapted to specific contexts.

The following guiding principles, with supporting practical operationalised steps (relevant to protracted displacement settings), are recommended by the UNHCR:

1. Use Rights-based, Community-based and Participatory Approaches
   1.1. Consult the community and people with mental and psychosocial problems when designing services
   1.2. Advocate for the economic and social rights of people with mental health and psychosocial problem

2. Ensure equity of care and access
   2.1. Monitor which groups access services and which do not
   2.2. Ensure that people have information about available services and supports for mental health and psychosocial problems
   2.3. Take measures to combat stigma and discrimination of people with mental disorders and psychosocial problems
   2.4. Take measures to ensure that individuals with specific MHPSS needs are able to access basic services

3. Assess needs and resources
   3.1. Assess MHPSS needs
   3.2. Assess resources for MHPSS

4. Use a systems approach
   4.1. Create a balance between a generic MHPSS approach and specific MHPSS interventions
   4.2. Build a system of multi-layered services
      Layer 1: Provision of basic services and security
      Layer 2: Strengthen community and family supports
      Layer 3: Focused psychosocial supports
      Layer 4. Clinical services
   4.3. Develop Standard Operating Procedures (SOPs) for referral
   4.4. Establish coordination mechanisms for MHPSS

5. Strive for integrated service provision
   5.1. Promote the adoption of an MHPSS approach within UNHCR and with partners
   5.2. Design and implement core MHPSS interventions in community-based protection programmes
   5.3. Design and implement MHPSS interventions within educational programmes
   5.4. Design and implement MHPSS interventions within health programmes

6. Adapt services to the stages of the refugee displacement cycle
   6.4. Protracted refugee situations
   Long-term refugee situations may lead to loss of hope and frustration and dependence. Interventions should focus on full participation of the refugees and on empowerment, while looking for linkages to surrounding systems of care in the host population. Interventions are rather similar to phase 2, but with even more attention to self-reliance for families, community development, self-help, and addressing socio-economic factors, which affect the wellbeing of refugees. Coordination with development agencies is important to work towards durable solutions. MHPSS problems in humanitarian contexts can be addressed through activities such as supporting communities' resilience, promoting mechanisms for social support, and offering services to individuals with more complex mental health needs

7. Build capacity
   7.1. Ensure appropriate training of staff
   7.2. Install supervision systems
   7.3. Seek an appropriate balance between providing services and building capacity

8. Use appropriate and systematic monitoring and evaluation
   8.1. Use relevant monitoring systems
   8.2. Evaluate MHPSS interventions

9. Ensure compliance with UNHCR policies and strategies and national and international standards and guidelines

10. Do no harm

UNHCR's Mental Health and Psychosocial Support for Persons of Concern: Global Review 2013.
Meyer, S., (2013). United Nations High Commission for Refugees. Geneva.
http://www.unhcr.org/51bec3359.html

Following on from the previous reference, this review was commissioned by the UNHCR's Policy Development and Evaluation Service in order to assess UNHCR's involvement with MHPSS activities, examine UNHCR's engagement with and adoption of best practices and guidelines, and understand UNHCR's current and potential position in the field of MHPSS activities. The review presents findings based on policy analysis, results from a survey of UNHCR staff, and interviews with UNHCR staff, MHPSS staff from other international organisations and non-governmental organisations, and academics in the field of MHPSS research.

The findings demonstrate that across the organisation and its functional sectors, UNHCR has a number of activities that already fall under the spectrum of activities discussed in the Inter-agency Standing Committee Guidelines. In some specific contexts, UNHCR has marshalled expertise and support for quality MHPSS interventions again demonstrating capacity in this field. The review describes the development of the field of MHPSS activities in humanitarian settings.

Key findings and Recommendations:

A. UNHCR has not adequately engaged with MHPSS concepts, definitions and approaches
    1. UNHCR should strongly and clearly articulate its role in the field of MHPSS by developing and issuing a MHPSS strategy
    2. UNHCR should promote and adapt the key principles in the field of MHPSS activities, including the Intervention Pyramid, within the organisation and within current policy approaches
    3. UNHCR should seek to build internal capacity to develop, implement and support MHPSS activities
B. There is a lack of strong assessment of MHPSS needs, and monitoring and evaluation of MHPSS interventions in the humanitarian sector
    4. UNHCR should identify feasible and effective assessment and evaluation methodologies and select commonly implemented MHPSS activities to evaluate, publishing case studies of results
    5. 5.UNHCR should play a central role in translating and disseminating research findings to practice and field-settings
C. The sectoral nature of UNHCR's work currently limits integration of MHPSS activities across the organisation
    6. UNHCR staff in different sectors should complete a mandatory online course on how to protect and promote the dignity and psychosocial well-being of displaced persons during their daily work.
    7. UNHCR should operationalise models for increased collaboration and communication on MHPSS activities, ensuring that Health, Protection and Community Services sectors utilise a MHPSS framework that enables referral systems and linkages between activities
    8. UNHCR should clarify the role of Community Services as lead on Level 2 activities (strengthening family and community supports), linking current activities to best practices in the MHPSS field and ensuring Community Services has the resources and expertise to support these activities
    9. UNHCR participatory assessments should be used to develop strategies to strengthen family and community self help and social supports.
D. Synergies between protection and MHPSS within UNHCR are not being maximised
    10. UNHCR should frame MHPSS activities as core components of its protection mandate
    11. UNHCR should integrate MHPSS principles and approaches into core protection activities
E. There is a lack of guidance on how to support MHPSS programmes in non-emergency and/or urban settings
    12. UNHCR should lead development of MHPSS guidelines for non-emergency and urban settings
    13. UNHCR should assess the role of MHPSS activities in the context of protracted refugee situations impacted by resettlement and/ or repatriation, identifying key interventions that should be supported as a part of ongoing activities or phasing out of humanitarian support
F. Clinical mental health services can be increased and strengthened
    14. UNHCR should actively engage implementing partners who have expertise to manage severe mental health problems in adults and children

Many PoC are situated in non-emergency contexts, for example, protracted refugee situations. UNHCR's discussion of the challenges of protracted refugee situations has included references to the MHPSS issues that emerge and persist in situations of prolonged displacement. For example, UNHCR describes protracted refugee situations as often resulting "basic rights and essential economic, social and psychological needs remain[ing] unfulfilled after years in exile," and that these situations are characterised by "high levels of personal trauma, social tension, sexual violence and negative survival strategies." Thus, it appears that UNHCR recognises that the very nature of protracted refugee situations can impact on mental health and psychosocial well-being.

Even though UNHCR, along with other humanitarian actors, does not plan on the situation becoming protracted, there are actions that can be taken in the midst of an emergency phase that can improve delivery, quality, and sustainability of services in the event that the displacement situation does become protracted. Given the focus of the MHPSS field on emergencies, there is currently limited guidance and expertise on how these measures could be applied in the area of MHPSS activities. Moreover, in situations of protracted displacement that are in a context of flux due to mass resettlement or impending repatriation, the need for MHPSS activities may increase due to widespread anxiety and fears as to the impact of the changes on individuals, households, and communities. For example, in the context of resettlement of Bhutanese refugees in Nepal, resettlement-related stressors are perceived to have increased mental health issues, including suicide, and impacted coping mechanisms amongst refugees in the camps. However, funding for MHPSS activities may actually decrease in these situations, in a context of a shift towards self-reliance, a focus on resettlement, or phasing out of humanitarian programmes, and as such Recommendation 13 is an important step towards supporting MHPSS needs in these settings.

Psychosocial Support for Refugees and Asylum Seekers in South Africa
UNHCR (2010) UNHCR Field Brief
http://www.unhcr.org/4b4dcfea9.html

Psychosocial support among refugees and asylum seekers (RAS) in South Africa can be effectively integrated into existing social work programmes by providing social workers with appropriate tools for assisting UNHCR's populations of concern and their families. When psychosocial support training is provided, social workers are better able to offer a more comprehensive assistance and RAS' needs are better met.

Mental health of refugees, internally displaced persons and other populations affected by conflict
http://www.who.int/hac/techguidance/pht/mental_health_refugees/en/

Despite scientific evidence to the fact that conflict has a devastating impact on health and on mental health, the latter is not seen as a priority by many decision-makers. Given the magnitude of the problem and the lack of resources, individual psychiatric care has a limited impact. Community-based psychosocial care must become an integral part of emergency response and of the public health care system created in camps and national services. This will help prevent psychiatric morbidity and accelerate the improvement of the psychosocial functioning of people. Efficiency is increased when the concerned community is involved. Cooperation with the refugee community is essential in this work.

8. Psychosocial impacts and gender

a) Gender based violence

Systematic review of prevention and management strategies for the consequences of gender-based violence in refugee settings

Asgary, R., Emery, E., Wong, M. (2013), Int. Health 5 (2): 85-91.
http://inthealth.oxfordjournals.org/content/5/2/85.full

This systematic review assessed the weight of evidence regarding effective strategies to prevent and address the consequences of gender-based violence (GBV) among refugees. The databases of PubMed, Cochrane Library, Scopus, PsycINFO, Web of Science, Anthropology Plus, EMBASE, DARE, Google Scholar, MSF Field Research, UNHCR and the regional and global indices of the WHO Global Health Library were searched twice within a 6-month period (April and September 2011) for English-language clinical, public health, basic and social science studies evaluating strategies to prevent and manage health sequelae of GBV among refugees before September 2011. Studies not primarily about prevention and treatment, and not describing population, health outcome and interventions, were excluded.

The searches produced multiple panels of expert recommendations and guidelines from international organisations such as UNHCR, Inter-Agency Standing Committee (IASC), WHO, Women's Commission for Refugee Women and Children and the International Rescue Committee (IRC) that outlined specific strategies to prevent and/or treat the health consequences of GBV, but none were supported by primary research on actual displaced populations

There is a dire need for research that evaluates the efficacy and effectiveness of various responses to GBV to ultimately allow a transition from largely theoretical and expertise driven to a more evidence-based field. The authors recommend strategies to improve data collection and to overcome barriers in primary data driven research.

SAFE HAVEN: Sheltering Displaced Persons from Sexual and Gender-Based Violence, a Comparative Report
Seelinger, K., T., Freccero, J. (2013) Human Rights Centre Sexual Violence Program
http://reliefweb.int/sites/reliefweb.int/files/resources/51b6e27b9.pdf

This comparative report summarises the findings of a four-country study that was conducted as part of the Sexual Violence Programme at the Human Rights Centre, University of California, Berkeley, School of Law.

Displacement is believed to exacerbate conditions that perpetuate sexual and gender-based violence and may create new ones. Women's vulnerability is believed to increase dramatically in refugee camp settings, where failure to address women's security and health needs places them at heightened risk of harm. Evidence also suggests that domestic violence, in particular, increases in displacement contexts. In fact, displacement often increases individual insecurity through new and exacerbating conditions, including the breakdown of family and community ties, collapsed gender roles, limited access to resources, insufficient security, and in-adequate housing in camp settings. When refugee or internally displaced persons experience sexual and gender-based violence, their needs can be particularly urgent and complex.

The authors highlight gaps in research and service provision, and urge the UNHCR, local governments, and funders to support further research on the following issues:

1. The impact of sexual and gender-based prevention efforts (e.g. awareness raising, education to shift gender norms, interventions with men, etc.) on rates of sexual and gender-based violence within communities and the need for shelters in the first place;
2. The particular protection and support needs of refugees, internally displaced persons, and other migrants fleeing sexual and gender-based violence;

3. The evaluation of unconventional shelter models composed of community host households and independent living arrangements, especially their effectiveness and security and the ways that they vet and support host families;
4. An inquiry into residents' priority support services;
5. An evaluation of the transition experiences of former shelter residents, including the impact of any income-generating activities or vocational training provided by the safe shelter programme;
6. The protection needs of members of marginalised victim groups, including the potential of specific models to meet these needs and members' desire for specialised versus main-stream shelter access;
7. Identification of "pull factors" and assessment of programmes' actual impact; and
8. Methods of evaluating shelter impact, including ways in which views of residents, staff members, and community members can be incorporated into impact assessments**.**

Exploring the Impact of Displacement and Encampment on Domestic Violence in Kakuma Refugee Camp
Horn R., (2010) Journal of Refugee Studies 23 (3): 356-376.
http://jrs.oxfordjournals.org/content/23/3/356.short

This paper explores how conditions of life in a refugee camp contribute to domestic violence. It draws on the 'nested ecological model' of domestic violence, which integrates individual and family factors, socio-economic context, and culture. Displacement depletes the resources available to refugees at each of these levels. Eighteen focus group discussions were held in Kakuma refugee camp (Kenya).

Three main aspects of culture were identified by participants as influencing the nature and prevalence of domestic violence: gender roles, marriage practices, and beliefs about the acceptability of using violence within the family. Participants identified two main ways in which poverty contributes to violence: the way an inability to provide for his family affects a man and the ways women try to improve their economic situation. One of the effects of dependency on outside agencies for basic needs, and of the rights and equality ideology underpinning the services provided by international agencies, is that both men and women are unable to maintain the traditional clear division of roles. In many communities, women are not dependent upon men in the way that they were in their home countries, and they may begin to challenge their husbands' authority. In some families, it is difficult for both the man and the woman to accept this forced change in gender roles. Most displacement-related factors identified as contributing to domestic violence are consequences of the structural conditions of refugees' lives. This suggests that systems for providing refuge have the potential not only to contribute to domestic violence, but to reduce it.

b) Changes to gender norms

Protracted Refugees in Sudan: Why Gender Matters
El Jack, A. (2011). Middle East Institute Refugee Cooperation Study Group.
http://www.refugeecooperation.org/publications/Sudan/06_eljack.php

This study examined the gender relations of protracted refugee situations in southern Sudan and used interviews conducted with Dinka and Nuer refugee women, men and children in Kenya and Uganda. The author contends that extreme violence, associated with militarised processes of displacement, has altered the Dinka and Nuer gender relations in complex and diverse ways. Protracted refugee experiences have caused physical dislocation, disruption of social and cultural traditions, and material dispossession. The cultural trauma associated with protracted refugee experiences point to the deep attachment to place that many Nuer and

Dinka people, and women in particular, feel, and the shame that accompanies their forcible displacement to Kenya and Uganda.

The perceptions that “normal life” can only be restored when refugees return to their roots (i.e., to their places of origin) inform the UNHCR, as well as international refugee policies. These policies assume that refugees are powerless victims and overlook the actual experiences of forced migration — refugees’ struggling for recovery, thereby displaying their agency rather than passivity. Although the negative aspects of their protracted displacement clearly outweigh the positive aspects, it is important to note that some Dinka and Nuer women and girls (and some boys as well) have derived benefits from their long-term refugee experiences in Kenya and Uganda. Many have attained a modest level of education and vocational training in the Kakuma and Rhino refugee camps, and in cities such as Nairobi and Kampala. Indeed, displacement has created new responsibilities for women that have enabled them to reevaluate and challenge some of the oppressive gender roles and relationships, as well as others’ perceptions of them as women.

Stereotypical assumptions about gendered roles and relationships of Sudanese refugees are created and sustained by individuals as well as social and cultural institutions, such as households, communities, schools, refugee camps, and national and international actors. Indeed, it is these institutions which reinforce and perpetuate gender discrimination, and it is these institutions which must be challenged if gender injustice is to be transformed into equality of treatment, opportunity, and rights.

Summarised policy recommendations:

1. Mainstream gender awareness into the structures that regulate protracted refugee situations.
2. Take the lead from the local displaced population.
3. Involve women and ensure gender sensitive training.
4. Ensure that people understand how gender roles and relations are shifting during times of conflict and war in Africa.
5. Refugee women and men are devastated by their experiences of food insecurity, increased morbidity and marginalisation, and community disintegration.

Violent Conflict and Gender Inequality: An Overview
Buvinic, M., Das Gupta, M., Casabonne, U., Verwimp, P. (2013), World Bank Res Obs (2013) 28 (1): 110-138.
http://wbro.oxfordjournals.org/content/28/1/110.short

Violent conflict, a pervasive feature of the recent global landscape, has lasting impacts on human capital, and these impacts are seldom gender neutral. Death and destruction alter the structure and dynamics of households, including their demographic profiles and traditional gender roles. To date, attention to the gender impacts of conflict has focused almost exclusively on sexual and gender-based violence. The authors of this review show that a far wider set of gender issues must be considered to better document the human consequences of war and to design effective post-conflict policies.

The emerging empirical evidence is organised using a framework that identifies both the differential impacts of violent conflict on males and females (first-round impacts) and the role of gender inequality in framing adaptive responses to conflict (second-round impacts). War's mortality burden is disproportionately borne by males, whereas women and children constitute a majority of refugees and the displaced. Indirect war impacts on health are more equally distributed between the genders. Conflicts create households headed by widows who can be especially vulnerable to intergenerational poverty. Second-round impacts can provide opportunities for women in work and politics triggered by the absence of men. Households adapt to conflict with changes in marriage and fertility, migration, investments in children's

health and schooling, and the distribution of labour between the genders. The impacts of conflict are heterogeneous and can either increase or decrease pre-existing gender inequalities. Describing these gender differential effects is a first step toward developing evidence-based conflict prevention and post-conflict policy.

9. Psychosocial impacts on displaced children

The nature and impact of chronic stressors on refugee children in Ban Mai Nai Soi camp, Thailand
Meyer, S., Murray, L.K., Puffer, E.S., Larsen, J., Bolton, P. (2013), Global Public Health; 8(9)
http://www.tandfonline.com/doi/abs/10.1080/17441692.2013.811531#.UqHLRuIqtEM

Refugee camps are replete with risk factors for mental health problems among children, including poverty, disruption of family structure, family violence and food insecurity. This study, focused on refugee children from Burma, in Ban Mai Nai Soi camp in Thailand, sought to identify the particular risks children are exposed to in this context, and the impacts on their mental health and psychosocial well-being. This study employed two qualitative methods – free list interviews and key informant interviews – to identify the main problems impacting children in Ban Mai Nai Soi camp and to explore the causes of these problems and their impact on children's well-being. Respondents in free list interviews identified a number of problems that impact children in this context, including fighting between adults, alcohol use by adults and children, and child abuse and neglect. Across the issues, the causes included economic and social conditions associated with living in the camp and changes in family structures. Children are chronically exposed to stressors during their growth and development in the camp environment. Policies and interventions in areas of protracted displacement in camp-based settings should work to address these stressors and their impacts at community, household and individual levels.

Does Combining Infant Stimulation With Emergency Feeding Improve Psychosocial Outcomes for Displaced Mothers and Babies? A Controlled Evaluation from Northern Uganda.
Morris, J., Jones, L., Berrino, A., Jordans, M. J. D., Okema, L. and Crow, C. (2012), American Journal of Orthopsychiatry, 82: 349–357
http://onlinelibrary.wiley.com/doi/10.1111/j.1939-0025.2012.01168.x/full

There is a paucity of studies examining the effectiveness of combined psychosocial and nutrition interventions on the development of infants in humanitarian settings. This article examines the impact of combining a group-based psychosocial intervention with an existing emergency feeding programme for internally displaced mothers in Northern Uganda. The intervention consisted of mother and baby group sessions and home visits for mothers attending 3 emergency feeding centres. Psychosocial outcomes were compared with a contrast group of mothers who received nutritional support alone. The outcomes investigated were infant stimulation and maternal mood. After controlling for the effects of interview site and baseline scores, mothers in the intervention group (n = 70) showed greater involvement with their babies, more availability of play materials, and less sadness and worry at follow-up in comparison to the contrast group (n = 77). The intervention was acceptable to the mothers and easily taught. A proportion of the mothers chose to continue the intervention spontaneously with other mothers in their neighbourhoods. The authors highlight the need for further research to validate these preliminary findings and explore the longer term impact on child growth and intellectual development as well as maternal mood.

Community-Implemented Trauma Therapy for Former Child Soldiers in Northern Uganda: A Randomised Controlled Trial
Ertl, V., Pfeiffer, A., Schauer, E., Elbert, T., Neuner, F. (2011) JAMA; 306 (5):503-512.
http://jama.jamanetwork.com/article.aspx?articleid=1104179

The objective of this study was to assess the efficacy of a community-based intervention targeting symptoms of PTSD in former child soldiers. This was an RCT recruiting 85 former child soldiers with PTSD from a population-based survey of 1113 Northern Ugandans aged 12 to 25 years, conducted between November 2007 and October 2009 in camps for IDPs. Participants were randomised to 1 of 3 groups: narrative exposure therapy (n = 29), an academic catch-up programme with elements of supportive counselling (n = 28), or a waiting list (n = 28). Symptoms of PTSD and trauma-related feelings of guilt were measured using the Clinician-Administered PTSD Scale. The respective sections of the Mini International Neuropsychiatric Interview were used to assess depression and suicide risk, and a locally adapted scale was used to measure perceived stigmatisation. Symptoms of PTSD, depression, and related impairment were assessed before treatment and at 3 months, 6 months, and 12 months post-intervention. Treatments were carried out in 8 sessions by trained local lay therapists, directly in the communities.

PTSD symptom severity (range, 0-148) was significantly more improved in the narrative exposure therapy group than in the academic catch-up (mean change difference, −14.06 [95% confidence interval, −27.19 to −0.92]) and waiting-list (mean change difference, −13.04 [95% confidence interval, −26.79 to 0.72]) groups. Contrast analyses of the time × treatment interaction of the mixed-effects model on PTSD symptom change over time revealed a superiority of narrative exposure therapy compared with academic catch-up ($F_{1,234.1} = 5.21$, $P = .02$) and wait-listing ($F_{1,228.3} = 5.28$, $P = .02$). Narrative exposure therapy produced a larger within-treatment effect size (Cohen d = 1.80) than academic catch-up (d = 0.83) and wait-listing (d = 0.81).

Among former Ugandan child soldiers, short-term trauma-focused treatment resulted in greater reduction of PTSD symptoms.

10. Additional Information

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