

Key considerations: mental health and psychosocial support, North Kivu, DRC

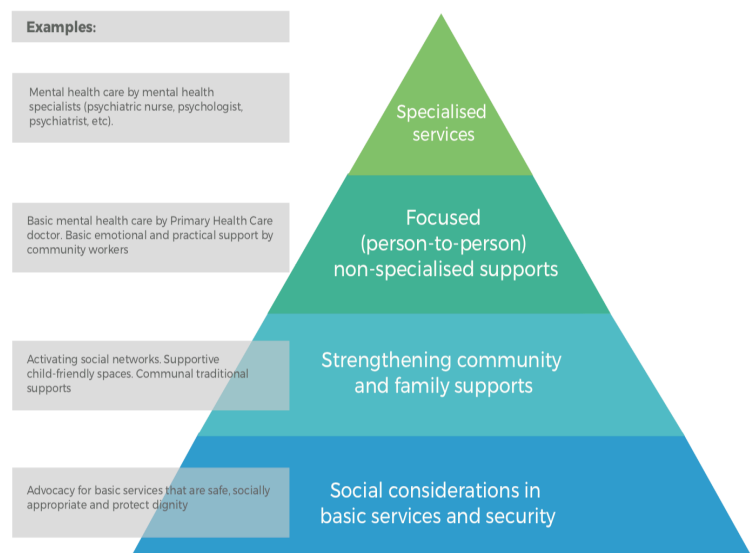
This brief summarises key mental health and psychosocial support considerations in relation to the response to the Ebola Virus Disease (EVD) outbreak in North Kivu, DRC in August 2018. The brief was last updated on 3 October 2018.

The brief is based on a rapid review of existing published and grey literature, existing Interagency Standing Committee Guidance materials, professional ethnographic research in DRC and the experience of previous Ebola outbreaks. It was developed through participatory engagement with in-country practitioners, health officials and local leadership. The development and review of this brief was facilitated by Anthrologica and the Social Science in Humanitarian Action Platform, together with the Department of Mental Health and Substance Abuse at the WHO and the Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings. Additional inputs were provided by the Mental Health and Psychosocial Support Working Group in Goma, colleagues from Bethesda Counselling Centre, Université Chrétienne Bilingue du Congo, University of Notre Dame, USAID-IMA World Health, Mercy Corps and Environment Management and Systems. The brief was reviewed by IASC Reference Group members.

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Mental Health and Psychosocial Support (MHPSS)

- Global definitions:** The composite term 'mental health and psychosocial support' (MHPSS) is used in the Inter Agency Standing Committee (IASC) Guidelines for MHPSS in Emergency Settings to describe 'any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder'. The global humanitarian system uses the term MHPSS to unite a broad range of actors, including those working with biological approaches and sociocultural approaches, as well as to 'underscore the need for diverse, complementary approaches in providing appropriate support'.¹
- IASC guidelines:** The IASC Guidelines for MHPSS in Emergency Settings recommends that multiple levels of interventions be integrated within outbreak response activities. These levels align with a spectrum of mental health and psychosocial needs and are represented in a pyramid of interventions (see Figure 1) ranging from embedding social and cultural considerations in basic services, to providing specialised services for individuals with more complex conditions. Core principles include: do no harm, promote human rights and equality, use participatory approaches, build on existing resources and capacities, adopt multi-layered interventions and work with integrated support systems. Checklists for using the guidelines have been produced by the IASC Reference Group.²



North Kivu

- Operational and psychological context:** There is a long history of conflict, insecurity and displacement in North Kivu, particularly in the *Grand Nord* (the territories of Beni and Lubero), and this remains an ongoing reality (see the SHHAP brief on the context of North Kivu).³ The mental health and psychosocial consequences of this violent context include elevated levels of distress and related disorders. Much of the mental health research conducted to date, however, has focused largely on sexual and gender-based violence against women and on children formerly associated with armed groups.^{4,5,6,7} Since the government declared the current Ebola outbreak (1 August 2018), there have been a number of attacks and killings in Beni city and the surrounding areas.
- Existing support structures:** The evident needs of the population have not been matched by MHPSS structures, which remain limited across the DRC. The 2014 DRC Mental Health Atlas reported that countrywide there were two mental health outpatient facilities, one day treatment facility, six mental health hospitals and two psychiatric units; there was one mental health worker to every 111,111 people.⁸ In North Kivu, the general hospitals in Beni, Matanda and Katya (Butembo) each have one government clinical psychologist assigned. Beni City has three private facilities that treat mental health conditions and prescribe psychiatric medicines: CEPIMA (*Centre de Protection des Indigents et Malades Mentaux*); CUPPM (*Centre Universitaire et Pastorale de Mulo*); and CERESAM (*Centre de Relance et Santé Mentale*). Butembo also has three private facilities: CEPIMA, CUPPM and the *Centre Psychiatrique Muisa*. Several NGOs providing psychosocial support are also active in North Kivu. TPO (Transcultural

Psychosocial Organisation) activities in North Kivu have focused on child protection with an emphasis on strengthening community structures to provide psychosocial support. This has included training school heads, teachers and Salvation Army DRC staff on the basics of psychosocial support. One of the main consortiums, Ushindi, operates in 10 health zones across the *Grand Nord* and provides counselling and cognitive processing therapy to survivors of gender-based violence and their families through local partners, including Heal Africa and PPSSP (*Programme de Promotion des Soins de Santé Primaries*). The main provider of non-clinical MHPSS care in Beni is the Bethesda Counselling Centre, part of the Congo Initiative – Université Chrétienne Bilingue du Congo. In Lubero, HealthNet TPO has previously led capacity-building initiatives (including in Butembo) focused on strengthening mental health in primary care. FEPSI (*Femmes Engagées pour le Promotion de la Santé Intégrale*) provides women in Butembo with health services, psychosocial support and HIV/AIDS prevention and awareness services. A small number of other actors, including UNFPA, the World Bank and IMA World Health have also provided psychosocial interventions across the *Grand Nord*, but these have been limited and have mainly focused on gender-based violence and HIV/AIDS programming. In the more isolated areas of Mabalako, Oichia, and Ituri province, mental health and psychosocial support structures remain inadequate.

- **Coping:** In dealing with decades of insecurity and protracted conflict with limited support from the under-resourced formal mental health and psychosocial support systems, Congolese communities have developed various ways of coping with distress including *débrouillardise* or *auto-prise en charge* (fending for oneself). It should be noted that although the psychosocial effects of violence are very real, violence has, to some degree, become normalised and is a common recourse action when frustrations become too great. To reinforce wellbeing, people turn to economic survival strategies, religious leaders and institutions, traditional healers and family members.^{9,10} Collective assets that promote wellbeing include music and dance, whilst somatic manifestations of grief expressed through the body are common and include gastric pain and hypertension.¹¹ As significant as these coping mechanisms are, they do not fully satisfy the need for mental health services or other important interventions for individuals identified with moderate to severe symptoms of mental disorders.
- **Perceptions of mental health:** It is notable that the words 'trauma' and 'psychosocial' are used locally, in both English and French, but mainly in relation to NGO programming. In the local language Kinande (used in Butembo), *kironda echomomuthima* is used to describe psychological trauma (derived from *kironda* meaning 'wound' and *muthima* meaning 'heart'). The term is used variably amongst practitioners and it is unclear whether people use it to refer to specific symptoms or a syndrome. It should also be noted that global MHPSS good practice cautions against the overuse of and singular attention to 'trauma'.¹ Conceptualisations of mental health and psychosocial distress are complex and dynamic, and in the DRC the mind, body, and spirit are not generally considered separate or distinct. Mental health is understood in terms of collective wellbeing (the harmony of the family or other social unit) rather than with the mind or emotions of the self. Previous research in the affected area (Butembo) has reported that local manifestations of distress resemble Western diagnostic categories, including psychotic disorders, mood disorders and complicated bereavement and/or anxiety disorders, but that it could be incorrect to label them as such.¹² In classifying mental health conditions, community members differentiated between a) presentations that are an adaptive reaction to a situation of distress and are expected to improve through the social, material and emotional support of relatives, religious leaders and community members; and b) more complex conditions that are thought to improve through treatment with western medication, unless sorcery or spirits are the cause (in which case visiting a *mukumu*, a traditional healer who works with spirits, is deemed appropriate).¹⁰ The culturally-specific aspects of mental health, psychosocial wellbeing and care must be carefully considered. Broadening the lens of interventions to address social networks (household, family and community relationships) rather than just addressing individual needs is important in North Kivu.¹³

The MHPSS response to Ebola in North Kivu

- **Ebola in the *Grand Nord*:** Because of its presentation and transmission, Ebola is a disease that cultivates fear, anger and despair and it can deeply impact the wider social fabric. In a context such as North Kivu, Ebola can magnify pre-existing tensions, whilst the response is highly influenced by the context. As such, elevated levels of distress and disorder are to be expected, and an effective psychosocial response is critical.
- **Psychosocial Commission:** In response to the current Ebola outbreak, the government has established the Psychosocial Commission as the coordinating body for psychosocial support. Co-chaired by the Department of Health and TPO, the Psychosocial Commission in Beni includes representatives from UNICEF, Bethesda Counselling Centre, Unite Familiale Sainte Kizito Anuarite, ICRC, Norwegian Refugee Council (NRC), Danish Refugee Council (DRC), Handicap International and others. At the time of writing, eight trained psychologists were reported to be working with the Psychosocial Commission in Beni, including three locally-recruited psychologists and five brought from Kinshasa by the government. TPO confirmed that assessments have been conducted by members of the Psychosocial Commission in Beni, and reported the Department of Health contracted an academic from the University of Kinshasa to conduct additional trainings for para-social workers and members of the Psychosocial Commission in Beni, although the content and coverage of this training has not been confirmed. A Psychosocial and Communications Commission has also been established in Butembo.
- **Support to Ebola Treatment Centres:** The Ebola Treatment Centres (ETCs) in Beni and Mangina are supported by psychologists. Psychologists and lay counsellors provide psychosocial support services to patients admitted to ETCs, including *écoute de malade* ('listening to the sick'), which involves attending to the fears and concerns of the patient in relation to their medical care, and 'psychoeducation', which provides information to the patient whilst aiming to develop trust in medical treatment. Colleagues who are part of the Psychosocial Commission in Beni have reported that the psychologists act as a main channel of communication between patients, their families and medical personnel, and it is within the psychologists' remit to call families to inform them of the death of a loved one and support them with the mourning process. Risk Communications and Community Engagement (RCCE) actors report that psychosocial considerations have been integrated into communication protocols for patient care, vaccination and engagement with families and communities of those who have died from Ebola at an ETC or at home. UNICEF has supported the distribution of recreational materials to children admitted to ETCs in Beni, Mangina and Butembo as part of their psychosocial work.
- **Community-based activities:** The International Red Cross and Red Crescent Movement has a Psychosocial Delegate in place to support the clinic- and community-based work of the Congolese Red Cross (Croix Rouge). Their focus is on integrating

psychosocial support into safe and dignified burials (SDB), social mobilisation and community engagement. Psychosocial support teams are also being established at various Red Cross branches with the aim of addressing longer-term consequences of Ebola within affected families and communities. UNICEF has combined its child protection and psychosocial support strategies which together seek to provide survivors, family members of Ebola cases and contacts with psychosocial support; establish or re-establish social and community support networks; provide 'social kits' and other material assistance to affected families; and provide appropriate care to orphans and unaccompanied children.¹⁴ UNICEF reported to have trained a number of 'psychosocial agents' and para-social workers in North Kivu (including Butembo and Oicha) to lead its psychosocial response to the Ebola outbreak.

- **Support to response workers:** Responders living and working in the *Grand Nord* are doing so in a prolonged crisis and protecting and promoting their wellbeing is important. The Psychosocial Commission and psychologists working with the ETCs also provide support to frontline responders when required. The International Red Cross and Red Crescent Movement and the Bethesda Counselling Centre have provided psychosocial support to frontline professionals, including safe and dignified burial teams, community engagement teams and health workers.

Overarching principles

- **Wider context:** The MHPSS response to Ebola must be grounded in the complex operational and psychological realities of North Kivu. Ebola is one of many issues communities face that threaten their lives and livelihoods. Communities perceive that their ongoing needs have been largely neglected by both the government and the international community and have expressed frustration that attention is now focused on North Kivu 'just' because of the current Ebola outbreak. It is important to address and reconcile these perceptions and ensure we listen and respond to people's needs in order to prevent further suspicion, mistrust and resentment. Approaches will need to address the pre-Ebola concerns of displaced communities and their experiences of conflict. These issues cannot be separated from the needs created by the current Ebola outbreak. Any MHPSS programme should therefore be inclusive and accessible to all communities, regardless of the extent to which they have been directly or indirectly affected by Ebola.
- **Strengthen MHPSS in the Ebola response:** Mental health and psychosocial support should be a core component of any public health response. Understanding and addressing mental health and psychosocial issues will be key to stopping transmission of Ebola in North Kivu. Specific technical expertise and dedicated resources are required to better integrate MHPSS into public health assessments at the facility and community levels and into preparation, response and recovery plans in accordance with the MHPSS guidelines of the global IASC.¹⁵ This includes the integration of MHPSS approaches and activities with community outreach, case identification and contact tracing as well as with activities at ETCs and health facilities.¹⁶ Any development or revision of tools or protocols should be done in collaboration with the Psychosocial Commission and must be based on international good practice and standards whilst maintaining local specificities. Appropriate resources must be committed to implementing MHPSS; technical expertise should be mobilised from existing in-country resources, and skilled personnel should be deployed to support the MHPSS response on the ground and remotely.
- **Emphasise coordination:** In the humanitarian architecture, MHPSS is positioned as a cross-cutting technical working group. Within the structure of the Ebola response, MHPSS should similarly cut across all response pillars. To do so effectively, clear inter-sectoral coordination mechanisms and entry points for MHPSS technical expertise must be agreed at global, national and local levels. With communities as the central focus, there needs to be particularly close collaboration with the Risk Communications and Community Engagement (RCCE), Safe and Dignified Burial (SDB) and Case Management pillars of the response, and support must be provided for the integration of psychosocial support into their work. It is unlikely that these actors have the technical expertise to develop and implement the full spectrum of interventions necessary, hence the need for resources to be dedicated to MHPSS. The Psychosocial Commission should be further strengthened as the coordinating structure for MHPSS interventions and cross-sectoral integration.
- **Existing services:** It is important to map existing local MHPSS expertise and structures as a number of private, governmental and NGO programmes and services are already active in North Kivu. Although these are limited, and many focus on issues of conflict and psychosocial services for survivors of gender-based violence, with additional training and resourcing existing services could provide further psychosocial support and mental health care in the context of Ebola. Several local organisations have confirmed they are starting to offer Ebola-related services (see above) and want to be more fully integrated into the response. Established local actors should be supported to identify their technical and resource needs (including adequate remuneration) to conduct this work, particularly in relation to their capacity to manage an increased workload.
- **Build on local care structures:** In the relative absence of formal mental health structures in North Kivu, sources of psychosocial support are evident at family and community levels, particularly through church networks as mental health and psychosocial issues are often seen through a spiritual lens. Local actors including trusted and respected community leaders, traditional healers and pastors (some of whom have been trained in psychosocial support skills by the Bethesda Counselling Centre) all serve as frontline providers offering psychosocial support to their communities. Pastors and other religious leaders can also play a role in providing spiritual support to patients at ETCs and their family members, and can provide advice and support regarding burial practices and ceremonies that are both safe and meaningful to communities.^{16,17} As normal ways of coping are likely to be affected by the Ebola outbreak (e.g. socialising with friends and family, collective music and dance, economic activity etc.), these community actors are best placed to help identify adaptations or safe alternatives. Given issues of insecurity, in addition to the sensitivities of this kind of care, it may be more feasible for individuals to seek and accept support from engaged community assets rather than only through formal or mainstreamed mental health services (existing or newly established). Such local structures form the fabric of community-based care and must not be overlooked or undermined but rather engaged in partnership as contextually-appropriate channels to provide MHPSS in North Kivu, as part of a multi-level system of care (see Figure 1 above).
- **Protective environments and a focus on strengths:** A narrative emphasising vulnerability is often assumed for those in crises, but this is not always correct or fair. Communities in North Kivu, particularly in the *Grand Nord*, consistently demonstrate a high level of resilience and resourcefulness. Whilst communities must be treated with compassion and sensitivity, the response must not create or contribute to perceived vulnerabilities through actions that (often unintentionally) can create fear, anger and mistrust.

Rather, the response must seek to create safe and protected environments for care and make use of existing resources and strengths. Individual actors and the collective response should ensure that all actions protect and promote wellbeing. Key psychosocial principles, including hope, safety, calm, social connectedness and self- and community efficacy, should be embedded across every intervention.¹⁸

- **'Whole of society approach'**: Whilst there is a need for focused interventions with specific objectives and target groups (e.g. immediate support to survivors and families directly affected by Ebola), MHPSS efforts must adopt a 'whole of society' approach. Providing support (including psychosocial support) to select individuals in a community can be counter-productive and create or entrench resentment and marginalisation. IASC guidelines note that although empowerment of those affected by Ebola virus disease (EVD) is necessary to recover from stigma (including 'felt' stigma), *'care should be taken to promote the integration of people who have been affected by EVD without over-targeting (i.e. without increasing stigma by drawing attention to them). Health and social services, for example, should, if at all possible, be available to all community members rather than just those affected by EVD.'*¹⁵ A 'whole of society' approach requires meaningful community participation at every level, including the involvement of local focal points to guarantee sustainability and respect (see above). Ensuring the broader community understands the cause and transmission of Ebola will help reduce stigma experienced by survivors and their families.
- **Longer-term perspective**: The current focus on Ebola and the related influx of resources into North Kivu is a prime opportunity to build stronger long-term mental health structures in an area that has faced chronic conflict and insecurity and has remained extremely under-resourced. This is particularly significant considering that evidence shows the mental health and psychosocial effects of Ebola are prolonged and persist well beyond the acute phase of crisis. Current resources should be used to strengthen the wider MHPSS system. For example, the Psychosocial Commission can be positioned as a standing working group to support not only the current outbreak but also future emergencies. Strengthening long-term MHPSS services needs to be done in collaboration with the government. It is notable that the country developed a mental health policy in 1999, with plans to establish a mental health programme in each province and ingrate mental health into primary care, although this is yet to be implemented.¹⁹

Recommendations

- **Globally recommended activities**: The MHPSS global technical team recommends ten key activities that should be implemented as part of the response to Ebola in North Kivu (detailed below). At the time of writing, a number of gaps between the recommended activities and activities reported in the field were evident. Response partners have expressed concern that there remains limited human resource capacity to provide the full spectrum of MHPSS services needed. Few responders have been trained in basic psychosocial skills, including psychological first aid. International agencies are continuing to advocate for the deployment of MHPSS technical staff to bolster expertise on the ground in North Kivu.

Recommended actions to strengthen MHPSS in the Ebola response	
1.	Conduct participatory assessment of the context and of culturally-specific MHPSS issues, needs and available resources, including training needs and capacity gaps across the spectrum of care.
2.	Ensure that the Psychosocial Commission is maintained and strengthened and that it involves all partners active in this area of work. Coordinating MHPSS should be a cross-sectoral initiative, including health, protection and other relevant actors.
3.	Integrate psychosocial considerations into all response activities. This will enhance the protective qualities, and reduce the potential risks, of humanitarian interventions. Each pillar should have clear guidance as to how MHPSS is included. A key area in which psychosocial expertise is required is to ensure that burials are not only safe but also dignified.
4.	Train all frontline workers (including volunteers, health workers, burial team members, MHPSS providers, community leaders, teachers, pastors and other religious personnel) on essential psychosocial care principles and psychological first aid for Ebola outbreaks (see PFA for Ebola Virus Disease guidance). ²⁰ ETCs should include trained MHPSS staff.
5.	Provide trained personnel with access to sources of psychosocial support. This must be of equal priority with ensuring their physical safety through adequate knowledge and equipment.
6.	Establish a mental health and psychosocial support strategy for Ebola cases, survivors, contacts (particularly those in isolation), family members, and the broader community. Ensure that the strategy addresses fear, stigma, negative coping strategies (e.g. substance misuse), and other needs identified through assessment and is building on positive, community-proposed coping strategies. ¹⁷ To assist in the care and social reintegration of survivors and their families, close collaboration is needed between communities and health and social welfare services.
7.	Develop and implement a community-based package of MHPSS services for all affected children and adolescents, including orphans and vulnerable children, to address their unique needs (see the Child Protection Alliance Guidelines on Child Protection for Infectious Disease Outbreaks and the UNICEF Community-Based MHPSS Guidelines). ^{21,22}
8.	In the early recovery phase, support health authorities to establish sustainable and community-based mental health and psychosocial services. These services should be built for the longer term to ensure they address the wider need.
9.	Use information from assessments, including identified needs, gaps and existing resources, to set up/contribute to a system for the identification and provision of care to people with common and severe mental health conditions. As part of ongoing health system strengthening, every health facility should have at least one person trained and a system in place to identify and provide care for people with common and severe mental health conditions (using the <i>mhGAP Humanitarian Intervention Guide</i> package and other tools). ²³ This requires the allocation of longer-term resources and the development of an MHPSS advocacy strategy to influence funding, quality coordination and sustainable, long-term initiatives
10.	Establish monitoring, evaluation, accountability and learning mechanisms to measure effective MHPSS activities.

Resources

- *Guidelines on Mental Health and Psychosocial Support in Emergency settings*. IASC (2007). https://interagencystandingcommittee.org/system/files/legacy_files/Guidelines%20IASC%20Mental%20Health%20Psychosocial%20%28with%20index%29.pdf
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