Field report

Bridging the gap in mental health and psychosocial services in low resource settings: a case study in Sudan

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Sudan has endured the longest civil war in Africa, with ongoing conflict since 1983. As a result, it has one of the largest internally displaced populations on the continent. The gap in care for mental health in Sudan is large, therefore, most of the people affected do not have access to the treatment they need (World Helath Organization, 2009). Mental health facilities in current day Sudan are few and concentrated in urban centres, where they are difficult to access and lack adequately trained professionals who are, in particular, lacking training for trauma related disorders. The objectives of this intervention were to bridge the gap in mental health psychosocial support services in Sudan by setting up a community based, nongovernmental trauma mental health centre providing free mental health services, in addition to mental health professional capacity building. This paper addresses difficulties and opportunities in providing mental health and psychosocial support in country torn by war and political embargo. Furthermore, it includes how to incorporate cultural adaption encompassing Afro/Arab cultures with a focus on gender and political sensitive approaches in introducing psychosocial support and specialised trauma services.

Keywords: capacity building, mental health and psychosocial support, narrative theatre, trauma counselling, war affected communities

Introduction

Background and context

Mental disorders are a source of substantial disability worldwide, with this burden likely to be greater in countries affected by mass conflict (World Health Organization (WHO), 2013). Depression alone accounts for 4.3% of the global burden of disease and is among the largest single cause of disability worldwide (11 % of all years lived with disability globally), particularly for women. The economic consequences of these health losses are equally large; a recent study estimated that the cumulative global impact of mental disorders in terms of lost economic output will amount to US$ 16.3 million between 2011 and 2030 (WHO, 2013). Resources and skills in developing countries are limited, requiring careful consideration in determining service priorities, while direct clinical services can only reach a small percentage of the population (Mannan et al., 2013). Alternatively, community based mental health services can provide accessible, equitable and effective care at low costs, thereby avoiding the harm created by institutionalising patients in large mental hospitals (Patel et al., 2016; Qureshi, Al-Habeeb, & Koenig, 2013).

Health systems worldwide have not yet adequately responded to the burden of mental disorders, therefore, the gap between the need for treatment and its provision is large all over the world. Between 76% and 85% of people with severe mental disorders receive no treatment for their disorders in low or middle income countries, and further compounding problems are the poor quality of care and stigma for those receiving treatment (Ali, & Agyapong, 2016; WHO, 2013).

This gap in mental health provision and quality of care is even worse in Sudan whereby the country has experienced decades of internal conflict that makes it difficult

to provide an adequate level of primary and tertiary health services across the country. Sudan is spread over a million square kilometres with a population of 40 million, of which 64% live in rural and nomadic areas, increasing health delivery challenges. Another challenge is that access to services are substantially lagging in areas in the north of the country (such as Darfur) and all rural areas (Meffert, & Marmar, 2009; Salah, Abdelrahman, Lien, Eide, Martinez, & Hauff, 2013).

Currently, mental health services are very limited, with only two mental health hospitals and 17 private clinics. The total number of psychiatrists working in mental health facilities or private practice per 100,000 population is 0.92. Additionally, mental health services are not yet integrated into primary health care or any community based organisations (Mannan et al., 2013). There are formal links between the mental health sector and other sectors, but many of the critical links are weak or not yet developed (e.g., links with welfare, housing, judicial, work provision, and/or education sectors). There are no coordinating bodies to oversee public education and awareness campaigns on mental health issues (WHO, 2009) (Goldberg, & Gater, 1996; Happell et al., 2015). The role of universities is focused primarily on education, with minimal community based mental health outreach programmes or interventions. Against this background complexity of low recourses, diverse populations and continued violence, stigmatising health beliefs require a more holistic approach to providing mental health services. The WHO 2001 recommendations on mental health service state that community mental health services need to provide comprehensive and locally based treatment and care, which is readily accessible to patients and their families (WHO, 2001). Services should be comprehensive in that they provide a range of facilities to meet the mental health needs of the population at large, as well as of special groups such as children, adolescents, women and elderly people (Fitzpatrick, 2010; Bramesfeld, Klippel, Seidel, Schwartz, & Dierks, 2007).

Bridging the gap in mental health and psychosocial support services

With the lack of well documented examples of mental health services that could guide replication of successful scaling up in other settings (Ali et al., 2016; Eaton et al., 2011), this paper presents a possible model for scaling up trauma service in order to bridge gaps in the provision of mental health psychosocial support (MHPSS)capacity building and services in Sudan. This intervention is based on adaptations of the Inter-Agency Standing Committee (IASC) guidelines (2007) and WHO 2001 recommendations. The following sections will elaborate on the three levels of capacity building: 1) specialised services; 2) non specialised support; and 3) community and family support), with three stages of service provision: 1) professional capacity building; 2) service provision; and 3) community family support. This paper also provides a guide on cohort selections and overall evaluation, challenges and recommendations with the aim to provide an approach to providing community based MHPSS in low recourse settings that could be further replicated.

Methodology

Intervention site

Ahfad University for Women (AUW) is a private non-profit university in Omdurman city, Khartoum State. Since its establishment in 1966, the university has aimed to provide a safe environment for women's education and empowerment. AUW has strong civic engagement in community based programmes. In 2010, a study was conducted by Badri, Crutzen, Eltayeb, and Van den Borne (2013) assessing the magnitude of post-traumatic stress disorder (PTSD), depression and anxiety among Darfur female students in AUW. The results indicated an

increase among Darfur students compared to Omdurman students. This led to the discussion of expanding the existing counselling service with students' affairs and as a result, introduced a trauma focused counselling office targeting students coming from war zone areas such as Darfur and South Sudan. The focus of this intended trauma centre was to serve war affected Sudanese communities and build the capacity of mental health professionals and psychosocial staff who were already working with displaced people, without taking ownership or service delivery from local resources.

Cohort group

The targeted cohorts of this intervention were at three levels. The first was specialised services, including 12 mental health service providers, such as psychotherapists, counsellors and psychiatrists. The cohort was selected based on a work experience of minimum five years, commitment to complete one year of three rounds of training in between supervision meetings and reports.

The second covered non specialised services comprised of 20 nongovernmental organisation (NGO) workers and government officials, these were selected from four different states based on the NGO profile of working in humanitarian aid or/and working with vulnerable groups, in addition to three government agencies that were selected (Ministry of Health, Family and Child Protection unit and the Ministry of Social Welfare).

The third was community and family support, including 16 community based workers that had been trained as community based animators.

The MHPSS intervention: using the *IASC Guidelines* and WHO recommendations

The MHPSS intervention was developed by Ahfad University for Women in partnership with the War Trauma Foundation. It is based on the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (2007) and is geared towards the WHO 2001 mental health recommendations to address treatment gaps. Moulding the WHO recommendations and the IASC guidelines led the current MHPSS intervention to: 1) provide three levels of capacity building trainings for specialised and non specialised service and community service providers; 2) provision of trauma mental health service in four community based centres; and 3) initiate community involvement and healing using narrative theatre activities.

The WHO 2001 recommendations stipulate that:

1. Mental health treatment should be accessible in primary care
2. Psychotropic drugs need to be readily available
3. Care should be shifted away from institutions and towards community facilities
4. The public should be educated about mental health
5. Families, communities and consumers should be involved in advocacy, policy-making and forming self-help groups
6. National mental health programmes should be established
7. The training of mental health professionals should be increased and improved
8. Links with other governmental and nongovernmental institutions should be increased
9. Mental health systems should be monitored using quality indicators
10. More support should be provided for research (WHO, 2001)

The current interventions targeted, in particular, recommendations 3–10 as the integration of MHPS support into primary care and availability of drugs are mainly the responsibility of governments and are

difficult to achieve by community initiatives alone (Kohn, Saxena, Levav, & Saraceno, 2004).

As for the *IASC Guidelines*, the resolution set up the IASC as the primary mechanism for facilitating inter-agency decision making in response to complex emergencies and natural disasters. The current intervention targeted capacity building at three levels (IASC, 2007) (see Figure 1), these are discussed in detail below.

Level I: Specialised services The top layer of the pyramid in the *IASC Guidelines* represents the support required for the small percentage of the population whose suffering is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric support for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services. The current MHPSS intervention developed in Sudan addressed the needs for capacity building in this level by training mental health workers and government personal in trauma case management, cognitive behaviour

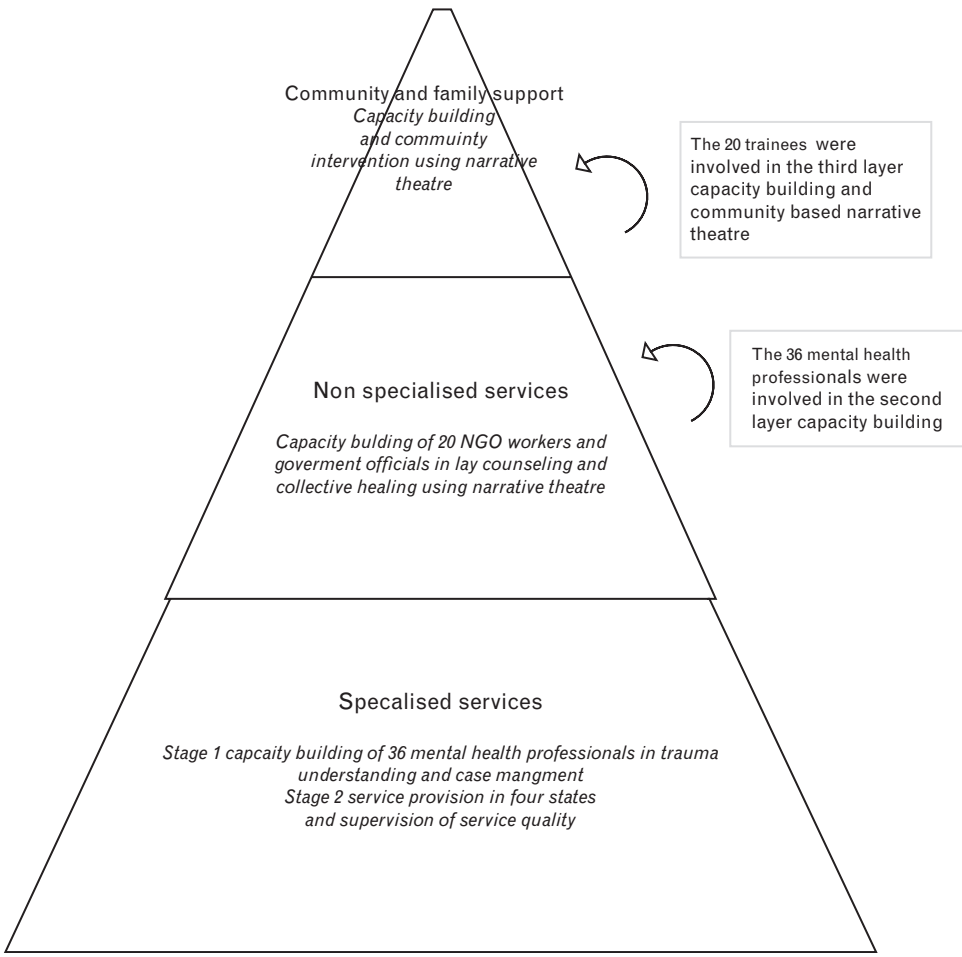

Figure 1: Sudan–MHPSS intervention pyramid.

competencies, referral and supervision. Furthermore, community needs of populations suffering from mental disorders, in particular trauma related disorders were addressed by four state level trauma MHPSS centres. These will be described further below.

Level II: Non specialised supports This layer (see Figure 1) represents the response for a smaller number of people who are able to maintain their mental health and psychosocial wellbeing if they receive help in accessing key community and family support (IASC, 2007). The current MHPSS intervention developed a series of modules including training of community based workers in lay counselling and psychological first aid.

Level III: Community and family support In most emergencies, there are significant disruptions to family and community networks due to loss, displacement, family separation, community fears and distrust. Moreover, even when family and community networks remain intact, people in emergencies will benefit from help in accessing greater community and family support. The current MHPSS intervention in Sudan (see Figure 1) developed a series of modules including training of community based workers in community healing using narrative theatre, organised direct community narrative theatre events exploring the needs of local communities and providing a safe space for collective healing.

It should be noted that the current MHPSS intervention targeted the capacity building starting from the top of the pyramid and moving downwards, which is in reverse to the *IASC Guidelines*. The rational for that was that before attempting to enter into community healing or intervene with mass populations, the specialised service should have at least a cadre that are able to manage and assist individuals with serious mental health needs and that this will ensure available referral pathways.

MHPSS intervention implementation

The following section describes the implementation of the MHPSS intervention three stages of capacity building, provision of trauma mental health service and community healing.

Stage I: Professional capacity building

Training of trainers The WHO 2001 mental health recommendation number seven emphasised that the training of mental health professionals should be increased and improved. Hence the intervention started with capacity building for three rounds of training in trauma specialised mental health service among 12 mental health professionals in Khartoum State. The first core group of 12 service providers represented AUW and the four main mental health hospitals in Khartoum State. The rationale was to build core trainers who could replicate the training in other states.

After the Khartoum cohort was trained, they spent several weeks adapting cases to the Sudan context and documenting the training process using video tapes. This resulted in the first Arabic trauma counselling manual. The next step was to build capacities in non conflict states as a soft landing approach to test the training modality and build further cadre to assist in conflict and emergency states. Hence an additional 12 mental health professionals from non conflict states were trained (Gadrif State Eastern Sudan bordering Ethiopia, White Nile State bordering Blue Nile State and North Kordfan bordering Darfur State). The state level training was conducted by the first cohort of core trainers under supervision of international experts.

A supervision model was set up using biweekly meetings and reports on number, type and gender of cases, as well as therapeutic approaches used. However, the supervision from Ahfad to other states did not continue beyond the first year (2012), due to

several reasons, including a change of staff at state levels and the increasing workload at Ahfad Trauma. The above training of trainers' modality created a well equipped cadre of 21 psychologists and three psychiatrists who were able to identify, diagnose and intervene with PTSD and other trauma related disorders.

Nevertheless, the training lacked direct affiliation to an international licensure body and direct supervision. Consequentially, while the trainees received three series of cognitive behaviour therapy (CBT) training, because the funded programme lacked funds for internship and supervision with an accredited body, professional certification in CBT or eye movement desensitisation could not be provided.

The western based structure of therapeutic training relies on providing training with calculated hours and credits under supervision. This constitutes an obstacle for professionals in poor resource settings whereby they only have access to reading material and some direct training from prominent scholars. Thus, the modality of international supervision needs to be more mobile and flexible, for instance by making use of modern technologies.

After the first cohorts were trained, the needs from conflict states were rapidly increasing. Darfur and Blue Nile are two of the conflict states where government and opposition troops continually bomb and attack villages, resulting in one of the largest internally displaced populations in history, as in Darfur more than 3 million people are in internally displaced person (IDP) camps. This situation has created a wider demand for services, exacerbated by the limited number of trained professionals at state level. The programme was therefore expanded to include North Darfur Elfashir, and Blue Nile Eldamzin in training and community outreach activities.

Three rounds of training (see Figure 2) were conducted by national trainers from the first core trainers, a total of 12 psychologists were trained, however, no psychiatrist was found in these two states to be involved in the training which meant targeting only psychologists. The inclusion of Darfur and Blue Nile States was an important step in building capacities, but the programme was unable to document the outcome of the therapeutic skills based training as no service unit is yet established. The community outreach activities were more tangible and are described further below.

Description of training modules

The first training for mental health professionals included three modules consisting of 14 units, with each unit 45 minutes in length, and the module spread over 5 days. This was based on an apprenticeship model, which includes initial training, practice among peers, limited clients' exposure with supervision and (based on skills gained) gradually more independent use of the intervention. Each training is followed by assignments where trainees have a chance to implement what learnt in the classroom and immediately provide support to

Figure 2: The 36 total cohorts trained at specialised service level.

individual clients and communities. Constant support and supervision was provided through the Ahfad trauma centre and though field supervisors not only to help professionals reflect on actual practice, but also to establish effective peer support. This practice period between the trainings was crucial in strengthening skills and as it fed in needs to consecutive trainings, this was a better approach than short term trainings with only instant pre and post evaluations.

Module one: understanding trauma

The trauma grid (developed by Papadopoulos) for understanding the effect of devastating events on individuals and communities was utilised to guide the first module (Papadopoulos, 2007). The trauma grid emphasises that psychological consequences of devastating events affect individuals both in ways that are highly personal (ranging from negative psychological suffering including PTSD to positive growth or adversity activated development), as well as impersonal, transpersonal, collective and social. Ultimately, the specific meaning that individuals and communities give to their suffering is dependent on a wide variety of factors that can be addressed most appropriately by perspectives that inter-relate to the individuals with their wider socio-political context, and other dimensions within which individuals are defined (Papadopoulos, 2007) (Figure 3).

> *'Before I attended the training, I had the knowledge [belief] that there is only one type of trauma that happens only to army soldiers, but now I learned that trauma can happen to anyone, [and they can] benefit from the relaxation techniques. I understand now that you don't look at trauma from one perspective, and family and community should be involved in support and therapy.'*
> Adam, *psychologist at family child protection Unit Gadrif State*

To prevent healthy, at risk populations from developing psychosocial problems, the training modality built the capacity of the targeted mental health professionals to use the trauma grid in the assessment of adversity and to look at the totality of survivors in response to adversities. Finally the trainees were able to design activities aimed at reaching the community at large while addressing negative and positive consequences of devastating events.

Module two: trauma counselling competencies

The second module aimed to strengthen professional skills in trauma case management using CBT as an approach. CBT is a type of psychotherapeutic treatment that helps patients understand thoughts and feelings that influence behaviours. During the course of treatment, people learn how to identify and change destructive or disturbing thought patterns that have a negative influence on behaviour (Tay, Rees, Chen, Kareth, & Silove, 2015). CBT is also empirically supported and has been shown to effectively help patients overcome a wide variety of maladaptive behaviours. The aim of the training was for participants to become familiar with CBT techniques for people affected by trauma and to be able to apply it with clients within Sudanese settings. The training programme consisted of three sections. The first section is a training workshop that covers CBT *'techniques and trauma'*, the second section is onsite training *'application of training in work settings'* and the third section is training of trainers: 'including Arabic translation and adjusting the training packages'. The selection of CBT came from participant's demands as it is the most widely used approach in mental health services in Sudan, nevertheless, the module also introduced approaches to Eye Movement Desensitization and Reprocessing (EMDR) and Narrative Exposure Therapy (NET) to broaden trainees' options for future trainings.