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 Health 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, 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 non-governmental 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 MHPSS 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 1: 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
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 counseling 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 bi-weekly 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 Afhad 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.](image-url)
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.

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**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).

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'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
Module three: referral and supervision

As indicated by the WHO 2001 recommendations that emphasises strengthening links with other governmental and nongovernmental institutions and mental health systems, there should be monitoring through use of quality indicators. Therefore, the third module addressed the issues of referral and monitoring and evaluation (M&E) processes. Currently there is no functioning referral system in Sudan. Patients can enter health systems at any point and determine their way through the system almost entirely on the basis of their own choice and ability to pay. Irrespective of the costs and who covers it, the absence of a good referral system has contributed to significant misallocation of health resources in the localities across the country (Mannan et al., 2013). Accordingly, the intervention aimed to develop a referral modality to enable service providers to identify potential available recourses in their states, for example medical doctors, legal aid and social services. This state level referral map led to the development of memorandum of understandings between trauma centres and other stakeholders, in which the agency agrees to provide services for survivors at free or minimal costs. Further, the supervision training emphasised counselling and
therapeutic ethical guidelines, the setting up of weekly supervision meetings and unified case reporting format. These micro skills may seem obvious, however, setting referral and supervision mechanisms in low resource settings are important in the process of M&E and in ensuring service quality and adequate coverage.

CBT is one of the commonly used approaches among Sudanese mental health professionals. During the training, several issues of cultural adaption were discussed including homework activities for illiterate clients, core beliefs and the religious beliefs, however complete adaption to a CBT therapeutic approach in Sudan is still an ongoing process.

Shima Bashir, counsellor Ahfad trauma Center

Stage II: Service provision
Shifting mental health care away from institutions and towards community facilities was stated by the WHO 2001 recommendations. Therefore, after the completion of the capacity building stage, the community based services provision was initiated targeting two levels of needs: clinical specialised mental health services and community based psychosocial support services.

Clinical service In the current intervention, four states were identified where a dedicated trauma mental health centre was setup: in Khartoum State the trauma mental health service centre was located in Ahfad University; in White Nile State and Gadrif State the centre was placed inside the city general hospital; and in Kordofan State the centre was placed inside a local medical NGO. The main selection criteria for the service placement was accessibility to the public.

The trauma centres aimed to primarily offer specialised trauma mental health services that helps individuals, families and communities to recover from the consequences of trauma and strengthen their resilience using free culturally sensitive therapeutic approaches. The trauma centres offer mental health treatment following international guidelines ICD-10 and DSM-V.

Since their opening in 2012, the centres received different cases related to violence and abuse and other mental disorders, mainly anxiety disorders and trauma and stress related disorders. Each state has its unique vulnerable groups of clients, for example Gadrif trauma centre received more trafficking survivors due to border issues with Ethiopia, while North Kordfan encountered war and conflict survivors, Kosti trauma centre dealt with massive numbers of South Sudanese refugees and Ahfad trauma centre received political detainees, as well as gender based violence survivors.

Figure 4: Trauma related cases incidents per year.
The graph (Figure 4) indicates the number of cases accepted in each centre. The number of cases varied annually due to different causes in each state; however, the reason behind the decline in the number of cases is mainly due to staff turnover and limited outreach activities. Furthermore, the complexities of referral pathways hinder clients from attaining accessible services. This issue of referral, as indicated previously, is important in accessing trauma services. Since accessibility is governed by affordability and information, the latter was challenging. For example, if survivors are not guided by primary health workers nor police or camp authorities, or survivors didn't seek formal services and opted to seek traditional healers, they will not know that trauma MHPSS services exist.

**Stage III: working with communities**

The public should be educated about mental health and families, communities and consumers should be involved in advocacy, policy making and forming self-help groups (WHO, 2001). After the first rounds of trainings for specialised professionals were completed and the service provision started, the MHPSS intervention identified two major gaps; one is accessibility of vulnerable groups to service units (i.e. how to disseminate information about mental health trauma services so that trauma survivors can make use of the free service). Further, how to increase community healing, as most of the violence survivors are suffering from deep rooted and community related violence from war, marginalisation or natural disasters. Therefore, the MHPSS intervention developed introduced a second tier of cohort representing community animators working in NGOs, governmental officials, family child protection units, and included the Ministry of Health and Ministry of Social Welfare. The rationale behind trainees’ selection was to increase networking and mobilisation of recourses to support communities affected by violence. The use of narrative theatre was identified as a strategy to reach greater numbers of people (Naidu & Sliep, 2012; Sliep, 2009; Sliep, Dageid, Akintola, & Duckert, 2011). Narrative theatre is a methodology where you work with local community members to make them active partners in the programme. A local assessment is done of both the problems and the resources of the area. Through drama based on stories from that specific community, awareness and skills are developed to deconstruct the problem story and build alternative strength based stories. In the dialogical space that is created, the opportunity is used to raise awareness, break down stigma, build trust and decrease suspicion. Awareness of human rights is raised around issues like gender based violence, while simultaneously building local expertise by providing training and referral guidelines (Ager, Sliep, & Ahmed, 2015). The methodology draws on a multi-sartorial approach (aholistic approach encompassing links between health and non health sectors) leading to equitable access of mental health to populations in low and middle income countries (Azad, Mashhadi, & Bibi, 2015). By building relationships with all local nongovernmental agencies and (where appropriate) governmental actors in the area and making use of cross referral. For example, mainstreaming MHPSS into nongovernmental programmes on income generating activities whereby a more holistic approach is taken, and where the gathering of women learning new skills for income generation is used to create a safe dialogical space. During this time, the women get an opportunity to share their concerns and tell their stories to each other. Having stories witnessed by others forms part of a healing process. The women are also encouraged to develop their strengths and abilities and to move from problem saturated stories to stories of ability and hope. Becoming financially more independent also enables the possibility that the women are able to take charge of their lives.
again (Sliep, 2011; 2014). The group received three trainings in narrative theatre as tool for collective healing. This phase ended with 20 mental health workers and 22 community animators trained in this methodology.

In using the narrative theatre with Syrian refugees in Khartoum

‘We faced great resistance. They are resistant to share (war) experiences, to cooperate with us, to use our services. After a while we were able to gain their trust (after the body mapping exercise). The women were nicer and able to share where the men were still hesitant and a bit reluctant.’

Shaz BabAllah, UNHCR-AUW project coordinator

**The training module: From Individual to Collective Healing**

We positioned our work within a social capital that helped us with planning our interventions. Social capital as a social foundation for human functioning has gained great momentum over the past two decades. The ability to access resources are embedded in, and can be accessed through, an individual’s social network. This is important when you want to increase awareness of referral networks for specialised services. In addition, the elements conceptualised within social capital like trust, safety, reciprocity, values and collaboration are usually compromised in post conflict areas, resulting in high levels of suspicion and lack of support (Murthy, & Lakshminarayana, 2006).

Social capital can be viewed in three levels and for this work all three levels were included in the identified geographical areas: social bonding which refers to relationships within a community where people have more or less similar power, like households living within close proximity; social bridging which refers to relationships we established with specific social groups like community based organisations (CBOs), nongovernmental organisations and other stakeholders; social linking where we tried to link services with health services in government, fostered close collaboration with our donors and the university responsible for training and research.

In war traumatised countries there is often an escalation of self-reproducing systems of chronic violence, driven by a complex combination of structural, disciplinary, hegemonic and interpersonal factors. An example of this is an increase of domestic and gender based violence, where fighting has entered households and is no longer about an outside enemy. Within the narrative paradigm, we work with the stories of people and how they are making meaning of their experiences. What is referred to as narrative theatre (NT) in this context is not only an event, but a process that is put into place with trained psychosocial workers and locally elected communities to rebuilding social fabric, as well as identification and referral of people who need more specialised psychosocial support.

A number of events are created where people can come together to explore what is happening in their households and communities, and to collectively find solutions for their problems. Historically, people may have had cultural practices in place to solve conflicts and problems, but the unravelling of social fabric and high levels of suspicion from ongoing violence result in a disruption of these practices.

The NT process also has the potential to create a safe space to experiment with alternatives, and to, ‘step into another person’s shoes’.

The presence of the community and the community leaders in the audience also makes it possible to negotiate achievable changes in behaviour. Problems that can be dealt with in this context are mainly related to destructive forms of behaviour.

During training, a safe environment has to be created. The participants are continually encouraged to look at how behaviour...
impacts on self and others. Once there is a clear understanding of the effects of harmful behaviour, the participants are encouraged to make plans of action that will decrease any harmful behaviour.

Exploring, experiencing and experimenting, the training started off in a circle with participants observing us full of anticipation, wishing for quick solutions and healing skills. However, healing is a process that takes time. We need to break down mechanisms of stigma, shame and silence to foster the healing process. We need to build safe reflective spaces within communities where we can use strategies like NT to explore, experience and experiment with better outcomes. We need to draw from local wisdoms and mobilise collective support and problem solving. We need to ensure that the voices of local men and women of all ages are included, that vulnerable groups (including children) are protected and that hope for a better and safer society is rekindled. The selected trainees we worked with have a very strong work ethic, never complained about long training days and remained eager for new knowledge and skills.

We drew up an ambitious and extensive programme covering all regions represented by the participants. Extensive community assessments that will inform collective healing strategies are currently completed. In total, 10 N Ts were conducted in Elfatah Khartoum, Elfashir, White Nile Refugees camps, Gadrif and Blue Nile.

The collective healing using NT as training programme was a well articulated and structured programme with a manual that had been translated and utilised. Further, the actual events were very popular, whether with South Sudanese refugees tackling (sexual) gender based violence or with IDPs in Darfur. The NT provided a platform for ventilating feelings and acknowledging weakness surpassing all stigma and shame aspects.

However, the main challenges faced by the MHPSS intervention were the follow-up with committees that were formulated after each event. This was related to two main aspects: 1) lack of resources to commute and follow-up; and 2) the complexity of cases addressed, whereby poverty, social injustice and security factors play a major role in the reinforcing of violence. These issues are seen as structural violence, which adds another layer of trauma to communities. The programme needs a more holistic approach to tap into bigger resources in order to provide the needed follow-up and strengthen networking opportunities among service providers to tackle community needs.

Conclusion

Even though psychological treatments have been advocated as treatments for a range of mental disorders by the WHO for scaling up through primary care globally, the vast majority of potential beneficiaries are unable to access these treatments. Two major barriers impede the path between evidence based treatments and improved access: the lack of skilled human resources and the acceptability of treatments across cultures (Patel, Chowdhary, Rahman, & Verdeli, 2011).

It is well known that population rates of not only PTSD, but also of other mental disorders, increase after exposure to adversity. Existing systems must be able to manage the ongoing needs and vulnerabilities of people with pre-existing mental disorders, as well as those who seek help for non pathological psychological distress (Eaton et al., 2011). While the initial focus of our MHPSS intervention in Sudan was almost exclusively on trauma treatment and advanced psychotherapeutic skills, the existing programme is now establishing a more comprehensive system of mental health and psychosocial support in Sudan, with active involvement of local partners and communities. This calls for community workers to identify and manage most cases,
Community outreach: Elafth narrative theatre event

Elafth area is located in Omdurman city, inside the capital city with a population of 250,000 and is characterized by extreme poverty, diverse ethnicity and was worst hit by floods in 2013. The needs assessment indicated the prevalence of women headed households as result of runaway husbands, which caused major social stressors to the family. The narrative theatre event helped the audience to open up publicly about their struggle in dealing with the effects of absent fathers in their community. The sharing during the gathering allowed women and children to break the silence and stigma they were experiencing, as well as mobilise support for each other. A strong vision about creating different father models was also spoken about by both young boys and the men who attended the gathering. The gathering also created an opportunity to build trust to deal with complex issues.

where lower intensity support is provided to affected individuals and communities through psychosocial counselling and narrative theatre. When specialised mental health interventions are indicated, interventions go beyond PTSD to address diverse forms of suffering that may be a result of exposure to war related violence and loss. Higher intensity focused support was granted through psychological and psychotherapeutic referral and intervention by trained mental health workers at state level trauma centres. Across this strategy, PTSD and trauma are managed alongside other mental disorders and sources of psychosocial distress.

The intervention was able to integrate its services within existing community based initiatives, rather than adding on additional services. We integrated MHPSS into existing microfinance, The Income Generating Activities programmes and HIV community based services, whereby referral between partners and level of specialised service and lay counselling took place. This offered an integrated and holistic response to both individual and community needs.

Another strategy to reduce attrition of personnel is to build the capacity of an educational institution, so that there is a formal degree programme related to the ongoing implementation of evidence based treatments in mental health.

The intervention provided a dynamic programme that worked on different levels of capacity building, offered specialised services and introduced community healing interventions. Furthermore, it was able to mobilise different agencies to support MHPSS activities in Sudan.

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DOI: 10.1097/WTF.0000000000000140