Assessing Mental Health in Humanitarian Emergencies:
A Representative Survey by the Center for Victims of Torture in Kalobeyei, Kenya

The Center for Victims of Torture
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The Center for Victims of Torture (CVT) carried out a mental health assessment in northern Kenya with a representative sample of residents (N=323) of Kalobeyei refugee settlement and the surrounding host community in November 2016. This report provides a summary of methodology and an overview of descriptive findings.

Rationale: A Gap in Mental Health Data

Understanding and meeting mental health needs of individuals and communities who have experienced war or other types of violence or human rights abuses is fundamental to the success of any other intervention with these populations. There can be severe psychological and physical effects of past traumas from loss of loved ones, experiences of torture or other abuse, the witnessing of violence or atrocities. Many refugees also experience negative effects of continuous traumas and ongoing stressors or threats associated with forced migration. In this context, it can be extremely difficult to process or cope with grief over those who have died or ambiguous loss over those whose whereabouts are unknown.

All of these factors can impair daily functioning of refugees fleeing conflict, leading to an inability to effectively meet the substantial challenges of daily living. This can mean diminished success of humanitarian interventions (such as education or livelihood initiatives), increased levels of ongoing violence in communities and households, or high rates of self-harm or destructive activities. Understanding and attending to the mental health needs of survivors, including interdisciplinary rehabilitation from trauma, is a key part of restoring dignity in the wake of human rights abuses and providing a form of justice for those who suffered harms. It may also be an important preventative mechanism in preventing future cycles of violence and promoting more effective peacebuilding.

There is very little representative data about mental health in refugee populations. Rather, much of the data we typically collect and analyze comes from help-seeking populations, those who come to service providers to receive care for mental health or physical health needs. This is problematic because it does not reveal the full range of needs among the population. The most vulnerable members of the community are unlikely to seek help for their needs. We also get data, typically qualitative, from key informants, community leaders, or other stakeholders who provide perspectives on mental health needs based on their expert positions or depth of experience within communities. Few NGOs have the capacity to collect data beyond this, and few scholars have contributed to filling this gap. This survey is one step in demonstrating the feasibility of representative sampling methods, conducted by a practitioner organization in a humanitarian setting.

Context: "A Major Paradigm Shift"

Kakuma refugee camps in northern Kenya have been in existence since 1992. One of the world's largest and most diverse camps, Kakuma now hosts over 170,000 refugees from 19 countries.[1] The largest populations are fleeing civil war and increasing atrocities in South Sudan or Sudan, from protracted conflicts in Somalia or DRC, or political persecution in Ethiopia. The population of Kakuma is not likely to decline in the near future; durable solutions to these complex conflicts do not seem to be imminent and the Government of Kenya's goal of closing Dadaab camps has meant relocation from Dadaab to Kakuma. The four sprawling camps of Kakuma are at or above full capacity, prompting consideration of where and how to expand; UNHCR has been promoting "alternatives to camps" in Kakuma and similar situations.

Kakuma camps are located in one of the poorest regions in Kenya, where the local Turkana population depends on livestock and limited subsistence agriculture. It is a region that has seen cycles of widespread violence, as the proliferation of small arms, breakdown of state control, and militarized social norms have increased the stakes of cattle raiding at the intersection of Kenya, Uganda, and South Sudan.[2] There has been a complex relationship between refugees and Turkana at Kakuma, including a framing that sees one another each as the violent "other," occasional eruptions of violence, and increases in psychosocial stress of the host community due to the presence of refugees.[3] Because of this, UNHCR and humanitarian partners have consistently allocated resources to support the host communities and promote peaceful coexistence between refugees and the local population.

Kalobeyei settlement is one attempted response to these issues; it is a 14-year project, begun in June 2016, to promote more sustainable solutions to the refugee crises in the region. The vision of Kalobeyei is a "major paradigm shift," to integrate refugees and members of the host community into a hybrid settlement, a planned urban center.[4] The hope is that this will allow greater autonomy and self-sufficiency for refugees and promote parallel developments for the local Kenyan population, in the meantime promoting social cohesion and interdependence among the two populations. In November 2016, the time of this survey, there were 10,905 refugees in Kalobeyei, a figure that has increased exponentially since then. By the end of July 2017, there were 37,365 refugees in the settlement.[5] The goal is that the settlement will eventually integrate 60,000 refugees and 20,000 members of the Turkana host community.

At the outset of this new initiative, CVT carried out this survey to collect baseline data on mental health issues, with plans to re-administer the survey annually as the settlement grows and as service provision begins. The data will aid in developing mental health and psychosocial support (MHPSS) services responsive to current needs. One contribution of this data is to contrast mental health issues among two communities with different histories of and vulnerabilities to conflict or violence. We

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[1] UNHCR Kakuma. 30 April 2017. "Population Statistics by Country of Origin, Sex and Age Group." Available at http://reliefweb.int/sites/reliefweb.int/files/resources/56243.pdf, accessed 8 August 2017.

[2] Osamba, Joshia O. 2000. "The Sociology of Insecurity: Cattle Rustling and Banditry in North Western Kenya." *African Journal on Conflict Resolution* 1 (2): 11–38. Leff, Jonah. 2009. "Pastoralists at War: Violence and Security in the Kenya-Sudan-Uganda Border Region." *International Journal of Conflict and Violence* 3 (2): 188–203.

[3] Vemuru, Varalakshmi, Rahul Oka, Rieti Gengo, and Gettler. 2016. "Refugee Impacts on Turkana Hosts: A Social Impact Analysis for Kakuma Town and Refugee Camp, Turkana County, Kenya." Washington, DC: The International Bank for Reconstruction and Development / The World Bank Group. https://openknowledge.worldbank.org/bitstream/handle/10986/25863/111309.pdf?sequence=5&isAllowed=y.

[4] UNHCR. "Kalobeyei Settlement." Available at: http://www.unhcr.org/ke/kalobeyei-settlement, accessed 8 August 2017.

[5] UNHCR Kakuma. 30 July 2017. "Kalobeyei Settlement Population Statistics." Available at http://reliefweb.int/sites/reliefweb.int/files/resources/Kalobeyei.pdf, accessed 8 August 2017.

surveyed: 1) refugees recently settled in a host country, fleeing civil wars or persecution; and 2) rural communities struggling with extreme poverty and recent histories of violent conflict over livestock and land. Considering these distinct populations can shed light on the complex types of relationships that may emerge between war, violence, forced migration, poverty, and mental health.

Methodology: Representative Sampling

This was the first effort by CVT to implement rigorous social scientific methods to carry out a representative survey of mental health issues, needs, and resources in a humanitarian setting. With methodologies that are replicable and feasible, the survey will be conducted annually in Kalobeyei and in other refugee camps. This commitment to on-going data collection in Kalobeyei will allow nuanced analysis of how mental health needs shift over time, especially as the two populations move increasingly towards an integrated settlement. By using comparable methodologies and questionnaires, we are building a global dataset of refugee mental health. This can lead to comparative analyses of levels of trauma, stigma, stressors and symptoms between refugee camps or between people from the same country of origin in different settings. This will contribute to helping the humanitarian sector design and prioritize effective responses, including advocating for resources.

Fieldwork was expedited, carried out in one week. We identified the interview team through recommendations of service provider organizations in the area, hiring a team of about 30 refugees and host community residents, including interviewers, supervisors, and community guides. The team represented the linguistic diversity of the populations, with interviews conducted in Arabic, Lotuko, English, Swahili, Didinga, and Turkana. We provided training and conducted about three days of data collection, resulting in two samples: the Kalobeyei refugee settlement (N=239) and the Turkana host community (N=84). The interviews were conducted in person, typically at the respondents' homes. The eight-page paper questionnaire took an average of 30 minutes to administer.

Questionnaire. The questionnaire collects data about attitudes about mental health, current stressors, symptom areas, coping mechanisms, access to services, torture history, and demographics. The first questions are statements about mental health, with a four-point agree/disagree response scale. These questions address definitions of mental health, stigma surrounding mental health, and attitudes about trauma and how to cope with it. These questions give a strong indication of stigma attached to mental health, and also help us understand perceived social support.

The second section asks about current stressors,[6] including meeting basic needs, dealing with migration-related issues, and more acute or trauma-related problems. Respondents ranked the severity of each problem in their life. The third set of questions asks respondents to report the frequency or severity of mental health symptoms.[7] In addition, we ask for an overall rating of mental health, to what extent mental health and physical health problems interfere with daily functioning, and about chronic pain.

[6] This section was loosely modeled after the Post-Migration Living Difficulties (PMLD) measure, which has been used to show how daily stressors can be potentially re-traumatizing to vulnerable migrants with traumatic histories. See: Aragona, Massimiliano, Daniela Pucci, Marco Mazzetti, and Salvatore Geraci. 2012. "Post-Migration Living Difficulties as a Significant Risk Factor for PTSD in Immigrants: A Primary Care Study." *Italian Journal of Public Health* 9 (3).

[7] These questions are modeled on the Self-Reporting Questionnaire (SRQ-8), a shortened version of a 20 item screening and diagnostic tool that has been validated in post-conflict settings. See: Scholte, Willem F, Femke Verduin, Anouk van Lammeren, Theoneste Rutayisire, and Astrid Kamperman. 2011. "Psychometric Properties and Longitudinal Validation of the Self-Reporting Questionnaire (SRQ-20) in a Rwandan Community Setting: A Validation Study." *BMC Medical Research Methodology* 11 (116). We kept the content areas for each of the eight items, but adjusted question wording to CVT client assessments across international programs, allowing comparability of symptom levels among these populations with help-seeking refugee populations in several other contexts.

Questions about symptoms are key to helping determine the prevalence of mental health problems, thus determining the size of the target population in need of services.

The next section asks respondents about activities they use to cope with feeling sad, anxious, or overwhelmed. They are asked about positive and more negative potential coping behaviors. Service providers can use this data to design interventions that draw upon positive strategies already in use, and help mitigate the risks that can come from negative coping strategies. Finally, there are sections on: identifying household members who struggle with mental health problems; reported torture experienced by the respondent, their family members, or community members; and access to (and barriers to accessing) and interest in mental health services in the community. Basic demographic information included age, gender, languages, country of origin, household size, level of education, and years in the current community.

Ethics and mental health support. As a mental health organization, our objective was to maintain a high standard in dealing sensitively with vulnerable populations, particularly those who are likely to have experienced significant trauma. Throughout the project, our goal was to understand the needs of the people we contacted and to provide them with support, both in the limited ways we could during the survey and in planning future service provision. This orientation can distinguish data collection conducted by a practitioner organization from research agendas in which data is sought from a population for purposes beyond them, such as to advance scientific knowledge.

The protocol used to introduce the survey and orient a potential respondent is particularly essential in this type of setting, as is the training provided for enumerators who implement it. This managed expectations that services would not be provided as a result of participation, explained that some questions may be upsetting or stressful, and emphasized voluntary participation. With extremely vulnerable populations, such as recent arrivals in a new refugee camp, this can be challenging to convey, but is essential.

Interviewers received training on particularly sensitive questions. We developed a follow up protocol for interviewers to follow if respondents reported suicidal thoughts "sometimes" or "often." We also implemented follow up procedures for respondents who experienced emotional distress or were triggered by the questions. First, all interviewers and supervisors were trained in "psychological first aid" (PFA), a set of actions or techniques used to respond to strong reactions to trauma.[8] Interviewers in the refugee settlement reported using PFA during about 9% of their interviews; it was rarely necessary in the host communities. Second, we established connections with local service providers. Interviewers were trained on how and when to give information about services that may be available to respondents. We also were able to make referrals directly to partner organizations for respondents with particular needs. Finally, we had two psychotherapists experienced with trauma in these populations available to respond to individual situations of distress that required immediate intervention.

The need for these follow up services was more frequent in the refugee community, perhaps reflecting more acute need or recent experiences of trauma, more easily triggered by the types of questions included in our survey. We strongly advocate for these or similar best practice procedures among any researchers collecting data among similarly vulnerable or traumatized populations, particularly refugees with recent experiences of war, violence, or forced migration.

A final ethical consideration was the mental health needs of the interviewers and supervisors themselves. As members of the same populations as the respondents, some of these individuals also experienced psychological distress throughout data collection, whether in response to a particularly emotional respondent, the cumulative burden of hearing others' stories or symptoms, or by experiencing

[8] Ruzek, Josef I., Melissa J. Brymer, Anne K. Jacobs, Christopher M. Layne, Eric M. Vernberg, and Patricia J. Watson. 2007. "Psychological First Aid." *Journal of Mental Health Counseling* 29 (1): 17–49.

triggers to traumas that they may have personally experienced. It is essential to consider the well-being of research staff in the design and implementation of this type of data collection effort.

Sampling. We used a multi-stage cluster sample methodology, with three sampling stages to select two distinct samples: the host community (N=84) and the refugee settlement (N=239).[9] Cluster sampling can help mitigate some of the challenges that make it difficult to collect data in humanitarian emergencies.[10] In stage 1, we randomly selected villages (host community) or compounds (refugee settlement), with selection probability proportionate to population estimates. Our host community sample covers the adult population of the two sub-locations surrounding Kalobeyei settlement.

Stage 2 sampling was household selection. In the host community, we used interval-based selection of households from a central starting point in the assigned village. In rural, dispersed, and semi-pastoralist villages, this sampling technique required a high degree of local knowledge of village boundaries and other demarcations, and careful coordination by the supervisor to ensure the entire village was covered. In the refugee sample, we randomly selected five households per compound for potential inclusion. Finally, stage 3 sampling was random selection of an individual within a selected household, to avoid disproportionately interviewing heads of households or the most accessible individuals.

While there were some deviations from these sampling procedures in practice, we generally maintain that a high degree of sampling precision is possible in this or similar settings, even in very challenging conditions of humanitarian contexts and with staff with minimal training, education, or experience. More complete methodological details are available upon request.

[9] The refugee sample was disproportionately larger than the host community sample due to the emphasis within the organization on providing services to refugee populations.

[10] Morris, Shaun K., and Claire K. Nguyen. 2008. "A Review of the Cluster Survey Sampling Method in Humanitarian Emergencies." *Public Health Nursing* 25 (4): 370–74.

Mental Health among Newly Settled Refugees and Host Communities

CVT's survey data reveal important trends and nuance in mental health and trauma-related issues facing these communities.[11] Preliminary findings include: positive attitudes and low stigma surrounding mental health; high rates of ongoing stress from feelings of grief, loss, and hopelessness; high levels of mental health symptoms, including suicidal thoughts; but also high prevalence of positive coping strategies. Social support is particularly linked to mental health and coping with trauma or human rights abuses.

Demographics. The samples include more women than men, with refugees generally younger and living in smaller households than their host community counterparts. Host community respondents were far less educated, with fully 86 percent reporting no education at all. They were also significantly more likely to report dealing with chronic pain. Refugees, on the other hand, experience the precariousness that comes from being extremely recent arrivals, having been in their current community for an average of just three months. This factor may contribute to lower levels of social support, less knowledge of resources, and other major adjustments to the new context that may lead to more mental health challenges. Surprisingly, both samples reported similar rates of having received mental health or psychosocial support services; refugees may be more recent arrivals to the area, but they have comparable access to services as long-term residents of host communities.

	Refugee settlement[12]	**Host community**
Total N	239	84
Women (valid %)	60	59
Age (mean)	27	39
Household size (mean)	4	7
Languages spoken (valid %)		
Arabic	42	0
Lotuko	31	0
Swahili	22	29
English	20	4
Didinga	19	0
Nuer	11	0
Turkana	2	100

[11] In descriptive analyses below, a design weight adjusts for the unequal probability of selection of each village or compound (EA). Each respondent is given a weight inverse to the probability of selection of their EA. This weight is applied in all descriptive analyses of the data.

[12] Our sample very closely resembles UNHCR demographic data from Kalobeyei as of 17 November 2016. On gender and country of origin (age breakdown was unavailable), our sample approximates population characteristics by within a 5 percent margin. As a result, we do not weight our data to adjust to population characteristics. Unfortunately, comparable demographic data for the host community sub-location populations was not available. Hopefully in future iterations of the survey, we will have this data to help correct for any variation in the relatively small sample from the host community.

	Refugee settlement	Host community
Home country (valid %)		
South Sudan	77	0
DR Congo	12	0
Kenya	0	100
Other	11	0
Completed levels of education (valid %)		
No education	45	86
Primary	55	14
Secondary	17	1
Time in current community		
Range	0 to 12 months	0 to 82 years
Mean	3 months	24 years
Experience chronic pain (% yes)	43	69
Torture survivor (% yes)	25	31
Have received MHPSS services (% yes)	25	28

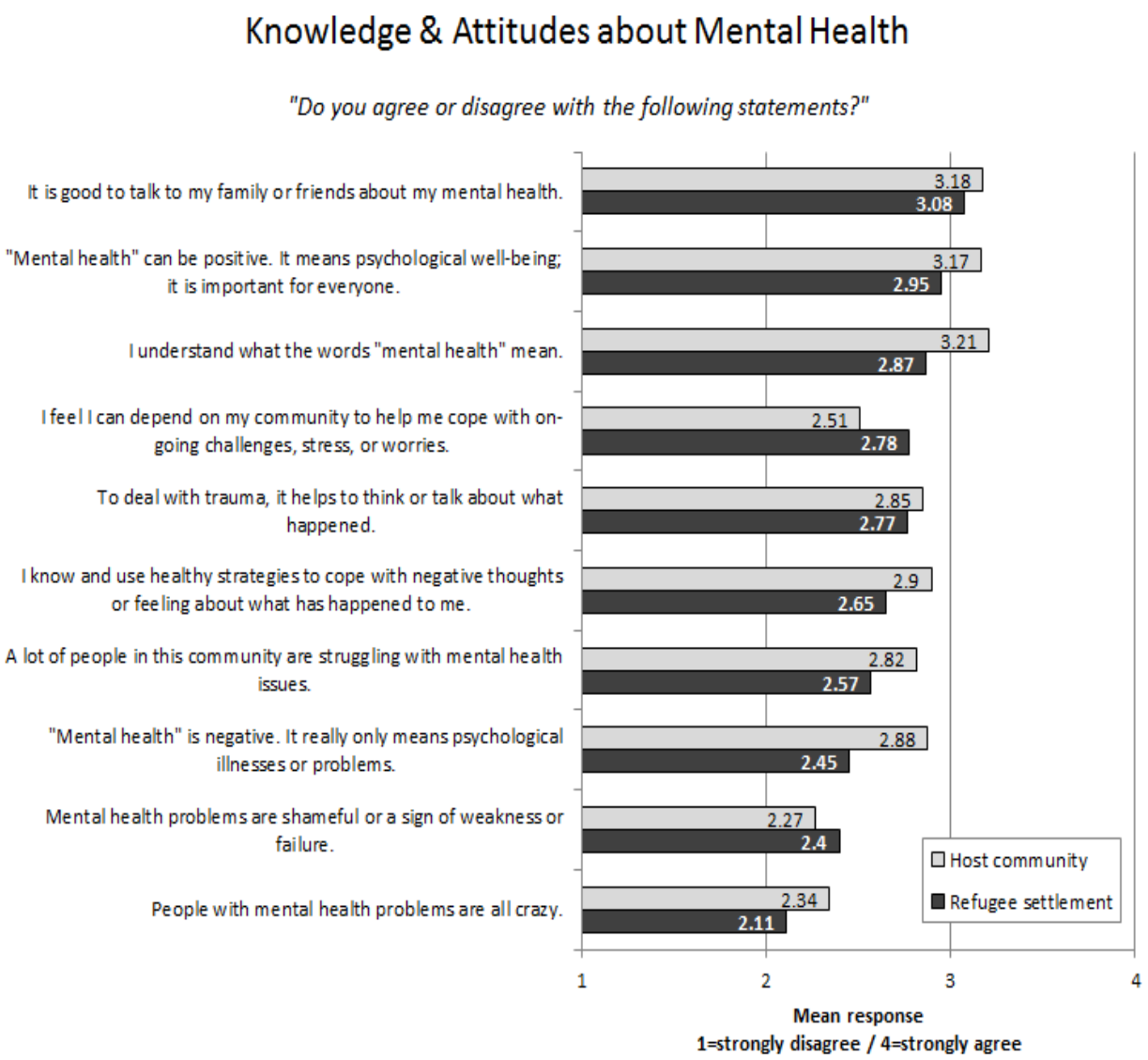
Torture Survivors. We found high rates of self-reported experiences of torture.[13] Torture is associated with unique mental health effects,[14] as a very particular type of violence or harm, one that is targeted, intentional, and inflicted by those in positions of authority or power who are supposed to offer protection, but instead commit abuses. It is unlikely that many respondents were aware of the UN Convention Against Torture definition, but self-identification as a torture survivor is important in many ways.

Among clients in CVT international programs, we often find that clients' self-identification as torture survivors is significantly related to severity of symptoms (even to suicidal ideations) or elements of social connection or support. In this data, we also find that reporting torture is significantly related to reports of chronic pain, for both refugees and host community residents. This is important because (in the refugee sample) we also found a significant relationship between chronic pain and having difficulty doing daily work and having overall much lower levels of mental health.

Knowledge, Attitudes, and Stigma. We found surprisingly positive attitudes about mental health, relatively high levels of (reported) knowledge, and strong reliance on social support to deal with mental health problems among the refugee sample.

[13] Definitions of torture can widely vary by context. We did provide a very basic description of torture prior to asking the respondent whether or not they had experienced torture, but this does not ensure respondents uniformly considered the same thing when thinking about "torture."

[14] Campbell, Thomas. 2007. "Psychological Assessment, Diagnosis, and Treatment of Torture Survivors: A Review." *Clinical Psychology Review* 27: 628–41.

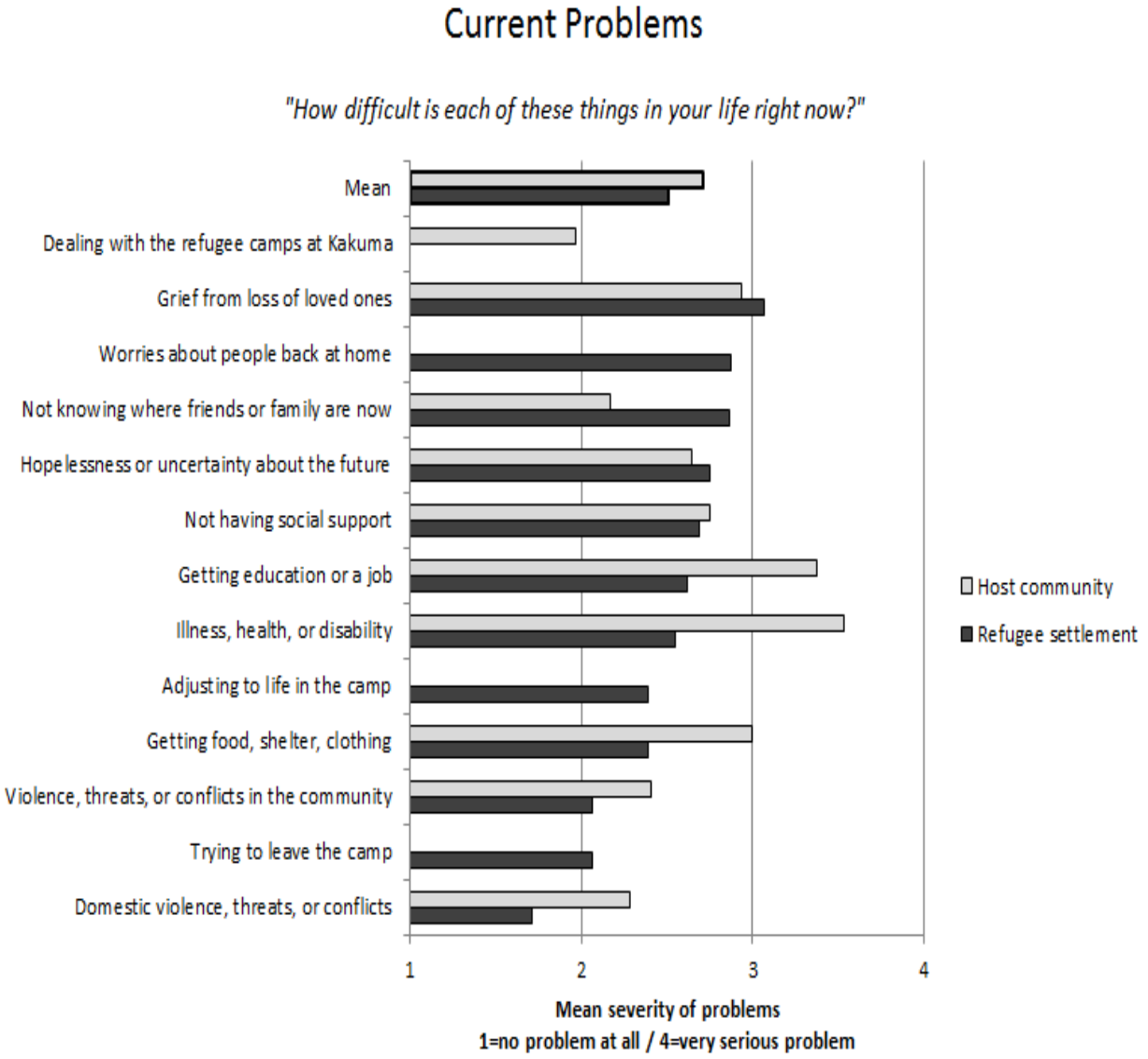


Most refugee respondents agreed that talking about their mental health is good, and similarly agreed that "mental health" can be a positive reference to psychological well-being. These are views that are not necessarily expected among such populations. They were also more likely to disagree with the most negative statements, suggesting relatively low levels of stigma surrounding mental health struggles in the refugee settlement. This is a positive collective resource that can be drawn upon. In other settings, CVT's observational experience has been that there is significant stigma against receiving mental health support, which can hinder the likelihood that those in serious distress will seek services. Having representative data from multiple contexts will allow comparative analysis and can help identify predictors and effects of widespread stigma.

The host community, however, reported lower knowledge and less positive attitudes. They were significantly more likely to conceptualize "mental health" primarily in negative terms, such as only referring to psychological illness or to refer to people who are "crazy." Furthermore, despite having been rooted in their communities about two dozen years (on average) more than refugees, host community members were much less likely to feel they could rely on their communities to help them cope with their challenges, stress, or worries. This may suggest weak social cohesion or heightened

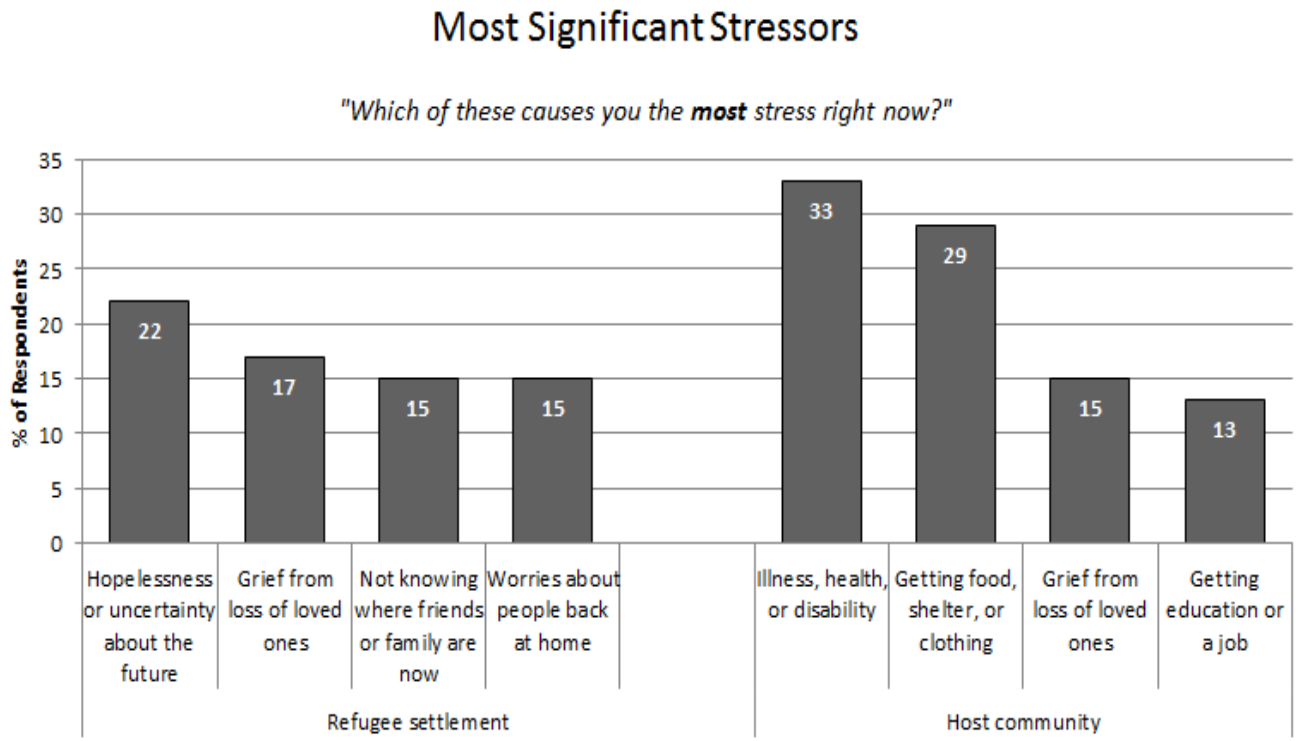
tensions from a history of internal conflicts. Comparatively, refugees, even recently settled arrivals, may have more social resources or social capital to draw upon than we might expect.

Daily Stressors. Ongoing, daily stressors can have substantial negative mental health effects, particularly among individuals who, due to trauma, may not have the resources or capacity to cope positively with such problems.[15] Daily stressors can be rooted in psychological problems, but also often stem directly from social and material conditions. Combined with high symptoms of depression, post-traumatic stress, or anxiety, and placed in a context of trauma, violence, or other abuses suffered in the (recent) past, daily problems or stressors have the potential to be a catalyst for conflict within households and entire communities.



[15] Silove, D., R. Brooks, C. Steel Bateman, Z. Steel, Fonseca C. Amaral, J. Rodger, and I. Soosay. 2010. "Social and Trauma-Related Pathways Leading to Psychological Distress and Functional Limitations Four Years After the Humanitarian Emergency in Timor-Leste." *Journal of Traumatic Stress* 23 (1): 151–60. Miller, K. E., and A. Rasmussen. 2010. "War Exposure, Daily Stressors, and Mental Health in Conflict and Post-Conflict Settings: Bridging the Divide between Trauma-Focused and Psychosocial Frameworks." *Social Science & Medicine* 70 (1): 7–16.

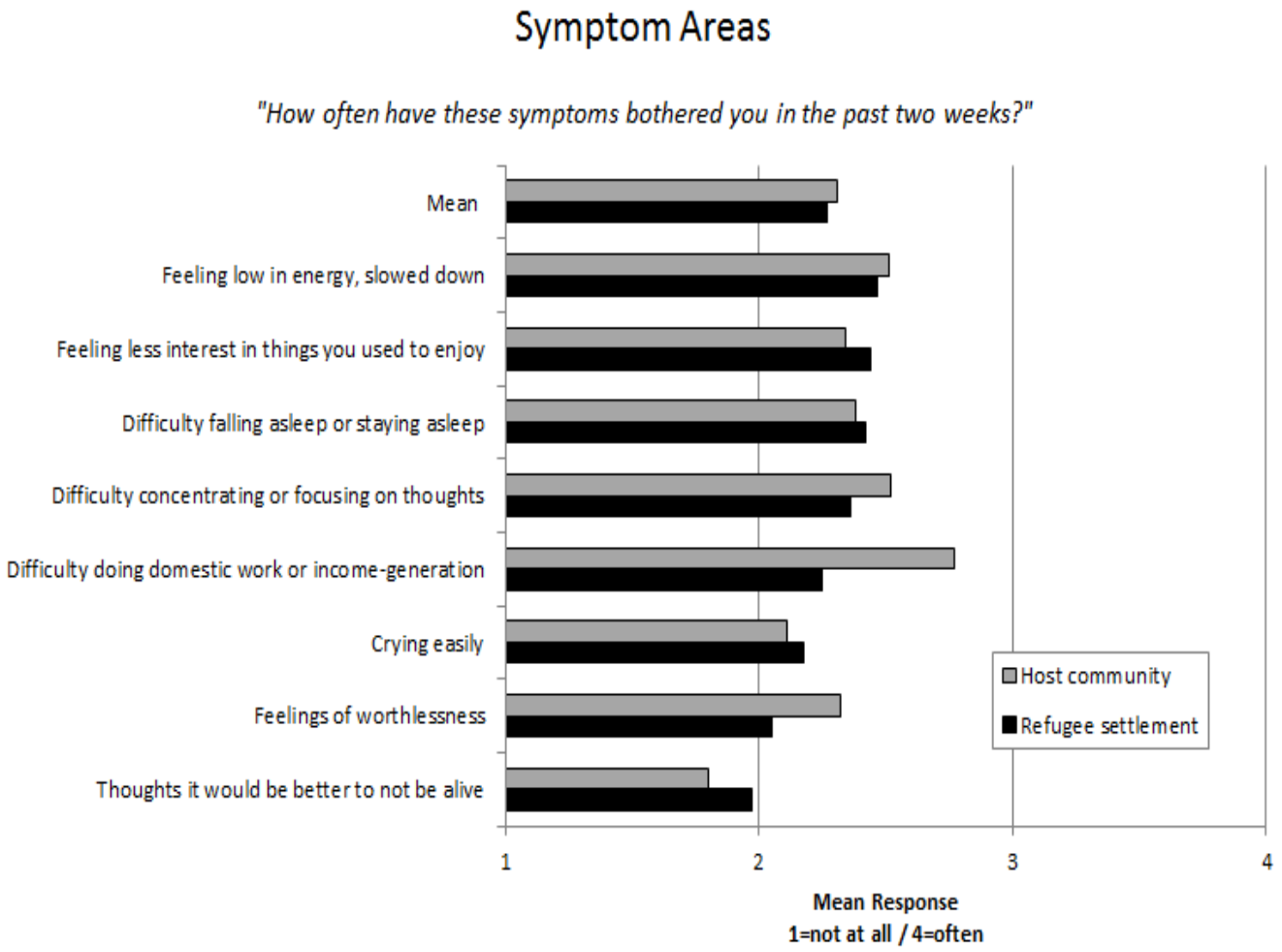
We found refugees and host community members struggling with very different sets of stressors. When given a list of about a dozen problems they may face in their daily life, as well as an opportunity to add to the list, host community respondents experienced the most stress from poor health or illness or from struggles to meet basic socioeconomic needs, such as food, housing, or education. Refugee respondents, on the other hand, experience more ambiguous stressors. They feel hopeless about the future and have high levels of worry about family or friends who are missing or remain at home. Both groups struggle with grief from loss of loved ones.



Symptoms and Functioning. We also measured a range of psychological problems or symptoms. While not diagnostic, high scores on these items are suggestive of high rates of depression, anxiety, PTSD, or behavioral functioning difficulties. Nearly half of the refugee respondents (48%) said they feel that mental health problems, like stress, depression, or anxiety, sometimes or often cause trouble with their daily functioning. In the host community, about 43% of respondents reported similar problems functioning on a daily basis. This is cause for concern, particularly as significant resources are invested in peacebuilding initiatives, livelihood programs, or many other areas that depend on the active participation of affected communities. If mental health problems, stemming from both trauma and daily stressors, are impeding the daily functioning of nearly half of the population, such efforts may ultimately be ineffective.

Among the refugee sample, 48% of respondents said they sometimes or often have trouble focusing on their thoughts, 48% had similar difficulty participating in activities to support themselves or their families, 34% reported frequently feeling worthless, and fully 32% reported sometimes or often

thinking it would be better if they were not alive.[16] All of these are important risk factors and suggest greater attention should be paid by both practitioners and researchers to the acute mental health needs of populations who have experienced conflict and violence. As suicides and attempts seem increasingly common among refugees,[17] a third of respondents reporting suicidal thoughts is highly alarming.



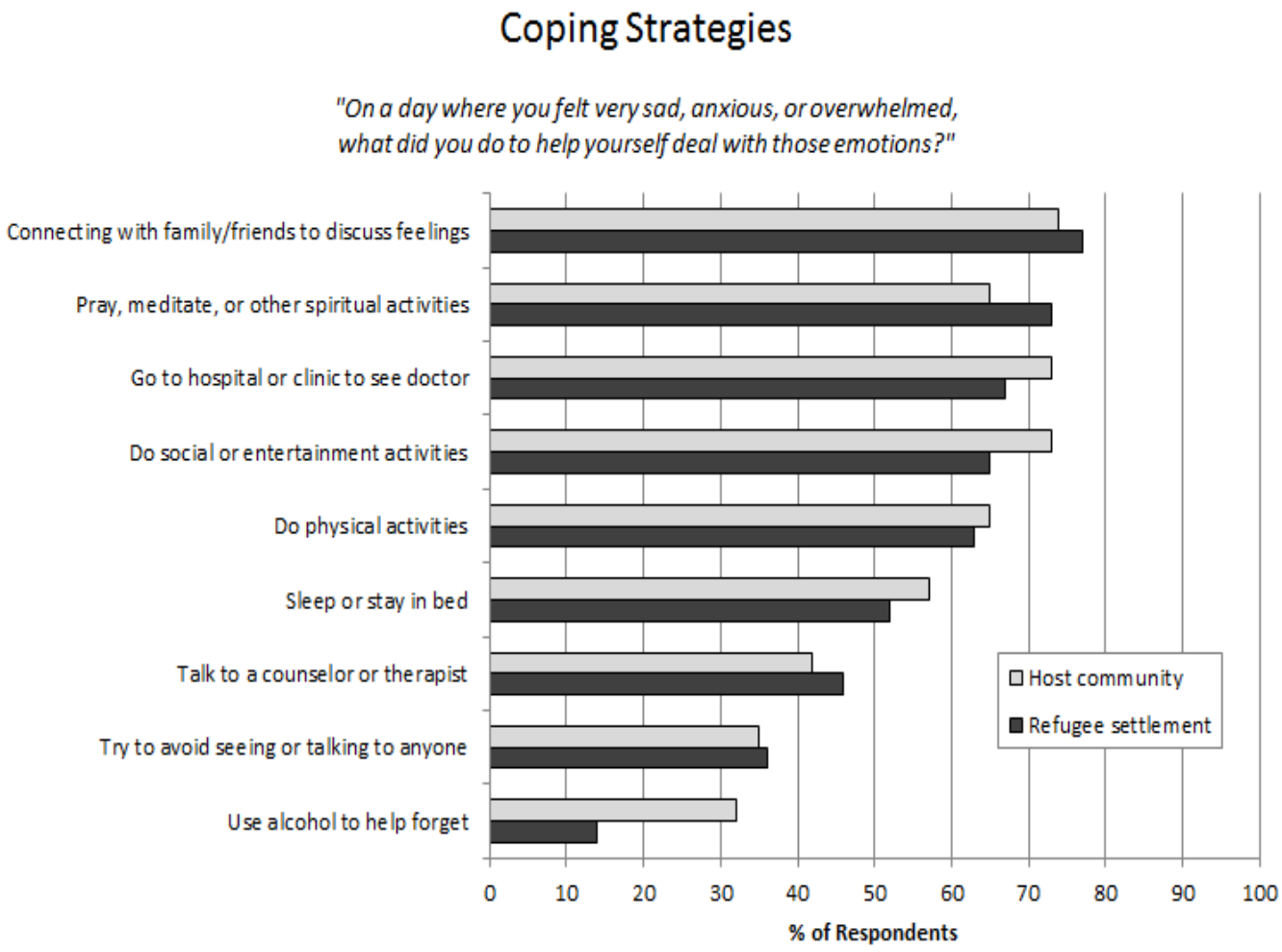
The host community displayed similar mean symptom levels, but variation in the specific items. They reported more often struggling to do their daily work and having feelings of worthlessness. This is likely related to the extremely high rates of poverty in Turkana, and that survey respondents generally had no education and high levels of stress about providing for even basic needs. In this difficult social

[16] On client assessments, CVT counselors ask the question about suicidal more directly, as "In the past two weeks, how often have you had thoughts of ending your life?" To decrease the pressure of this question in the context of a survey, rather than a supportive clinical relationship, we reframed the question to be more passive, as "Thoughts it would be better not to be alive."

[17] See, for example: Dearden, Lizzie. 16 March 2017. "Child refugees attempting suicide amid increasing desperation among thousands of trapped migrants in Greece." *The Independent*. Available at: http://www.independent.co.uk/news/world/europe/refugee-crisis-eu-turkey-deal-year-results-latest-child-suicide-attempts-self-harm-drownings-a7631941.html, accessed 8 August 2017. Kakissis, Joanna. 20 June 2017. "Refugees Struggle with Mental Illness, Suicide Attempts Increase." *NPR*. Available at: http://www.npr.org/2017/06/20/533631145/refugees-struggle-with-mental-illness-suicide-attempts-increase, accessed 8 August 2017.

context, feeling they are worthless or have no sense of purpose is perhaps not surprising. About 23% reported in the past two weeks sometimes or often having thoughts that it would be better not to be alive.

Coping Strategies and Resilience. In addition to cause for concern, we also found significant signals of resilience and positive coping strategies practiced among these communities. Relying on social support systems is the most commonly used method to deal with emotional distress, followed by a dependence on spiritual beliefs or practices. Arguably the two most destructive coping strategies on our list—drinking alcohol and total social avoidance—were reported least commonly, although undoubtedly social desirability bias likely contributes to this. Understanding the coping strategies already used by people in communities affected by violence is an important first step to understanding how to develop deep individual and collective resilience to trauma.



This report has presented evidence to support the argument that mental health and trauma must be key considerations in any humanitarian response. Using an interdisciplinary lens, we also highlight the interconnections between psychological challenges, social factors, and physical health suggesting that trauma rehabilitation must integrate these various perspectives. This data collection was one effort to help fill a gap in the field of representative data about trauma and mental health among refugee populations in humanitarian contexts. CVT's planned representative surveys in Ethiopia, a second round survey in Kalobeyi, and other international locations will continue to contribute to our understanding of mental health needs. Our experience illustrates the challenges of survey data collection in such settings, but also highlights the feasibility. We have also highlighted significant ethical concerns about such surveys, including suggesting some procedures that can be implementing to help minimize and mitigate harms. Finally, in a descriptive review of the resultant data, we find opportunities or strengths in generally low stigma surrounding mental health, strong social support among refugees, and positive strategies to cope with emotional struggles. The data also suggest high need for trauma-sensitive services, as both populations display high levels of psychological problems and are likely to be in need of rehabilitation support. There also very high rates of reported torture and suicidal thoughts among refugees and the host community, providing evidence of acute need that can be used to advocate for and design effective interventions.