Best Practices for Para-professionals Providing Mental Health Care and Psychosocial Support Services for Adolescents and Children in Refugee and Internally Displaced Person Settings and a Mental Health Needs and Resource Assessment in Four Refugee Settlements in Uganda

Playing to Live!

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INTRODUCTION

Playing to Live (PTL) in collaboration with the Danish Refugee Council (DRC) sought to create a comprehensive report to highlight the immense need for mental health and psychosocial support (MHPSS) for children and adolescents in Uganda's refugee settlements hosting South Sudanese refugees. Through the financial support of a grant from the Humanitarian Innovation Fund (HIF)/ELHRA and PTL donors, the following activities were successfully completed: background review, literature review, and needs and resource assessment.

The activities were performed from March 1, 2017- October 31, 2017. During this time, PTL sought continual conversations and support from Uganda's Office of Prime Minister (OPM) and UNHCR. Key stakeholders across for-profit, non-profit, and governmental organizations acted as advisors throughout this process. In addition, all collaborating organizations mentioned in this report provided essential information about their MHPSS services and recommendations for future growth. Transcultural Psychosocial Organization (TPO) Uganda provided additional support through validating the final information in the needs and resource assessment.

The background review is a comprehensive review based on published literature of South Sudan's culture and history. It provides insight into the role of religion, gender, and health. Insight into the cultural understanding and roles of mental health is also explored. Based on this information and additional literature, a review of the need and impact of mental health is stated.

The literature review in this report highlights best practices, barriers, and outcomes for MHPSS child and adolescent programming in refugee/internally displaced persons (IDP) settings using paraprofessionals. The literature review was performed by three independent reviewers, began with 4,584 articles, and after three stages of inclusion criteria, 28 articles were included for the review. The 28 articles were reviewed, compared and contrasted, and rated for quality. This complete literature review can be used as a foundation to advocate for effective and sustainable programs.

The needs and resource assessment used the Inter-Agency Standing Committee (IASC) rapid MHPSS needs assessment guidelines to perform an assessment on four of Uganda's largest refugee settlements. This report contains the qualitative interviews, the methods followed, and the results from this assessment.

Conclusions and recommendations pull together the background, literature review, and needs and resource assessment to highlight the urgent need for MHPSS programs for children and adolescents. Recommendations highlight the need for services on all levels of MHPSS response and describe how PTL could be an effective model to build capacity and support.

I. SECTION I – DESK REVIEW

RATIONAL FOR DESK REVIEW

In addition to an assessment of the current needs and resources in Uganda's refugee settlements, there was a need to address current and past literature. A background review was performed to obtain information about culture, mental health, the historical context and the current conflict. A literature review was performed to obtain information of the current best practices of mental health programs for children and adolescent refugees. The aim of this section was to build a foundation of understanding prior to researching the current response in Uganda.

BACKGROUND & SIGNIFICANCE

This report was conducted to educate on the situation of South Sudanese refugees in settlements in Uganda and includes information on subjects such as historical and political context, information on the religion, culture, education, and economy of South Sudan, details of the refugee experience, rights and resources of refugees, health and mental health, and challenges of daily life. A prior review was conducted by the Peter C. Alderman Foundation in 2015 and provided a thorough report that has been utilized as a foundation for this current report. This report will primarily focus on the two years following the Peter C. Alderman Foundation report to cover the enormous surge of refugees crossing the border since 2016 due to the development of a new civil war in South Sudan, characterized by its violence and brutality towards civilians.

General Context

<u>Historical Context of South Sudan</u>
The Sudanese independence referendum of 2011, which divided Sudan in two countries and created the new nation of South Sudan, followed decades of a brutal and destructive civil war (Peter C. Alderman Foundation, 2015). The peaceful secession led many to look hopefully towards the future, but after so many years of strife South Sudan was a nation born into poverty and meager infrastructure; on both the 2015 United Nations Human Development Index and the United Nations Gender Development Index, South Sudan ranks at 169 out of 188 countries (Beaubien, 2017, Oxfam International, 2017). Tensions and small border skirmishes continued between North and South Sudan, but with no major clashes until recently ("South Sudan: What is the fighting about?" 2017).

Although the nation's secession has held, internal power struggles have revived the cycle of violence in South Sudan. In 2013, President Salva Kiir simultaneously dismissed his cabinet and his vice president, Riek Machar, citing a plotted coup (Peter C. Alderman Foundation, 2015). The two leaders hail from the Dinka and Nuer tribes respectively, and in the resulting contest for power the battlegrounds have been drawn along ethnic lines, with President Kiir's Sudan People's Liberation Army (SPLA) and Vice President Machar's Sudan People's Liberation Movement/Army in Opposition (SPLM/A-IO) militias feuding against one another. Fighting escalated quickly, and in the years since 2013 civilians, peacekeepers, humanitarian

workers and journalists have also come under attack from both sides ("South Sudan: What is the fighting about?" 2014). Multiple attempts have been made to negotiate lasting peace, yet both sides continued to break cease-fire agreements, and ultimately attempted peace negotiations have failed to end the conflict ("Civil war in South Sudan", 2017, Peter C. Alderman Foundation, 2015).

In July of 2016, fighting between SPLA and SPLM/A-IO forces rose to new levels. Heightened tensions in the first days of the month stemming from Riek Machar's return in April intensified into skirmishes in the streets, and then erupted into attacks not only between military forces, but also against civilians, aid workers, children, internally displaced persons, and in particular targeted many members of the Nuer tribe (OHCHR & UNMISS, 2017). The intense conflict lasted from roughly July 7-25, 2016, during which time numerous human rights abuses were committed (OHCHR & UNMISS, 2017). A total of 217 victims of rape or gang rape were reported, and many of those violations were reported to have taken place at SPLA security checkpoints or as women and children left United Nations (UN) secure refuges to collect firewood, food, or conduct other daily activities (OHCHR & UNMISS, 2017). Looting was rampant and included a raid on supplies of the Food and Agriculture Organization of the United Nations (FAO) and the World Food Programme (WFP), the latter of which lost enough commodities to have fed 260,000 people for a month (OHCHR & UNMISS, 2017). UN compounds were caught in crossfire, and the South Sudan Red Cross warehouse was also bombed and suffered from looting (OHCHR & UNMISS, 2017). Many civilians were actively prevented from reaching safety at UN compounds as well as crossing the border into Uganda. However, in July 2016 alone a total of 103,500 people fled across the border to Uganda with an additional 49,427 refugees in August 2016 (OHCHR & UNMISS, 2017).

These migrant numbers surpass those of the entire first six months of 2016 combined, and the surge of South Sudanese refugees entering Uganda has increased to a total of over 1,006,800 as of August 2017 (UNHCR, 2016b, UNHCR, 2017b). Prior to July 2016 the total number of South Sudanese Refugees in Uganda was 231,259, which in itself was a staggering jump from the 22,483 refugees registered before the conflict began in 2013 (UNHCR, 2017b).

The turmoil of ongoing fighting has left South Sudan bereft of resources and stability. With a reported 2 million internally displaced persons (IDPs) in addition to the 1.93 million refugees fleeing across borders into surrounding countries (UNHCR, 2017a), much of the agriculture of South Sudan has been disrupted or abandoned, leading to increased food prices and elevating 45% of the population into need for immediate food relief assistance (Oxfam International, 2017, Reid, 2017). Though since mitigated due to timely humanitarian assistance, two counties were declared to suffer from famine in February 2017 (Oxfam International, 2017, Reid, 2017). Children suffer further deprivation as their educations become disrupted, eliminating hopes for a brighter future for South Sudan. As many as 15,000-17,000 children may have been abducted and forced to become child soldiers (Okiror, 2017, Reid, 2017). The national healthcare system was exceedingly understaffed and undersupplied at the nation's birth, with only an estimated 120 doctors and 100 registered nurses for the entire population of 9 million in 2012, (ICRC, 2012) and has continued to crumble, leading to outbreaks of measles, cholera, and guinea worm (Reid, 2017).

Political Context in Uganda

Uganda has long been a generous and reliable friend to regional refugees. A United Nations High Commissioner for Refugees (UNHCR) report on Uganda's refugee system found that Uganda has accepted an average of 161,000 refugees annually since 1961 until the recent influx (UNHCR, 2016a). Although the South Sudanese refugee population currently surpasses all others, refugees living in Uganda come from various countries such as the Democratic Republic of the Congo, Rwanda, Kenya, and countries within the Horn of Africa (UNHCR, 2016a).

Both the Ugandan people and their government maintain a friendly and welcoming attitude towards refugees (UNHCR, 2016a). Uganda's Refugee Act of 2006 and Refugees Regulation of 2010 formally outlined refugee rights to access to healthcare, employment, education, and the justice system, and include provisions for land, shelter, food, and water (UNHCR, 2016a, Refugee Act 2006, Refugees Regulation 2010). Once registered in Uganda's system, refugees are allotted a plot of land within the settlements, intended to create sustainable living, which they may farm for subsistence (profit is rarely achievable based on size and quality of the plot) but may not sell or lease (UNHCR, 2016a, Refugee Regulations 2010, Refugee Act 2006). Land assignment may also include distribution of a temporary shelter kit, and each refugee family unit is provided with a supply of Core Relief Items (CRIs) such as soap, a jerry can, a mosquito net, a sickle, plastic sheeting, a hoe, kitchen set, a monthly supply of sanitary napkins for females, etc (UNHCR, 2016b). Refugees are allowed freedom of movement within the country, and some opt to move to cities rather than remain in settlements (UNHCR, 2016a).

These refugee laws intend to create peaceful and sustainable integration of refugees into local communities. Ugandan Commissioners are expected to educate and sensitize residents about incoming refugee populations as well as to take refugee concerns into consideration when forming sustainability or environmental plans (Refugees Regulation 2010). On a federal level, Uganda has incorporated refugee management into its *National Development Plan II* by creating an initiative known as the *Settlement Transformative Agenda* (UNHCR, 2016a). The initiative seeks to provide safety for and harmonious incorporation of refugees and host communities, and works in accompaniment with the larger framework of the United Nations-World Bank Refugee and Host Population Empowerment plan (UNHCR, 2016a).

Despite the welcoming national attitude, Uganda's legal system does present several challenges to refugees settling in the country. Primarily, while refugees are welcome to live and work alongside locals for indefinite periods of time, they are largely barred from citizenship (Peter C. Alderman Foundation, 2015, UNHCR, 2016a). Children born in Uganda, whose parents or grandparents were refugees may not obtain citizenship by birth, leaving a possibility for statelessness, and adults have no pathway to naturalization regardless of duration of residency in the country, save for marriage to a Ugandan citizen (UNHCR, 2016a). Refugees may also face security obstacles, as law enforcement in settlements is frequently inadequate due to restricted finances and resources. Shortages include a lack of female security officers in particular, which may be linked to the underreporting of sexual and gender-based violence cases (UNHCR, 2016a). Consequently, despite having legal access to courts and the justice system, refugees may still not receive due protection and security.

Religion and Culture

Religion plays an important role in daily life for the South Sudanese. The population of over 60 different ethnic groups typically adheres to Christian, animist, or Islamic beliefs, with some occasional crossover (CARE, n.d., Collins et al., 2017, Oxfam International, 2017, Peter C. Alderman Foundation, 2015). Religion and spirits are frequently used to explain misfortunes or offer coping strategies and pathways to resilience in times of distress (Luster et al., 2009, Peter C. Alderman Foundation, 2015, Tempany, 2009).

South Sudanese society is tightly knit and community-focused, with a much lesser focus on the individual than Western societies. The South Sudanese provide care and support for one another both in everyday life and times of strife, and this community support can be an essential part of the psychological well-being of refugees (Coker, 2004, Peter C. Alderman Foundation, 2015, Tempany, 2009). Community members make a point of looking after one another, with elders often stepping in to guide orphaned youths or ensure that community members do not suffer alone (Coker, 2004, Luster, Qin, Bates, Johnson, & Rana, 2009, Peter C. Alderman Foundation, 2015, Tempany, 2009). Despite the dependence on community ties, Coker (2004) emphasizes that these bonds were mostly ethnic or tribal in nature prior to civil war with North Sudan, during which the threat of cultural erasure and oppression by the North drew in independent tribes, who for the first time created an identity of being "South" Sudanese in defense.

It is important to heed the distinction of various 'tribes', or ethnic groups, of South Sudan, although use of the word 'tribe' itself is often regarded as a derogatory remnant of South Sudan's Anglo-Egyptian colonial history (Fukui & Markakis, 1994, Rolandsen & Daly, 2016). Ethnic groups across South Sudan include not only the aforementioned Dinka and Nuer, but others including the Bari, Shilluk, Acholi, Murle, Uduk, Toposa, Latuka, and multitudes of smaller groups that have intertwined and clashed throughout their long histories of contact (Fukui & Markakis, 1994, Rolandsen & Daly, 2016). Ethnic groups or 'tribes' have been one of the few constant determinants of identity across an otherwise turbulent history before the idea of "South Sudanese" existed, and often determine individuals' livelihoods, religious beliefs, and cultural practices (Fukui & Markakis, 1994, Rolandsen & Daly, 2016).

Elders are also a source of the thriving oral tradition in South Sudanese culture; oral traditions are used to teach both mythology and history, accounting for the scarcity of written history of the peoples of South Sudan in pre-colonial times and remaining quite popular today. (Collins, Spaulding, Sabr, & Sikainga, 2017, Essien & Falola, 2009, Peter C. Alderman Foundation, 2015, Rolandsen & Daly, 2016) Oral traditions may be unique to each ethnic group, and include poetry and songs, proverbs, and folktales, of which the latter two categories serve as reminders of values and social obligations, and as warnings for those who transgress such norms (Essien & Falola, 2009). A preference for oral conversation may be demonstrated in the strong prevalence of radio as primary communication, also popular due to the population's low literacy rates (Collins et al., 2017, Essien & Falola, 2009, Oxfam International, 2017, Peter C. Alderman Foundation, 2015). Essien & Falola (2009) note that before the referendum of 2011, the Sudanese government also invested in the development of radio broadcasting throughout the country and in various local languages as the easiest way to reach the widespread and rural population, as newspapers were difficult to circulate.

In addition to poetry, folktales, and proverbs, many ethnic groups across South Sudan may also participate in arts that often represent their daily lives and cultural or religious values (Essien & Falola, 2009). Most South Sudanese live in rural environments and uphold cultural traditions such as ritualistic tattooing or facial scarring as well as traditional bead working or craft making from various materials (CARE, n.d., Collins et al., 2017, Essien & Falola, 2009Peter C. Alderman Foundation, 2015). Singing, music, and dance are integral parts of South Sudanese traditions, religions, and ceremonies, and are equal parts entertainment and instruction on cultural norms (Essien & Falola, 2009).

Educational Context

The education system in South Sudan has been disrupted and stalled from growth by decades of civil war, resulting in a highly illiterate population (estimated up to 27%) with few students pursuing education beyond the primary level, even where schools are available (Collins et al., 2017, Oxfam International, 2017). In a 2016 survey of 490 IDPs, Oxfam International found that 64% of women and 38% of men had never been to any school at all (Oxfam International, 2017). The lack of female enrollment may be due to several reasons, including early marriage, fear of violence (rape or sexual harassment) while traveling to school, a lack of female educators, and a lack of sanitation facilities or products in schools during menstruation (Collins et al., 2017, Oxfam International, 2017). In addition, both boys and girls struggle to pay for school fees and supplies, and boys may also fear being forcefully conscripted into armed conflict while traveling to school or suffering violent attacks (Oxfam International, 2017).

For refugees resettled within Uganda, access to education is protected under law (UNHCR, 2016a, Refugee Regulation 2010) but schools in settlements are often vastly overcrowded and understaffed with few resources or materials, and female enrollment remains low (Okiror, 2017, UNHCR, 2016b). A November 2016 UNHCR report on Bidi Bidi settlement warned that teacher to pupil ratios were reaching levels as high as 1:150, and that 72 classrooms would need to be added to bring those ratios down to the "acceptable" level of 1:60 (UNHCR, 2016b). Although settlement schools may provide unique opportunities such as clubs or the first accessible education to many, (Kim, Torbay, & Lawry, 2007, UNHCR, 2016b), continued interruption of an already weak educational system offers little hope for giving youth the capacity to rebuild their country in the future (Okiror, 2017, Reid, 2017).

Economic Context

Traditionally, South Sudanese livelihoods beyond the oil division have revolved around agricultural and pastoral activities (Collins et al., 2017, Oxfam International, 2017, Peter C. Alderman Foundation, 2015). Cattle herding is a large part of South Sudanese culture (CARE, n.d.) and economic activities beyond subsistence feature farming, fishing, and forestry as primary endeavors (Collins et al., 2017, Oxfam International, 2017). Conflict has not only destroyed farms and deprived citizens of their livestock and tools, but also disrupted markets and therefore access to income (Oxfam International, 2017, Reid, 2017). At a time when severe food shortages and skyrocketing prices have driven many regions of the country to near-famine, families are left scrambling to find revenue for food and shelter (Oxfam International, 2017, Reid, 2017, Peter C. Alderman Foundation, 2015). Women in particular have been left with the burden of finding alternative sources of income, often collecting

firewood to sell or engaging in small trade both in South Sudan and as refugees in settlements in Uganda (Oxfam International, 2017).

Ugandan provisions by law allow registered refugees access to employment and provide each family with a plot of land to farm for subsistence and profit, yet such plots are not necessarily large nor the most fruitful, and lack of sufficient water in some settlements may negatively affect farming (Karunakara, Neuner, Schaur, Singh, Hill, Elbert, & Burnha, 2004, UNHCR, 2016a, Peter C. Alderman Foundation, 2015, Refugee Regulations 2010). Although some refugees may find work within settlements in small trade or shelter construction, more employment opportunities are needed (UNHCR, 2016b).

Gender Context

The United Nations estimates that as many as 86% of South Sudanese refugees are women and children (Peralta, 2017a). South Sudanese culture confers a higher status on men than women, ensuring their dominance both in and out of the home (CARE, n.d., Oxfam International, 2017, Peter C. Alderman Foundation, 2015). Post-Independence in 2011, South Sudan created the Transitional Constitution and Bill of Rights that bestows equal rights in law to men and women and pushes an Affirmative Action agenda in legislative and executive branches (CARE, n.d.). However, daily interactions maintain the status quo of men as chief decision-makers and heads of the household (CARE, n.d., Peter C. Alderman Foundation, 2015). Husbands make decisions surrounding methods of birth control, (often opting for none) women's access to healthcare, and education of children, and are typically charged with tasks such as cattle herding, hunting, fishing, construction, and other economic pursuits outside the home (CARE, n.d., Kim et al., 2007, Oxfam International, 2017). The female domain includes tasks such as cooking and cleaning, collecting firewood and water, and being primary caretakers in the family (CARE, n.d.).

Marriage in South Sudanese culture is often polygamous and rarely terminates in divorce, which typically may only be initiated by men (CARE, n.d., Collins et al., 2017). Girls can be expected to marry as early as their first signs of menstruation, and in 2016 an estimated 52% of girls were married before the age of 18 (Oxfam International, 2017). Early marriage is associated with premature termination of education for girls and early childbirth, but is on the rise as bridal dowries offer financial relief to families impoverished by conflict (Kim et al., 2007, Oxfam International, 2017) or as a solution to cases of rape or pre-marital sex and pregnancy (Peter C. Alderman Foundation, 2015). Women often have deferential attitudes towards their husbands within marriage, and neither gender regards domestic violence as extreme or unusual behavior (Kim et al., 2007, Oxfam International, 2017). A Care International (n.d.) gender based violence baseline survey conducted in 2013 indicated that 82% of female participants agreed with the statement "*women should tolerate violence in order to keep her family together*" (p. 4), and found that rape, psychological abuse, beatings, and denial of education and economic opportunities were common experiences for women in South Sudan, yet seldom reported.

Conflict and war have deeply impacted gender relations and norms. With many men conscripted to or lost in the fighting in South Sudan, some women have assumed the head of household position, and continue to hold the position after migration to Ugandan settlements (CARE, n.d., Oxfam International, 2017). While this can open up further economic or

educational opportunities, it may also put strain on women who must become sole providers as well as caretakers for their families (Oxfam International, 2017).

Conflict has also steeply increased sexual and gender-based violence (SGBV) both within South Sudan and in refugee settlements in Uganda. Women are particularly at risk for rape or abuse as they collect water and firewood outside of safety zones, and often suffer harassment within settlements as well (OHCHR & UNMISS, 2017, Oxfam International, 2017, Peter C. Alderman Foundation, 2015). Many cite insufficient and crowded temporary shelters as a contributor to SGBV, as shelters may not give adequate privacy for washing, menstrual care, or even sexual acts performed by adults, and do not provide protection from abuse (Oxfam International, 2017). Domestic violence is also increasing, and was linked by women in a 2016 Relief Web International gender analysis to men's increasing dependence on alcohol and substance abuse as coping methods for stress during the conflict (Ayazi, Swartz, Eide, Lien, & Hauff, 2015, Oxfam International, 2017, Tempany, 2009,). Men's stress reportedly derives from a loss of livelihoods and, subsequently, provider or leadership positions, and feelings of idleness (Oxfam International, 2017). Due to the economic hardships many South Sudanese now face after destruction of homes and livelihoods, in addition to early marriages women and girls are also at risk for entering prostitution work to fend off poverty and hunger (Oxfam International, 2017).

General Health Context

Obtaining access to healthcare in South Sudan remains challenging for much of the population. Conflict often prevents patients or victims of violence from reaching the care that they need (OHCHR & UNMISS, 2017), and facilities are few and poor in quality, particularly maternal and pediatric care centers (ICRC, 2012, Oxfam International, 2017). Approximately 90% of women in South Sudan do not give birth with a medical professional present (Oxfam International, 2017), and unsurprisingly South Sudan's maternal mortality rate of 1 in 6 (estimated in 2013) is one of the highest in the world (Collins et al., 2017, Peter C. Alderman Foundation, 2015) while neonatal mortality and infant mortality are estimated at 39 per 1,000 and 64.1 per 1,000 respectively (Oxfam International, 2017). Most health centers are extremely understaffed as many health professionals have either migrated or left their positions due to non-payment of salaries (ICRC, 2012, Oxfam International, 2017). Many facilities lack medicines and resources to treat patients, and those that can often have a high cost, which can be an obstacle for IDPs or other citizens experiencing financial strain (Oxfam International, 2017). Malaria, meningitis, acute respiratory infections, measles, tuberculosis, sleeping sickness, and cholera are amongst some of the most common morbidities facing the population (Collins et al., 2017, ICRC, 2012, Oxfam International, 2017). The persistence and severity of these infectious diseases may be in part due to the South Sudanese preference for traditional medicine, which often causes patients to not seek care in hospitals until conditions have progressed too far to treat (Oxfam International, 2017).

As previously described, the population of South Sudan has seen negative consequences of conflict on health such as severe food insecurity and hunger (Oxfam International, 2017, Reid, 2017) and increases in SGBV (OHCHR & UNMISS, 2017, Oxfam International, 2017, Peter C. Alderman Foundation, 2015). Elevated episodes of SGBV may be one cause for swelling rates of HIV/STI prevalence amongst South Sudanese populations, along with the growing number of women entering prostitution to procure food or money (OHCHR & UNMISS,

2017, Oxfam International, 2017). Government figures from 2015 estimate HIV numbers to be as high as 2.5% amongst civilians aged 15-49, and there is a lack of awareness of prevention, protection, and screening for these diseases (Oxfam International, 2017). Conflict has also increased psychological trauma and war injuries (Oxfam International, 2017, Peter C. Alderman Foundation, 2015). In 2012 the Red Cross estimated that there were approximately 50,000 people in South Sudan with war-related disabilities and injuries, which is likely to have significantly increased after the outbreak of violence in 2013 (ICRC, 2012).

Refugees resettled in Uganda continue to face obstacles to quality healthcare. Provisions under law grant refugees access to healthcare facilities and professionals (UNHCR, 2016a, Peter C. Alderman Foundation, 2015, Refugees Regulation 2010), but in practice the system does not have the necessary capacity and resources to meet the high demand (Okiror, 2017, Peter C. Alderman Foundation, 2015). While refugees were previously enrolled in a health system parallel to that of Uganda's citizens, in 1999 refugees were integrated into local systems that are financed both by Uganda's government and the UNHCR (Peter C. Alderman Foundation, 2015). This merger created mixed results in which refugees have easier geographical access to facilities and services, but without specialized refugee centers patients may not receive the quality of healthcare called for by their specific needs (Peter C. Alderman Foundation, 2015). Healthcare worker numbers within refugee settlements are insufficient, with a November 2016 report from Bidi Bidi settlement listing only 6 per 10,000 refugees, falling far short of the target goal of 22 healthcare workers per 10,000 settlement residents (UNHCR, 2016b,). Morbidities seen in the settlements include malaria, acute respiratory tract infections, acute watery diarrhea, STIs and SGBV (UNHCR, 2016b, Peter C. Alderman Foundation, 2015).

Mental Health and Psychosocial Context

There remains a paucity of studies of mental health morbidities generated by the current fighting in South Sudan. However, the previous 20 years of civil war with North Sudan produced a number of studies outlining key information on the impact of trauma, loss, and migration on the mental health of South Sudanese, which is summarized here.

<u>Epidemiological Studies of Mental Disorders amongst South Sudanese</u>
South Sudanese nationals and refugees may experience or witness a variety of traumatic events such as violence and rape, the loss of loved ones, property, and hope; and many refugees in Uganda arrive after difficult journeys exposing them to hunger, the elements, and the shock of migration and acculturation (Karunakara et al., 2004, Pacione, Measham, & Rousseau, 2013, Tempany, 2009). These experiences leave many refugees vulnerable to psychological illness, which has been well reviewed during past periods of conflict.

Numerous studies included in a 2015 literature review by the Peter C. Alderman Foundation found levels ranging from 12.3%-39% of post-traumatic stress disorder (PTSD) prevalence in South Sudanese participants, with high occurrences of depression (6.4%-50%), anxiety (5.5%-23.6%), and other disorders common as well across different reports (Peter C. Alderman Foundation, 2015). Three studies found gender to account for differences in disorder prevalence or risk factors, and most studies included in the review focused on PTSD, major depressive disorder, or anxiety disorders, leaving the possibility for other outcomes to go

unnoticed (Peter C. Alderman Foundation, 2015). Much of the epidemiology surrounding refugee care similarly focus on conflict-related trauma, leaving a gap in resources for those with pre-existing conditions such as psychotic disorders, substance abuse, mental retardation, and epilepsy, the latter of which is known to be prevalent along with Nodding Disease in South Sudan (Colebunders, Hendy, Mokili, Wamala, Kaducu, Kur,..&Laudisoit, 2016, Kane, Ventevogel, Spiegel, Bass, van Ommeren, & Tol, 2014). While unspecific to South Sudanese refugees, a 2014 study of alternative psychological illnesses amongst refugees across 90 camps and 15 different countries revealed that refugees in Uganda presented as many as 100 cases per month of pre-existing mental health conditions at primary care units (Kane et al., 2014). These numbers suggest a need for expanding mental health epidemiology to include other conditions that may be negatively affecting refugees' mental health outcomes beyond conflict-related trauma, and to help guide the allocation of resources to care for alternative conditions (Kane et al., 2014).

Karunakara et al. (2004) conducted a much larger study to survey and analyze 3,323 South Sudanese refugees, nationals, and Ugandan nationals between 1990-2000 to investigate the relationship between traumatic events and PTSD. Participants were questioned on their exposure to traumatic events "ever" and "in the past year", and differentiated between "experienced" and "witnessed" events (Karunakara et al., 2004). Prevalence of PTSD for South Sudanese refugees, nationals, and Ugandan nationals was 50%, 44%, and 21% respectively. Contrary to expectations, migration seemed to reduce PTSD, which the authors conjectured might occur because fleeing from violence may detract from the number of traumatic events experienced or witnessed (Karunakara et al., 2004). The refugee group also had the highest exposure to different types of traumatic events, including "ever" and "in the past year," and continued to report feelings of insecurity in Uganda (Karunakara et al., 2004). "Witnessed" events were more significant predictors of PTSD than "experienced" events, which the authors suggest may be due to refugees' feelings of insecurity compounded with the ongoing fear that such an event may happen to them, in contrast to experiencing a traumatic event and surviving (Karunakara et al., 2004). However, participants may have also misreported or underreported their experiences, claiming to "witness" rather than "experience" events, or not claiming them at all, due to their taboo or upsetting nature (Karunakara et al., 2004).

In a study of women's health and mental health amongst IDPs in South Darfur, one of the most populous states in the Republic of Sudan, Kim et al. (2007) found that women in displacement camps had a high prevalence of major depressive disorder, reaching 30%, and that up to 61% of all participants reported some feelings of depression, hopelessness, or feeling "down". Participants reported that suicide contemplation or attempts (by themselves or within their households) reached only around 2.5% prevalence, but the authors note that this frequency is much higher than international levels (Kim et al., 2007). Of the 390 women interviewed that met criteria for major depressive disorder, 381 (98%) responded positively to the idea of receiving counseling or aid from international organizations (Kim et al., 2007). The study did not use a validated survey.

Paardekooper, de Jong, & Hermanns (1999) explored the impact of war and the refugee experience on children, comparing South Sudanese refugee children in transit camps and settlements with local Ugandan children. Refugee children experienced significantly higher

quantities of torture (28%), separation from family (25.5%), and sexual abuse (9%) than their Ugandan counterparts (Paardekooper et al., 1999). Both groups of refugee children also reported higher numbers of stressors in daily life, less satisfactory social support, a variety of coping methods, and displayed a higher number of PTSD-like symptoms (trouble sleeping, behavioral issues, nervousness, and thinking about traumatic experiences) than the Ugandan children (Paardekooper et al., 1999). The study was unable to include psychopathology reports due to a lack of validated psychopathology questionnaires suitable for the population (Paardekooper et al., 1999).

Ayazi et al. (2015) conducted a cross-sectional study in South Sudan of both residents and recently returned migrants to understand perceived needs and any potential associations with mental health or functional impairment. Trained community members matching in gender to interviewees conducted the interviews; these interviewers were able to translate difficult concepts into tribal languages and protect the anonymity of participants (Ayazi et al., 2015). Results concluded that the correlation between stressful conditions and low mental health outcomes was stronger than that of traumatic event exposure and low mental health outcomes, and that being female is a higher predictor of psychological distress or PTSD symptoms (Ayazi et al., 2015). However, the study was limited by a relatively small sample size and a non-comprehensive list of traumatic experiences under review (Ayazi et al., 2015).

Extreme variation in the prevalence of mental health disorders found across these studies may be due in part to different methodologies or a shortage of culturally validated assessment tools, but researchers and practitioners must remember that even the lower percentiles of these estimations still represent tens of thousands of refugees in need of mental health care (Lambert & Alhassoon, 2015).

Local and Cultural Understandings of Mental Health, Concepts of Trauma/Loss, and Concepts of Self

Mind, body, and community are the essential and undeniably interwoven concepts that make up the base of South Sudanese concepts of self as well as concepts of mental health and well-being (Coker, 2004, Peter C. Alderman Foundation, 2015, Tempany, 2009). Although these concepts are at odds with Western interpretations, the amalgamation of these elements combines seamlessly to explain the refugee experience of South Sudanese.

Coker (2004) conducted group and individual interviews with South Sudanese refugees living in Cairo, Egypt, during a 1-year period in order to determine the underlying causes of many somatic symptoms the population presented at local clinics. Coker's conclusions revealed the complex manner in which the South Sudanese physically experience their mental and social traumas. Although physical symptoms differed, many refugees described pains, illnesses, or burning sensations traveling through their bodies, often disappearing for years before returning, that mirrored their experiences of migration (Coker, 2004). The refugees also used 'embodied metaphors' to explain their suffering. The heart, often the final resting place for traveling pains and illnesses, was seen as a particularly significant embodiment of a loss of culture and identity, and some refugees described having wounded hearts, or strong hearts when a sense of family stability and community was maintained (Coker, 2004). Blood and blood relationships tied into the concept of being human, and refugees who felt their humanity was unrecognized or that they were poorly treated by Egyptians often described feeling as

though the Egyptians saw them as being 'bodies without blood' (Coker, 2004). Lack of freedom as refugees in a foreign country and restrictions on expressing culture were experienced as a physical inability to move, and was often associated with *rotuba*, or a form of rheumatism that left refugees feeling unable to breathe (Coker, 2004). The study also revealed that many refugees were cognizant of their psychological distress and described symptoms of 'thinking too much', anger, guilt, loneliness, and anxiety as being synchronous with their physical ailments, if not unique sicknesses unto themselves (Coker, 2004).

In a comprehensive literature review of the mental health of South Sudanese refugees, Tempany (2009) found reports of somatic symptoms similar to those of Coker (2004). The study confirmed findings that the South Sudanese concept of self did not distinguish between mind and body, and refugees described emotions of anger and irritability with metaphors such as 'boiling/on fire stomachs', translated the word 'mind' as 'heart', and described a 'hunger' in their blood when thinking about relatives who were suffering, reaffirming the connection between kin, humanity, and blood described by Coker (Coker, 2004, Tempany, 2009).

Local perceptions of mental health summarized in a more recent literature review by the Peter C. Alderman Foundation (2015) confirmed a strong community-focused identity shared by South Sudanese refugees, as well as the use of physical metaphors for suffering. Refugees in the reviewed studies commonly described 'thinking too much' or 'jinn' as a source of psychological distress, and understood mental illness to be caused by curses, punishment for sins, or as the result of a breakdown in family support or stress from the ongoing conflict (Peter C. Alderman Foundation, 2015). Symptoms of mental illness could include changes in behavior or attitudes, social isolation, lack of an appetite, alcohol abuse, and poor sleep (Peter C. Alderman Foundation, 2015). Although commonly described with words such as 'crazy', 'bad', or 'without value', different tribes amongst the South Sudanese often had native words to describe different types of mental health conditions, which reflected, but also mixed, characteristics of Western mental health diagnoses (Peter C. Alderman Foundation, 2015). Such syndromes were often categorized through aggressive or strange behavior, becoming sad, suicidal and socially isolated, having many thoughts, and self-neglect (Peter C. Alderman Foundation, 2015).

Daily Stressors

Research indicates that, independent of past traumatic events, daily stressors and high levels of needs or social stress are correlated with low mental health outcomes amongst South Sudanese refugees and IDPs (Ayazi et al., 2015, Tempany, 2009). In a 2012 survey of perceived needs and psychological well-being of South Sudanese residents and returnees, Ayazi et al. found that many interviewees shared common needs of access to drinking water, sanitation (toilets), food, and education, and were concerned with rates of alcohol and drug use in the community (Ayazi et al., 2015). Higher levels of these perceived needs were predictors of both psychological distress and lower levels of functioning, with some differences between genders, ages, and location (Ayazi et al., 2015). For men, higher numbers of perceived needs and higher amounts of exposure of traumatic events were predictors of lower physical functioning, but traumatic event exposure itself was not a strong predictor of psychological distress, unlike high perception of needs (Ayazi et all, 2015). Women also presented a strong correlation between high perceived needs and psychological distress, but not exposure to traumatic events and psychological distress, while both exposure to traumatic

events and higher numbers of perceived needs predicted lower physical and mental functioning (Ayazi et al., 2015).

Tempany (2009) found that in addition to traumatic events, post-migration daily stressors were significant predictors of low mental health outcomes, and included non-material stressors such as the loss of loved ones and community leaders, security issues, feelings of hopelessness, and dependence on aid. In a study of PTSD prevalence amongst Sudanese nationals, refugees, and Ugandans, Karunakara et al. (2004), found that the likeliness of PTSD decreased with the presence of salaried jobs, education, and material possessions. Kim et al. (2007) reported that female IDPs in the Darfur region of the Republic of Sudan explicitly expressed a desire for security, basic needs, education, and healthcare to assist in their psychological health, reaffirming that daily stressors are considered by the South Sudanese as key to mental health. However, Neuner (2010) cautions prioritizing relief of daily stressors over mental health interventions, emphasizing that these correlations do not indicate direction of cause, and that psychological conditions may very well be the driving forces behind stressors such as poverty or unemployment.

Many current South Sudanese refugees in settlements in Uganda may be facing unemployment, loss of loved ones (including lack of closure on loved ones' status), insufficient water supply, poor or nonexistent shelter, poor sanitation, health issues, and hunger/poor nutrition (Luster et al., 2009, UNHCR, 2016b, Peter C. Alderman Foundation, 2015). Resources in Uganda have become highly strained as refugee numbers have swelled to over a million while international funding has simultaneously fallen far short of need (Obwot, 2017, Okiror, 2017). In May of 2017, the WFP was forced to cut refugee rations in half in Ugandan resettlements after receiving only $49 million in funding support of a need of $109 million (Obwot, 2017). The following month, the United Nations requested $2 billion in aid for the crisis and received only $350 million by July 2017 (Okiror, 2017). Faced with insufficient support, some refugees have reportedly been caught stealing animals and vegetables from locals, furthering concerns over future clashes and sources of tensions (Obwot, 2017). The Ugandan government spent over $323 million on refugees in the 2016-2017 year, totaling 46% of the country's annual education budget and 62% of health spending, pushing many Ugandans to feel that their government is prioritizing refugee care over its own citizens (Okiror, 2017).

<u>Help-Seeking Patterns, Coping Systems, and Support Systems</u>

Help-seeking patterns utilized by South Sudanese are frequently determined by the perceived cause of distress or illness (Peter C. Alderman Foundation, 2015). Syndromes thought to stem from supernatural causes may be addressed through traditional healers, while natural causes might indicate the need for medical attention (Peter C. Alderman Foundation, 2015). Difficulties in addressing psychological distress may arise from these patterns, given that poor mental health is often conceptualized as a supernatural problem, leading patients to seek aid from traditional healers and "witch doctors" rather than presenting at health centers (Peter C. Alderman Foundation, 2015).

South Sudanese culture strongly engages community support as a coping method when individuals experience distress, including seeking support and advice from family members, religious leaders, elders, and neighbors (Coker, 2009, Luster et al., 2009, Peter C. Alderman

Foundation, 2015, Tempany, 2009). Comfort may be found in communal experiences of loss and suffering, as well as gaining perspective through seeing the more extreme suffering of others and focusing on wishes and hopes for the future (Luster et al., 2009, Peter C. Alderman Foundation, 2015, Tempany, 2009). Many South Sudanese refugees also report finding solace in religion and praying, or find meaning in their survival (Luster et al., 2009, Paardekooper et al., 1999). Social support in particular was found by Tempany (2009) to be significantly predictive of higher mental health wellbeing and essential to a higher quality of life, leading to increased resiliency. Luster et al. (2009) suggest that South Sudanese culture also has a lower dependency on 'mastery', or the need to be in control of one's situation, allowing refugees to let go of their negative experiences.

South Sudanese refugees are also known to cope with, or stifle, their experiences of trauma in privatized manners. Young resettled male refugees experiencing multiple traumas and relocations in Luster et al.'s 2009 study reported coping through avoidance or distraction from their situation. Other studies have shown the use of suppression and stoicism to avoid dwelling on problems, in addition to maintaining 'silence', particularly in cases of female rape, which remains taboo to discuss in public (Paardekooper et al., 1999, Peter C. Alderman Foundation, 2015, Tempany 2009).

Need for Mental Health Interventions

The potentially severe burden of psychological distress on South Sudanese refugees from trauma exposure and daily stressors merits a concentrated effort for intervention by governmental and non-governmental organizations alike. Although South Sudanese concepts of mental health differ from those of Western nations, and therefore diagnoses of conditions such PTSD and depression may not be entirely applicable to South Sudanese refugees (Coker, 2004, Pacione et al., 2013, Tempany, 2009), ignoring low mental health outcomes may negatively affect the functioning and productivity of the population (Ayazi et al., 2015). Furthermore, Coker (2004) has shown that the interwoven nature of the mind and body in South Sudanese culture inhibits the effects of medical treatments targeting only physical symptoms. Failure to address psychological distress could result in perpetual somatic pains and illnesses for refugees.

Similarly, negligence of psychosocial treatments for children may predict long-term negative consequences for health. Symptoms of psychological distress in children can include anger and aggression, nervousness, and delayed cognitive development (Paardekooper et al., 1999, Pacione et al., 2013). The UNHCR estimated in June 2017 that 63% of the 1.93 million South Sudanese refugees resettled into neighboring countries are between the ages of 0-17 (UNHCR, 2017a). Simply stated, this implies that 1,215,900 youths may be at risk for growing up with poor cognitive development or tendencies for aggressive and risky behavior. Unaccompanied minors may be especially disadvantaged as they lack the familial support system proven to be central to South Sudanese culture and coping methods (Coker, 2004, Luster et al., 2009, Pacione et al., 2013, Peter C. Alderman Foundation, 2015, Unterhitzenberger, Eberle-Sejari, Rassenhofer, Sukale, Rosner, & Goldbeck, 2015).

Tackling these pressing needs remains a challenge for the Ugandan government, which was reported to channel only 1% of health care expenditures towards mental health in primary care in 2014, and in the same year reported 136 staff members working in mental health inpatient

care and 266 in mental health outpatient care (Peter C. Alderman Foundation, 2015, WHO Mental Health Atlas, 2014). Primary healthcare doctors are licensed to prescribe psychotherapeutic medicines, while nurses may diagnose and treat psychological disorders, and their training theoretically expands opportunities to access mental health care, but realistically most mental health services can only be found in urban areas (Peter C. Alderman Foundation, 2015). Furthermore, Uganda's current legislation towards mental health, the Mental Health Act, has not received updates since 1964 and lacks politically correct language as well as human rights protections for those suffering from mental illness (Peter C. Alderman Foundation, 2015, WHO Mental Health Atlas, 2014). Private sector and non-governmental organizations work to fill in the gaps left by government-provided care by offering an array of services ranging from support groups and counseling to psychoeducation and referrals, but need remains high (Peter C. Alderman Foundation, 2015).

II. SECTION II – LITERATURE REVIEW

In March 2017, a literature review was performed to seek to answer the question, "What are the best practices for mental health and psychosocial support for children and adolescent refugees?". Criteria were set for this search, which included: selection of key terms (Figure 1), selection of four databases, and inclusion and exclusion criteria. The review initially produced 4,584, after duplicates were removed, and after a multi-level review process using three people, 21 articles were approved for inclusion. Grey literature was also added into this review, and seven additional articles were included. The 28 articles were reviewed and described below. A PRISMA Flow Chart was created to outline this process (Figure 2). A literature review matrix with all studies included was created to organize and present the findings; a quality review which was completed on each study that met inclusion criteria (Table 1).

OBJECTIVES

Research Question
What is current research on best practices for para-professionals providing mental health care and psychosocial support services for children and adolescent refugees and internally displaced persons?

Research Aims
In order to address the critical gaps in current knowledge, this descriptive literature review has the following aims:

1. Review the current body of research on mental health care and psychosocial support services for children and adolescent refugee and internally displaced persons (IDP), specifically children;
2. Determine mental health and psychosocial support program models;
3. Identify type of care according to the Inter-Agency Standing Committee Pyramid;
4. Review intervention outcomes; and
5. Identify barriers to care and service implementation.

METHODS

Inclusion & Exclusion Criteria

Type of Studies
A number of study types were included in this review in order to encompass the full body of literature. Study types integrated in the inclusion criteria included, but were not limited to: randomized control trials (RCT), controlled clinical trials, observational studies, cohort studies, and mixed method studies. Studies were limited to the English language.

Types of Participants
Participants were limited to children and adolescents receiving mental health services or psychosocial support services and classified as living in refugee settlements/camps or IDP.

The WHO definition of children and adolescents (under the age of 19) was used to categorize the parameters of the participant's age (WHO, 2013). Participants were not limited by country location.

Types of Intervention
All psychosocial and mental health interventions with focused research studies were included in the inclusion criteria.

Types of Comparator
There was no comparator, given that this literature review was a descriptive review.

Types of Outcome
All intervention outcomes were included in the inclusion criteria.

RESULTS

Summary of Main Findings

The literature review accompanies the desk review and mental health needs assessment of Uganda's South Sudanese refugee response, which was implemented, from March - November 2017. The literature review aims to identify best practices for para-professionals providing mental health and psychosocial care for adolescents and children in internally displaced and refugee settings. The literature review's focus was to investigate best practices in MHPSS. There were 4,584 journals initially selected based on exclusion and inclusion criteria using four different academic search engines and grey literature was added, but after an abstract review and a full review of the literature 28 journals were selected. Information was extracted from the 28 articles including: models of care delivery; program interventions; research methodology and tools used; intervention outcomes; limitations and barriers; types of care, participants, and location; additional findings; and future suggestions. Reviewers used an assessment tool to assess the quality of each article. A discussion about the overall findings and conclusion discusses what can be learned from the literature reviewed.

Location, Participants, and Population
The articles reviewed included studies spanning five continents and fifteen countries with the most in Africa. Six studies were conducted in Eastern Africa with two studies in Ethiopia (Betancourt, Yudron, Wheaton, Smith-Fawzi, 2012a; Falb et al., 2016) and four in Uganda (Betancourt, Newnham, Brennan, Verdeli, Borisova, Neugebauer, Bass, 2012b; Bolton et al., 2007; Ager et al., 2011; Onyut et al., 2005).

The study by Falb et al. (2016) took place over three years, not only in Western Ethiopia, but in the Democratic Republic of Congo (DRC) and Pakistan as well. However, the article only focuses on the interventions in the DRC and Ethiopia. The studies by Betancourt et al. (2012b) and Bolton et al. (2007) were both conducted in Internally Displaced Persons (IDP) camps near Gulu, Uganda. The study by Ager et al. (2011) was held in the Gulu and Amuru districts of Uganda and the study by Onyut et al. (2005) looked at refugee children of Somali origin in the Nakivale refugee settlement. The intervention by Gupta et al. (2008) was held in refugee camps in Sierra Leone. Six studies were performed in Western Europe, with England and

Germany as the only Western European locations reviewed (Dura-Vila et al., 2012; Ehntholt et al., 2005; Fazel et al., 2009, Ruf et al., 2010; Unterhitzenberger et al., 2015; Möhlen et al., 2005). Only one study was performed in Eastern Europe in Bosnia (Layne et al., 2008). Three studies were conducted in the Southeast Asia region (Annan et al., 2016; Huss et al., 2016; Tol et al., 2008). Of the four studies that took place in the Middle East, three were in Palestine (Thabet et al., 2005, Barron et al., 2013, Quota et al, 2012) and one was conducted in Lebanon (Nakkash et al., 2012). There were two studies conducted in Australia (Ooi et al., 2016; Quinlan et al., 2016). Five studies were held in North America, two in the United States (Kowitt et al., 2016; Schottelkorb et al., 2012) and three in Canada (Rousseau, Drapeau, Lacroix, Bagilishya, Heusch, 2005; Rousseau, Benoit, Gauthier, Lacroix, Alain, Viger, Moran, Bourassa, 2007; Rousseau, Beauregard, Daignault, Petrakos, Thombs, Steele, Vasiliadis, Hechtman, 2014). No studies from either Central or South America were reviewed.

The living situations of participants varied greatly by location. In seven of the studies, participants lived in refugee camps (Betancourt et al., 2012a; Betancourt et al., 2012b; Bolton et al., 2007; Falb et al., 2016; Gupta et al., 2008; Nakkash et al., 2012; Onyut et al., 2005). All of the refugee camps were located in Africa, with the exception of the Burj El Barajneh camp in Lebabon. In other studies, such as the one conducted by Ruf et al. (2010), refugee children and their parents had re-established themselves in other countries. The study by Unteritzenberger et al. (2015) was a unique case in which all six adolescent participants were URMs living in Germany. Five of the participants lived in child and youth welfare (CYW) facilities, while the sixth participant lived on his own in a CYW facility provided apartment.

Child and adolescent participants ranged in age from 3-19 years old. For many of the studies, children and adolescents were participants in the same studies. Ten of the studies included participants under the age of 10 (Annan et al., 2016; Dura-Vila et al., 2012; Fazel et al., 2009; Gupta et al., 2008; Rousseau et al., 2005; Ruf et al., 2010; Schottelkorb et al., 2012; Tabet et al., 2005; Ager et al., 2011; Tol et al., 2008). Only three studies had participants aged 18 years or older (Layne et al., 2008; Unterhitzenberger et al., 2015; Rousseau et al., 2007). The article by Huss et al. (2016) was a community study using adult and child aged Sri Lankan refugees; however, ages or other detailed descriptions of the participants were not mentioned. Annan et al. (2016) and Betancourt et al. (2012a) used adult primary caregivers in their studies. Both males and females were included in all studies, except for Falb et al. (2016), which included only females.

The ethnic backgrounds of the participants spanned multiple continents and several countries. Participants were from African, Asian, European, and North American countries. Specific populations represented include Ugandan (Betancourt et al., 2012b; Bolton et al., 2007; Ager et al., 2011), Burmese (Annan et al., 2016; Kowittt et al., 2016), and Albanian (Ehntholt et al., 2005; Möhlen et al., 2005). The studies conducted in England, Canada, Australia, and Germany were all multi-ethnic. One of the studies conducted in the United States (Schottelkorb et al. 2012) had participants representing 15 countries. Some of the articles noted participant's religion. The study by Tol et al. (2005), had Muslim, Protestant, Hindu, and Catholic participants.

As inclusion criteria for our literature review, participants needed to be defined as refugee, displaced, or asylum seeking. Inclusion criteria for many of the studies included in this

literature review included participants being a refugee, having war or trauma exposure, being a certain age, living in an area for a specific amount of time, and meeting a particular score on various assessments that evaluate mental health conditions. Although each study has its own criteria, these were common themes throughout the articles. Layne et al. (2008) excluded participants who showed signs of psychosis or were a threat to themselves or others. Betancourt et al. (2012a) excluded participants who displayed suicidal ideation. Rousseau et al. (2007) had no exclusion criteria for their study.

In several of the reviewed studies participants had become refugees, displaced, or asylum seeking due to war exposure; however, this is not the case for all participants. In the study conducted by Fazel et al. (2009), refugees arriving to the United Kingdom from conflicted countries were compared with non-refugee ethnic minorities and indigenous white children. Participants in the study by Huss et al. (2016) were affected by either disaster or civil war. The study by Rousseau et al. (2014) gave no explanation as to why participants were refugees or had immigrated to Canada.

Models of Care Delivery

Of the articles reviewed, the majority of the program models were children's programs (N=12), followed by adolescent programs (N=10). However, the terms child and adolescent are used interchangeably in the other six articles; therefore, accurately quantifying the number of children's specific and adolescent specific programs is difficult. In addition to these two main program models, six other program models were used. Although only one program (Annan et al., 2016) was a parenting and family skills program, many of the articles did focus on parent/caregiver skills as part of the intervention (Möhlen et al., 2005; Ager et al., 2011; Schottelkorb et al, 2012; Unterhitzenberger et al., 2015). The article by Möhlen et al. (2005) was a psychosocial treatment program for both child and adolescent refugees. Whereas in the articles by Schottelkorb et al. (2012) and Unterhitzenberger et al. (2015) trauma-focused cognitive behavioral therapy (TF-CBT) was used as treatment. TF-CBT has components of parenting skills as well as child's skills. Unfortunately, the intervention by Schottelkorb et al. (2012) was unable to achieve the parental participation desired for their program. Betancourt et al. (2012a) studied the mental health of both adolescents and their caregivers. This study was unique because none of the other reviewed articles focused on the relationship between caregiver mental health and the effect on adolescents. Only one article was a community-based program (Huss et al., 2016), where the program held separate art therapy sessions for both adults and children.

Program Interventions

A total of twenty-eight interventions were analyzed. Ten were primarily school-based, while the remaining eighteen were based in various settings, including villages, refugee and IDP camps, and refugee centers. Both the ten school-based and the eighteen non-school-based interventions varied in type and population of intervention.

The ten school-based studies included six arts-based interventions and four non-arts-based interventions. The six arts-based studies were interactive and included a variety of techniques. The study by Quinlan et al. (2016) utilized Home of Expressive Arts and Learning (HEAL) creative arts therapy program, which encompasses arts, music, and dance activities, for an intervention with newly arrived refugee adolescents in Australia. Two of the six arts-based

studies are drama therapy programs (Rousseau et al. 2007, 2014), both conducted in Canada, which aim to improve mental health and academic performance of refugee and immigrant children and adolescents. Tol et al. (2008) used elements of both creative arts and psychoeducation techniques for an intervention in Poso, Indonesia. Rousseau et al. (2005) focus specifically on the migration process of refugee and immigrant children living in Canada, separating it from all of the other programs we analyzed. Finally, Ager et al. (2011) conducted a Psychosocial Structured Activities (PSSA) program, containing elements of drama, music, and art, in Northern Uganda.

The remaining four school-based interventions used a variety of program types. Ehntholt et al. (2005) used a cognitive behavioral therapy (CBT) program for asylum-seeking and refugee adolescents in London. Quota et al. (2012) conducted a teaching recovery techniques (TRT) program as an extracurricular activity on school premises in Gaza. Fazel et al. (2009) conducted a school-based mental health intervention in Oxford, England schools that focused on weekly consultation with key mental health workers. Layne et al. (2008) conducted a classroom based psychoeducation program in Bosnia, followed by Trauma and Grief Component Therapy (TGCT).

Of the remaining eighteen non-school-based studies, six are unique in including parenting skills attributes (Betancourt et al., 2012a; Unterhitzenberger et al., 2015; Annan et al., 2016; Möhlen et al., 2005; Falb et al., 2016; and Huss et al., 2016). Huss et al. is unique because it is an arts-based program for both children and adults. Betancourt et al. (2012a) focused on caregiver mental health and its effect on youth. Annan et al. (2016) focused only on parenting skills for their intervention in Thailand. Möhlen et al.'s intervention is a combination of individual, family, and group therapy paired with an arts based intervention for children. Falb et al. used the COMPASS program, which creates opportunities through mentorship and parental involvement. Unterhitzenberger et al. focused on both children and parenting skills using a TF-CBT for asylum seeking youth in Germany.

The final twelve non-school-based interventions focus exclusively on children or adolescents. Similar to Unterhitzenberger et al. (2015), Schottelkorb et al. (2012) used TF-CBT in their intervention, but focused only on children and compared TF-CBT and CCPT interventions; the only program of the sort. Similarly, Betancourt et al. (2012b) and Bolton et al. (2007) also ran two separate interventions for comparative purposes: an interpersonal psychotherapy group and a creative play group. Both the Ruf et al. (2010) and Onyut et al. (2005) studies used a form of Narrative Exposure Therapy called KIDNET, which is not quite interactive, but consists of multiple therapy sessions. Gupta and Zimmer (2008) similarly conducted a therapy program, rather than interactive arts program, consisting of structured and unstructured trauma healing activities, such as drawing, essay writing, and physical activities.

Like Quota et al. (2012), Barron et al. (2013) used a TRT technique in Palestine that is a form of CBT intervention. Thabet et al. (2005) uses what they define as non-active techniques, including drawing, free play, and storytelling. This study is unique because it is exclusively done in an area, Gaza Strip, with ongoing war trauma. Similar to other analyses, Kowitt et al. (2016) combine art therapy and therapy sessions for child refugees from Burma. Two of the final three articles are community based mental health interventions that rely on various elements of the adolescent's community to participate in the intervention (Dura-Vila et al.,

2012; Nakkash et al. 2012). The final intervention is unique in that rather than being a pure intervention, Ooi et al. (2016) institute a CBT program that is less interactive and meant more to be educational to assist children in understanding their symptoms and potential coping strategies.

Research Methodology and Tools Used

Only two of the studies reviewed were not clinical trials (Betancourt et al., 2012a; Huss et al., 2016). Ten studies were RCT (Ager et al., 2011; Barron et al., 2013; Layne et al., 2008; Qouta et al., 2012; Betancourt et al., 2012b, Bolton et al., 2007; Schottelkorb et al., 2012; Tol et al., 2008; Falb et al., 2016; Rousseau et al., 2014). Three of these RCT studies were clustered randomized control studies (Tol et al., 2008; Falb et al., 2016; Rousseau et al., 2014). The studies by Ehntholt et al. (2005) and Quinlan et al. (2016) did not use randomization. Eleven of the reviewed studies involved treatment and control groups (Ager et al., 2011; Barron et al., 2013; Bolton et al., 2007; Falb et al., 2016; Fazel et al., 2009; Ooi et al., 2016; Quinlan et al., 2016; Rousseau et al., 2014; Ruf et al., 2010; Thabet et al., 2005; Ehntholt et al., 2005). Nine studies had no control group (Möhlen et al., 2005; Onyut et al., 2005; Gupta et al., 2008; Kowitt et al., 2016; Rousseau et al., 2007; Rousseau et al., 2005; Unterhitzenberger et al., 2015; Layne et al., 2008; Schottelkorb et al., 2012).

Twenty-eight different scales were used in all of the reviewed studies. Scales were used to diagnose mental health conditions, assess symptoms, and measure severity. In studies, such as the one by Unterhitzenberger et al. (2015), scales were administered prior to the study to determine inclusion criteria. Other studies, such as Qouta et al. (2012), used different scales to assess symptoms and determine diagnosis as part of the study. The two most utilized scales were the Strength and Difficulties Questionnaire (SDQ) and the Depression Self-Rating Scale for Children (DSRS). The SDQ is used to assess emotional and behavioral problems and hyperactivity; ten studies used this scale (Barron et al., 2013; Qouta et al., 2012; Dura-Vila et al., 2012; Ehntholt et al., 2005; Fazel et al., 2009; Kowitt et al., 2016; Ooi et al., 2016; Quinlan et al., 2016; Rousseau et al., 2014; Rousseau et al., 2007). The DSRS is a self-report instrument used to assess the cognitive, affective, and behavioral dimensions of depression; six studies used the DSRS (Barron et al., 2013; Layne et al., 2008; Qouta et al., 2012; Tol et al., 2008; Ehntholt et al., 2005; Ooi et al., 2016). Four studies did not use scales (Ager et al., 2011; Falb et al., 2016; Huss et al., 2016; Nakkash et al., 2012). See Table 3 below for scale utilization.

Table 3: Intervention Instrument Scale Utilization

Scale Name	Scale Abbreviation, if applicable	Number of times Scale Utilized	Measures
Piers-Harris Children's Self-Concept Scale	CSCS	2	Self-perception
Children's Revised Impact of Event Scale	CRIES-13	3	Posttraumatic stress symptoms

Scale Name	Scale Abbreviation, if applicable	Number of times Scale Utilized	Measures
University of California Posttraumatic Stress Disorder Reaction Index for DSM-IV	UCLA PTSD Index	4	Trauma history and posttraumatic stress symptoms
Depression Self-Rating Scale	DSRS	6	Depressive symptoms
Peritraumatic Dissociative Experiences Questionnaire		1	Peritraumatic dissociation
Traumatic Grief Inventory for Children	TGIC	1	Traumatic grief
Impact on School Performance Scale	ISPS	1	Traumatic experiences impact on school performance
Strength and Difficulties Questionnaire	SDQ	10	Psychological distress
University of California Grief Inventory	UCLA Grief Inventory	1	Grief reactions
Exposure to War Stressors Questionnaire	EWSQ	1	Traumatic event exposure
Acholi Psychosocial Assessment Instrument	APAI	2	Depression-like and anxiety-like symptoms & conduct problems
Child Posttraumatic Stress Disorder Reaction Index	CPTSD-RI	1	Posttraumatic stress
Children's Depression Inventory	CDI	1	Depressive symptoms
Impact of Events Scale	IES	1	Posttraumatic stress symptoms
Harvard Trauma Questionnaire	HTQ		Posttraumatic stress symptoms
Child Psychosocial Protective Factors Scale		1	Sources of support, social skills, emotional outlook, self-esteem

Scale Name	Scale Abbreviation, if applicable	Number of times Scale Utilized	Measures
Diagnostic System for Psychological Disorders	DISYPS-KJ	1	Depressive and anxiety symptoms
Achenbach Child Behavior Checklist	CBCL	1	Behavioral problems
Clinician Administered PTSD Scale for Children and Adolescents	CAPS-CA	1	Posttraumatic stress
Posttraumatic Diagnostic Scale	PDS	2	Posttraumatic stress
Children's Global Assessment Scale	CGAS	1	Psychosocial functioning
Youth Self-Report	YSR	2	Behavioral problems
Child Posttraumatic Stress Scale	CPSS	1	Posttraumatic stress
Self-Report Anxiety Related Disorders 5-item version	SCARED-5	1	Anxiety symptoms
Children's Hope Scale	CHS	1	Hope
Children's Aggression Scale for Parents	CAS	1	Aggression
Hopkins Symptoms Checklist	HSCL	5	5 underlying symptom dimensions: somatization, obsessive-compulsive, interpersonal sensitivity, anxiety, depression
Parent Report of Posttraumatic Symptoms	PROPS	1	Posttraumatic stress

Table 3 provides a brief overview of the 28 different scales used, how many times the scale was used, and what the scales measured in the reviewed articles of the literature review to measure depressive, posttraumatic stress, and anxiety symptoms, as well as other indicators of psychosocial functioning in refugee and internally displaced children and adolescents.

Intervention Outcomes

In general, the overall findings of the 28 articles analyzed have a positive outcome. The interventions use a variety of clinical scales to determine the effectiveness on the psychosocial well-being of the participants, which synthesize well across the literature. In multiple interventions, gender is a determining factor of effectiveness. Bolton et al. (2007) found statistically significant improvements to depressive symptoms for girls only in their

interpersonal psychotherapy for groups (IPT-G) intervention, though changes to other psychological health indicators are not statistically significant. On the contrary, Qouta et al. (2012) found reduced clinical posttraumatic stress symptoms (PTSS) among boys, but not girls in their intervention. However, Betancourt et al. (2012b) found that gender was not a significant determinant of their intervention.

There are also differing outcomes in the externalizing and internalizing of problems by children. A variety of scales use externalizing and internalizing as outcome measures. The Achenbach Youth Self Report scale (YSR) is used across many of the interventions and defines externalizing as outward-directed behaviors such as hostility or aggression. YSR defines internalizing as inward-directed experiences of distress commonly in depression or anxiety. Annan et al. (2016) found statistical significance in reduction of externalizing problems, but no significance on internalizing problems. Rousseau et al. (2005) report lower mean levels of both internalizing and externalizing symptoms. Revisiting gender outcomes, Rousseau et al. (2005) also find the effect on self-esteem especially notable in boys. Betancourt et al. (2012a) conducted the only caregiver analysis we analyzed and found that caregiver distress is a robust predictor of children externalizing and internalizing emotional and behavior problems.

A remarkable amount of the interventions are effective in reducing PTSD in adolescents/children. Layne et al. (2008), Möhlen et al. (2005), Barron et al. (2013), Tol et al. (2008), Schottelkorb et al.(2012), Ruf et al. (2010), and Ehntholt et al. (2005) all observe reductions in PTSD resulting from their interventions. However, Ooi et al. (2016) do not observe a reduction in PTSD measures. Of the remaining interventions, eight of them find some form of effectiveness in their interventions. However, Thabet et al. (2005) and Rousseau et al. (2007, 2014) did not see significant differences. Falb et al. (2016) did not draw conclusions yet, as the intervention is still ongoing. The final two articles, Nakkash et al. (2012) and Kowitt et al. (2016) are process evaluations that do not have statistical outcomes to measure.

Quality Assessment

The quality assessment tool from Hawker et al. (2002) was used to appraise all articles. The tool evaluates nine aspects of an article: abstract and title, introduction and aims, methods and data, sampling, data analysis, ethics and bias, results, transferability and generalizability, and implications and usefulness. Scores of 1 (very poor), 2 (poor), 3 (fair), and 4 (good) are assigned to each of the nine areas. Lower scores indicate poorer quality of the article. The total maximum score is 36. None of the reviewed studies had a score of 36. The highest score was 34; 2 articles assessed received this score (Annan et al., 2016; Barron et al., 2013). Five articles each received a 30 and 27; these scores had the highest frequencies. The lowest quality article was by Huss et al. (2016), with a score of 22.

All articles were scored as good and/or fair for abstract, introduction and aims, and methods and data, with the expectation of Huss et al. (2016) who's abstract was poor due to missing components of the abstract, such as the results. Five articles were rated as either poor or very poor for sampling (Huss et al., 2016; Nakkash et al., 2012; Rousseau et al., 2005; Möhlen et al., 2005; Onyut et al., 2005). Four articles scored either poor or very for data analysis (Ager et al., 2011; Huss et al., 2016; Nakkash et al., 2012; Schottelkorb et al., 2012). Almost half

(N=13) of all articles reviewed scored either poor or very poor for ethics and bias. Only one of those articles was from the grey literature search (Qouta et al., 2012). Only two articles had poor or very poor results. The article by Falb et al. (2016) does not include results. The article by Huss et al. (2016) only discusses general themes from their art project.

The transferability and generalizability criteria for the quality assessment tool scores articles based on their generalizability to a wider population. Sampling and context to replicate or compare the study with other studies are taken into consideration for this criterion. The majority (N=20) of our articles did score high in this area. The study by Unterhitzenberger et al. (2015) only had a sample size of six and was given a score of two for transferability and generalizability. Implications and usefulness looks at the findings of the article. In order to have a higher score in this area, findings must contribute something new or different and researchers should discuss ideas for future research and suggest implications for policy and/or practice based on their findings. Eleven articles were scored as lower quality for implications and usefulness (Unterhitzenberger et al., 2015; Thabet et al., 2005; Ruf et al., 2010; Kowitt et al., 2016; Qouta et al., 2012; Huss et al., 2016; Möhlen et al., 2005; Rousseau et al., 2014; Rousseau et al., 2005; Rousseau et al., 2007; Onyut et al., 2005). The implications and usefulness criteria for the quality assessment tool scores articles based on their contribution to research and policy.

Limitations and Barriers

Most of the reviewed articles experience similar limitations. Because of the nature of psychotherapy, many of the interventions lacked a control group because of either ethical reasons or population reasons. Small populations led to difficulties in randomization and separation. When control groups were able to be implemented, the program directors expected that interactions between the intervention and control groups may have occurred, creating bias in the outcomes. Falb et al. (2016) were particularly concerned with this interaction of wait-list and intervention groups.

Furthermore, due to the nature of the interventions, heterogeneity across groups was a concern for a majority of the authors; both by having a lack of it or by having too much of it. Unterhitzenberger et al. (2015) were particularly concerned with the lack of heterogeneity in their sample size. According to them, “six cases can hardly represent the heterogeneity of the group of URMs [unaccompanied refugee minors]”. Likewise, other interventions were concerned with too much heterogeneity in their sample sizes. Betancourt et al. (2012b) cite “great heterogeneity within the groups assessed (male subjects, female subject, abducted and nonabducted youth)” as major barriers.

Operational difficulties often limited the scope of the interventions, particularly in those located in ongoing conflict areas, such as Bolton et al. (2007). Because of ongoing conflict, lack of infrastructure, and huge sample losses over time, interventions were unable to be fully implemented in many cases. Lastly, perhaps the two most significant limitations/barriers across the interventions were the lack of sample size and the inability to conduct long-term follow-ups. Nearly every group of authors is concerned with the inability to draw substantial long-term conclusions.

Types of Care
All of the articles were examined against the IASC intervention pyramid for mental health and psychosocial support to determine what type of care each of the interventions focused on (IASC, 2012). At the base of the pyramid are basic services and security, followed by community and family supports, focused non-specialized supports, and at the top, specialized services. A brief description of each layer of the pyramid is provided. The first layer, basic services security, advocates for basic services delivered in a safe, socio-culturally appropriate way. The second layer represents people who are able to maintain their mental health if they have access to community and family support systems, such as social networks, support groups, and educational activities. The third layer represents people who require a more focused level care, such as basic mental health from primary care physicians or support from other trained workers. The top layer represents a small portion of the population who require specialized mental health support, for severe conditions, from psychologists, psychiatrists, traditional healers, or other specialists.

Of the articles we reviewed, the majority (N=21) of the interventions fell into the third layer of the pyramid, focused non-specialized. In these articles, therapists, counselors, community workers, and other professionals trained in mental health provided mental health services. Community and family supports were the second most utilized type of care (N=4). Two of the articles focused on specialized services for their interventions (Onyut et al., 2005; Unterhitzenberger et al., 2015). In those two articles, clinicians treated posttraumatic stress in refugee children. One article (Dura-Vila et al., 2012) was both community and family support and focused non-specialized. None of the articles reviewed were basic services and security.

Figure 3: Types of Care IASC Pyramid

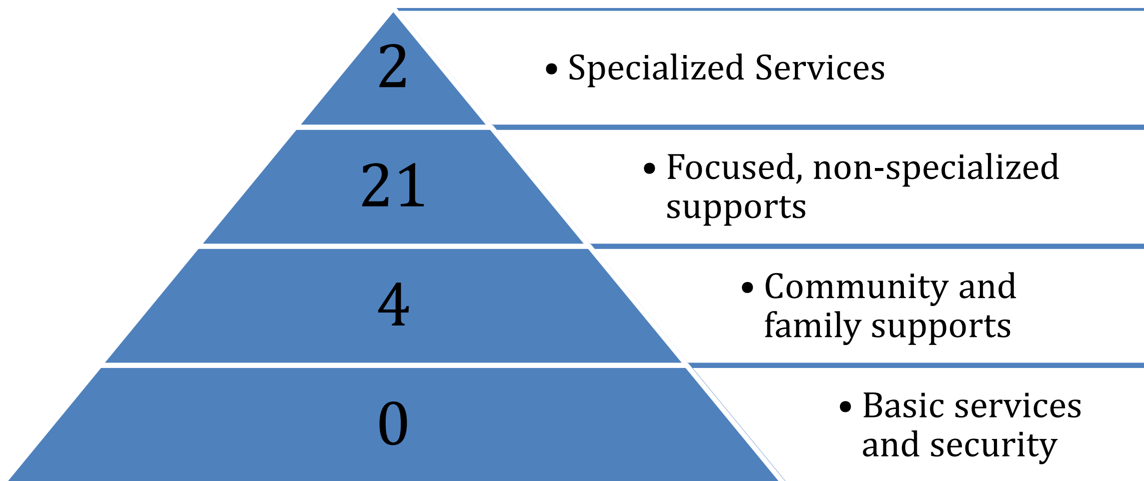


Figure 3 shows the type of care, using the IASC pyramid, that were utilized in the literature review. The pyramid shows 27 of the 28 articles represented. One article fell into both focused, non-specialized supports and community and family supports.

Additional Findings

Of the 28 articles analyzed, nearly all of them are able to draw significant conclusions about either the effectiveness of the interventions or the feasibility of the interventions. The findings section discusses significant outcomes, but the conclusions drawn are equally as important. Each of the interventions focused on psychosocial support, whether it be at the community, parent, or child level. Generally, there is a large amount of evidence that the interventions are helpful, but there are limitations to the effectiveness.

Thabet et al. (2005), one of the earliest interventions analyzed, concluded "such interventions may help engage children, but are not in themselves sufficient to reduce stress reactions". The findings of the intervention by Annan et al. (2016) suggest evidence-based parenting skills intervention can have positive effects on children's externalizing symptoms. Similarly, Betancourt et al. (2012a) conclude that family and other social support systems are critical to children's recovery from war stressors. The other differing articles are three process evaluations by Nakkash et al. (2012), Falb et al. (2016), and Kowitt et al. (2016). Each group of authors concluded that the interventions are feasible and realistic.

While many of the interventions draw strong conclusions, the two that stand out are Mohlen et al. (2005) and Qouta et al. (2012). Each of these interventions conclude that psychotherapy programs are useful in calmer times, but programs for severely traumatized patients or patients living in the midst of a war-zone are not effective. Qouta et al.'s psychosocial intervention enhances cultural activities as extracurricular activities on school premises by using a modified version of TRT, a commonly used intervention. Similarly, Mohlen et al. also use a psychoeducational approach, paired with individual, family, and group sessions.

The remaining 20 interventions all differ in participants, location, and specific intervention process, but nonetheless each set of authors conclude there is evidence that their psychosocial interventions are successful at some level and should continue to be used as a way to provide a chance at recovery for traumatized adolescents or children. These interventions include a variety of school-based and community-based programs that include characteristics such as drama, art, and music therapy.

Future Suggestions

Throughout the review, most of the authors had clear suggestions for future research. Of the 28, five of the articles lacked any clear suggestions. Of the 23 with suggestions, the most common was the inclusion of more and/or stronger measurement instruments to better analyze interventions. Layne et al. (2008) believe future studies would benefit from measures inclusive of a broader range of domains, such as measures of risky behavior, peer and family relationships, academic performance, and/or school behavior. Quinlan et al. (2016) encourage more qualitative elements to add depth, especially if the best practice develops into individualized approaches. Many of the articles attribute sample size as a distinct limitation and three focus on increasing sample size as their primary recommendation. Möhlen et al. (2005) recommended determining whether their intervention or other similar interventions can be carried out by local professionals to improve the cost-effectiveness of widespread implementation in the future. The other most common recommendations were to focus on longer term follow-up periods and inclusion of wait-list/control groups. Unterhitzenberger et al. (2015) recommend both of those for future research on their intervention. The most unique

suggestion comes from Bolton et al. (2007), who suggest differing interventions for boys and girls because their findings were only significant for one gender.

DISCUSSION

Comparison to Other Studies/Reviews

In this literature review, we examined mental health based interventions for refugee, asylum seeking, and internally displaced children and adolescents. The interventions were largely successful in both improving psychosocial functioning and reducing PTSD, depression, and behavioral problems. Studies with treatment and control groups consistently showed greater reductions in depression and distress symptoms and greater improvement to psychosocial behavior within the treatment groups. Schottelkorb et al. (2012) and Thabet et al. (2005) did not produce statistically significant results overall; however, their interventions decreased PTSD (Schottelkorb et al., 2012) and depressive reactions (Thabet et al., 2005). The majority of school-based interventions effectively reduced posttraumatic stress and decreased behavioral difficulties. These findings indicate that school-based interventions are feasible in low-resource settings and are appropriate for war-exposed youth (Tol et al., 2008; Ager et al., 2001; Layne et al., 2008; Qouta et al., 2012).

Arts-based, drama-based, and play-based therapies effectively reduced posttraumatic stress and depression in most of the studies reviewed. The studies by Rousseau et al. (2014) and Rousseau et al. (2007) used art and drama therapies; however, there were no reported improvements or reductions in emotional or behavioral symptoms. Both articles discuss that their interventions were limited to short-term outcomes, which may be why their findings do not reflect greater improvements to adolescent mental health. Interventions involving parenting skills demonstrated that parental involvement and social support are beneficial to improving child and adolescent mental health. These findings are consistent with Annan et al.'s (2016) and Betancourt et al.'s (2012a) studies and research by Schottelkorb et al. (2012). Gender played a critical role in the outcome of several of the reviewed studies. In the studies with gender significance, girls benefitted more from the interventions (Tol et al., 2008; Bolton et al., 2007; Betancourt et al., 2012b). It is important to note that in some of these studies girls only benefit more under certain conditions. The intervention by Betancourt et al. (2012b) was most effective for war-exposed girls without a history of abduction, whereas males without an abduction history benefitted the least from their intervention. Qouta et al. (2012) found girls benefitted from the intervention if they had low peritraumatic dissociation, but overall, boys had significant reduction in posttraumatic stress. Previous research concludes girls are more likely to suffer from PTSD and depression than boys (Qouta et al., 2012). Quota et al. (2012) discuss specifically how their intervention goes against previous research, including Bolton et al.'s (2007) study, which indicates that girls may benefit more from psychosocial help.

Completeness and Quality of Evidence

The quality of the reviewed articles were, generally, good. All articles were reviewed while simultaneously evaluating the Hawker et al. (2002) quality assessment tool. The two highest rated articles using the quality assessment tool were Annan et al. (2016) and Barron et al. (2013). Both articles scored a 3 (fair) for transferability and generalizability. Per the quality

assessment tool, in order for an article to receive a good rating (4), sufficient context for study replication and external generalizability are needed. Barron et al. (2013) also received a 3 for implications and usefulness and Annan et al. (2016) received a 3 for data analysis. Many of our studies were not rated well for transferability and generalizability. This is largely due to small sample sizes and heterogeneity of participants. Unterhitzenberger et al. (2015) addresses both of these issues. That study only had six participants who were all unaccompanied refugee minors (URMs) living in Germany. Participants ranged in age from 16-18 years old and four of the six participants were from Afghanistan. Although the intervention was significant in reducing posttraumatic stress, these results are not generalizable and these participants are not a representative population of URMs. Despite the intervention not being generalizable, the article is worth reviewing because it adds to current literature about treating mental health in URMs.

Potential Biases

A major potential bias in our articles is interaction between control and intervention groups. With small sample sizes, participants living in the same communities, and participants attending the same schools, it is possible that interaction occurred. Many of the school-based programs were multi-ethnic and the majority of our participants were refugees, asylum seekers, or immigrants. All programs need to be verified for cultural appropriateness. Falb et al. (2016) identified social desirability as a potential bias. These researchers hope that using Audio Computer Administered Self Interviews (ACASI) will reduce this bias, as interviewers will not know participant responses. Selection bias may be present. Many of our studies were not randomized and participants were selected and recruited for some of the studies (Dura-Vila et al., 2012; Kowitt et al., 2016). Loss to follow up is a major bias for the reviewed articles. Participants in the studies are refugees, URMs, IDP, and asylum seeking, which means many participants do not have permanent resident status in the countries where they reside. Ongoing conflict may also result in relocation or inconsistent participation in interventions. Another bias is in the ability to actually administer the program. Nakkash et al. (2012) reported program instructors did not follow guidelines. Kowitt et al. (2016) found similar problems in instruction delivery, but also reported challenges with instrument administration and analyzing data.

III. SECTION III - INFORMATIONAL SITE VISITS & INTERVIEWS

METHODS

Tools

The document *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for humanitarian settings* and *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* was used as a guideline to gather qualitative information (IASC, 2012). IASC, 2012 interview and free listing tools were used as guide for interviews (IASC, 2012). All tools were presented to cultural representatives and community stakeholders for cultural adaptation and approval prior to utilization, though minimal adaptation was suggested.

Population

The interviewers of this report attempted to access a diversity of populations within the South Sudanese settlements in Uganda. Due to the large population of refugees, government, and non-government organizations, the interviewers were limited to available groups and populations within three settlements in Uganda's West Nile Region (Bidi Bidi, Rhino Camp, and Adjumani) and one settlement in Uganda's Western Region (Kiryandongo). The interviewers asked most of the interviewees about mental health issues, resources, and gaps specific to adolescent females. Community and stakeholder's suggestions led the focus of this project on gaps of care specific to adolescent females. Interviewers were informed that adolescent females are considered the most vulnerable group in this population and are therefore of most interest to focus on.

The interviews were conducted inside and outside of the settlements. The following individuals were interviewed using the interview guides as a framework: representatives of the Ugandan Office of Prime Minister, the UN Refugee Agency, and local and NGOs working in the settlements, community leaders, and adolescent females. The free listing exercise was used with the following individuals and groups: adolescent females, the Danish Refugee Council's (DRC) community volunteers, and DRC staff working within their adolescent girl program. Group size would range from two female adolescents to eighty female adolescents and their mentors. It is difficult to gauge in all how many were interviewed due to the sizes of the groups.

Analysis

Topics from conversations with mentors and adolescents were transcribed. The information was categorized into one of five categories: (1) resources, (2) mental health issues and behaviors, (3) issues faced, (4) needs, and (5) other. The topics were also organized under by who said it, which was categorized as adolescent, mentor, or group, and what settlement they were speaking about. Once transcribed and sorted, total frequencies of categories and topics were reported for the results.

RESULTS

Resources

Resources within this topic are defined as resources available to the refugees within their settlements. The three themes are: (1) human resources in community, (2) resources within self, and (3) programs and trainings. In total resources were mentioned 115 times in the interviews. Table 1:1 shows the total times mentioned under each category. Table 1:2 shows the topics that fell under one of the three categories.

Table 1:1: Frequency of Resources

Resources within Self	Human Resources in Community	Programs & Training
35	40	40

Table 1:2: Topics Under Resource's Themes

Resources within Self	Human Resources in Community	Programs & Training
o Laugh o Story Books o Tell Stories o Be alone/rest o Cool down and think about it o Pray o Talk humbly o Be alone/rest o Sports o Writing poetry o Songs o Play games o Dance o Songs o Radio o Play o Emotional support o Drama o Culture is important o Safe Space	o Mentors o Church/church leaders o Loved Ones o Friend Relationships o Community Leaders o Parent Involvement o Adolescents are encouraged to be ambassadors o Educated refugees o Community leads programming o Social Network	o Vocational Training o Training Programs o Counseling o Education o Early Childhood Development Center o Social Action Group o Group programs o Teaching self esteem o Public awareness (use community structures) o Group counseling o Multi-organization collaboration o Counseling programs o Mentors know how to give advice/refer o Mentors begin to forget their own trauma while working o Counseling has taught her to say no o Mentors counsel (hygiene, self-care, safety, etc.)

Mental Health Issues and Behaviors

Mental health issues and behaviors are defined in this review as when issues specific to mental health or adverse behaviors were mentioned by interviewee. The three themes in this area included: (1) stress symptoms, (2) social issues, and (3) emotional and psychological issues. In total topics under this theme were mentioned 213 times. Table 1:3 shows the total each theme was mentioned, and Table 1:4 shows the topics under each theme.

Table 1:3: Frequency of Mental Health Issues and Behaviors

Stress Symptoms	Social Issues	Emotional and Psychological issues
33	111	69

Table 1:4: Topics Under Mental Health Issues and Behaviors

Stress Symptoms	Social Issues	Emotional and Psychological Issues
o Overthinking/worry o Stress o Thinking of returning to South Sudan o Physically sick because of stress o Lose weight (can't eat, not enough food) o Start fights o Nightmares o Can't sleep o Intrusive memories	o Not respecting elders o Poverty o Quarrels at home/domestic violence o Physical disability o Idleness and unemployment o Family separations o Single parent/caregiver o Head of household o Child mothers o Night discos o Unaccompanied minors o Neglect o Early marriage o Love affairs o Lost husband o Beat or want to kill children out of stress o Child labor o Children run away o Don't care/don't do anything o Fighting o Sexual abuse o Isolation o Giving power/taking power o Child abuse o Saw violence and parents killed o Family is still in South Sudan o Boys give them little money o Sex for money	o Grief o Drug abuse o Risky behaviors o Angry o Sad o Crying o Quiet o Mentally disturbed o Hurting/feel Bad o Hard to do daily activities o Feeling left behind o Suicide o Hate everyone/disrespect o Suffering o Not happy o Tired o Guilty o Afraid o Trauma o Pain in heart o Frustrated o Depression o Psychological problems o Over drinking o Forget to play o Denial o Emotional abuse

	○ Children are brought up very bad ○ Dropout rate is high ○ Mentors also have lost people ○ Moving at night is dangerous ○ Did not know what adolescence was/body has changed ○ Dreaming about marriage ○ Too much sleeping ○ No support	

Issues Faced

Issues Faced are defined in this review as all issues refugees face outside of mental health and behavioral issues. The themes included: (1) basic needs, (2) social issues, and (3) lack of training/education. In total topics under this category were mentioned 126 times. It should be noted, though, that both interviewers reported that they did not record each time basic needs were brought up due to the high frequency they were mentioned, so it should be noted that basic needs should have a significantly larger frequency. This has been included in the report as more of a summary to highlight the identified issues faced rather than the specific number/frequency. Table 1:5 shows the total each theme was recorded, and Table 1:6 shows the topics under each theme.

Table 1:5: Frequency of Issues Faced

Basic Needs	Social Issues	Lack of Training/Education
93	26	7

Table 1:6: Topics Under Issues Faced

Basic Needs	Social Issues	Lack of Training/Education
○ No Food ○ Water ○ Education ○ Food ration delays ○ Lack of sanitary items/body care ○ Lack of clothing ○ No lights ○ No food in programs ○ Core relief ○ Medical ○ Basic needs ○ No money ○ Firewood ○ Need house shelter	○ Orphan ○ Head of household at early age ○ Guardian is mean ○ Gambling in community ○ Lack of market ○ Lack of capitol ○ Children are not supported ○ Child labor ○ Population is too big ○ Women and men are left behind in services ○ Parental guidance ○ Lack of freedom of expression ○ Moving around community ○ Family needs support too	○ No books ○ Mentors struggle to reach out to families ○ Mentors don't have skills to speak to families ○ Mental health is not considered a priority

○ Land ○ Money ○ Lost items from past life ○ Sleeping on carpet ○ Minimal options for future ○ Breast feeding ○ No materials ○ Menstruation and lack of education on it	○ Not easy ○ Parents disabled ○ Used to make local brew ○ People are not willing to participate 50/50 ○ Language barrier ○ Some culture and religion is harmful	

Needs

Needs are defined in this report as a stated need based on gaps of services within the settlements. The themes are: (1) basic needs, (2) skills needed, and (3) other. The total topics under these themes were mentioned 46 times. Similar to basic needs, interviewers did not rigorously record every time basic needs that was mentioned, so it should be noted that basic needs most likely were mentioned at a significantly larger frequency. Table 1:7 shows the total recorded frequency under each theme, and Table 1:8 shows the topics within each theme.

Table 1:7: Frequency of Needs

Basic Needs	Skills needed	Other
8	33	5

Table 1:8: Topics Under Needs

Basic Needs	Skills Needed	Other
○ More food ○ School ○ School supplies ○ Soap ○ Basic needs ○ Shelter	○ Parental support ○ Child protection ○ One organization can't do everything ○ Need more training ○ New mentors need training ○ Basic counseling skills ○ Special support services ○ Mental health care ○ Advanced care ○ Coping skills ○ Psycho-education ○ Mentors need more training ○ Mentors need listening skills and to talk less ○ Mentors need to learn not to make decisions for adolescents ○ Mentors need to be calm and patient ○ Mentors need learn how to approach someone upset ○ Mentors need how to make someone calm ○ Mentors need how to talk to a person to help them calm down ○ Programs that empower communities ○ Mentors need knowledge about emotions, to see them	○ Sports ○ More payment ○ Mental health needs

	o Mentors need to know resources and leadership	

DISCUSSION

Resources

During the interviewing and free listing exercises, resources were discussed frequently. The adolescents were the ones to mostly highlight the resources within themselves. The interviewers noted that the adolescents would appear to get animated when speaking about doing activities that they enjoyed, which included drama, singing, playing ball, listening to the radio, etc. When discussing the resources within the community and the programs and training, the groups and individual interviewees spoke on the current resources, but they noted that there wasn't enough for everyone and all resources were very limited. The interviewees mentioned that there were many qualified refugees, but they needed a role and payment.

The majority of the residents that were interviewed were associated with the DRC adolescent mentoring program, so there is a bias evident due to the roles and training of the mentors interviewed and the adolescent females who were receiving supportive programming, but it was evident in the interviews that there are strong human resources within the settlements, and while some individuals carry roles as community volunteers and mentors, there is a limit to their capacity due to finances, limited educational and vocational opportunities, and further skill development. The discussion of resources also appeared synchronistic with the background review in this report about the cultural importance of community. There was a focal point on the importance of community, even within resources within self, where most activities highlighted focus on community.

Mental Health and Behavior Issues

The discussion of mental health and behavioral issues tended to follow after in depth discussions of basic needs and education. The interviewees appeared to put emphasis on the severity of the issues. Behavioral issues like early marriage, pregnancy, going to discos, child labor, and alcoholism were connected back to issues like no access to education, child abuse, and females seeking basic needs through finding men to take care of them.

Adolescent females spoke about troubles with over thinking, isolating themselves, hitting their children due to extreme feelings of anger, and having trouble with performing daily tasks due to intrusive memories or overwhelming sadness. Thoughts of suicide, running away, and over drinking were mentioned frequently, and unaccompanied minors stated that they felt guilty being in someone else's home and were mistreated by their caregivers. Metaphors like "pain in heart" were used to describe their emotions, which correlated with this report's background research (Coker, 2004). Mentors stated that when an adolescent is in distress they are silent and won't speak or speak fast but don't make sense.

Issues Faced

The interviewees predominantly focused on issues about not receiving their basic needs, which included water, food, shelter, farming, no money, etc. Social issues were also

frequently spoken about. There were many adolescents who were unaccompanied minors within the interviewed groups, and they spoke to their need for familial or community support for logistics and emotional needs, which was not being met. There was a major theme of separation from family, community, and culture due to being refugees. Mentors and adolescents spoke about the issue of idleness and not having anything to do, which they attributed to increased risky behavior and potential abuse. Mentors spoke about needing more mental health training. They stated that they did not feel confident in their skills to support the trauma healing of the children and adolescents or how to approach family members.

Needs

The discussion about needs had a large focus on basic needs and education. Mentors spoke predominantly about training and program needs for psychosocial and mental health support. This includes empowerment programming, basic counseling skills, child protection, family support, and teaching coping skills. Some mentors and community volunteers spoke about previous training, which they gave positive feedback to, but they stated the need for further development, monetary support, and sporting equipment.

Additions from Stakeholder Meetings

During the presentation of this information in the stakeholders meeting suggested additions to this list were mentioned.

The use of traditional healers was mentioned in all four meetings. Traditional Healers are used as the first step in finding relief from mental health issues, where psychosis is thought to be related to curses and evil spirits. This is a belief by both South Sudanese and Ugandans. They also highlighted that many refugees experience mental health issues through somatic pain, so they go to the medical center or traditional healer for pain relief, which does not fix the mental health issue. A lack of knowledge towards mental health and services was mentioned as a major barrier to accessing care.

Harmful coping skills were frequently spoken about. This included excessive drinking and use of drugs, suicide, running away, and early marriage. Sexual and Gender Based Violence (SGBV) was mentioned as a coping skill for men trying to regain control due to feelings of vulnerability, loss of purpose, and not being respected. Domestic violence was frequently mentioned as a major issue in the settlements. There were multiple requests for more services to men and women, which include education to men about mental health issues because they shy away from services due to stigma.

Requests for an increase of services were frequently mentioned in all meetings. Stakeholders stated that if education and basic needs were provided then there would be a decrease of mental health symptoms. They stated that spirituality should be added as a basic need. Typically, once the information from the report had been provided, the conversation would become more specific to requests for specific MHPSS services as opposed to basic needs. Many stakeholders stated that families needed to be part of the MHPSS services. It was mentioned that families “transfer trauma” to their children, so there needs to be a focus on family recovery.

Physical and emotional disabilities were frequently mentioned as a major topic of concern. HIV related psychosis was mentioned due to refugees not accessing care due to stigma. It was also frequently mentioned that children with disabilities are not specifically cared for. A request for education on how to work with children with disabilities was also mentioned.

While it was explained to stakeholders that female adolescents and their mentors were solely interviewed due to the primary focus of this project, stakeholders from all four settlements expressed their discontent that males were not involved in the information gathering process. They stated that males are frequently overlooked, despite their high need for services. PTL encouraged participants to use the tools to interview the males and provide the information back to the team, but PTL did not receive any follow up information. Key stakeholders also emphasized that Ugandan nationals, who share land with the refugees, are facing similar issues and should be considered in future programming.

Potential Biases

There are several types of potential biases present in this qualitative assessment. While the mapping processes included programs that reached all children and adolescents, the qualitative interviewing focused on adolescent females and their mentors. The primary focus of this project was specific to adolescent females, though as highlighted by the stakeholders, it is important to hear from the different age groups and genders. The girls and mentors who were interviewed were also members of DRC's vocational training. Most female adolescents in the refugee settings are not receiving this type of programming, so the information provided is limited on its generalizability. Several times during the interviewing process an adolescent female would state that "she has no more problems thanks to DRC's program," which limits generalizability for the majority of the population. Though during the key stakeholder interviews, stakeholders stated that the information present did represent the needs and issues faced by most adolescent females.

There is also potential biases due to the perceived role and a perceived hierarchy of interviewer. Several times the PTL interviewer was referred to as "donor," despite the interviewer describing her role and reason for gathering information. The interviewer, being an America, also was also not from the community, which could have created barriers to what information was provided. There were language barriers and communication barriers, which could cause potential issues in information gathering. There is a limit to mental health specific language due to limited dissemination of information, which could cause a barrier to identify and explore MHPSS gaps and needs.

Summary

The information gathered during the adolescent and key stakeholder interviews highlight the need for an increase of support among all factors in a child refugee's life in Uganda. Basic needs, family support, and education was the most spoken about need from all populations interviewed. Information gathered specific to gaps and needs and symptoms experienced by adolescent females highlight the necessity of a need for increases in MHPSS services.

Additionally, the gathered information is complementary to the information gathered from literature. The importance of religion, community involvement, and education were highlighted strongly both in literature and interviews. Early marriage and differences in gender roles were confirmed during the interview process, and the interviewers spoke about increased issues in domestic violence, alcohol use, and basic needs were due to becoming refugees, which agreed with the literature report. The literature stated that men's stress was related to loss of livelihood, leadership positions, and feelings of idleness (Oxfam International, 2017), which was spoken about frequently in the interviews as a contributor to increased SGBV cases. Cultural concepts highlighted in the literature, for example the connection of body pain and mental health issues, were spoken about frequently in the interviews. There was virtually no information gathered in the interview process that contradicted the background literature.

IV. SECTION IV – 4Ws MAPPING EXERCISE

4WS MAPPING PROCESS

Introduction to the 4Ws Tools

The Inter-Agency Standing Committee (IASC) established a Task Force on Mental Health and Psychosocial Support (MHPSS) in response to a lack of coordination in humanitarian emergencies. In 2012, the IASC Reference Group on MHPSS published the Who is Where, When, doing What (4Ws*)* mapping tools to map MHPSS activities in humanitarian settings across sectors. The 4Ws tools are used in many areas to map activities conducted across large geographical areas (IASC, 2012); these tools generally aim to map supports by government and non-governmental agencies, including pre-emergency services and supports (IASC, 2012). They were designed to help humanitarian actors better understand what is happening regarding MHPSS in emergency or post-emergency settings by mapping supports, as well as to foster collaboration, coordination, referrals, and accountability for all involved actors.

The 4Ws mapping tool consists of two parts: a manual and a data collection spreadsheet. The Manuel, "Who is Where, When, doing What (4Ws) in Mental Health and Psychosocial Support: Manual with Activity Codes", describes how to collect the data and outlines key information in the process (IASC, 2012). The 4Ws Data Collection Spreadsheet application (in Excel) is available online at mhpss.net/4Ws1; the data collection spreadsheet can be adapted to appropriately reflect the specific location, population, and context needs in order to meet the goals of specific mapping exercises.

This mapping tool is also a component of the World Health Organization's (WHO) "Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for major Humanitarian Crises" and has been piloted in various emergency settings, including Jordan, Nepal, Haiti, Kenya, and the Philippines.

4Ws Mapping in Uganda

In 2017, Playing to Live (PTL) received a grant from the Humanitarian Innovation Fund (HIF)/Elrha to complete a needs and resource assessment for South Sudanese refugees residing in four settlements in Uganda. This comprehensive assessment included the following components: (1) desk review, (2) literature review, (3) informational site visits and interviews, and (4) mapping exercise of current services. For the completion of the mapping component, PTL utilized the IASC MHPSS 4Ws tools, adapted for the setting. The following four site locations in Uganda were selected for the completion of this mapping: Kiryandongo, Arua, Yumbe, and Adjumani.

The 4Ws mapping process proceeded as follows:

1. Completion of pre-mapping conversations with key stakeholders;
2. Adaption of the 4Ws Data Collection Spreadsheet to meet location, population, and context needs;

3. Completion of feedback on the 4Ws Data Collection Spreadsheet from stakeholders and collaborating organizations and completion of adaption of 4Ws Data Collection Spreadsheet to meet setting needs;
4. Completion of adapted 4Ws Data Collection Spreadsheet in person with contacts from collaborating organizations conducting work across the four site locations;
5. Completion of adapted 4Ws Data Collection Spreadsheet by email correspondence from collaborating organizations, when in-person data collection was not possible due to time and/or scheduling limitations;
6. Completion of data confirmation by looping back with organization contacts with submissions;
7. Completion of data entry and data cleaning throughout data collection process;
8. Summarization of findings and completion of 'Report Draft One';
9. Submission of 'Report Draft One' to key stakeholders for feedback and to ensure data and information collected was accurately recorded and met the needs of the community;
10. Completion of 'Report Draft Two' based on feedback from key stakeholders;
11. Submission 'Report Draft Two' to all key stakeholders including but not limited to local health officials, government officials, OPM officers, and UNHCR representatives in addition to submission of file to all collaborating organizations;
12. Completion of a summary of findings meeting held at each of the four site locations with the purpose to share findings with collaborating organizations and key stakeholders to receive final feedback and edits and collect additional data from organizations missing in 'Report Draft Two';
13. Completion of validation of data and findings with leading in-country MHPSS organization collaborating on the report, Transcultural Psychosocial Organization Uganda (TPO);
14. Completion of 'Final Report' with updated data and feedback from TPO, collaborating organizations, and key stakeholders;
15. Submission of 'Final Report' to grantor, HIF/Elrha; and
16. Dissemination of 'Final Report' among key stakeholders and all collaborating organizations after approval from grantor.

TIMEFRAME

The assessment took place between March 2017 and November 2017. The 4Ws Data Collection Spreadsheet was refined and pilot tested during May – July 2017. The estimated data collection timeframe was initially March 1, 2017 – August 31, 2017, but the deadline was extended to November 15, 2017 in order to accommodate additional data inputs by collaborating organizations. 'Report Draft One' was compiled during September 2017, and disseminated to key stakeholders on September 15, 2017 for review and edit suggestions. 'Report Draft Two' was completed by October 15, 2017 after incorporating feedback and edits from key stakeholders. 'Report Draft Two' was presented to both key stakeholders and collaborating organizations in person during the summary of findings meetings held in each of the four site location during October 2017 and send by email to contacts unable to attend the meeting. The 'Final Report' was completed on November 30, 2017 and submitted to the grantor, HIF/Elrha. The 'Final Report' will be disseminated across all collaborating organizations and key stakeholders in December 2017 after approvals from grantor.

OBJECTIVES

The overarching objective of this mapping exercise was to highlight existing MHPSS services for the South Sudanese refugees in Uganda, residing in settlements within the following four target districts: (1) Kiryandongo, (2) Arua, (3) Yumbe, and (4) Adjumani. For this mapping exercise, specific settlements within three of the districts were selected: (1) Kiryandongo Refugee Settlement, (2) Rhino Camp Refugee Settlement, (3) and Bidi Bidi Refugee Settlement, respectively. In Adjumani District, the mapping exercise was not limited to one settlement due to the proximity and number of settlements in this district. All data received from collaborating organizations working in Adjumani was included.

In addition to recognizing existing services, this report also sought to identify gaps in order to enhance coordination, collaboration, and accountability among involved agencies. This report seeks to inform national emergency preparedness policy and set an example for future mapping exercises. This report focused on programs provided to children and adolescents aged 0-23, with a specific focus on adolescent girls. This report sought to serve as an initial template for future mapping exercises; PTL fully recognizes that due to the nature of the emergency setting, the report will need to be updated frequently for accuracy.

Specific objectives of the 2017 Uganda MHPSS mapping:

1. Compile a summary of existing MHPSS programs and services for South Sudanese refugees, including services to both host community and refugees in selected districts;
2. Identify gaps in MHPSS activities due to location and service provision;
3. Raise awareness and increase stakeholder engagement in coordination efforts; and
4. Disseminate findings and recommendations of the mapping exercises to stakeholders.

MAPPING PROCESS

Who is involved in the Process

Playing to Live in collaboration with DRC sought to work collaboratively with non-profit, for-profit, and government organizations to complete the 4Ws mapping exercise. Key agencies included the following: Danish Refugee Council (DRC), Transcultural Psychosocial Organization Uganda (TPO); Offices of the Prime Minister (Kampala, Arua, and Adjuamni), Office of the Prime Minister Settlement Commanders (Kiryandongo District, Arua District, Yumbe District, and Adjumani District), United Nations High Commissioner for Refugees (UNHCR), and all collaborating organizations that participated by submitting data for the 4Ws mapping process (Appendix 4). DRC acted as the key collaborating organization for logistics and support throughout this process. TPO acted as the key collaborating organization as an expert advisor on MHPSS in Uganda and completed a validation process for the data and report results.

Process of Adapting Tools

A review of the current IASC 4Ws tools was completed in preparation for the 4Ws mapping exercise and adaptation to the 4Ws Data Collection Spreadsheet was completed by PTL.

First PTL team members completed a full review of the following key documents: (1) IASC 4Ws Manuel & Codes Document, (2) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, (3) Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergency Settings, and (4) Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for humanitarian settings (IASC, 2012; IASC, 2007; IASC 2014; WHO & UNHCR 2012). Additional key resources PTL suggests for review can be found at the IASC website, https://mhpss.net/emergency-toolkit/.

Second, the PTL team completed an adaptation process to ensure the 4Ws Data Collection Spreadsheet was suitable for the selected context. In collaboration with three key stakeholders, PTL made adaptations to the 4Ws tool as directed (Appendix 1 & 2). Overall, a few minor adaptations were necessary to use the 4Ws mapping tool in this setting. In the "General Information" section of the original mapping tool, PTL made the following additions for data collection: (1) "project name" and (2) "title of contact person". In the same section, PTL changed "town/ neighborhood where activity occurs" to "settlement" and "government/OCHA geographical code for the location" to "settlement zone/area". In the "Activity Information" section of the original mapping tool, PTL made the following addition for data collection: does this service also support nationals and/or IDPs. Additional minor edits were made to the 4Ws Data Collection Spreadsheet (Appendix 2 & 5).

Third, a final adaptation was completed midway through implementation, in which the PTL team members converted the adapted 4Ws Data Collection Spreadsheet from the excel format to a word document format. This was done due to the suggestion from contacts of collaborating organizations that the tool would be easier to complete if it was in a format that was easier to upload and use.

The 4Ws Data Collection Tool

The adapted 4W Data Collection Spreadsheet was submitted by collaborating organizations in two ways throughout this process. The preferred method for data collection was for program information to be collected in person by a PTL team member. This method of data collection required a PTL team member to ask questions specific to the tool and a collaborating organization's representative to verbally respond; responses were recorded by the PTL team member and any clarifying questions were later emailed to the organization's representation to ensure the information was collected accurately.

The second way the 4Ws Data Collection Spreadsheet was completed was via email. During this process, the spreadsheet was sent to participating organization contacts via email with instructions for completion. Emails sent to organizations included a brief introduction of PTL and the needs assessment project, a Microsoft Excel and/or Microsoft Word version of the adapted 4Ws Data Collection Spreadsheet, and the IASC manual and codes (IASC, 2012). The Excel format included a one-page introduction of the 4Ws tool, one page of questions for the organization to fill out, and one page of MHPSS activity code and sub code (Appendix 3). The Word format included questions for the organization to fill out and one page of MHPSS activity code and sub code at the end of the form.

How many requests sent, how many received

A total of 66 separate requests were submitted by PTL either in person or by email to MHPSS organization contacts in Uganda. By September 1, 2017, 30 responses were received across 17 organizations. PTL recognizes that due to the nature of the process organizations providing MHPSS may have not been included due to lack of knowledge and/or contacts for organizations working in the MHPSS sector.

Data Collection and Staffing Timeline

In total, two PTL staff members were in Uganda to complete the 4Ws mapping exercise between February 2017 – October 2017 one PTL team member completed 3.5 months total between February 2017 – July 2017. The second PTL team member completed 1.5 months total over February 2017, July 2017, and October 2017. Key stakeholder meetings were completed February – April 2017; during this time PTL was waiting for permission to access the settlements.

Stakeholder Engagement and Validation Meetings

During October 2017, a PTL staff member travelled to Uganda to provide the report in person to all collaborators and stakeholders. Multiple stakeholders requested this trip stating that it was a sign of respect and would allow for the most authentic conversations. PTL began the trip by visiting OPM and UNHCR in Kampala. Following this, PTL met with stakeholders in all four of the site locations. Participants represented OPM, UNHCR, collaborating MHPSS organizations, and Ugandan and refugee community leaders. Participants were provided with all up to date information from the report and were asked to discuss their thoughts on the results, suggest addendums, and suggest additions for the final report. Information gathered during these meetings was then incorporated into the final draft. Participants mainly provided insight into qualitative and cultural information.

The four meetings were all well attended, though while four hours were allotted, the meetings typically were only two and a half hours due to timing and availability of participants. Most meetings began one hour after the allotted time. The meetings proved to be one of the most effective way of gathering additional data for the 4Ws mapping process. The PTL staff member was able to provide data collection sheets to organizations present in the meeting but absent from the data previously collected. Conversations that arose from the presentation were fruitful, where stakeholders from different organizations discussed the reported gaps and discussed ways to address them.

There were challenges in the meetings. A limited number of refugees were present, where in Adjumani there were none in attendance. The goal of this project was to involve all levels of leaders from the settlements, but it proved more difficult to find a communication pathway with some of the refugee leaders to invite them to the meeting.

CHALLENGES & LIMITATIONS

Challenges

Throughout the process of completing the 4Ws mapping exercise a number of challenges presented themselves. Key challenges included the ability to identify appropriate organizations to complete the mapping process, accessing key contacts to complete the mapping exercise, limited time & resources, and general misconceptions and confusion in filling out the data collection spreadsheet.

Challenges surrounding the identification of appropriate organizations to complete the mapping included the instability of an emergency and humanitarian setting. Additionally, growing projects and changing grant cycles across NGOs, where project goals were identified clearly but programs changed regularly based on funding challenged the identification process and clear data collection. Likewise, regular personnel changes of key contacts across multiple partnering organizations and minimal coordination or established referral systems in some settlements prior to 2017 provided the final challenge in completion of data. Key stakeholders in two of the districts, namely Adjumani and Kiryandongo highlighted a clear referral pathway, whereas key stakeholders in Yumbe identified a weaker referral pathway for MHPSS services at this time.

Challenges surrounding access to key contacts to complete the mapping exercise included the following: the 4Ws form can be time consuming to complete, collaborating organizations did not necessarily see the immediate importance of the mapping, slow response time, and incomplete or varied details in the responses received. Challenges surrounding limited time & resources included the 4Ws tool's requirement of a high level of human resources to complete, the broad scattering of settlement organizations, the inability to confirm meeting time with representatives, and the ineffectiveness of emailing the 4Ws tool in lieu of in person paper form completion. Challenges surrounding misconceptions in filling out the form included the collaborating organizations' tendency to report what was in the program proposal rather than what was actually happening, the lack of clear understanding of the pyramid by collaborating organizations and their subsequent tendency to over or under-report their activities for different categories, and the misconception by participating organizations that they are being judged and therefore leading to extended conversations regarding purpose of the project.

Limitations

The process of completing the 4Ws mapping exercise had a number of limitations. Key limitations included the following: self-reported data from organizations, not all organizations known to provide MHPSS services in specific sites were included in final report, inconsistencies in reporting due to lack of unified use of specific terminology, lack of report on training of personnel due to the lack of information from the person filling out the form, and quality of activities not measured.

FINDINGS

Background

As of September 2017, a total of 1,381,207 refugees and asylum-seekers sought refuge in Uganda (UNHCR, 2017c). Of those, 1,034,106 are South Sudanese (UNHCR, 2017c). An average of 1,800 South Sudanese have been arriving in Uganda every day over the past 12 months (UNHCR, 2017c). In Uganda, over 61% of refugees are children (under the age of 18 years old); and 52% are women and girls (UNHCR, 2017c). Uganda has a long-standing history of hosting refugees and currently hosts' refugees from the following countries: South Sudan (68%), Democratic Republic of Congo (21%), Burundi (4%), Somalia (4%), Rwanda (2%), and other (2%) (UNHCR, 2017d). Current refugee locations in Uganda as outlined by UNHCR include Yumbe (25%), Adjumani (20%), Nakivale (12%), Arua (9%), Kampala (8%), Moyo (7%), Rwamwanja (6%), Kiryandongo (5%), Kyangwali (4%), Kyaka II (2%), Oruchinga (1%), and Kisoro (0.02%).

In Uganda, as of September 2017, there were 29,660 registered refugees and 100 partners working across sectors to meet the comprehensive needs of refugees and asylum seekers (UNHCR, 2017c). There are 12 refugee-hosting districts in Uganda and within those, 30 total refugee settlements. In order to meet the comprehensive needs of refugees and asylum seekers, a refugee response plan for the South Sudan requested a total of $674.35 million; to date only 32% of this funding has come through leaving a 68% gap in funding.

Of the 12 refugee-hosting districts in Uganda, this mapping exercise was completed across four districts Kiryandongo, Arua, Yumbe, and Adjumani. These districts were selected based on high percentages of South Sudanese refugee populations in settlements within these districts and availability/access to the areas to complete the mapping exercise. Due to time restrictions, this mapping exercise only focused on specific settlements within these four districts. Additional mapping may be beneficial across all districts and settlements in Uganda. A map created by the UNHCR summarizing UNHCR's presence and current refugee locations in Uganda is included for reference on the following page. Key stakeholders throughout this process highlighted the importance of expanding this mapping exercise to additional districts and settlements.

Results Overview

This mapping exercise presets both a summary of all site locations and provides a breakdown of MHPSS services across each site locations. A table of the organizations and their activities focus can be found in each of the sections that follow, as well as a chart with the concentration of activity categories. Based on the reported MHPSS activity codes, interventions were categorized as community-focused MHPSS, case-focused MHPSS, and general MHPSS.

UGANDA

UNHCR Presence and refugee locations

SOUTH SUDAN

DEMOCRATIC REPUBLIC OF THE CONGO

KENYA

RWANDA

UNITED REPUBLIC OF TANZANIA

Lake Victoria

Lake Albert

Lake Kyoga

Field Unit Moyo

Bidibidi

Kuluba

Field Unit Yumbe

Lobule

Imvepi

Sub Office Pakelle

Sub Office Arua

Ocea RC

Rhino Camp

Ngomoromo

Lokung

Madi Opei

Waligo

Kitgum

Gulu

Pader

Kotido

Moroto

Pakwach

Lira

Field Unit Kiryandongo

Kiryandongo TC

Kiryandongo

Masindi

Sub Office Hoima

Kyangwali

Field Unit Kyangwali

Bubukwanga TC

Field Unit Bundibugyo

Fort Portal

Field Unit Rwamwanja

Rwamwanja

Kyaka II

Field Office Kyaka

Branch Office Kampala & Field Unit Kampala

Entebbe

Mbale

Soroti

Masaka

Sub Office Mbarara

Matanda TC

Nakivale

Field Office Nakivale

Oruchinga

Field Office Isingiro

Field Unit Kisoro

Nyakabande TC

INSET: WEST NILE REGION

SOUTH SUDAN

DRC

Kerwa

Menzere

Metu

Moyo

Bidibidi

Laufori

Elegu

Kuluba

Yumbe

Olijii

Alere 2

Baratuku

Elema

Nyumanzi

Nyumanzi TC

Lobule

Palorinya

Pakelle

Pagirinya

Palorinya

Mirieyi

Boroli

Ayilo I

Imvepi

Maaji I

Olua I, II

Ayilo II

Maaji II

Mungula I

Maaji III

Mungula II

Ocea RC

Arua

Rhino Camp

Adjumani

Amuru

Gulu

Lamwo

- UNHCR Country Office
- UNHCR Sub Office
- UNHCR Field Office
- UNHCR Field Unit
- Refugee settlement
- Refugee transit / reception centre / collection point
- Refugee location
- International boudary
- District boundary
- Main road
- Minor road

20km

The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

Creation date: 12 Jan 2017 **Sources:** UNHCR, UNCS, UBOS. **Author:** UNHCR Regional Service Centre in Nairobi kenrsgis@unhcr.org

Community-focused MHPSS activities are activities that target entire communities (IASC, 2012). These include activity codes 1-6: (1) disseminating information to the community at large; (2) facilitating conditions for community mobilization, community organization, community ownership or community control over emergency relief in general; (3) strengthening community and family support; (4) safe spaces; (5) psychosocial support in education; (6) supporting including social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation (IASC, 2012).

Person focused MHPSS activities target identified people (IASC, 2012). These include activity codes 7-10: (7) (person-focused) psychosocial work; (8) psychological intervention; (9) clinical management of mental disorders by non-specialized health care providers (e.g. primary health care (PHC), post-surgery wards); and (10) clinical management of mental disorders by specialized mental health care providers (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/general health facilities/mental health facilities) (IASC, 2012).

General MHPSS activities include all general activities that support MHPSS (IASC, 2012). This includes activity code 11: (11) general activities to support MHPSS (IASC, 2012). Some general MHPSS sub-codes include situation analyses/assessment, monitoring/evaluation, training/orienting, technical or clinical supervision, psychosocial support for aid workers, and/or research.

This report also reviewed the concentration of activities and organizations on the IASC MHPSS intervention pyramid. The intervention pyramid ranks level services from Level 1 to Level 4. This report summarized where organizations fall on the IASC MHPSS intervention pyramid. Level 1 services include social/psycho considerations in basic services and security. Level 2 services include services that strengthen community and family support. Level 3 services include focused, non-specialized supports. Level 4 services include specialized supports.

The age and gender distribution of beneficiaries targeted by MHPSS service was also examined in this mapping exercise. Age groups were based on a previous Uganda national survey that defined children as 0-9 years old, adolescents as 10-19 years old, and adults as 20 and above years old.

The settings where MHPSS services were provided were also included in this mapping exercise. Settings were categorized into general public spaces, hospitals and clinics, schools, churches, community centers, child friendly spaces, and homes.

Additional information that was collected throughout this process can also be found in narrative form across the summary of all selected sites and each individual site location. Key stakeholders advised the areas of interest for reporting. Results focus was also directed by the completeness of the data points collected; due to incomplete data, some areas were not focused on for the results section. This mapping provided a good preliminary exploration of the MHPSS services across the selected four districts in Uganda and can serve as a baseline for future mapping exercises. PTL team members highly suggest that in further mapping of these districts and beyond that all identified collaborating organization and contacts are sought out for updated programming and activities.

Results Summary of Selected Sites

Who and What

This 4Ws mapping exercise received a total number of 30 responses from 17 organizations across 4 site locations between March – November 2017. Due to the time limitations and staffing changes, not all contributing organizations completed the data collection process within the dates of this assessment. However, a full list of organizations can be found in Appendix 4. Table 1 lists the collaborating organizations included in this 4Ws mapping exercise with the reported activities in each of the following areas of focus: community-focused MHPSS, case-focused MHPSS, and general MHPSS.

Table 1: Organizations and focus of activities

Name of Organization	Community-focused MHPSS	Case-focused MHPSS	General MHPSS
American Refugee Committee (Bidi Bidi)	√	√	
Danish Refugee Council (Adjumani)	√	√	
Danish Refugee Council (Bidi Bidi)	√	√	
Danish Refugee Council (Kiryandongo)	√		
Danish Refugee Council (Rhino Camp)	√	√	
International Aid Services (Rhino Camp)	√	√	√
International Rescue Committee (Bidi Bidi)	√		
International Rescue Committee (Kiryandongo)	√		
Lutheran World Federation (Adjumani)	√	√	√
Medical Teams International (Adjumani)	√	√	√
Peter C. Alderman Foundation (Rhino Camp)			√
Peter C. Alderman Foundation - Clinic (Rhino Camp)	√	√	
PLAN International (Bidi Bidi)	√		
Real Medicine Foundation (Kiryandongo)		√	√
Save the Children (Adjumani)	√	√	
Save the Children (Rhino Camp)	√	√	
Transcultural Psychosocial Organization (Adjumani)	√	√	√
Transcultural Psychosocial Organization (Bidi Bidi)	√	√	√

Name of Organization	Community-focused MHPSS	Case-focused MHPSS	General MHPSS
Transcultural Psychosocial Organization (Kiryandongo)	√	√	√
Tutapona (Adjumani)	√	√	
War Child Canada (Adjumani)	√		
War Child Canada (Kiryandongo)	√	√	
War Child Canada (Rhino Camp)	√	√	√
War Child Holland (Adjumani)	√	√	
War Child Holland (Bidi Bidi)	√		
Windle Trust (Adjumani)	√		
Windle Trust (Rhino Camp)	√	√	
Yumbe District local government (Bidi Bidi)	√	√	√

*Data received from Right to Play (Adjumani) and Save the Children (Bidi Bidi) was collected but was missing MHPSS activity codes and therefore was excluded from the above table.

Figure 1: Concentration of activities per area of focus

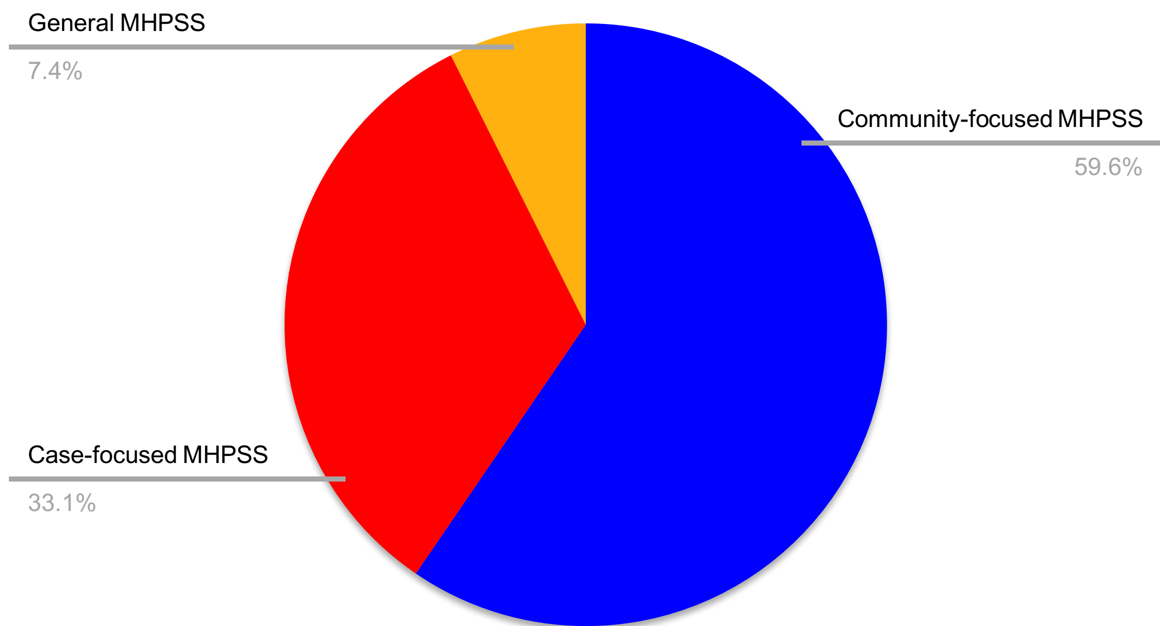
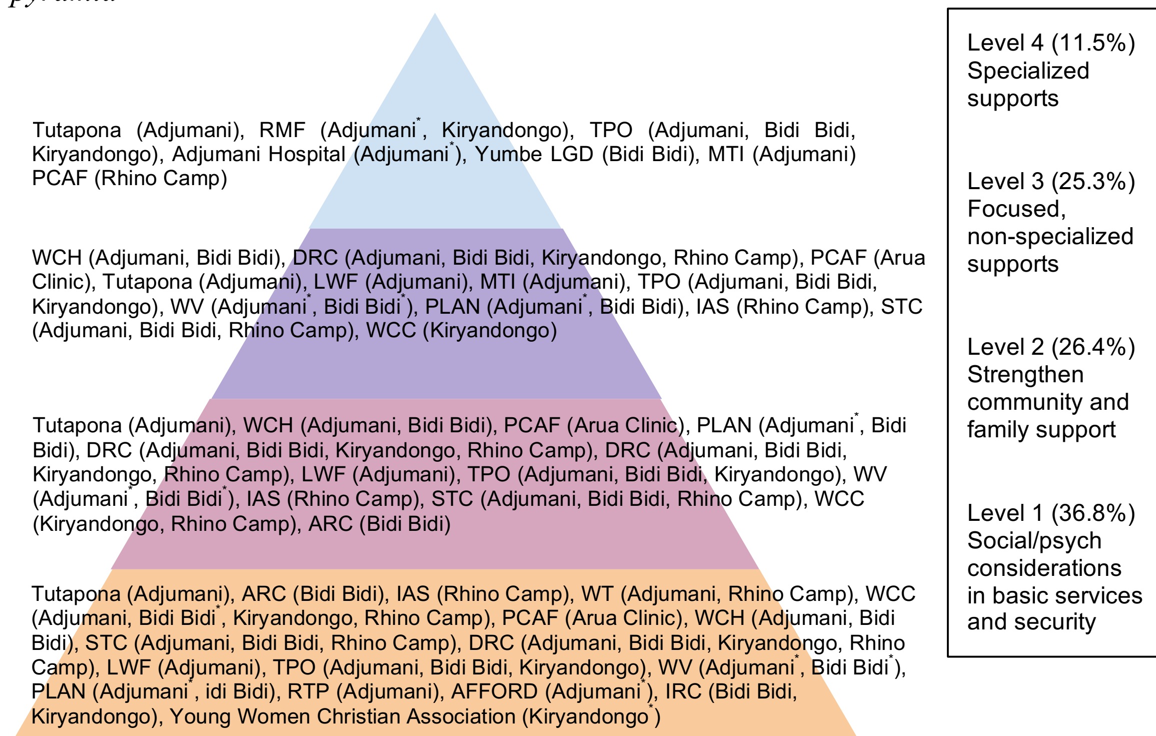


Figure 1 shows the concentration of activities per area of focus. Results of the reported interventions are included here. Community-focused MHPSS reported as 59.6%; these included disseminating information, community organization, community and family support, safe spaces, education support, and social support in protection. Case-focused MHPSS reported as 33.1%; these included individual psychosocial support and intervention and clinical management of clinical disorders. General MHPSS reported at 7.4%; these included training, research, etc.

Activity Concentration
Figure 2 shows the concentration of organizations on the IASC MHPSS intervention pyramid (IASC, 2007). The intervention pyramid is a depiction of MHPSS services on a spectrum of general to specialized services. This figure indicates the percentages of services provided across all the site locations. It shows that most services are Level 1 (social/psych considerations in basic services and security), which accounted for 36.8% of all interventions. Level 2 services (strengthen community and family support) accounted for 26.4% of all interventions. Level 3 services (focused, non-specialized supports) accounted for 25.3% of all interventions. Level 4 services (specialized supports) accounted for 11.5% of all interventions. It is important to note that these percentages are the percentages of organizations providing services within this level and not a percentage of the population at large that is receiving these supports. Many of the organizations included in this report provide services across multiple levels; some organizations services varied across different site locations.

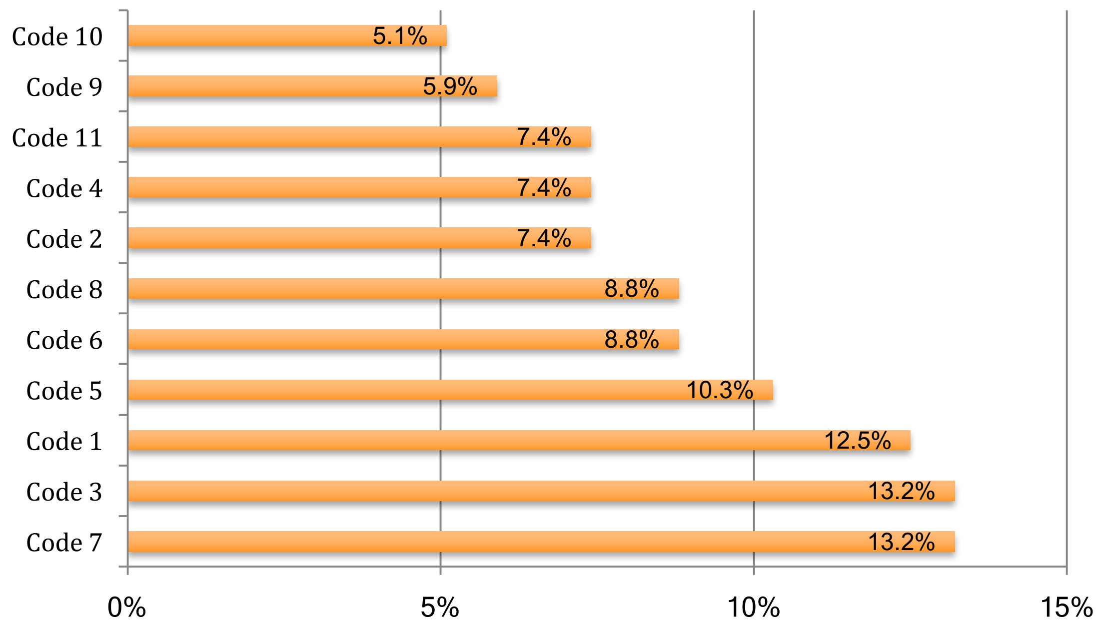
Figure 2: Concentration of activities and organizations on the IASC MHPSS intervention pyramid



*PCAF (Rhino Camp) only reported activity 11 and is therefore excluded from the intervention pyramid. PTL only received information about intervention pyramid and not a detailed data from the following organizations: World Vision (Adjumani), PLAN International (Adjumani), Real Medicine Foundation (Adjumani), AFFORD (Adjumani), Adjumani Hospital, and Young Women Christian Association (Kiryandongo), War Child Canada (Bidi Bidi), and World Vision (Bidi Bidi). Please note, due to data lacking across other areas of the 4Ws data collection process, these organizations are only listed in intervention pyramid and are not included in additional data analysis.

Figure 3 below shows the concentration of activities by code (11 activity codes in total). The most frequently reported activity categories were code 3 (strengthening of community and family support) and code 7 (person-focused psychosocial work), both presenting at 13.2%. The least frequently reported activity code was code 10 (clinical management of mental disorders by specialized mental health care providers), presenting at 5.1%. Followed by code 9 (clinical management of mental disorders by non-specialized health care providers) at 5.9%.

Figure 3: Concentration of activities per code



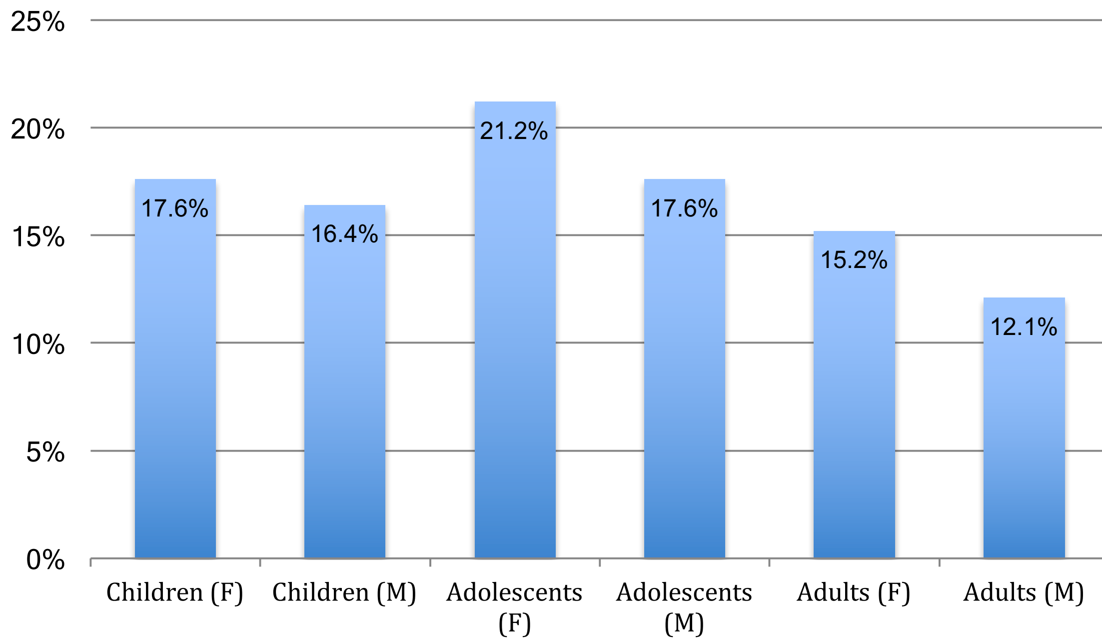
*Code descriptions are omitted here for brevity purpose. See Appendix 3 for the full list of activity codes.

Age & Gender Distribution

The age and gender distribution of beneficiaries was calculated from number of services provided to a specific age and gender group divided by total number of services provided.

Based on Figure 4, across all sites females received more MHPSS than males (54% females, 46% males) overall. Likewise, when compared across age groups, females received more services than males in each grouping (children, adolescents, adults). Among different age/gender groups, adolescent females were reported to receive the most services (21.2%) and adult males receive the least (12.1%).

Figure 4: Age/gender distribution of beneficiaries targeted by MHPSS services



MHPSS Workers

MHPSS workers staffed by organizations included in this report ranged widely. MHPSS Workers were presented as holding the following roles: social workers, child friendly spaces (CFS) activity facilitators, teachers, volunteers, case managers/officers, psychiatrists, psychologists, nursing officers, counselors, community psychosocial assistants, child protection officers, program officers, community activists, community mentors, early childhood development (ECD) caregivers, and life skills officers/assistants.

In general, MHPSS workers providing services were lacking across site locations. According to the data received, the number of MHPSS workers providing services ranged from 2 to about 70 per organization. The ratios of MHPSS workers to target participant ranged from roughly 1:1,200 (one MHPSS worker to 12,000 participants) to 1:10, while most services reported a generally low worker to participant ratio of 1:200 to 1:100. The organizations that reported a very high MHPSS worker to participant ratio shared that the organization provides care services to the entire population but did not report exact numbers. It is expected that the high ratio reports are reflecting the number of people in the population group (i.e. victims of gender based violence in a specific settlement zone) rather then the specific caseload receiving services. In addition, the time/extent of the program reported may have also impacted this number. This report included both target group support services and specific numbers of direct participants receiving interventions. PTL sought clarification from contacts on this data point but it was difficult to assess for accuracy due to varied responses. In future reports, additional specification on this data would be beneficial.

In terms of the training, most organizations provided on-job training for MHPSS workers. Content of trainings included: knowledge and skills about child protection and other psychosocial support, introduction to an organization's model and methodology, mentoring, and refreshing courses. Some organizations noted that they hire licensed professionals who

would be providing specialized care, such as psychiatrists and nurses. TPO and Tutapona were named by key stakeholders as two key MHPSS organizations, which provided MHPSS training for organizations included in this sector.

Where

This section describes locations of MHPSS programs/activities across settlements and districts, which included Adjumani, Bidi Bidi, Kiryandongo and Rhino Camp. It also provides information on the settings where services were available. Table 2 provides information on what agencies were operating in each settlement/district.

There are additional organizations providing MHPSS in the area (Appendix 4). Due to time limitations, completed 4Ws Data Collection Spreadsheet from all organizations was not received for the date of this report due to challenges and limitations previously discussed in this section. However, it is PTL's understanding that those organizations also may contribute to MHPSS programs/activities in this region. Inclusion of these organization and additional outreach during further reports is highly suggested to ensure that the report is accurate.

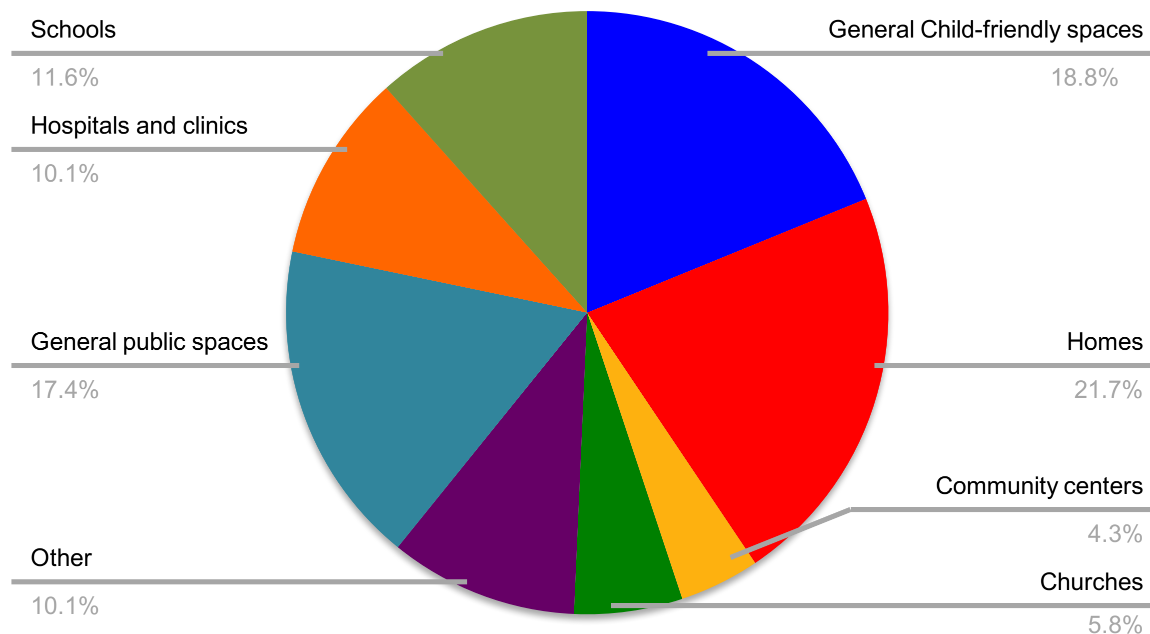
Table 2: Known agencies operating MHPSS programs/activities per settlement/district

District; Settlement	Organizations With Completed Data	Organizations Without Data
Adjumani; All settlements	Save the Children, Danish Refugee Council, War Child Holland, War Child Canada, The Lutheran World Federation, Medical Teams International, Transcultural Psychosocial Organization, Right to Play, Windle Trust, and Tutapona	International Rescue Committee, Real Medicine Foundation (RMF), AFFORD, Adjumani Hospital, PLAN International, and World Vision.
Yumbe; Bidi Bidi Settlement	American Refugee Comittee, Danish Refugee Council, PLAN International, War Child Holland, Yumbe Local Government, Transcultural Psychosocial Organization, International Rescue Committee, and Save the Children	CARE, Médecins Sans Frontières, World Vision, and World Child Canada
Kiryandongo; Kiryandongo Settlement	War Child Canada, Real Medicine Foundation, International Rescue Committee, Danish Refugee Council, and Transcultural	Save the Children, We Techa Peace and Development, ZOA International, InterAid Uganda, and Young Women

	Psychosocial Organization	Christian Association
Arua; Rhino Camp Settlement	Danish Refugee Council, International Aid Services, Peter C. Alderman Foundation, Save the Children, War Child Canada, and Windle Trust	Uganda Red Cross Society, Medical Teams International, Médecins Sans Frontières, and PLAN International

As shown in Figure 5 below, the majority of services are provided in homes (21.7%), child friendly spaces (18.8%), and general public spaces (17.4%). Services were also provided in hospitals and clinics, schools, churches, and community centers. The "other" category includes offices, outreaches, and police. According to the data received, some organizations reported general child friendly spaces or public spaces, while some reported with more specific descriptions such as "shades under a tree in the neighborhood". Therefore, there could be some potential overlap in the breakdown categories, as general child friendly spaces and public places are listed separately here; this may skew the data. Key stakeholders and contacts shared that MHPSS services were provided in a wide range of settings in order to accommodate varying needs of population served.

Figure 5: Settings where MHPSS services are provided



<u>When</u>

All responses received reported program activity status as currently being implemented. The majority of programs were initiated in 2016 and 2017, with only 5 organizations providing services before 2016. The earliest service reported was PCAF Arua clinic, dating back to early 2012. Due to various funding cycles, some program activities have specific start and end dates, while many reported are not specified. Confirmed end dates range from August 2017 to September 2019. It is acknowledged that in humanitarian settings, funding availability places

a big influence on program/activity availability. Therefore, it is important to update this mapping exercise in this area in order to capture a more accurate and timely picture in the future. In addition, it would be beneficial for these mapping results to be updated and integrated into Uganda's social care and health systems across specific site locations and beyond.

Kiryandongo District

Kiryandongo District is located in the Western Region of Uganda within the Bynyoro sub-region. The Kiryandongo Refugee Settlement is a refugee camp in Kiryandongo District, housing Kenyan and South Sudanese nationals. This settlement was initially established in 1954 to support Kenyan refugees. In 1990, the land was repurposed to settle ethnic Acholi people fleeing the Sudan People's Liberation Army from Parjok in South Sudan. During 1990, Sudanese were joined by Ugandan Acholi IDPs escaping from the LRA-affected areas of Gulu and Kitgum (Kaiser, 2000). Kiryandongo Settlement has also served over the years as an interim stop and transition location for individuals as they transitioned to other camps. As of September 2017, Kiryandongo Refugee Settlement housed a total of 56,855 refugees and asylum-seekers from South Sudan, which included a total of 162 households (UNHCR, 2017e; UNHCR 2017c).

Overview of Intervention Concentration

Among all studied sites, this report collected the least data on organizations providing services in Kiryandongo settlement. Five organizations in this area contributed to this mapping exercise. Despite limited data, interventions were reported across all levels of the intervention pyramid. The majority of services focused on community-focused MHPSS. Services were provided to all age groups and both genders, though the most services were focused on women and adolescent females. Reported MHPSS activities were implemented in a wide range of settings. Homes, general public spaces, and other reported the largest frequency for use of settings in Kiryandongo. For an update of this report, PTL advises to complete outreach to additional organizations listed as providing MHPSS services in Kiryandongo.

Who, Where, What, When

Table 3 summarizes the organizations and focus based on reported MHPSS activity codes. It shows that activities in Kiryandongo covered all three categories of MHPSS service types.

Table 3: Organizations and focus of activities, Kiryandongo district, Kiryandongo settlement

Name of Organization	Community-focused MHPSS	Case-focused MHPSS	General MHPSS
Danish Refugee Council (DRC)	√		
International Rescue Committee (IRC)	√		
Real Medicine Foundation (RMF)		√	√
Transcultural Psychosocial Organization (TPO)	√	√	√
War Child Canada (WCC)	√	√	

*For organizations that operate across sites, the graph above is only accounting for activities implemented specifically in Kiryandongo district – Kiryandongo settlement.

Figure 6 shows the concentration of activities per area of focus. Results show that among the reported interventions 52.4% were community-focused MHPSS, 38.1% were case-focused MHPSS, and 9.5% were general MHPSS.

Figure 6: Concentration of activities per area of focus, Kiryandongo district, Kiryandongo settlement

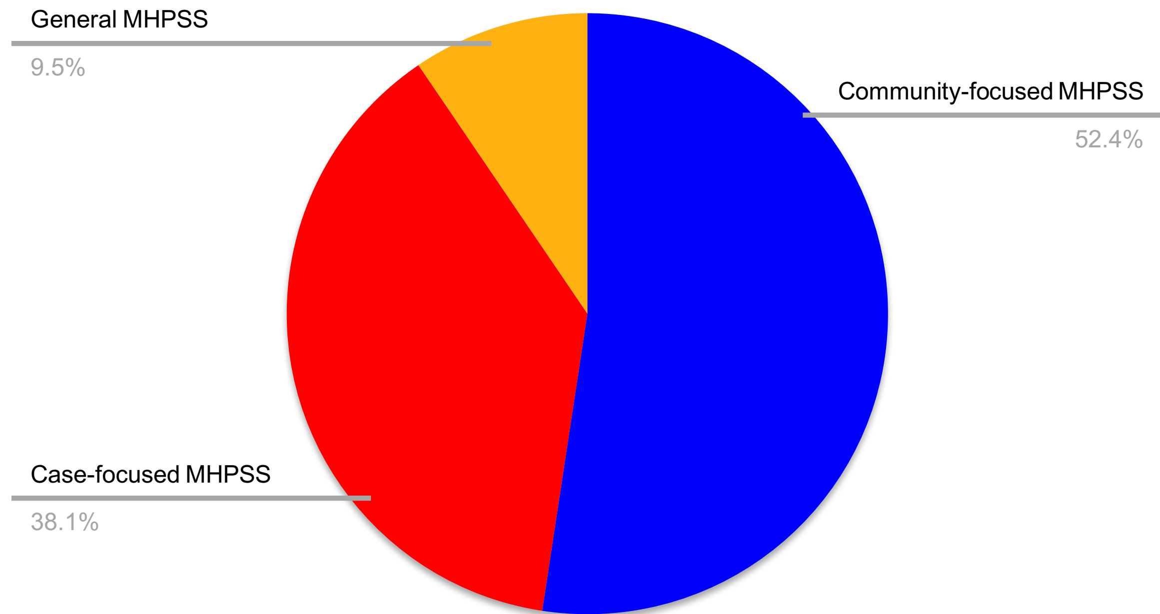
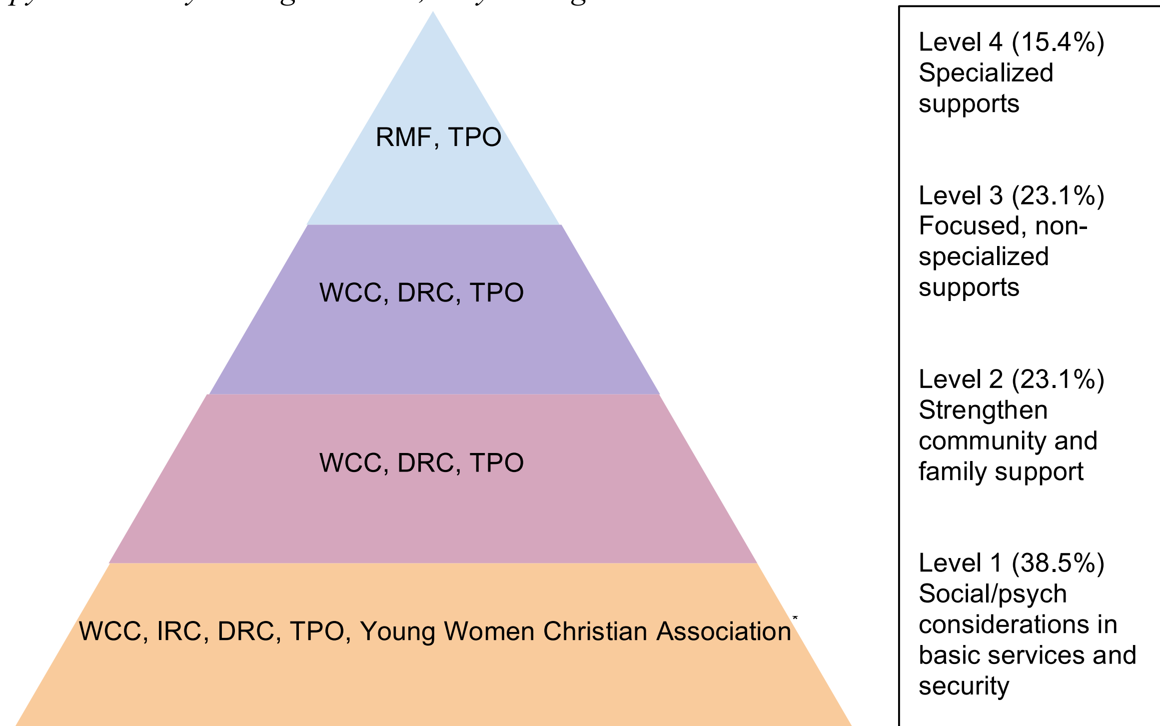


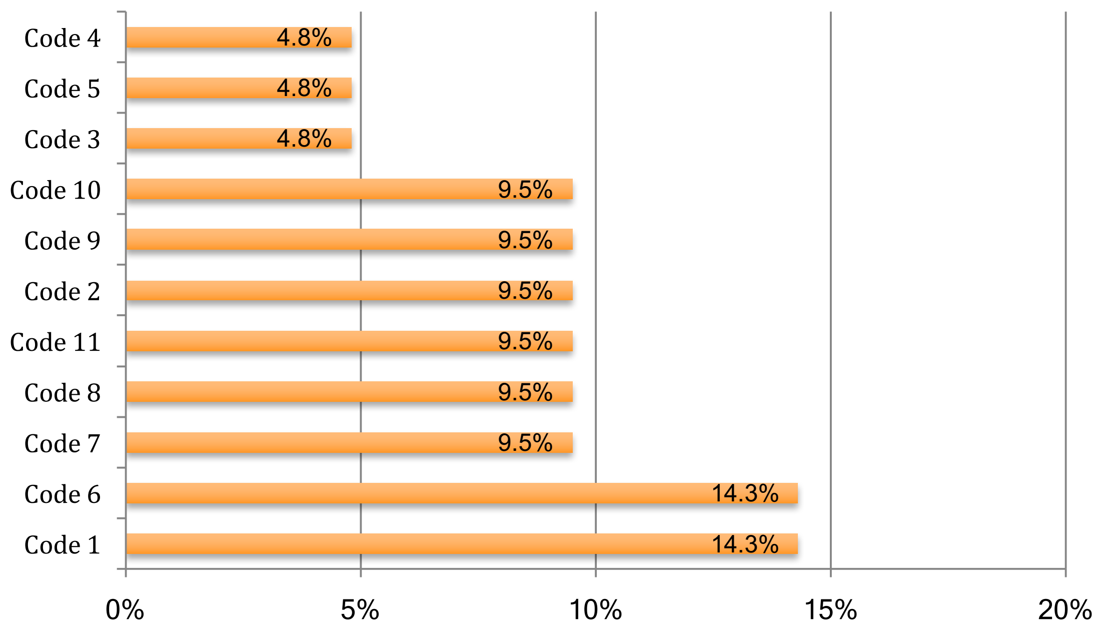
Figure 7: Concentration of activities and organizations on the IASC MHPSS intervention pyramid - Kiryandongo District, Kiryandongo Settlement



*For organizations that operate across sites, the graph above is only accounting for activities implemented specifically in Kiryandongo district – Kiryandongo settlement. PTL only received information about intervention pyramid on Young Women Christian Association (Kiryandongo); therefore the organization was only listed in intervention pyramid and not in additional data review.

Figure 7 shows the concentration of organizations on the IASC MHPSS intervention pyramid. Of all interventions, 38.5% fell under Level 1 services (social/psych considerations in basic services and security). Level 4 services (specialized supports) accounted for 15.4% of all interventions. TPO was the only organization working in Kiryandongo with services across all levels of intervention.

Figure 8: Concentration of activities per code, Kiryandongo district, Kiryandongo settlement

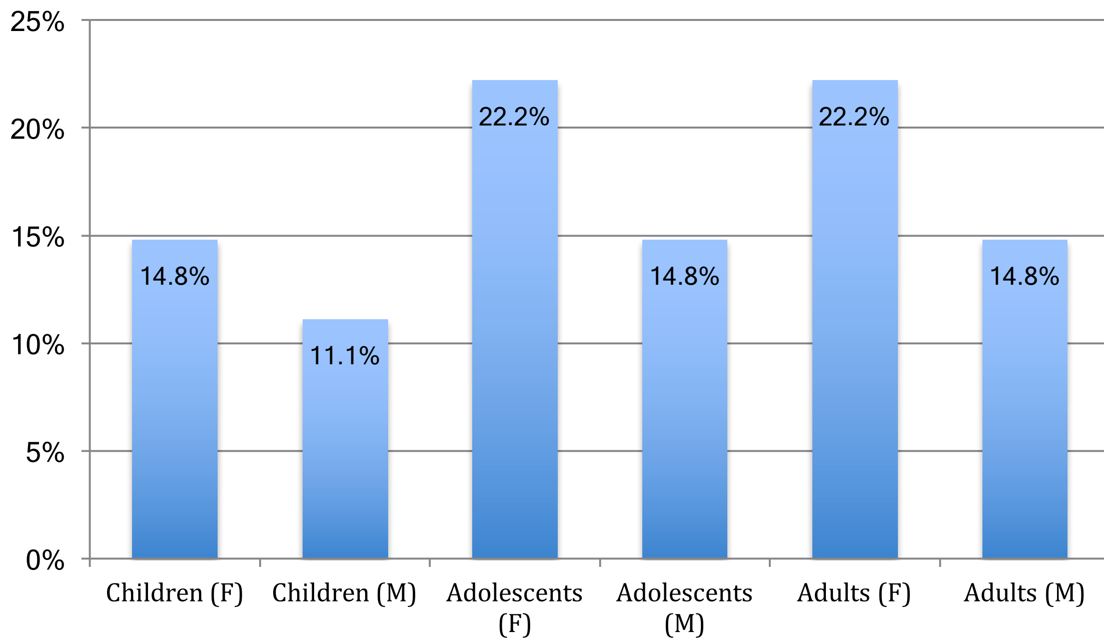


*Code descriptions are omitted here for brevity purpose. See Appendix 3 for the full list of activity codes.

Figure 8 shows the concentration of activities by code. All codes were reported in this area. Among all activity codes, the most reported were code 1 (information dissemination to the community at large) and code 6 (supporting the inclusion of social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation). Both code 1 and code 6 were reported at 14.3%. The least reported were codes 3 (strengthening of community and family support), code 4 (safe spaces), and code 5 (psychosocial support in education). All three codes were reported at 4.8%.

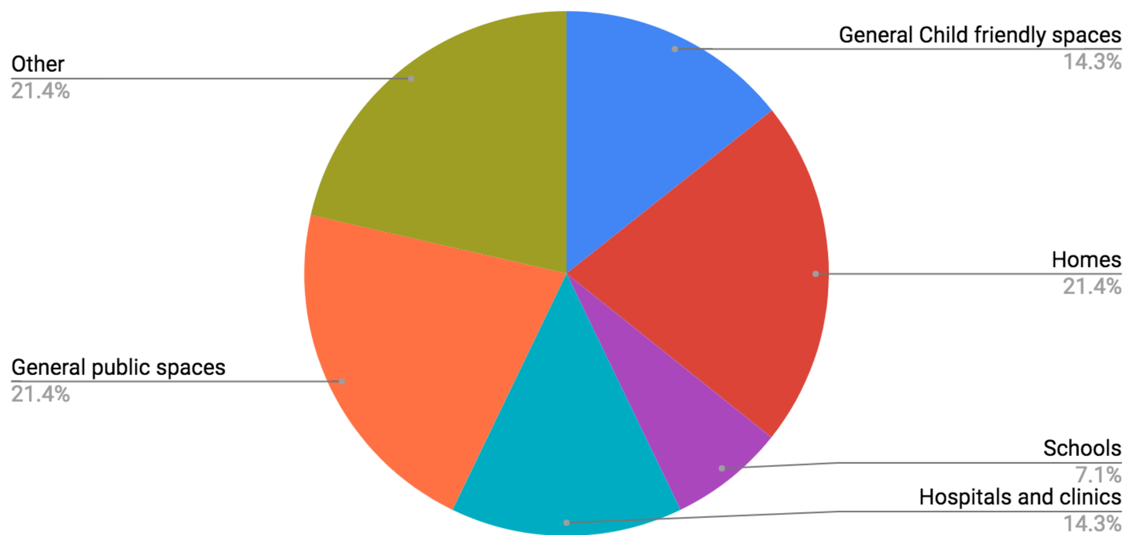
Figure 9 below shows age and gender distribution of beneficiaries targeted by MHPSS services. The majority of these organizations that reported providing services to all ages and both genders without discrimination. WCC and IRC reported that the majority of their services target women and young girls impacted by gender based violence but that services are not restricted by gender. TPO reported the majority of services are provided to youth but without restrictions to gender or age.

Figure 9: Age/gender distribution of beneficiaries targeted by MHPSS services, Kiryandongo district, Kiryandongo settlement.



MHPSS services were reported a wide range of settings for the provision of services in Kiryandongo settlement. These settings included homes (21.4%), general public spaces (21.4%), other (i.e. offices and police stations) (21.4%), hospitals and clinics (14.3%), general child friendly spaces (14.3%) and schools (7.1%). Figure 10 shows the breakdown of these settings. Unlike other site locations, Kiryandongo does not have data on the provision of MHPSS services provided by the schools; this is important to note in considering the results.

Figure 10: Settings where MHPSS services are provide, Kiryandongo district, Kiryandongo settlement



Arua District

Arua District is located in the Northern Region of Uganda within the West Nile Sub-region. Rhino Camp Refugee Settlement is a refugee camp in Arua District. As of October 2017, a total of 223,097 refugees and asylum seekers from South Sudan were recorded to reside in Arua (UNHCR, 2017c). Of those, over 55,000 reside in Rhino Camp which recorded approximately 10,218 households in September of 2016 (UNHCR, 2016c). Due to the influx in 2016 and 2017, it is expected that Rhino Camp now hoses more refugees and asylum seekers than previously reported.

Overview of Intervention Concentration
In this mapping exercise, six organizations contributed to the 4Ws information. Peter C. Alderman Foundation submitted two responses, one for the general research team, and the other for the Arua clinic team; both were included individually due to the fact that the services for each varied dramatically. The majority of services were community-focused MHPSS (58.3%) with only 8.3% of services reported as general MHPSS. Interventions provided in this area were primarily level 1 (37.5%) and level 2 (31.3%). Services were provided to all identified age and gender groups, though there was a disparity in different population groups. Services were provided in a wide range of settings the majority in homes (35.3%) and general public spaces (29.4%).

Who, Where, What, When
Table 4 summarizes the organizations and focus based on reported MHPSS activity codes. It shows that activities in Rhino Camp covered all three categories of MHPSS service types.

Table 4: Organizations and focus of activities, Arua district, Rhino Camp settlement

Name of Organization	Community-focused MHPSS	Case-focused MHPSS	General MHPSS
Danish Refugee Council	√	√	
International Aid Services	√	√	√
Peter C. Alderman Foundation			√
Peter C. Alderman Foundation - Clinic	√	√	
Save the Children	√	√	
War Child Canada	√	√	√
Windle Trust	√	√	

*For organizations that operate across sites, the graph above is only accounting for activities implemented specifically in Arua district – Rhino Camp settlement.

Figure 11 shows the concentration of activities per area of focus. Results show that among the reported interventions 33.3% were case-focused MHPSS, 58.3% were community-focused MHPSS, and 8.3% were general MHPSS.

Figure 11: Concentration of activities per area of focus, Arua district, Rhino Camp settlement

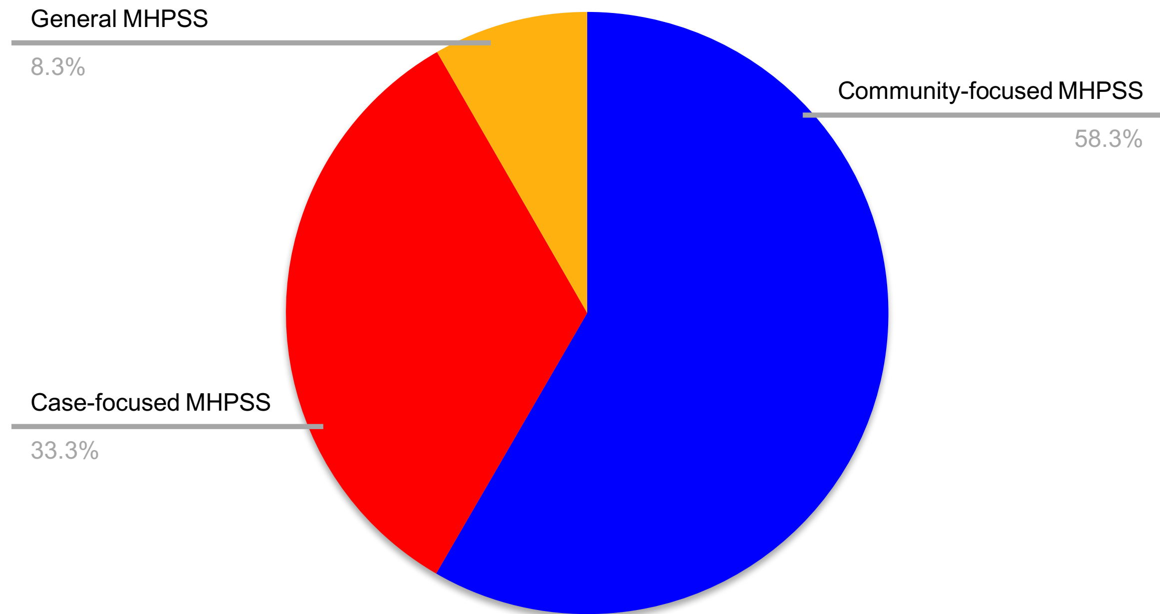
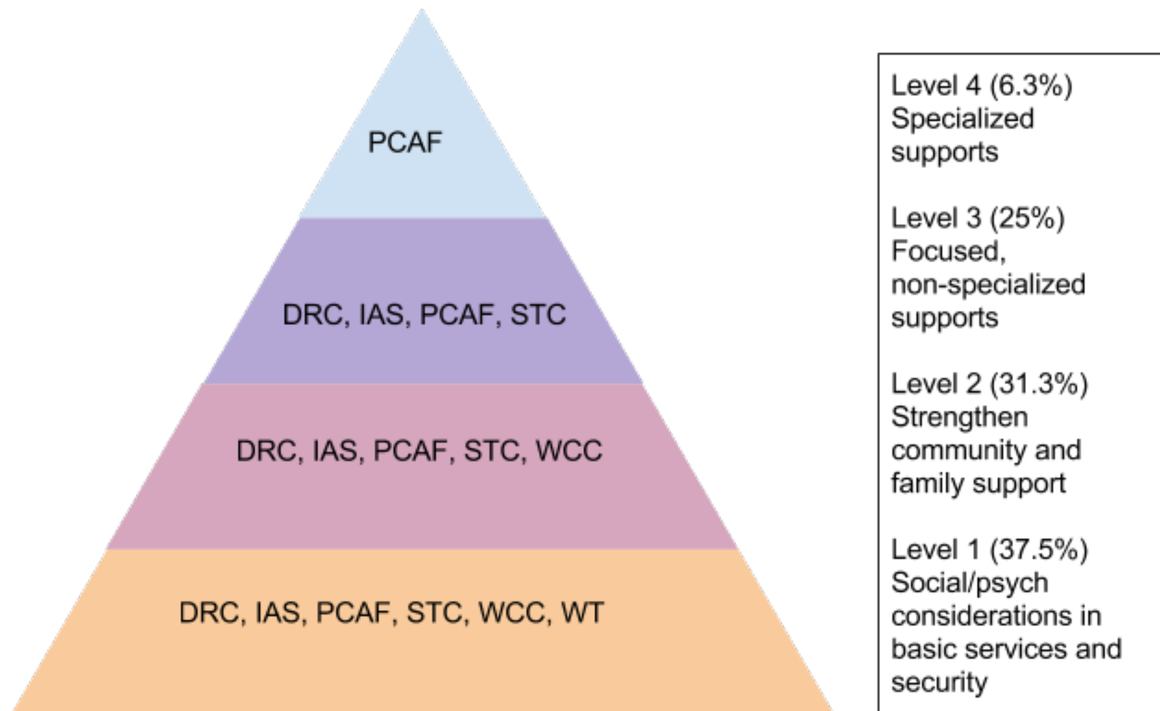


Figure 12: Concentration of activities and organizations on the IASC MHPSS intervention pyramid – Arua District, Rhino Camp Settlement

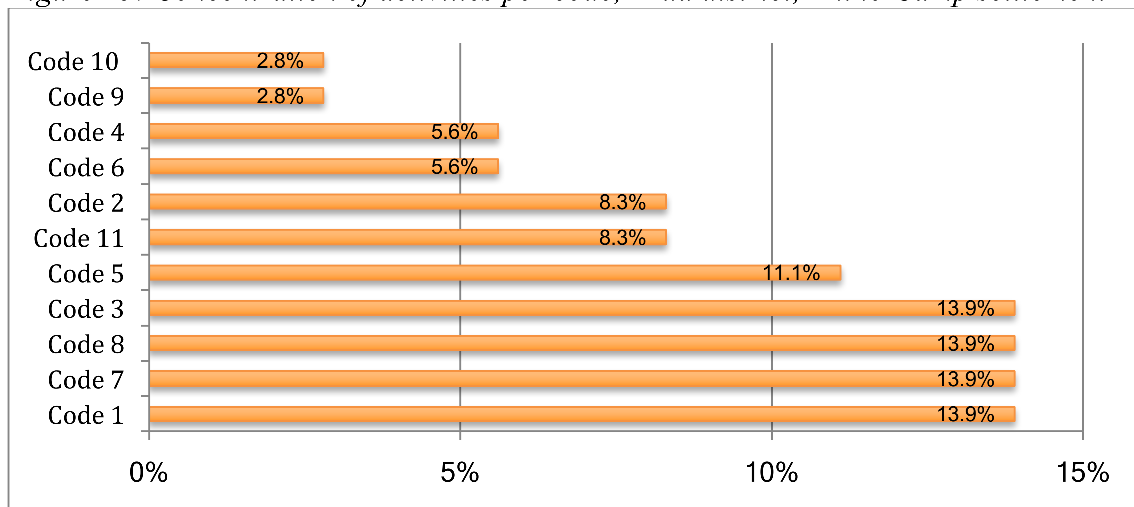


*For organizations that operate across sites, the graph above is only accounting for activities implemented specifically in Arua district – Rhino Camp settlement.

Figure 12 shows the concentration of organizations on the IASC MHPSS intervention pyramid. It shows that most services were Level 1 (social/psych considerations in basic services and security), which accounted for 37.5% of all interventions. Only PCAF was reported to provide Level 4 services (specialized supports) in this location.

Figure 13 below shows the concentration of activities by code. The most frequently reported were code 1 (information dissemination to the community at large), code 3 (strengthening of community and family support), code 7 (person-focused psychosocial work), and code 8 (psychological intervention). All of these codes were reported at 13.9%. The least frequently reported activity codes were codes 9 (clinical management of mental disorders by non-specialized health care providers) and code 10 (clinical management of mental disorders by specialized health care providers); both reported at 2.8%.

Figure 13: Concentration of activities per code, Arua district, Rhino Camp settlement



*Code descriptions are omitted here for brevity purpose. See Appendix 3 for the full list of activity codes.

Figure 14 below shows age and gender distribution of beneficiaries targeted by MHPSS services. The group that was most frequently targeted was female adolescents (21.2%) and the least frequently targeted group was male adults (9.1%). In general, females received more services than male across adolescent and adult groups. Adolescents and children received more services than the other age groups at 18.2% and above.

Figure 14: Age/gender distribution of beneficiaries targeted by MHPSS services, Aura district, Rhino Camp settlement

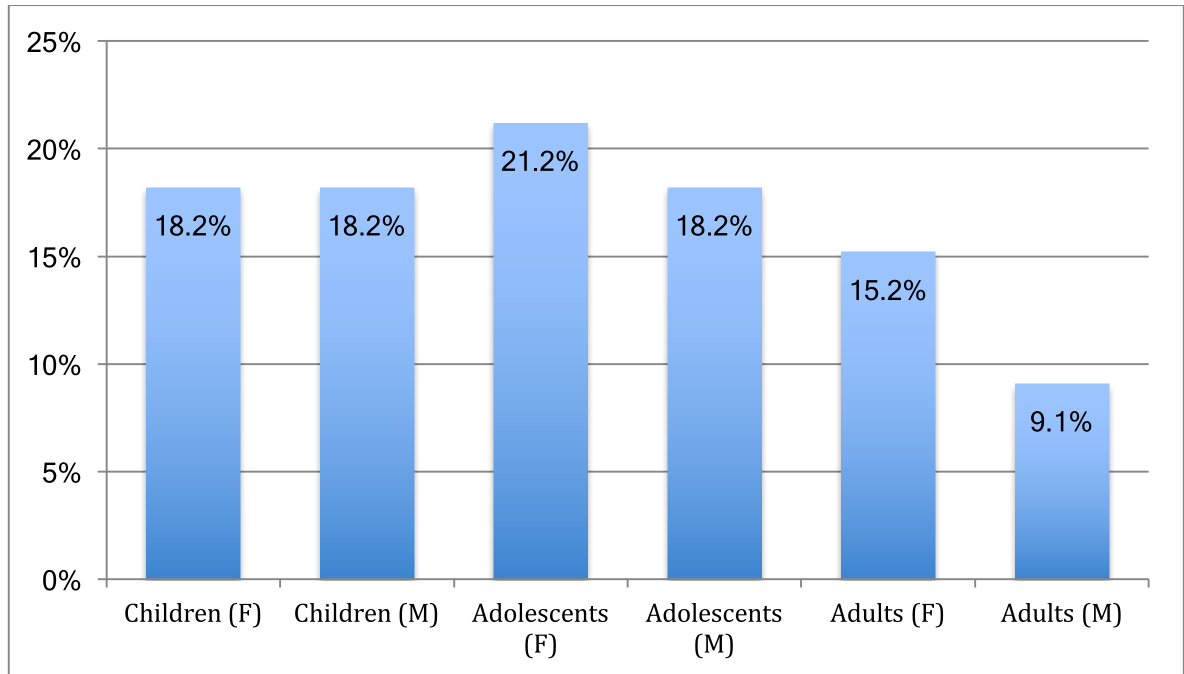


Figure 15: Settings where MHPSS services are provide, Arua district, Rhino Camp settlement

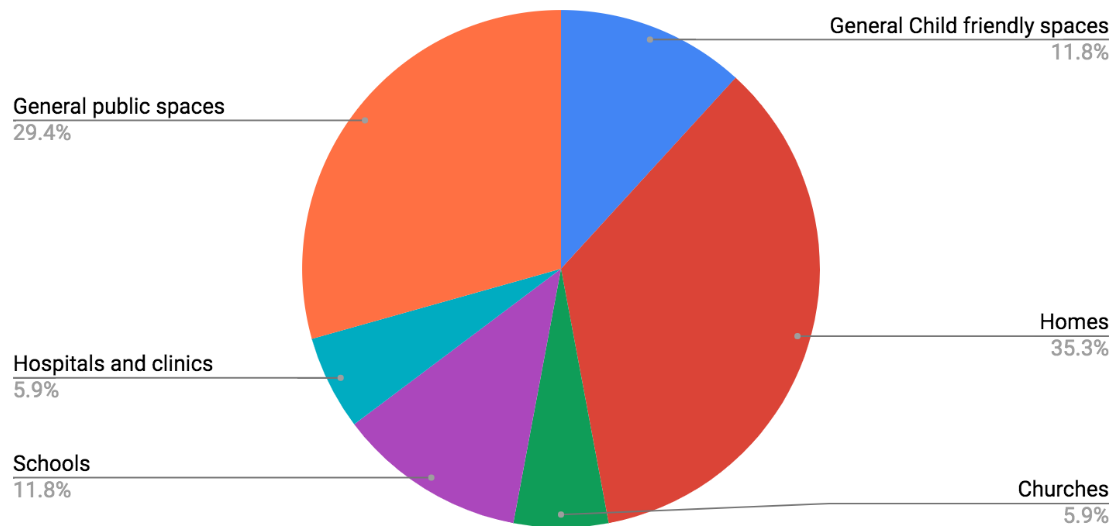


Figure 15 shows that MHPSS services were provided in a wide range of settings in Rhino Camp settlement. The majority of services were provided in homes (35.3%) and general public spaces (29.4%). Services were also provided in general child friendly spaces, schools, hospitals and clinics, and churches.

Yumbe District

Yumbe District is located in the Northern Region of Uganda within the West Nile sub-region, one of Uganda's most northern districts bordered by South Sudan to the north. The population of Yumbe District is mainly Muslim (76%), which is a large exception for the majority of Uganda where approximately 80% of Ugandans are Christians (UBOS, 2002). The Bidi Bidi Refugee Settlement is in Yumbe District; before opening in August of 2016 Bidi Bidi was a small village. Bidi Bidi covers approximately 250 square kilometers of the eastern half of Yumbe district and reaches south from the South Sudanese boarder and west to Moyo District (Reliefweb, 2017). As of September 2017, Yumbe housed 285,014 refugees and asylum seekers (UNHCR, 2017c). As of April 2017, it was reported that Bidi Bidi Refugee Settlement housed over 270,000 South Sudanese refugees fleeing from the ongoing civil war. As of early 2017, it was recognized as the largest refugee settlement in the world (Hattem, 2017). Bidi Bidi is divided into 6 zones and each zone is divided further into multiple subzones. Services and support for basic needs in addition to MHPSS services vary across both zones and subzones.

Overview of Intervention concentration

In this mapping exercise, eight organizations/contacts in Bidi Bidi settlement provided their 4Ws information. However, PTL did not collect the activity codes for Save the Children in Yumbe, therefore, it was excluded from some of the descriptions below. All areas of focus were provided in this area with the majority being community-focused MHPSS (62.5%) and case-focused MHPSS (31.3%). Across all levels of interventions, Level 1 (37.5%) interventions were most frequently reported. Services were provided to all age and gender groups, adolescent females reported as receiving the majority of services (22.6%). Settings in which MHPSS activities were available were limited compared to other sites with the majority of provision reported in general child friendly spaces (50%).

Who, Where, What, When

Table 5 summarizes the organizations and focus based on reported MHPSS activity codes. It shows that activities in Bidi Bidi covered all three categories of MHPSS service types.

Table 5: *Organizations and focus of activities, Yumbe district, Bidi Bidi settlement*

Name of Organization	**Community-focused MHPSS**	**Case-focused MHPSS**	**General MHPSS**
American Refugee Committee	√	√	
Danish Refugee Council	√	√	
International Rescue Committee	√		
PLAN International	√		
Transcultural Psychosocial Organization	√	√	√
War Child Holland	√		
Yumbe District local government	√	√	√

*For organizations that operate across sites, the graph above is only accounting for activities implemented specifically in Yumbe district – Bidi Bidi settlement.

*Data received from Save the Children (Bidi Bidi) was missing MHPSS activity codes and was therefore excluded from the above table.

Figure 16 shows the concentration of activities per area of focus. Results show that among the reported interventions, 62.5% were community-focused MHPSS, 31.3% were case-focused MHPSS, and 6.3% were general MHPSS.

Figure 16: Concentration of activities per area of focus, Yumbe district, Bidi Bidi settlement

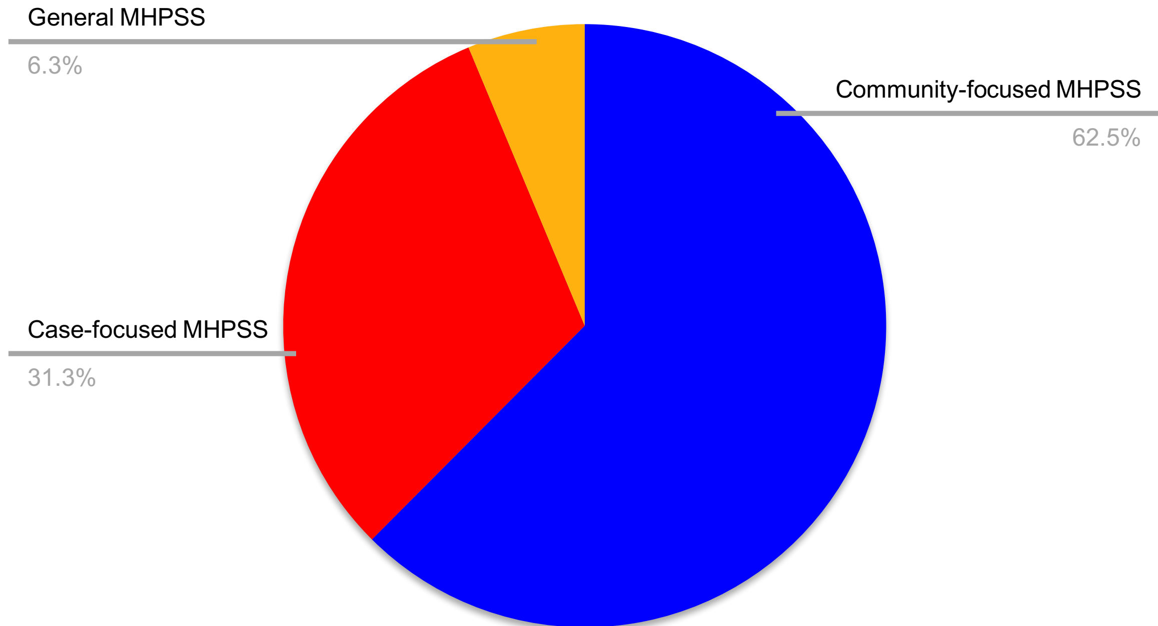
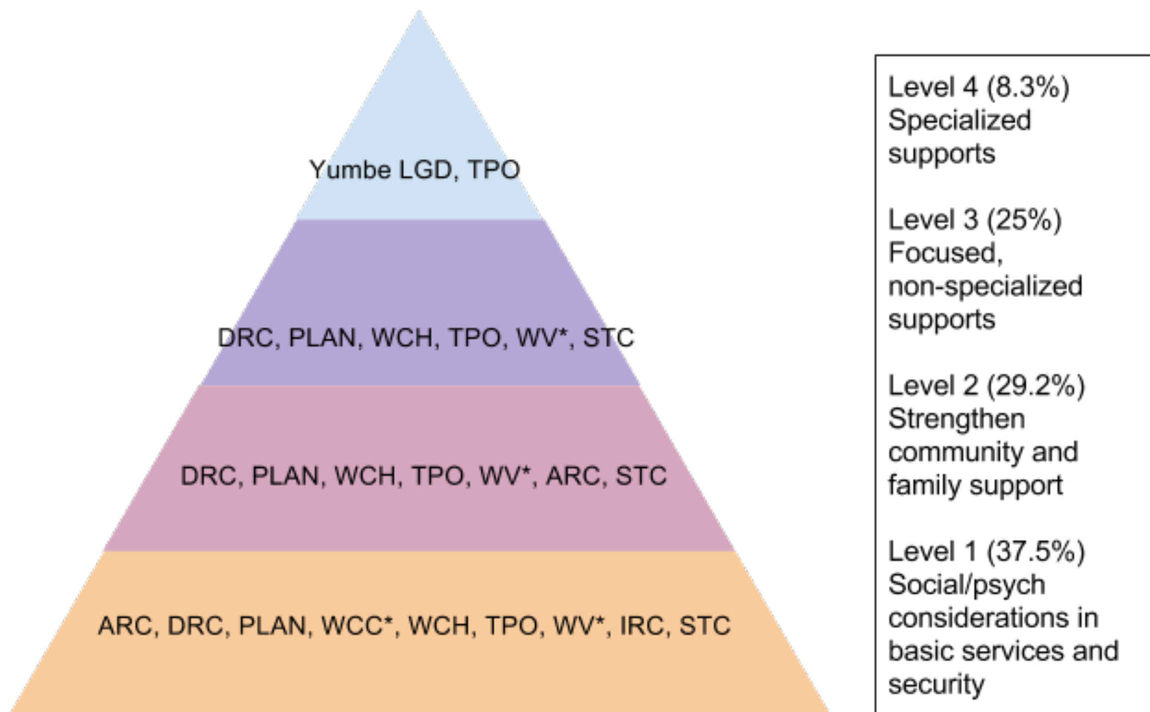


Figure 17: Concentration of activities and organizations on the IASC MHPSS intervention pyramid – Yumbe District, Bidi Bidi Settlement



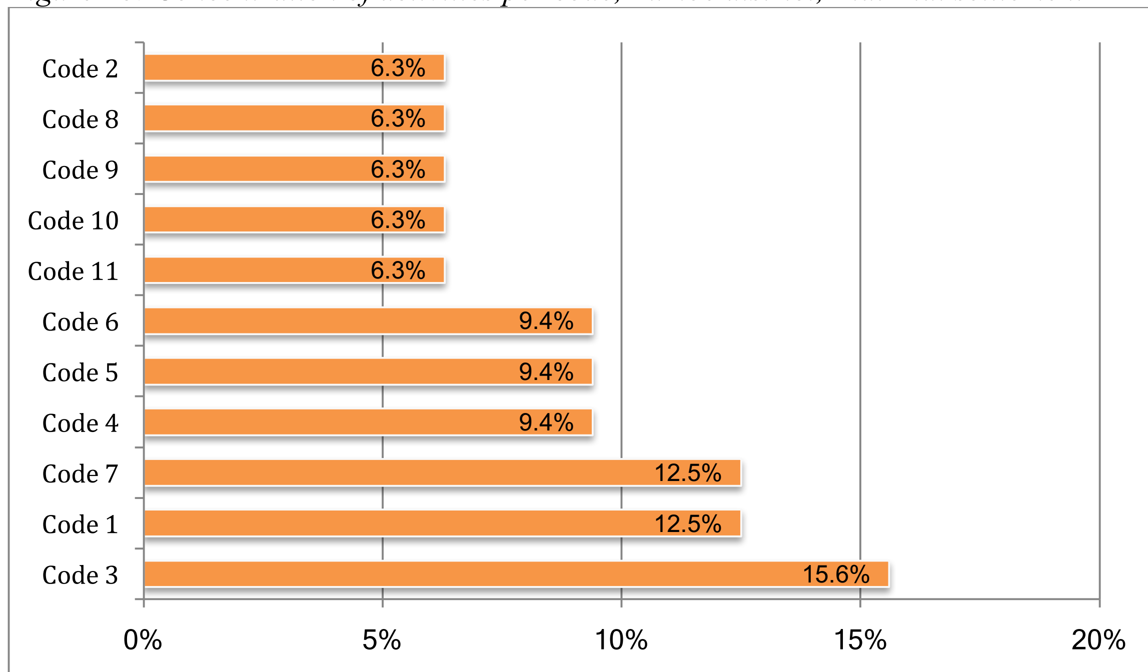
*For organizations that operate across sites, the graph above only accounts for activities implemented specifically in Yumbe district – Bidi Bidi settlement.
*PTL only received information about intervention pyramid on War Child Canada (Bidi Bidi), and World Vision (Bidi Bidi), therefore these organizations are only listed in intervention pyramid and not included in additional data reporting.

Figure 17 shows the concentration of organizations on the IASC MHPSS intervention pyramid. It shows that most services were Level 1 (social/psych considerations in basic services and security), which accounted for 37.5% of all interventions. The least reported services were Level 4 (specialized supports), which only accounted for 8.3% of all interventions.

Figure 18 shows the concentration of activities by code. All activity codes were reported from this site. The most frequently reported activity code was code 3 (strengthening of community and family support) at 15.6%.

The least frequently reported activities were code 2 (facilitating conditions for community mobilization, organization, ownership or control over emergency relief in general), code 8 (psychological intervention), code 9 (clinical management of mental disorders by non-specialized health care providers), code 10 (clinical management of mental disorders by specialized health care providers), and code 11 (general activities to support MHPSS). All reported at 6.3% concentration.

Figure 18: Concentration of activities per code, Yumbe district, Bidi Bidi settlement



*Code descriptions are omitted here for brevity purpose. See Appendix 3 for the full list of activity codes.

Figure 19 shows age and gender distribution of beneficiaries targeted by MHPSS services. The group that was most frequently targeted was female adolescents (22.6%). The group least targeted were children of both genders with each accounting for 13.2% of all participants.

Figure 19: Age/gender distribution of beneficiaries targeted by MHPSS services, Yumbe district, Bidi Bidi settlement

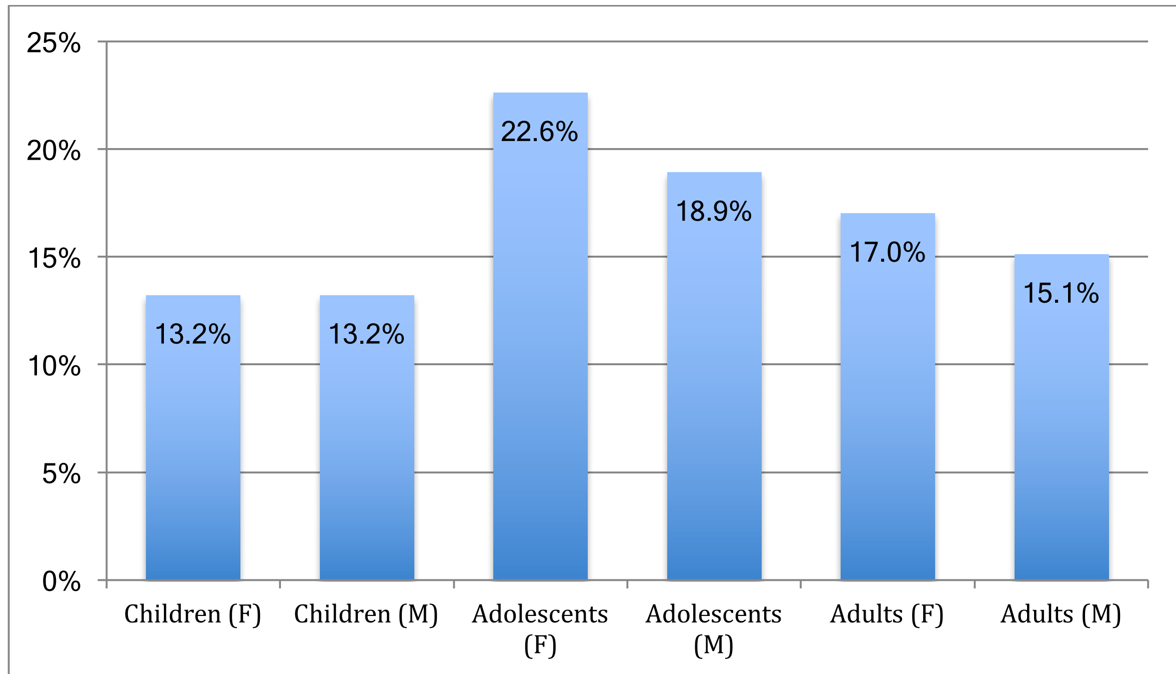
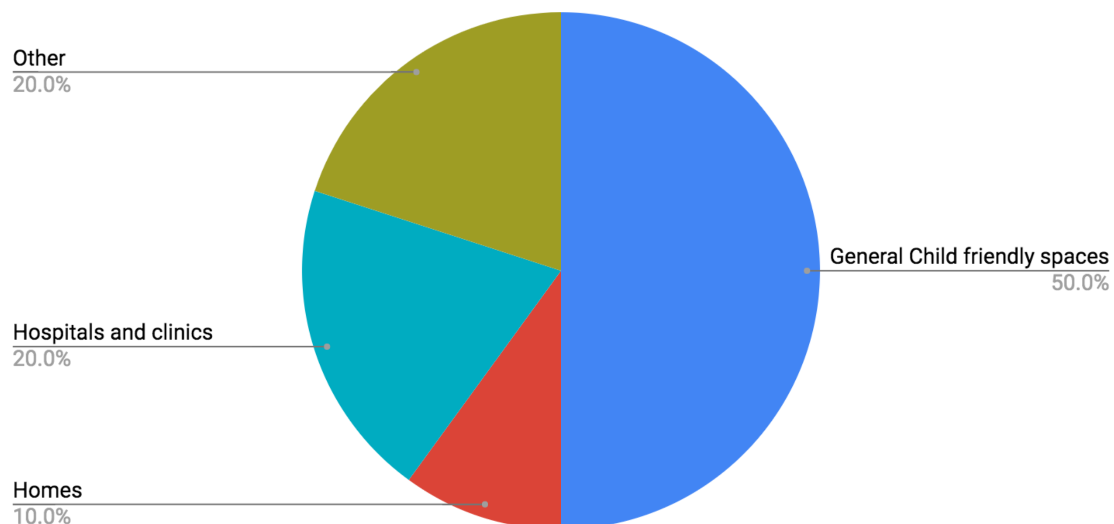


Figure 20 shows the settings where MHPSS services were provided in Bidi Bidi. MHPSS services were mostly provided in general child friendly spaces (50%). The rest were provided in hospitals and clinics (20%), other (20%), and people's homes (10%).

Figure 20: Settings where MHPSS services are provide, Yumbe district, Bidi Bidi settlement



Adjumani District

Adjumani District is located in the Northern Region and West Nile sub-region of Uganda and named, as most other Ugandan districts, after its 'chief town', Adjumani, the location of district headquarters. Adjumani District is bordered by Moyo District to the north, South Sudan to the northeast, Amuru District to the east and south, Arua District to the southwest and Yumbe District to the northwest. Adjumani District was created in May 1997, when Moyo District was split into two; the eastern part of Moyo District was re-named Adjumani District and the western part of the old Moyo District remained as what is known today as Moyo District. As of September 2017, a total of 239,335 refugees and asylum-seekers from resided in Adjumani. Within Adjumani District, there are 19 settlements, each varying in size and the date of opening.

Overview of Intervention Concentration

It is important to note that for Adjumani District, PTL included all organization providing MHPSS services across the district rather than restricting to services provided to one specific settlement. This is different from the site locations due to the vast number of settlements in Adjumani District. Key stakeholders and PTL staff members felt it was important to complete the mapping exercise on a district level rather than settlement level in Adjumani to ensure mapping collected information that would be valuable for participating organizations.

In this mapping exercise, nine organizations based in Adjumani District contributed to 4Ws data collection. Organizations offered services across all focus areas (community-focused, case-focused, and general MHPSS); the majority of services were community-focused MHPSS at 61.7%. Services in this district were distributed across all levels of interventions; level 1 accounted for the majority of services at 35.3%. All age and gender groups received services; children and adolescents across both genders received more services than adults. Female children reported the most services at 23.1%, followed by male children at 21.2%. Services were available across a large variety of settings. The majority of services were reported as provided in homes (17.86%) and schools (17.86%).

Who, Where, What, When

Table 6 summarizes the organizations and their focus based on reported MHPSS activity codes. It shows that activities in Adjumani covered all focus areas. TPO, LWF, and MTI reported services across all three areas.

Table 6: *Organizations and focus of activities, Adjumani district*

Name of Organization	Community-focused MHPSS	Case-focused MHPSS	General MHPSS
Danish Refugee Council	√	√	
Lutheran World Federation	√	√	√
Medical Teams International	√	√	√
Save the Children	√	√	
Transcultural Psychosocial Organization	√	√	√
Tutapona	√	√	

War Child Canada	√		
War Child Holland	√	√	
Windle Trust	√		

*For organizations that operate across sites, the graph above is only accounting for activities implemented specifically in Adjumani district.

Figure 21 shows the concentration of activities per area of focus. Results show that among the reported interventions, 61.7% were community-focused MHPSS, 31.9% were case-focused MHPSS, and 6.4% were general MHPSS.

Figure 21: Concentration of activities per area of focus, Adjumani district

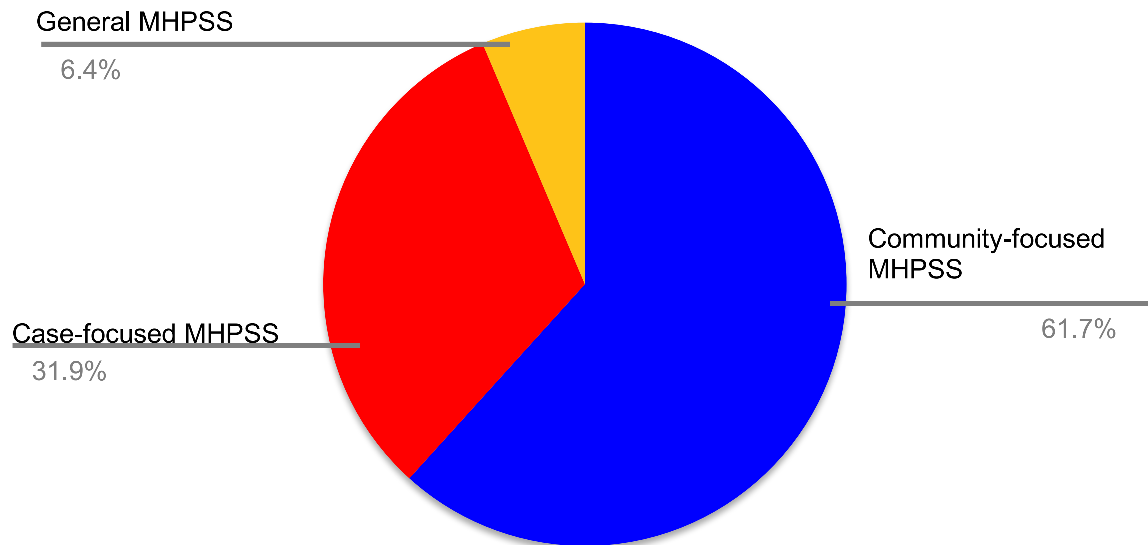
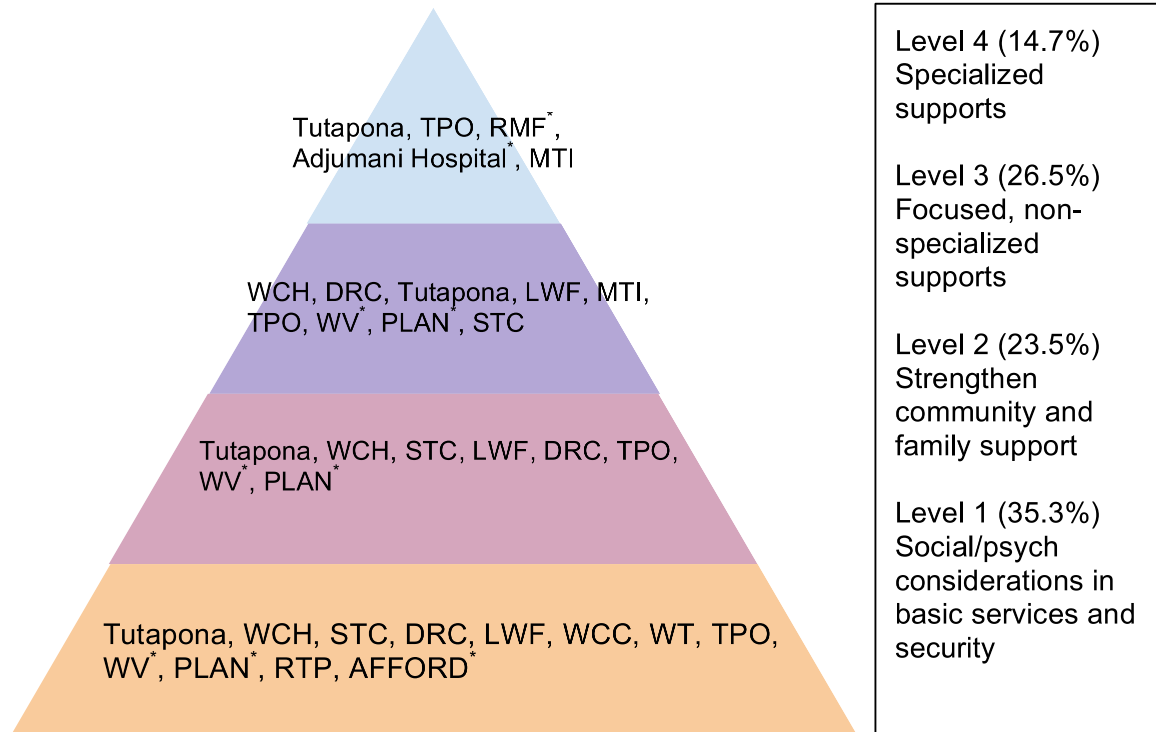


Figure 22 below shows the concentration of organizations on the IASC MHPSS intervention pyramid. It shows that most services were level 1 (social/psych considerations in basic services and security), which accounted for 35.3% of all interventions. The least reported services were level 4 (focused, specialized supports), which only accounted for 14.7% of all interventions. The interventions in Adjumani presented a good example of ideal structure of MHPSS services; that is, most activities faced the general public and fell on the lower levels (level 1, level 2, and level 3), while more focused care was targeted to specific groups and accounted for less of all activities.

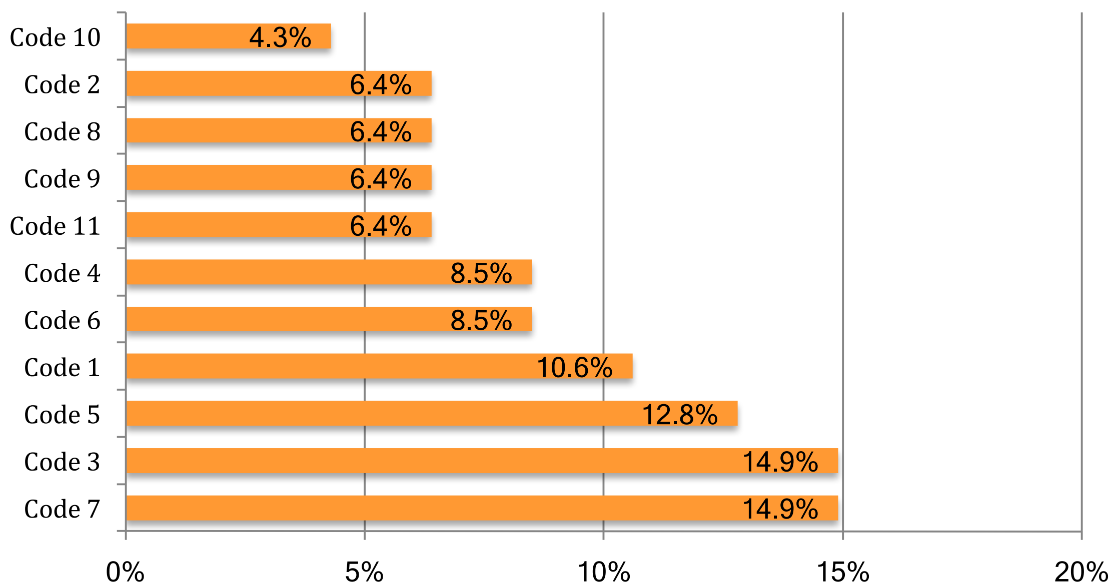
TPO and Tutapona are key MHPSS organizations working in Uganda, both with service provision in Adjumani. Both TPO and Tutapona provide MHPSS services that span across the intervention pyramid. Key stakeholders in Adjumani reported a comprehensive referral pathway for the provision of MHPSS services. Key stakeholders also highlighted that despite many organizations working to support MHPSS services, access to services for participants were often unavailable due to lack of funding and resources. It is important to note that in this district, services are distributed across multiple settlements; therefore organizations working in some settlements are not present in others due to limited resources and funding. Multiple organizations reported the goal to expand services into other settlements currently lacking care.

Figure 22: Concentration of activities and organizations on the IASC MHPSS intervention pyramid – Adjumani District



*For organizations that operate across sites, the graph above is only accounting for activities implemented specifically in Adjumani district.
*PTL only received information about intervention pyramid on World Vision (Adjumani), PLAN International (Adjumani), Real Medicine Foundation (Adjumani), AFFORD (Adjumani), and Adjumani Hospital, therefore the three organizations are only listed in intervention pyramid and not reflected in other data.

Figure 23: Concentration of activities per code, Adjumani district



*Code descriptions are omitted here for brevity purpose. See Appendix 3 for the full list of activity codes.

Figure 23 shows the concentration of activities by code. All codes of activities were reported in this district. The most frequently reported activity code were code 3 (strengthening community and family support) and code 7 (person-focused psychosocial work). Both presented at 14.9%. Among all reported codes, the least frequently reported activities was code 10 clinical management of mental health disorders by specialized mental health care providers) at 4.3%.

Figure 24 shows the age and gender distribution of beneficiaries targeted by MHPSS services. Among all groups, female children were most targeted, accounting for 23.1% of all beneficiaries, while adults of both genders were least targeted, each only accounting for 9.6% of all beneficiaries.

Figure 24: Age/gender distribution of beneficiaries targeted by MHPSS services, Adjumani district

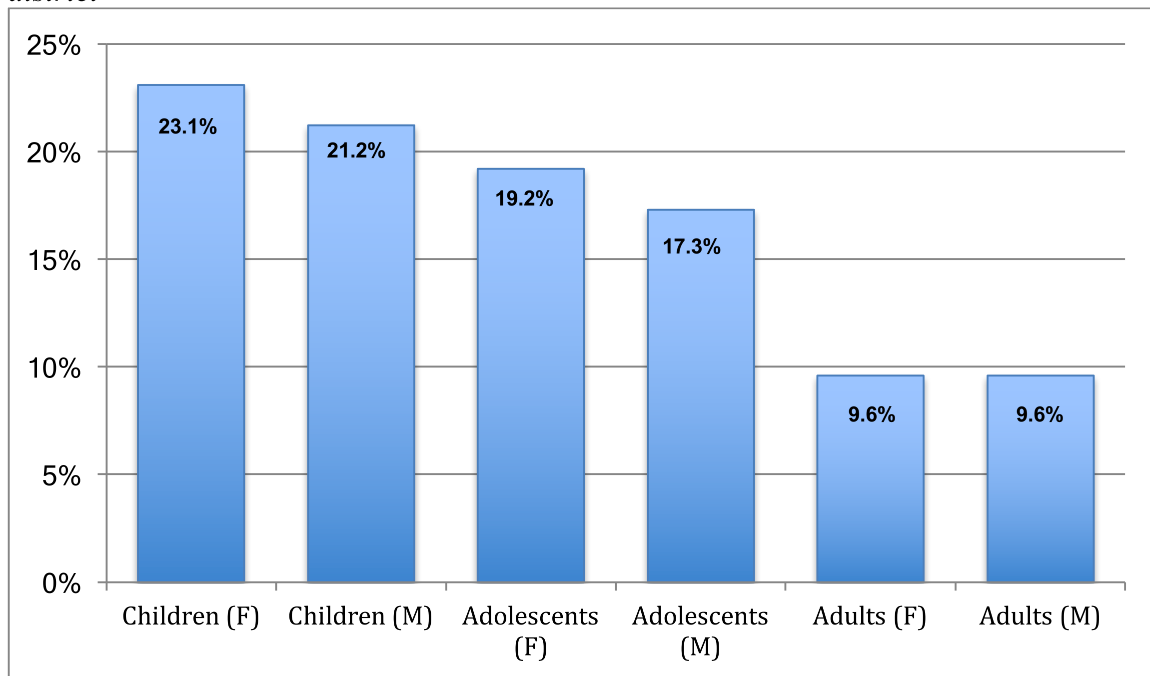
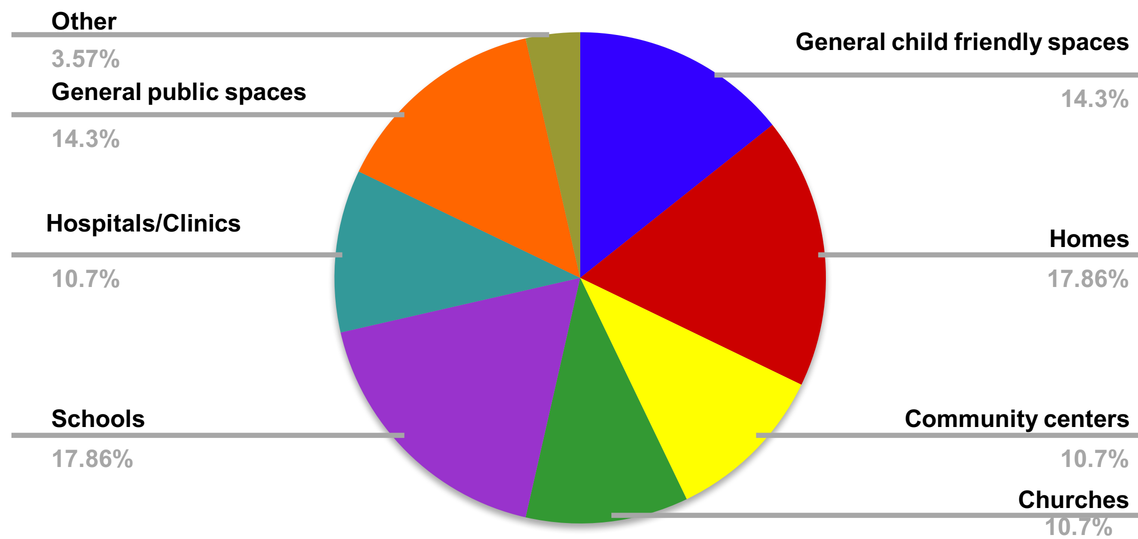


Figure 25 below shows that MHPSS services were provided in a largest variety of settings in Adjumani District compared to other site locations. The majority of services were provided in homes (17.86%) and schools (17.86%). Other settings included general child friendly spaces (14.3%), community centers (10.7), general public spaces (14.3%), churches (10.7%), hospitals and clinics (10.7%), and other (offices, etc.) (3.57%).

Figure 25: Settings where MHPSS services are provide, Adjumani district



DISCUSSION

Comparisons of Site Locations

In general, the MHPSS services provided for South Sudanese refugee population in the selected site locations is scarce. Despite a broad number of organizations working to bridge the gap in services, PTL found that services in settlements are often isolated to the number of zones/areas within a settlement due to limited finances and human resources. Key stakeholders and collaborating organizations highlighted the desire to expand across other zones in order to increase MHPSS care services. Among the existing services, there is a gap in coverage in the four investigated sites across the scope of interventions, availability of services across age groups, and across the service setting.

It is vital to note that these findings are a preliminary examination of the MHPSS organizations working across the selected site locations and that only organizations that completed the 4Ws mapping exercise were able to be included in the data analysis process. Additional information on specific zones where services were provided in each settlement would be valuable information for further evaluating the gap in services.

<u>Type and Concentration of Activities</u>
When mapping the type and concentration of activities, the types of activities included: community-focused MHPSS, case-focused MHPSS, and general MHPSS. Across all sites, community-focused MHPSS was the highest reported, followed by case-focused MHPSS. General MHPSS services accounted for a smallest portion of all services in all sites when combined and also all individual site locations.

The levels of service intervention were mapped across the IASC intervention pyramid. These levels included the following: level 1(social/psycho considerations in basic services and security), level 2 (services that strengthen community and family support), level 3 (focused, non-specialized supports), and level 4 (specialized supports). When looking at the

concentration of all activities across all sites together presented the most services at level 1 (36.8%), followed by level 2 (26.4%), level 3 (25.3%), and level 4 (11.5%). Though varying in numbers, when examined individually, all site locations presented the majority of services in level 1 and the minority of services in level 4. Percentages of activities in level 2 and 3 varied across the site locations. Literature highlights the importance of community and family support services when approaching MHPSS due to the link between daily stressors/current life experiences and well being.

Beneficiaries

All sites reported service provision across age groups and genders, though each site had slightly different makeup of their targeted populations. Based on data collected, across all sites adolescent females received the majority of services and adult males received the least services. Some organizations provided specialized programs by age/gender (ex. DRC's provision of basic services to adolescent females through the vocational program) whereas others provided services to all individuals (ex. RMF's provision of clinical care services in hospitals and clinics). Key stakeholders across many organizations highlighted that despite services that were open to all age/genders the majority of the participants were adolescent females due to high levels of gender-based violence.

The majority of services were provided for both South Sudanese refugees and Ugandan nationals across all sites, usually with a divide of 70% refugees and 30% nationals; the only programs that reported not providing services to refugees and nationals were in the pilot stage of programming and therefore only provided services to refugees. These organizations projected increasing services to nationals after the pilot phase of programming was complete before full-scale roll out.

Numbers of participants in each activity varied based on the capacity and focus of each organization. For example, IAS at Rhino Camp only targeted 90 teenage girls in total and provided extensive services, including counseling, education and recreational activities. On the other hand, ARC at Bidi Bidi offered general protection to participants, and had 76,000 refugees registered since they implemented the program. It is also important to note that different zones within each settlement may vary in services for participants based on age and gender. These results, therefore, need to be interpreted with caution because of the limited data.

Settings

When mapping the setting of MHPSS services, PTL focused on the following eight key settings: general public spaces, hospitals and clinics, schools, churches, child friendly spaces, homes, community centers and other. In looking at all sites together, the majority of MHPSS activities reported occurring in homes, general child-friendly spaces, and general public spaces. In reviewing the data, it is important to note that the majority of organizations reported activities across multiple settings rather than one specific setting. Each time a setting was mentioned across a site location, it was incorporated into the setting data.
The greatest variety in settings was reported in Adjumani District where all eight setting options were reported. This may be due to the fact that Adjumani District included all settlements in Adjumani whereas the other site locations only included one settlement per district. Bidi Bidi in Yumbe District reported the least variety of settings of MHPSS services

with only four different types of settings. Of note, this could be greatly skewed for each site location and not a full representation of the settings due to minimal data in this area.

Completeness and Quality of Evidence

This information compiled in this report is based on the 4Ws mapping tools; information not received by organizations is not included in the report. PTL sought to collect key MHPSS program information from known MHPSS organizations across the identified site locations. PTL received feedback and suggestions for contacts from both key stakeholders and collaborating organizations to ensure that the information in this summary report was as accurate as possible and beneficial for all parties use.

As previously noted, the 4Ws information was filled out either in-person or through emails. For data collected across both methods, there was usually missing information in initial response. When missing information was noted, PTL team members reached out to collaborating organization contact for clarity to ensure all information was accurately recorded. The data points missing most included the following: "description of activity", "topic and lengths of non-university training for MHPSS workers", and "availability of services". It is assumed that these items usually require more detailed information from the organizations, and that one person might not have all information to fill out the form.

For data collected, there was ambiguity in some data points. For example, when answering "target population of services", some responses were only vague age groups without specifying genders, which required additional clarification afterwards. Another ambiguous response item was "settings where MHPSS activity is provided", where organizations report general child friendly spaces without clarifying specific locations, such as homes, schools, etc.

Follow-ups requests for missing information or clarifications were sent out via emails after initial data collection. However, due to the emergency situation in Uganda and the frequent staff turnover in some organizations, not all missing information was received by the time of this report. Due to the nature of qualitative data collection, there was still some level of ambiguity in certain data points so reviewers worked to make educated decisions on how to analyze and present the data. Two reviewers completed independent data analysis to minimize errors and discrepancies.

To minimize the misrepresentation of collaborating organizations MHPSS services, PTL team members sought to complete two drafts of the summary report prior to the final report to give ample time for feedback from key stakeholders and collaborating organizations. The first draft was sent via email to key stakeholders for feedback requests, the second draft was brought to in-person meetings led by PTL team members and afterward sent to collaborating organizations. After both of these steps were completed and feedback from all contributing organizations through both draft opportunities was included, a final summary report was completed. It is important to note that despite efforts, PTL staff members may have missed sending versions of the draft to contacts due to staff error or turnover in collaborating organizations contacts. PTL also recognizes that due to the nature of this context and time constraints that this summary report is still missing organizations providing MHPSS in these

areas. PTL seeks this report to be an initial framework for further expansion and use by all collaborating organizations and key stakeholders.

Potential Biases

This mapping exercise has many potential biases. First, due to the small sample size, it was not able to capture an accurate picture of the MHPSS programs/activities in the field. The 4Ws information received was limited because of the frequent staff turnover in organizations, difficulty in email communications, the time-consuming feature of the task, and no immediate benefits perceived by partner organizations. Second, many responses lacked the desired details needed for a more precise summary of ongoing activities. For example, in answering settings where MHPSS were provided, not all organizations delved into details and described specific locations or zones within the settlements where programs were implemented. The lack of details can cause inaccuracy in reporting. In addition, some of the items are still missing data to the date. Third, since the data is self-reported by each organization, there could be some over- or under-reporting of some items. Frequent personnel change can also cause inconsistencies in reporting.

PTL worked to mitigate these biases by completed ongoing cyclical conversations with collaborating organizations and key stakeholders both in person and via email correspondence for feedback. In addition, PTL collaborated with TPO, one of the leading MHPSS organizations in Uganda. TPO completed a final validation review of the data and recommendations. In addition to completing a validation of data, TPO completed a comprehensive review of draft two of this report and made recommendations for the final draft; additional edits may be completed with TPO prior to publication. PTL recognizes the importance of working collaboratively with organizations such as TPO in order to minimize the potential biases in the reporting process.

V. SECTION V – RECOMMENDATIONS

PROGRAMMING AND CAPACITY BUILDING WITHIN THE FOUR LEVELS

It is recommended from the literature review and needs and resource assessment that there is an increase in capacity across all four levels of the IASC pyramid. With over a million new South Sudanese refugees, there is a dire gap in services across all site locations. The following are suggestions specific to each level. It should be noted that within all levels it is highly recommended to involve the refugee and host community in decision-making, development, and implementation. These communities are the experts in their needs and cultures, and the inclusion of their ideas and involvement will grow advocacy, knowledge, integration, and sustainability. The *UNHCR Community-Based Protection and Mental Health and Psychosocial Support* was used to guide the following recommendations (UNHCR, 2017).

Level One: Social Considerations in Basic Services and Security

There have been an unprecedented number of refugees who fled to Uganda in 2016-2017, and due to this, all systems within Uganda's refugee infrastructure have been significantly stretched. When basic services and security is limited, a person and family can experience an increase of anxiety, frustration, tension, and stress. This can lead to the need for more specialized services when basic services are not met.

There is a dire need for basic needs including: food security, sanitation, shelter, special needs support, water, security, health, education, and MHPSS programming. It is recommended that there is an increase of basic services across the board to meet the MHPSS needs of incoming and settled refugees. It is recommended that an increase of training for psychological first aid (PFA) be provided to front line community volunteers. By increasing PFA services, incoming refugees will understand where they can receive their basic needs, and refugees with more specialized needs will have guidance through the referral pathway.

An increase of basic programming for Sexual and Gender Based Violence (SGBV) and Protection, which include: education, advocacy, and identification of refugees needing services, is recommended with this level. By increasing programming and services, there should be an increase of needs identification and case management for refugees needing more specialized services, as well as an increase in knowledge and awareness.

Currently 36.8% of programming reported across all included site locations in this assessment fall into this category. It is recommended that more agencies working within the protection, security, and basic needs sector adopt MHPSS training, advocacy, and policy within their approach. This level of care can be implemented at a low cost and can be easily integrated into multiple sectors and clusters. By doing so refugees and the host community will have more basic support of the MHPSS needs, which should lead to a decreased need for more specialized services.

Level Two: Strengthening Community and Family Supports

Community and family support can be one of the most effective tools to decrease stress and improve resiliency. When a person is experiencing stress and issues, they typically reach out to their community and family first. In a refugee context, many families and communities have been torn apart through displacement and death. It is imperative that agencies focus on building support systems through building community structures, safe spaces, social support for persons with disabilities, psycho education of MHPSS and SGBV, promotion of safety and connections, peer to peer support, mentoring programs, and livelihood programs.

This assessment found that 26.4% of programming across all site locations focused in this area. Some examples of programming included child friendly spaces, livelihood programming, and peer support programs. During the semi structured interview process, interviewees within the settlement mentioned community and family resources, which included: churches, community leaders, adolescent ambassadors, strong social network, etc. The interviews also produced a list of needs, which highlighted the need to increase these resources.

It is recommended that an increase of community and family support programs be implemented to strengthen the leadership resources within the refugee and host community population. Examples of agencies that can increase these programming are: education organizations, religious organizations, organizations that have child friendly spaces, community health organizations, and agencies focused on health, protection, and SGBV. It is recommended that residents themselves be trained to be facilitators, community outreach volunteers, peer counselors, and educators.

Level Three: Focused (person to person) Non-specialized Supports

This assessment found that 25.3% of programming across all site locations focused on level 3. This level focuses on individuals who cannot overcome their MHPSS issues through community and family support and require additional and outside support. Interventions within this level are individual, family, and group interventions and programming focused on more severe mental health issues like depression, grief, anxiety, and complex social issues. During the interviews, many of the community volunteers, mentors, and facilitators working in the level three programming stated that they were trained in basic support and referrals but felt unskilled in basic counseling skills. Many stated that they were trained in identifying the issue but felt unskilled in helping to address the individual or family's need.

It is recommended that an increase of programming focused on training basic mental health interventions to para professionals be implemented. Within this level para professionals should have ongoing training and supervision to decrease risk of harm and increase quality of programming. Training can be two-fold, where refugees can be trained as peer MHPSS providers and also Ugandan social workers can be trained with more psychological skills. This could be done through existing university programs at Makere University in Uganda, for example. There is a high need to build a cadres of health and social care professionals. In the interviews, many facilitators stated they were only trained once on the mental health programming they were providing and in turn felt unprepared when providing services.

Program beneficiaries should be persons who have indicated mild to moderate mental health issues ranging from all ages and genders. Based on interviews and literature review, it is also recommended to increase mental health recreational programming, including therapeutic expressive arts, livelihood using creative arts, and sports.

Level Four: Specialized Services

Level four programming is focused on severe cases of mental health that could require medical or professional intervention. This assessment found that 11.5% of programs provided this support. While the majority of the population can find healing in the three other levels of support, there is a population of people who are highly vulnerable to protection due to severe mental health issues. Focus for care should be on treatment for persons with severe mental health disorders.

It is recommended that there is an increase of mhGAP training to general practitioners due to the limited number of psychiatrists within the districts and settlement areas (WHO & UNHCR, 2015). Additionally, practitioner led individual and group therapy for persons experiencing severe distress should accompany medical interventions. The increase in skilled professions across level 1, level 2, and level 3 would ideally reduce the burden at level 4.

COORDINATION

It is recommended that all agencies interviewed during this mapping process continue to coordinate efforts in addressing the MHPSS gap. During the interviewing process, coordination seemed to be a priority in all settlements' main offices, but in the settlements there was confusion for the current MHPSS facilitators on who to contact and how. Organizations should collaborate together to provide supervision and training to inform other acting agencies and share best practices. Organizations who provide specialized care should continue to work with organizations doing less specialized care to build a referral system. Of note, even in areas where coordination and communication was reflected across key stakeholders, due to funding and resource gaps the availability of services were minimal.

The Uganda MHPSS working group should also play an active role in organizing programming and responses, while ensuring that all programming implemented are meeting ethical criteria set by IASC.

FUTURE 4WS MAPPING & TOOL ADAPTION

It is recommended that a mapping process is created and implemented throughout the year or annually to keep organizations and coordination up to date. It was clear during the interview process that many programs and service provisions change throughout the year and change vastly from year to year due to grant cycles and the changing environment and influx.

Training for all MHPSS working groups in each site location on the 4Ws mapping tools and an identified organization to manage the process is recommended moving forward. In addition, an easy to access database is recommended for use of all organizations, where organizations can fill out the 4Ws questions and access information on what populations are

receiving services. This could help provide better coordination and limit the chance for duplication of services to the same population. There is now an online version available of the original 4Ws mapping tool, which could also be used in the future in Uganda; this tool may be beneficial to facilitate data collection for updates to this report. Funding and resources for the update of this report would need to be secured.

If done properly this report could provide agencies, the Ugandan government, UNHCR, and donors the understanding of where the gaps are and what organizations are close by. Collaborating organizations could use the report in grant and funding applications to highlight their work and areas of focus for seeking advancement of services.

PLAYING TO LIVE PILOT PROGRAM DEVELOPMENT AND IMPLEMENTATION

This assessment has identified major gaps in all IASC levels of MHPSS services. During key-stakeholder meetings, there was complete agreement that all levels need to be increased in order to better support the needs of children, adolescents, and their communities. The majority of key-stakeholders emphasized the importance of prioritizing level 2 (strengthening community and family supports) and level 3 (focused non-specialized supports). The stakeholders recognized the dire gap in local professionals, and they spoke about the importance of strengthening the resources within the community.

Playing to Live specializes in building custom psychosocial expressive arts programs in low resource, high trauma communities, where our development and programming fits within level 2 and 3 primarily. PTL's program focuses on building community and family MHPSS capacity through advocacy, building knowledge, and collaborating with the community. Additionally, PTL focuses on building skill capacity within the community through continuous training and supervision throughout the life of the programming. PTL's focus is to build upon existing infrastructures and resources rather than recreate existing programming. PTL looks to partner with organizations currently working within the refugee communities with the goal to build a complimentary, low cost, and effective program. Appendix 6 outlines PTL's program model from the start where the child experiences a traumatic, to PTL's four-model intervention, to the impact of our model, and to the outcome of our full intervention. Appendix 7 outlines the roles of PTL and the partner organization during the program implementation. PTL seeks to build a program that works with established resources in communities. PTL acts as program developers, trainers, and program support through a partnered community organization. PTL believes that this will build capacity within the community for sustainability and efficiency even after programming is finished.

This report has provided PTL with essential knowledge, connections to organizations, and relationships within the refugee response to move forward with building a pilot program. The first step will be to finalize a partnership with an organization within Uganda and to build a pilot program that will last 10 months. Appendix 8 outlines the initial work plan PTL has created to build an effective pilot program. The pilot will be used to test and adapt PTL's program, and following a successful pilot program, PTL will seek to scale up the programming to meet the enormous need for MHPSS programming for Ugandan and South Sudanese children.

THE ROLE OF ECONOMIC OPPORTUNITY

Qualitative interviews in this report were primarily through the DRC's adolescent girls vocational skills program. The adolescent interviewees stated that due to receiving vocational training they were beginning to gain a higher quality of life. They stated that they now could feed themselves and their siblings, were less likely to agree to early marriage, were abstaining from previous risky behavior, and were experiencing less stress. Their mentors agreed with these statements based on their observations, but when the questions became more specific to mental health and psychosocial wellbeing, the majority of adolescents spoke about their still present grief and stress due to their loss and experiences, and their mentors spoke about not feeling equipped with skills to work with the girls and their families.

Playing to Live noted that the vocational training significantly helped fill in some of the gaps in basic needs for the adolescent girls, but the girls are still experiencing a large impact on their mental health due to the immense loss and trauma they have experienced. Additionally, their mentors feel that they do not have the skills to support these needs. Playing to Live recommends that a vocational or educational program is combined with a MHPSS program, so that children receive a holistic program to aid in their recovery.

CONCLUSION

Uganda has one of the most progressive and welcoming refugee policies in the world. Over a million South Sudanese refugees have sought safety within its borders, but due to the continual large migration of refugees in the past year, all resources, including basic needs and protection, are continually stretched to the maximum capacity. While basic needs, like shelter, food, and water, are the top priority, this assessment's research and literature review highlight the significance of establishing MHPSS programs that will assist in the psychological and social wellbeing of the children, adolescents, families, and communities.

This assessment found that there are MHPSS programs being implemented, but there is a severe gap in regard to the entire population. It is our recommendation that each level of the IASC triangle is bolstered in order to respond to the needs of the incoming and settled refugees. It is the recommendation of this assessment that a focus on building capacity of para professionals is the primary focus. Through interviews and the 4ws mapping process, we found that community leaders and volunteers knew how to identify MHPSS cases and to refer, but they lacked knowledge of basic mental health support skills to provide supportive care. Social workers and counselors should receive continual training and be utilized as supervisors of para professionals. Additionally, psychiatric services should be increased in order to respond to the referrals from the social workers and para professionals.

In regards to the limited monetary resources within this crisis and continual response, programming and services can be implemented as a complementary addition to basic needs programming, e.g. food areas, livelihood, vocational skills programs, and child friendly spaces.

VI. SECTION VI – ACKNOWLEDGEMENTS & CONTRIBUTIONS

ACKNOWLEDGEMENTS

Playing to Live would like to acknowledge sincere gratitude for the extensive support and contributions provided for this report.

In particular, PTL would like to acknowledge the DRC as a key partner in this report to facilitate logistics and initiate connections with MHPSS organizations and partners. The contributions of DRC have been truly vital to the completion of this report; additional information on key contributions and individuals will be completed and included before the final report. PTL would also like to acknowledge TPO Uganda for their efforts in validating the data included in the needs and resource assessment.

Playing to Live would like to extend a special note of gratitude for the Offices of the Prime Minister in Uganda and the UNHCR offices for their support throughout this process. The IASC workgroup in Uganda, and the IASC reference group and MHPSS coordinator for their edits, suggestions, and guidance.

Playing to Live also acknowledges all of the collaborating organizations and contacts within these organizations who provided time, energy, and support to make this report possible. These organizations and individuals are the leaders in MHPSS in Uganda; it is an honor for PTL to have the opportunity to connect with these teams and learn from and with them.

CONTRIBUTIONS OF AUTHORS

The primary author is C. Alexis Decosimo, DrPH, ATR, LPCA; Alexis Decosimo is the Founder and Executive Director of Playing to Live and oversaw the completion of all components of this report including the background and significance, literature review, qualitative review, and conclusions. The secondary author is Catherine Reilly Boland, MS, CCLS. Catherine Boland is the Clinical Program Manager for Playing to Live and oversaw the completion of the needs and resources assessment including the 4Ws mapping exercise and the structuring of the literature review; Catherine acted as a primary reviewer across the comprehensive report document.

The background and significance was compiled and written by Rebecca Payne, B.A. Jessica Murray, B.A and Tanner Steinkopf, B.A acted as authors for the literature review. Rui Wang, M.Ed contributed to the 4Ws mapping section narrative in addition to assisting in data management and analysis. Jessica Murray acted as a contributor for the 4Ws mapping section and completed data analysis. Tanner Steinkopf acted as a reviewer for the 4Ws mapping section. All authors and contributors made major contributions to this report.

VII. ACRONYMS

4Ws	Who is Where, When, doing What
ARC	American Refugee Committee
ACASI	Audio Computer Administered Self Interviews
CYW	Child and youth welfare
CBT	Cognitive behavioral therapy
CFS	Child Friendly Spaces
CRIs	Core Relief Items
DRC	Danish Refugee Council
DSRS	Depression Self-Rating Scale for Children
ECD	Early Childhood Development
FAO	Food and Agriculture Organization of the United Nations
HIF	Humanitarian Innovation Fund
IAS	International Aid Services
IASC	Inter-Agency Standing Committee
IDP	Internally displaced persons/populations
MHPSS	Mental Health and Psychosocial Support
NGO	Non-governmental organization
PCAF	Peter C. Alderman Foundation
PFA	Psychological First Aid
PHC	Primary health care
PTSD	Post-traumatic stress disorder
PTSS	Posttraumatic stress symptoms
PTL	Playing to Live
PSSA	Psychosocial Structured Activities
RMF	Real Medicine Foundation
RCT	Randomized control trials
STC	Save the Children
SGBV	Sexual and gender-based violence
SDQ	Strength and Difficulties Questionnaire
SPLA	Sudan People's Liberation Army
SPLM/A-IO	Sudan People's Liberation Movement/Army in Opposition
TRT	Teaching recovery techniques
TGCT	Trauma and Grief Component Therapy
TF-CBT	Trauma-focused cognitive behavioral therapy
URMs	Unaccompanied refugee minors
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
WCC	War Child Canada
WCH	War While Holland
WHO	World Health Organization
WFP	World Food Program
YSR	Achenbach Youth Self Report scale

VIII. REFERENCES

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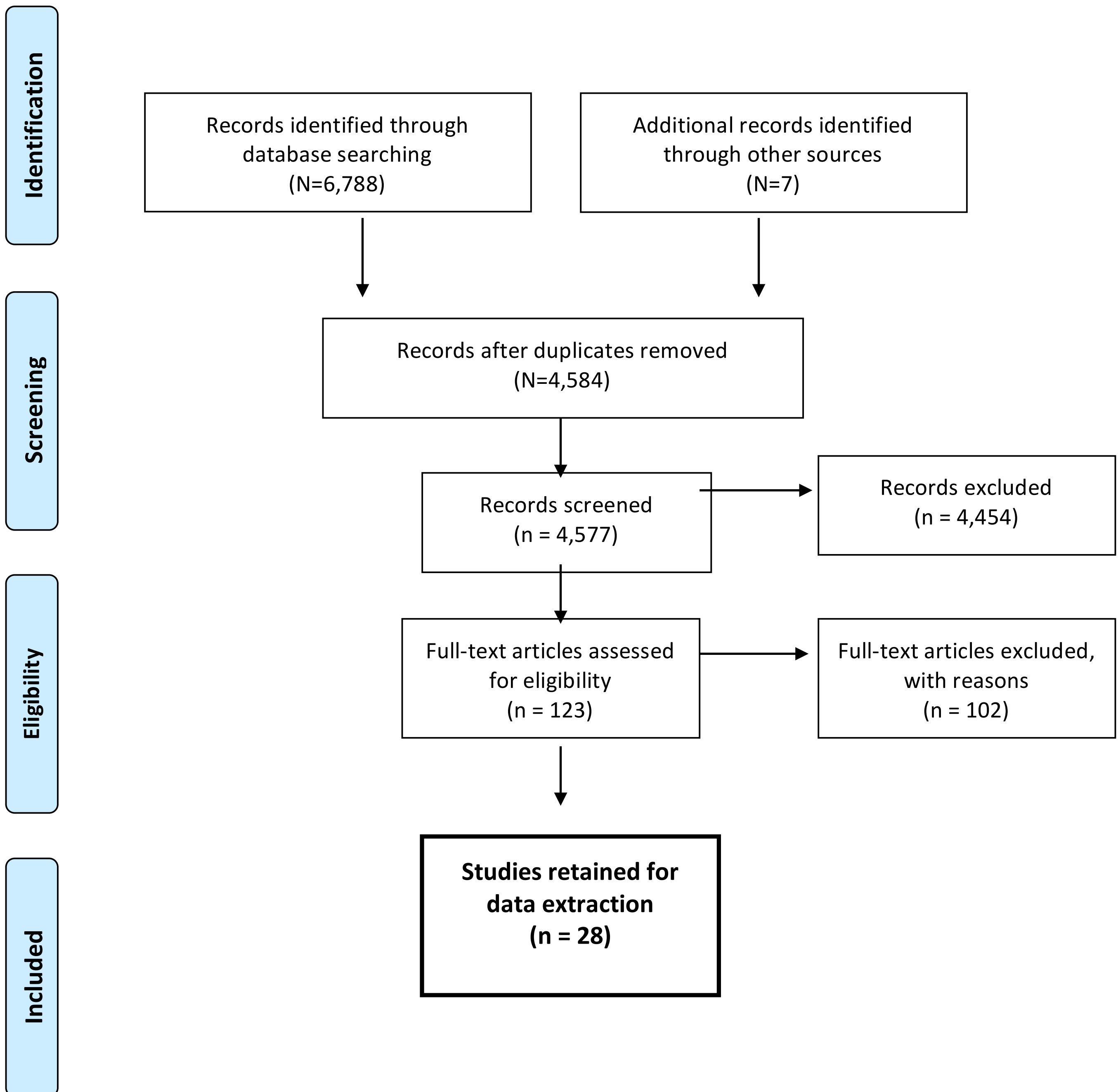
IX. FIGURES

FIGURE 1: Literature Review; Key Terms

Figure 1: Key Terms
(“child*” OR “children” OR “adolescent” OR “minor” OR “ped*” OR “paed*” OR “pediatric” OR “paediatric” OR “youth” OR “minor” OR “adolescent” OR “teen”) AND (“mental health” OR “psychosocial” OR “psych*" OR “expressive arts” OR “yoga” OR “dance” OR “music” OR “child life” OR “play” OR “art” OR “thera*”) AND (“refugee” OR “IDP” OR “internally displaced person” OR “humanitarian” OR “asylum” OR “fugitive” OR “exile” OR “displaced” OR “war” OR “refugee settlement” OR “refugee camp”) AND ("randomized controlled trial" OR "controlled clinical trial" OR "clinical trials as topic" OR "random allocation" OR "double-blind method" OR "single-blind method" OR "clinical trial" OR "research design" OR "comparative study" OR "evaluation studies" OR "follow-up studies" OR "prospective studies" OR "cross-over studies" OR "clinical trial" OR (("single*" OR "double*" OR "treble*") AND ("mask*" OR "blind*")) OR "placebo*" OR "random*" OR "control" OR "controls" OR "prospective*" OR "volunteer*" OR "cohort studies" OR "case-control studies" OR "comparative study" OR "risk factors" OR "cohort" OR "compared" OR "groups" OR "case control" OR “multivariate")

FIGURE 2: Literature Review; PRISMA Flow Diagram



X. TABLES

TABLE 1: Literature Review; Quality Assessment Matrix

Quality Assessment											
Full Reference	Publication Title	Abstract and Title	Introduction and Aims	Methods and Data	Sampling	Data Analysis	Ethics and Bias	Results	Transfeability and Generalizability	Implications and Usefulness	Total
Annan, J., Sim, A., Puffer, E. S., Salhi, C., & Betancourt, T. S. (2016). Improving Mental Health Outcomes of Burmese Migrant and Displaced Children in Thailand: a Community-Based Randomized Controlled Trial of a Parenting and Family Skills Intervention. *Prevention Science*, 1–11. http://doi.org/10.1007/s11121-016-0728-2	Improving Mental Health Outcomes of Burmese Migrant and Displaced Children in Thailand: a Community-Based Randomized Controlled Trial of a Parenting and Family Skills Intervention.	4	4	4	4	3	4	4	3	4	34
Betancourt, T. S., Newnham, E. A., Brennan, R. T., Verdeli, H., Borisova, I., Neugebauer, R., … Bolton, P. (2012). Moderators of treatment effectiveness for war-affected youth with depression in Northern Uganda. Journal of Adolescent Health, 51(6), 544–550. http://doi.org/10.1016/j.jadohealth.2012.02.010	Moderators of treatment effectiveness for war-affected youth with depression in Northern Uganda.	4	4	4	3	4	2	3	3	3	30
Betancourt, T. S., Yudron, M., Wheaton, W., & Smith-Fawzi, M. C. (2012). Caregiver and adolescent mental health in ethiopian kunama refugees participating in an emergency education program. Journal of Adolescent Health, 51(4), 357–365. http://doi.org/10.1016/j.jadohealth.2012.01.001	Caregiver and adolescent mental health in ethiopian kunama refugees participating in an emergency education program.	3	4	4	3	4	3	4	4	4	33
Bolton, P., Bass, J., Betancourt, T., Onyango, G., Clougherty, K. F., Neugebauer, R., … Verdeli, H. (2007). Interventions for depression symptoms among adolescent survivors of war and displacement in Northern Uganda: A randomized controlled trial. JAMA, 298(5), 519–527.	Interventions for depression symptoms among adolescent survivors of war and displacement in Northern Uganda: A randomized controlled trial.	4	4	4	3	4	2	3	3	3	30
Dura-Vila, G., Klasen, H., Makatini, Z., Rahimi, Z., & Hodes, M. (2012). Mental health problems of young refugees: Duration of settlement, risk factors and community-based interventions. Clinical Child Psychology and Psychiatry, 18(4), 604–623. http://doi.org/10.1177/1359104512462549	Mental health problems of young refugees: Duration of settlement, risk factors and community-based interventions.	3	4	4	3	4	2	4	3	3	30
Ehntholt, K. A., Smith, P. A., & Yule, W. (2005). School-Based Cognitive-Behavioural Therapy Group Intervention for Refugee Children who have Experienced War-related Trauma. Clinical Child Psychology and Psychiatry, 10(2), 235–250. http://doi.org/10.1177/1359104505051214	School-Based Cognitive-Behavioural Therapy Group Intervention for Refugee Children who have Experienced War-related Trauma.	3	3	4	3	4	2	4	2	3	28
Falb, Kathryn L. Sophie Tanner, Leora Ward, Dorcas Erskine, Eva Noble, Asham Assazenew, Theresita Bakomere, Elizabeth Graybill, Carmen Lowry, Pamela Mallinga, Amy Neiman, Catherine Poulton, Katie Robinette, Marni Somner, L. S. (2016). Creating opportunties through mentorship, parental involvement, and safe spaces (COMPASS) program: multi-country study protocol to protect girls from violence in humanitarian settings. BMC Public Health, 16(231), 1–10. http://doi.org/10.1186/s12889-016-2894-3	Creating opportunities through mentorship, parental involvement, and safe spaces (COMPASS) program: multi-country study protocol to protect girls from violence in humanitarian settings.	3	4	4	4	4	4	1	2	4	30
Fazel, M., Doll, H., & Stein, A. (2009). A school-based mental health intervention for refugee children: an exploratory study. Clinical Child Psychology and Psychiatry, 14(2), 297–309. http://doi.org/10.1177/1359104508100128	A school-based mental health intervention for refugee children: an exploratory study.	3	4	3	3	4	2	3	2	3	27

Gupta, L., & Zimmer, C. (2008). Psychosocial intervention for war-affected children in Sierra Leone. *British Journal of Psychiatry*, *192*(3), 212–216. http://doi.org/10.1192/bjp.bp.107.038182	Psychosocial intervention for war-affected children in Sierra Leone.	4	3	4	3	2	4	4	1	3	28
Huss, E., Kaufman, R., Avgar, A., & Shuker, E. (2016). Arts as a vehicle for community building and post-disaster development. *Disasters*, *40*(2), 284–303. http://doi.org/10.1111/disa.12143	Arts as a vehicle for community building and post-disaster development.	2	3	3	2	2	4	2	2	2	22
Kowitt, S. D., Emmerling, D., Gavarkavich, D., Mershon, C.-H., Linton, K., Rubesin, H., … Eng, E. (2016). A pilot evaluation of an art therapy program for refugee youth from Burma. Art Therapy, 33(1), 13–20. http://doi.org/10.1080/07421656.2015.1127739	A pilot evaluation of an art therapy program for refugee youth from Burma.	3	3	4	3	4	3	3	2	2	27
Nakkash, R. T., Alaouie, H., Haddad, P., El Hajj, T., Salem, H., Mahfoud, Z., & Afifi, R. A. (2012). Process evaluation of a community-based mental health promotion intervention for refugee children. *Health Education Research*, *27*(4), 595–607. http://doi.org/10.1093/her/cyr062	Process evaluation of a community-based mental health promotion intervention for refugee children	3	4	4	1	2	1	3	2	3	23
Ooi, C. S., Rooney, R. M., Roberts, C., Kane, R. T., Wright, B., & Chatzisarantis, N. (2016). The Efficacy of a Group Cognitive Behavioral Therapy for War-Affected Young Migrants Living in Australia: A Cluster Randomized Controlled Trial. Frontiers in Psychology, 7(October), 1641. http://doi.org/10.3389/fpsyg.2016.01641	The Efficacy of a Group Cognitive Behavioral Therapy for War-Affected Young Migrants Living in Australia: A Cluster Randomized Controlled Trial.	4	4	3	3	4	4	4	2	3	31
Quinlan, R., Schweitzer, R. D., Khawaja, N., & Griffin, J. (2016). Evaluation of a school-based creative arts therapy program for adolescents from refugee backgrounds. Arts in Psychotherapy, 47, 72–78. http://doi.org/10.1016/j.aip.2015.09.006	Evaluation of a school-based creative arts therapy program for adolescents from refugee backgrounds	3	4	3	3	3	3	3	2	3	27
Rousseau, C., Beauregard, C., Daignault, K., Petrakos, H., Thombs, B. D., Steele, R., … Hechtman, L. (2014). A cluster randomized-controlled trial of a classroom-based drama workshop program to improve mental health outcomes among immigrant and refugee youth in special classes. PLoS ONE, 9(8). http://doi.org/10.1371/journal.pone.0104704	A cluster randomized-controlled trial of a classroom-based drama workshop program to improve mental health outcomes among immigrant and refugee youth in special classes.	4	4	4	3	4	3	4	1	1	28
Rousseau, C., Benoit, M., Gauthier, M.-F., Lacroix, L., Alain, N., Rojas, M. V., … Bourassa, D. (2007). Classroom drama therapy program for immigrant and refugee adolescents: A pilot study. Clinical Child Psychology and Psychiatry, 12(3 PG-451-465), 451–465. http://doi.org/10.1177/1359104507078477	Classroom drama therapy program for immigrant and refugee adolescents: A pilot study.	3	4	4	2	3	2	4	1	1	24
Rousseau, C., Drapeau, A., Lacroix, L., Bagilishya, D., & Heusch, N. (2005). Evaluation of a classroom program of creative expression workshops for refugee and immigrant children. Journal of Child Psychology and Psychiatry and Allied Disciplines, 46(2), 180–185. http://doi.org/10.1111/j.1469-7610.2004.00344.x	Evaluation of a classroom program of creative expression workshops for refugee and immigrant children.	4	4	4	2	3	2	4	1	2	26
Ruf, M., Schauer, M., Neuner, F., Catani, C., Schauer, E., & Elbert, T. (2010). Narrative exposure therapy for 7- to 16-year-olds: A randomized controlled trial with traumatized refugee children. Journal of Traumatic Stress, 23(4), 437–445. http://doi.org/10.1002/jts.20548	Narrative exposure therapy for 7- to 16-year-olds: A randomized controlled trial with traumatized refugee children.	3	3	4	3	3	2	3	2	2	25

XI. APPENDICES

APPENDIX 1: Literature Review; Quality Assessment Tool

This checklist is from Hawker, S., S. Payne, et al. (2002). "Appraising the Evidence: Reviewing Disparate Data Systematically." Qualitative Health Research 12(9): 1284-1299.

Please assess each paper on the following criteria. For scoring please refer to notes below.

Good=4
Fair=3
Poor=2
Very poor=1
Lower scores =poor quality

Notes for appraising the quality of each paper:

1. Abstract and title:
Did they provide a clear description of the study?
Good Structured abstract with full information and clear title.
Fair Abstract with most of the information.
Poor Inadequate abstract.
Very Poor No abstract.

2. Introduction and aims:
Was there a good background and clear statement of the aims of the research?
Good Full but concise background to discussion/study containing up-to date literature review and highlighting gaps in knowledge. Clear statement of aim AND objectives including research questions.
Fair Some background and literature review. Research questions outlined.
Poor Some background but no aim/objectives/questions, OR Aims/objectives but inadequate background.
Very Poor No mention of aims/objectives. No background or literature review.

3. Method and data:
Is the method appropriate and clearly explained?
Good Method is appropriate and described clearly (e.g., questionnaires included). Clear details of the data collection and recording.
Fair Method appropriate, description could be better. Data described.
Poor Questionable whether method is appropriate. Method described inadequately. Little description of data.
Very Poor No mention of method, AND/OR Method inappropriate, AND/OR No details of data.

4. **Sampling:**
Was the sampling strategy appropriate to address the aims?
Good Details (age/gender/race/context) of who was studied and how they were recruited. Why this group was targeted. The sample size was justified for the study. Response rates shown and explained.
Fair Sample size justified. Most information given, but some missing.
Poor Sampling mentioned but few descriptive details.
Very Poor No details of sample.

5. **Data analysis:**
Was the description of the data analysis sufficiently rigorous?
Good Clear description of how analysis was done. Qualitative studies: Description of how themes derived/ respondent validation or triangulation. Quantitative studies: Reasons for tests selected hypothesis driven/ numbers add up/statistical significance discussed.
Fair Qualitative: Descriptive discussion of analysis. Quantitative.
Poor Minimal details about analysis.
Very Poor No discussion of analysis.

6. **Ethics and bias:**
Have ethical issues been addressed, and what has necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?

Good Ethics: Where necessary issues of confidentiality, sensitivity, and consent were addressed. Bias: Researcher was reflexive and/or aware of own bias.
Fair Lip service was paid to above (i.e., these issues were acknowledged).
Poor Brief mention of issues.
Very Poor No mention of issues.

7. Results:
Is there a clear statement of the findings?
Good Findings explicit, easy to understand, and in logical progression. Tables, if present, are explained in text. Results relate directly to aims. Sufficient data are presented to support findings.
Fair Findings mentioned but more explanation could be given. Data presented relate directly to results.
Poor Findings presented haphazardly, not explained, and do not progress logically from results.
Very Poor Findings not mentioned or do not relate to aims.

8. **Transferability or generalizability:**
Are the findings of this study transferable (generalizable) to a wider population?
Good Context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling).
Fair Some context and setting described, but more needed to replicate or compare the study with others, PLUS fair score or higher in Question 4.Poor Minimal description of context/setting.
Very Poor No description of context/setting.

9. **Implications and usefulness: How important are these findings to policy and practice?**
Good Contributes something new and/or different in terms of understanding/insight or perspective. Suggests ideas for further research. Suggests implications for policy and/or practice.
Fair Two of the above (state what is missing in comments).
Poor Only one of the above.
Very Poor None of the above.

APPENDIX 2: 4Ws Mapping Exercise; IASC 4Ws Data Collection: Original Tool

Complete one data entry sheet per location

General information

Date of providing or updating this information	Name of implementing agency	Name(s) of other organisation(s) with whom you are doing this activity (in case of a joint activity)	Name of focal point	Phone number of the focal point	Email address of the focal point	Region/ district where the activity occurs	Town/ neighbourhood where the activity occurs	Government/ OCHA geographical code for the location
Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete

Activity information

MHPSS activity code (See activity codes and subcodes tab below)	MHPSS activity subcode (See activity codes and subcodes tab below)	Description of the activity in one sentence (for subcode "Other" or for any other activity that is not clearly described by the subcode)	Target group(s) for this activity (specify age group(s) where relevant)	Number of people in target group directly supported in previous 30 days	This activity is (1) currently being implemented, (2) funded but not yet implemented, or (3) unfunded and not yet implemented	Start date for implementing the activity (for current activities, provide actual start date and not the originally proposed start date)	End date (specify on what date committed funding to implement the activity ends)	Number and type of MHPSS workers who do this activity (e.g., 4 community volunteers, 1 psychologist and 1 nurse)	Topic and length of non-university training on MHPSS (e.g. nurses received 1 day on psychological first aid)	(if applicable) Availability of the activity (e.g. child friendly space or clinic is 40 hours/week open)	Where is MHPSS provided? (people's homes, clinic, public spaces etc)	Do people have to pay to use these services / supports?
Insert one row per subactivity												
Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete	Please complete

APPENDIX 3: MHPSS Activity Codes & Sub-codes

	Column A: MHPSS activity code (4Ws)	Column B: Examples of interventions with subcodes. Record all that apply.
Community-focussed (targeted at communities or segments of communities)	1. Disseminating information to the community at large	1.1 Information on the current situation, relief efforts or available services in general 1.2 Raising awareness on mental health and psychosocial support (e.g., messages on positive coping or on available mental health services and psychosocial supports) 1.3 Other (describe in column C of the data entry sheet)
	2. Facilitating conditions for community mobilisation, community organisation, community ownership or community control over emergency relief in general	2.1 Support for emergency relief that is initiated by the community 2.2 Support for communal spaces/meetings to discuss, problem-solve and plan action by community members to respond to the emergency 2.3 Other (describe in column C of the data entry sheet)
	3. Strengthening community and family support	3.1 Support for social support activities that are initiated by the community 3.2 Strengthening parenting/family supports 3.3 Facilitation of community supports to vulnerable people 3.4 Structured social activities (e.g. group activities) 3.5 Structured recreational or creative activities (do not include activities at child-friendly spaces that are covered in 4.1) 3.6 Early childhood development (ECD) activities 3.7 Facilitation of conditions for indigenous traditional, spiritual or religious supports, including communal healing practices 3.8 Other (describe in column C of the data entry sheet)
	4. Safe spaces	4.1 Child-friendly spaces 4.2 Other (describe in column C of the data entry sheet)
	5. Psychosocial support in education	5.1 Psychosocial support to teachers / other personnel at schools/learning places 5.2 Psychosocial support to classes/groups of children at schools/learning places 5.3 Other (describe in column C of the data entry sheet)
	6. Supporting including social/psychosocial considerations in protection, health services, nutrition, food aid, shelter, site planning or water and sanitation	6.1 Orientation of or advocacy with aid workers/agencies on including social/ psychosocial considerations in programming (specify sector in column C of the data entry sheet) 6.2 Other (describe in column C of the data entry sheet)
Person-focused (targeted at identified people)	7. (Person-focused) psychosocial work	7.1 Psychological first aid (PFA) 7.2 Linking vulnerable individuals/families to resources (e.g., health services, livelihoods assistance, community resources etc.) and following up to see if support is provided. 7.3 Other (describe in column C of the data entry sheet)
	8. Psychological intervention	8.1 Basic counselling for individuals (specify type in column C of the data entry sheet) 8.2 Basic counselling for groups or families (specify type in column C of the data entry sheet) 8.3 Interventions for alcohol/substance use problems (specify type in column C of the data entry sheet) 8.4 Psychotherapy (specify type in column C of the data entry sheet) 8.5 Individual or group psychological debriefing 8.6 Other (describe in column C of the data entry sheet)
	9. Clinical management of mental disorders by nonspecialized health care providers (eg PHC, post-surgery wards)	9.1 Non-pharmacological management of mental disorder by nonspecialized health care providers (where possible specify type of support using categories 7 and 8) 9.2 Pharmacological management of mental disorder by nonspecialized health care providers 9.3 Action by community workers to identify and refer people with mental disorders and to follow-up on them to make sure adherence to clinical treatment 9.4 Other (describe in column C of the data entry sheet)
	10. Clinical management of mental disorders by specialized mental health care providers (eg psychiatrists, psychiatric nurses and psychologists working at PHC/general health facilities/mental health facilities)	10.1 Non-pharmacological management of mental disorder by specialized mental health care providers (where possible specify type of support using categories 7 and 8) 10.2 Pharmacological management of mental disorder by specialized health care 10.3 Inpatient mental health care 10.4 Other (describe in column C of the data entry sheet)
General	11. General activities to support MHPSS	11.1 Situation analyses/assessment 11.2 Monitoring/evaluation 11.3 Training / orienting (specify topic in column C of the data entry sheet) 11.4 Technical or clinical supervision 11.5 Psychosocial support for aid workers (describe type in column C of the data entry sheet) 11.6 Research 11.7 Other (describe in column C of the data entry sheet)

APPENDIX 4: List of MHPSS Agencies & Locations

Organization Name	Settlement/ District	Key Contact Person	Email Address
AFFORD	Adjumani	TBD	TBD
Danish Refugee Council	Adjumani	Emmalu Meri Lawrence	m.emmalu@drcuganda.org
International Rescue Committee	Adjumani	TBD	TBD
The Lutheran World Federation	Adjumani	Annet Bileru	annet.bileru@lwf.or.ug
Medical Teams International	Adjumani	Olwa Geoffrey Cloney	golwa@medicalteams.org
PLAN International	Adjumani	Manjeri Nandera	manjeri.nandera@plan-international.org
Right to Play	Adjumani	Evelyn Frances Aguti	Eaguti@righttoplay.com
Real Medicine Foundation	Adjumani	TBD	TBD
Save the Children	Adjumani	Kevin Mubuke	Kevin.Mubuke@savethechildren.org
Transcultural Psychosocial Organization	Adjumani	Albert Byaruhanga	byaruhangaalbert@yahoo.com; byaruhangaalbert@gmail.com
Tutapona	Adjumani	David Wilkes	dave@tutapona.com
War Child Canada	Adjumani	TBD	TBD
War Child Holland	Adjumani	Hamba Cephas	hamba.cephas@warchild.nl
Windle Trust	Adjumani	Joyce (Okello?)	ayikoruokello@gmail.com
World Vision	Adjumani	TBD	TBD
American Refugee Committee	Bidi Bidi	Paul Aceba	AcebaPa@arcrelief.org
CARE	Bidi Bidi	TBD	TBD
Danish Refugee Council	Bidi Bidi	Faidah Dede Obombasa	obombasa@yahoo.com
International Rescue Committee	Bidi Bidi	TBD	TBD
Médecins Sans Frontières	Bidi Bidi	TBD	TBD

Organization Name	Settlement/ District	Key Contact Person	Email Address
PLAN International	Bidi Bidi	Joy Mary Oyado	joy.oyado@plan-international.org
Save the Children	Bidi Bidi	Alma Rose	rose.temayia@savethechildren.org
Transcultural Psychosocial Organization	Bidi Bidi	Omolo Stella	omolistella@gmail.com
War Child Canada	Bidi Bidi	TBD	TBD
War Child Holland	Bidi Bidi	Nancy Akello	akello.nancy@warchild.nl
World Vision	Bidi Bidi	TBD	TBD
Yumbe Local Government	Bidi Bidi	TBD	TBD
Danish Refugee Council	Kiryandongo	Mariam Namutebi; Florence (Namugere?)	m.namutebi@drcuganda.org mercyflorence95@gmail.com; florencenamugere@yahoo.com
InterAid Uganda	Kiryandongo	TBD	TBD
International Rescue Committee	Kiryandongo	Filda (and Barbra)	Filder.ClaretAdyoro@rescue.org
Real Medicine Foundation	Kiryandongo	Caroline Tukugize	Caroline.Tukugize@realmedicinefoundation.org
Save the Children	Kiryandongo	Maurice Okoth	maurice.okoth@savethechildren.org
Transcultural Psychosocial Organization	Kiryandongo	Racheal Atuheire; Dr. Egan Tabaro	rachealatuheire@yahoo.com; Egantabaro@yahoo.com
War Child Canada	Kiryandongo	Carol Aijuka	aijukacarol@gmail.com
We Techa Peace and Development	Kiryandongo	TBD	TBD
Young Women Christian Association	Kiryandongo	TBD	TBD
ZOA International-Uganda	Kiryandongo	TBD	TBD
Danish Refugee Council	Rhino Camp	Isaac Khamis Cosmas	ikhamiscosmas@gmail.com
International Aid Services	Rhino Camp	Patrick Oyugi	patrick.oyugi@ias-intl.org
Medical Teams International	Rhino Camp	Allan Amandu	aamandu@medicalteams.org

Organization Name	Settlement/ District	Key Contact Person	Email Address
Médecins Sans Frontières	Rhino Camp	TBD	TBD
Peter C. Alderman Foundation	Rhino Camp	Marx Leku; Aketoko Dradria Ronny Ocatre	mrleku@pcaf.org; radocatre@pcaf.org
PLAN International	Rhino Camp	TBD	TBD
Save the Children	Rhino Camp	Flavia Mayokia	flavia.mayokia@savethechildren.org
Uganda Red Cross Society	Rhino Camp	TBD	gurcs@redcrossug.org
War Child Canada	Rhino Camp	Bako Juliet	bakojuliet2006@gmail.com
Windle Trust	Rhino Camp	Gordian Rubarunda	rubarundagordian@gmail.com

APPENDIX 5: Playing to Live 4Ws Adapted Tool

Playing to Live – Program Information Request
Needs and Resource Assessment of Psychosocial and Mental Health Services
'Who is Where doing What until When (4Ws)'
Inter-Agency Standing Committee Framework

Section 1: General Information

1. Date of providing or updating this information:
2. Name of implementing agency/organization:
3. Name(s) of other agencies/organization(s) with whom you are implementing this activity (if applicable, in case of a joint implementation activity/service/program):
4. Name/Title of activity/service/program (if applicable):
5. Name of contact person:
6. Phone number of contact person:
7. Email address of contact person:
8. Organization specific title/position of contact person:
9. Region/district where the activity/service/program occurs:
10. Name of settlement:
11. Zone(s)/area(s) and all locations within settlement where the activity/service/program occurs:

Section 2: Activity/Service/Program Specific Information

1. MHPSS activity code (See activity codes and subcodes document included below on page 4):
2. MHPSS activity subcode (See activity codes and subcodes document included below on page 4):
3. Description of the activity/service/program in one sentence for subcode "Other" or for any other activity that is not clearly described by the subcode (see activity codes and subcodes document included below on page 4, if applicable):

4. Participant target group(s) for this activity/service/program (please specify age group(s) and gender; if all ages and genders are included in participant target group, please state 'no participant restrictions'):

5. Number of participants in target group directly receiving services:

6. This activity/service/program is:
   a. Currently being implemented
   b. Funded but not yet implemented
   c. Unfunded and not yet implemented

7. Start date for implementing the activity/service/program (for current activities, provide actual start date and not the originally proposed start date):

8. End date (specify on what date committed funding to implement the activity ends):

9. Number and type of MHPSS workers who do this activity (e.g., 4 community volunteers, 10 mentors, 1 social worker, etc.):

10. Topic and length of non-university training on MHPSS (e.g. community volunteers received 2 days of psychosocial training, mentors received 2 days of psychosocial training and 5 days program training, social worker holds certificate in social work and has received 3 day training on psychological first aid from _______ organization, etc.):

11. Availability of the activity (e.g. child friendly space or clinic is open 40 hours/week and/or program is run 2x per week for 5 hours; if applicable):

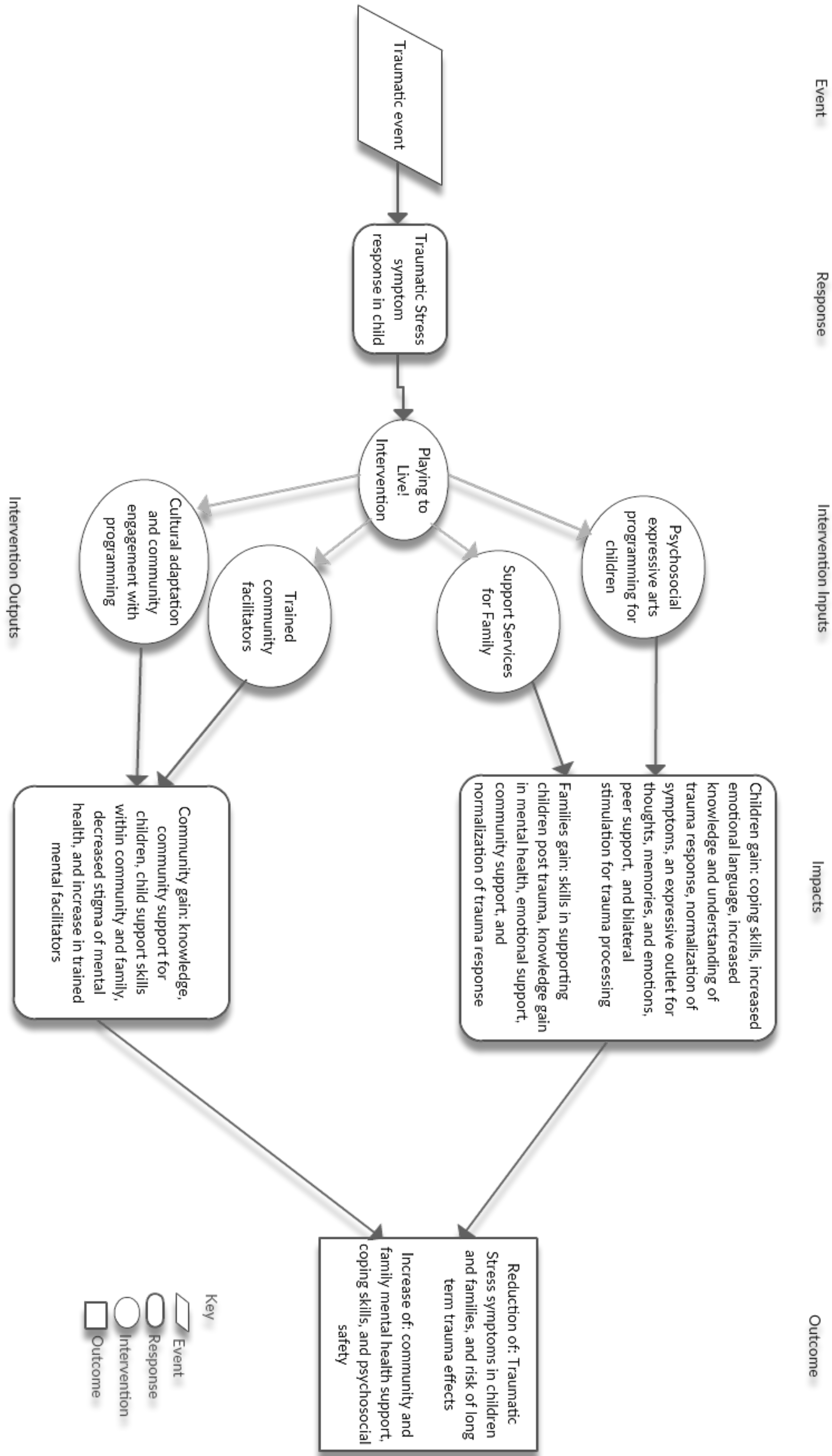
12. Where is MHPSS activity provided? (e.g. community member's homes, clinic, district hospital, public spaces, child friendly spaces, churches, etc.):

13. Do participants have to pay to use these services/supports? Yes/No. (Note: this question was included with respect that the majority of services are free to participants in this setting and activity/service/program(s) are often reliant on donor and/or government funding):

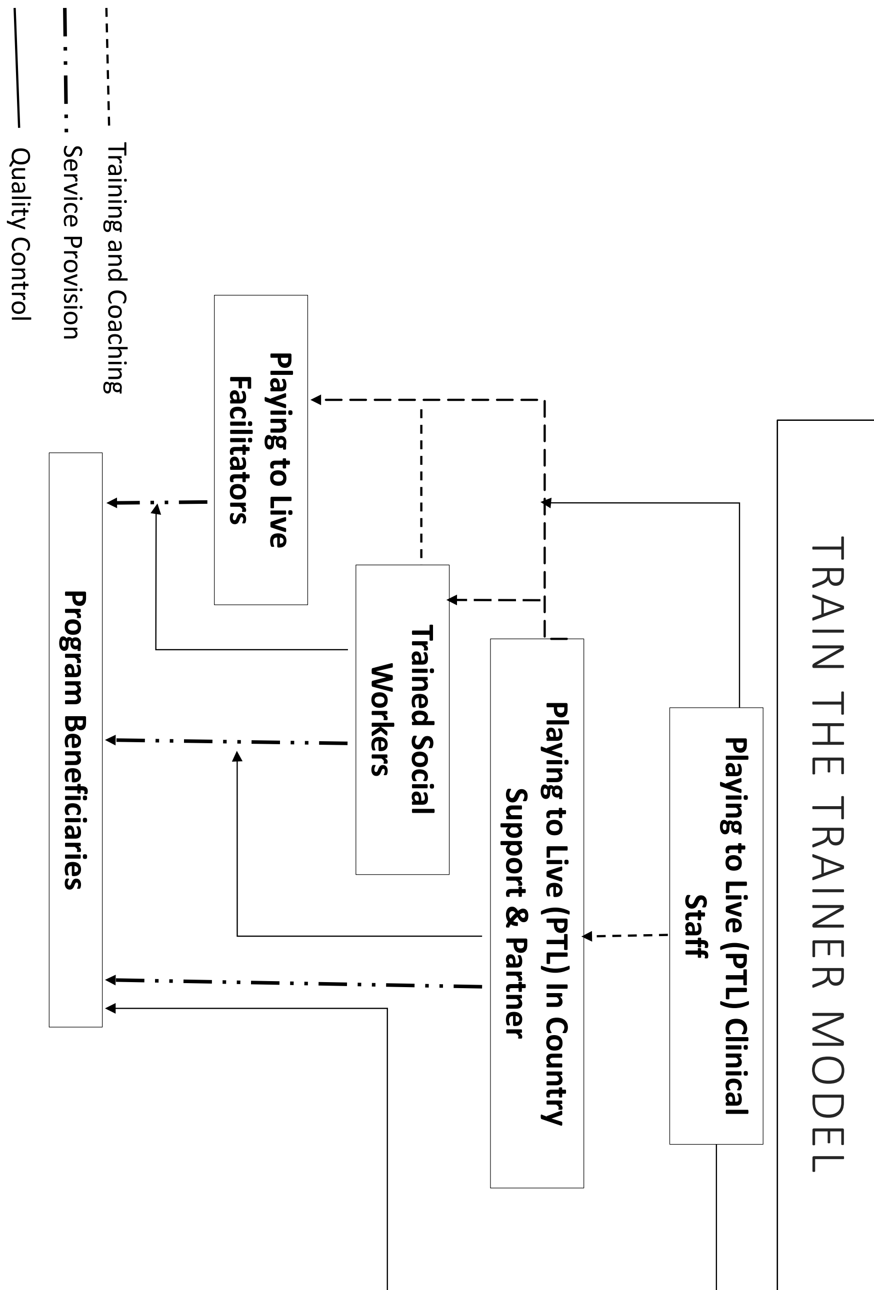
14. Does this service also support nationals and/or IDPs? Yes/No. (Note: if yes, is the percentage 70% provision for refugee population/30% provision for national population? Please clarify percentage of support across the target population):

Thank you so much for your time and support in answering these questions.
We appreciate you work and the work of your team. If you have any clarifying questions, don't hesitate to reach out to info@playingtolive.org

APPENDIX 6: PTL Pilot Program; Playing to Live: Program Model



APPENDIX 7: PTL Pilot Program; Roles During Program Implementation



(Murray et al., 2011).

APPENDIX 8: PTL Pilot Program; Pilot Program Work Plan

Name of project: The Development and Implementation of a Psychosocial Expressive Arts Program for Adolescent South Sudanese Refugees Receiving Vocational Skill Training

Expected Results	Main Planned Activities	Implementation Period (Months)									
		1	2	3	4	5	6	7	8	9	10
Month 1-3 Informal Review: Desk Research, Rapid Needs Assessment, and Focus Groups Program Development: Programming & Training Adaptation and M&E Development	Review current research & best practices in refugee settlements	X	X								
	Establish logistics plan	X									
	Focus groups with key stakeholders, families, beneficiaries	X	X								
	Creation of working group	X	X								
	Pilot Program & training adaptation/development based on information gathered		X								
	M&E adaptation/development	X	X								
	Cultural adaptation through working group		X								
	Written Summary Report		X								
Month 4-8 Pilot Program Implementation	M&E Implementation & monitoring- Pre Test			X							
	4-day training for facilitators			X							
	Program Implementation					X	X	X	X		
	Follow up Trainings: 1 per month (minimum)						X	X			
	Supervision with facilitators: 1 per month (minimum)					X	X	X	X		
	On-going Program Support					X	X	X	X		
	M&E Evaluation					x	X	X	X		

Month 9-10 Final Report & Wrap Up	M&E Results & Conclusions										
	Review of programming										
	Final focus groups								X	X	
	Final Report										X

Personnel Key

- Executive Director – ED
- Clinical Program Manager – CPM
- M&E Specialist – M&E
- Clinical Team Member - CTM
- Site Coordinator – SC
- Graduate Intern – GI
- Undergraduate Intern - UI