IASC RG Field Support Mission to South Sudan

18 – 29 June 2016

**Background**

South Sudan has been marred by conflict and instability since 2013. A large proportion of the population are displaced, struggling to access basic services and exposed to significant protection threats. Protection of civilians is at the Centre of the 2016 Humanitarian Response Plan reflecting the humanitarian community’s commitments to respond appropriately to the unique needs of the different groups affected by the crisis: IDPs, host communities, refugees, boys and girls, the elderly, persons with disabilities, youth, and women and men. The first strategic objective for 2016 focuses upon saving lives and alleviating suffering through safe access to services and resources with dignity. The second objective ensures communities are protected, capable and prepared to cope with significant threats – placing protection at the centrality of humanitarian response, as well as ensuring humanitarian action builds upon the resilience and coping capacities of at-risk communities.

Within this context, the members of the Psychosocial Task Force and the Mental Health Platform in South Sudan have identified a need to strengthen the coordination of mental health and psychosocial support (MHPSS) programmes conducted by humanitarian actors and to ensure greater advocacy for MHPSS within the in-country humanitarian coordination architecture and with Donors. A request was lodged in May 2016 for a field support mission to be conducted by the Coordinator for the Inter-Agency Standing Committee’s Reference Group on Mental Health and Psychosocial Support (IASC MHPSS RG), with a view to supporting the restructuring of the MHPSS coordination groups and to improve advocacy and funding for MHPSS interventions within the Humanitarian Response Plan and other development initiatives.

**Mission objectives**

1. Support the creation and set-up of the newly formed MHPSS WG in South Sudan.
2. Encourage buy-in and support from relevant Government line ministries – MoGSD and MoH.
3. Facilitate the linkages between the new MHPSS WG and other relevant coordination groups, e.g., clusters and the ICWG.
4. Increase the quality of MHPSS interventions and programmes through increased awareness of the IASC MHPSS in Emergency guidelines by practitioners and donors.
5. Improved MHPSS coordination and inter-agency referrals.
6. Identify and establish a suitable way to collect and report MHPSS data across different sectors and also clarify the linkages between the MHPSS WG and the clusters regarding ownership and commitment.

**Key activities conducted in Juba**

1. Facilitate a Training of Trainers (ToT) on the IASC Guidelines for *MHPSS in Emergency Settings* for selected MHPSS WG members. Assess and plan, where possible, for a continued training programme for actors with limited capacity on MHPSS interventions.
2. Facilitate meetings with relevant field level cluster coordinators and the newly formed MHPSS WG regarding the ‘housing’ of the new WG and working modalities.
3. Facilitate meetings with OCHA and field level clusters on reporting lines and indicators related to MHPSS within the 5Ws reporting system.
4. Meetings with relevant Government Line Ministries (MoGSD and MoH).
5. Meet with the Humanitarian Country Team and/ or donor community to advocate for MHPSS in emergencies within the HRP, humanitarian coordination structures and regarding funding streams.

**Deliverables**

1. ToT training package delivered with accompanying manuals/ materials.

A ToT training on the IASC RG MHPSS Guidelines, was organised and funded by IOM on 27 – 28 June, in Juba. I facilitated the training over the 2-days. Training participants were invited to attend through the previous Mental Health platform and the PSS Taskforce e-mail lists. 17 participants from local NGOs, INGOs, Unicef, IOM, Danish Red Cross and the Ministry of Gender, Social Development and Education took part in the training. Unfortunately, there was no representation from the Ministry of Health. The training was supported through funding from the Italian Government, and with plans for participants to further cascade orientation seminars to fellow colleagues, within the priority clusters and to other humanitarian actors.

* Pre-test results: 36.5% (17 participants)
* Post-test results: 63.5% (16 participants)
* Knowledge increase: 27%

Participants were overall pleased with the training facilitation (rating good or excellent). Areas for improvement included a better selection of participants – especially the inclusion of actors from other INGOS working in the MHPSS sector and from the Ministry of Health. Additional feedback included making the training longer – expanding it to 3-5 days from two days.

1. Creation of a ToR for the MHPSS WG.

A ToR was drafted via a brainstorming session in the first joint MHPSS coordination group meeting on 23 June 2016. The ToR was subsequently circulated to the Board members of the new Coordination group for their feedback and also with the Donor Community (please see the annex). The group is open to humanitarian actors and partners working more in development (e.g., social protection or mental health systems strengthening). The agenda for the main coordination meetings is to be set once the group meets at its next monthly meeting (last week in July). Please see the Annex for the location of the MHPSS group within the humanitarian architecture in Juba.

1. Support with the identification of focal points within relevant Government entities.

Two focal points were identified. Dr. Atong, who Heads up the Directorate of Mental Health Services in the Ministry of Health and Ms Fidensia, from the Ministry of Gender, Social Development and Education. Ms Fidensia attended the ToT training on the IASC Guidelines and is a key interlocutor on Child Protection and Child Welfare issues within the Ministry. Overall, the staffing levels within the respective ministries is very low, some only have staff at the Directorate level with no further support staff beneath this aside from the individual staff members’ technical capacity, responsibilities and competencies. Government representatives are welcome to attend the MHPSS coordination group and to lead sub-groups or taskforces where relevant (e.g., Juba prison/ tertiary MH services group).

1. Draft 2016 work plan for the MHPSS.

A draft workplan was shared with Board members of the MHPSS Coordination group – based upon discussions from the first MHPSS coordination group meeting on 23 June 2016. The workplan needs to be further populated and refined in the July 2016 coordination meeting.

1. Briefing to the South Sudan donor community on the *IASC MHPSS in Emergency Settings* guidelines and the activities of the MHPSS WG.

A donor briefing was held on 29 June 2016. Key areas arising from the meeting include the need for humanitarian actors to submit integrated projects when requesting funding from donors. Examples of this include: PSS & Education, PSS & Nutrition, MH within Health/ PHC, including PSS within the minimum response package when responding to incidences of GBV. The capacity and resources in South Sudan are unlikely to substantially increase in the near future and especially with the decision to drop the system wide emergency level down to Level 2. MHPSS actors thus need to find a way to train, mentor and supervise their current staff and volunteers on a variety of approaches and techniques. For example, training a nurse at a nutrition centre on early childhood development techniques so she can impart this information to parents/ caregivers rather than just ‘treating the child’s malnutrition’; integrating mental health into primary health care (trainings & supervising PHC Doctors, nurses and community health workers) and including MHPSS in the curriculum for community child protection actors, Social workers, Teachers, community leaders and community health workers (CHWs).

The MHPSS coordination group should create a capacity building plan and priority areas that that they wish to focus on in the immediate and mid-term period. Such projects or initiatives can then be pitched towards the donor community for possible funding opportunities, but MHPSS actors need to actively engage with the donors and make such requests as a unified body.

The deplorable situation in Juba Central Prison (see later section) is unlikely to be funded with humanitarian funds from the Donors that I was able to engage with during this visit. Support is required to further develop Juba teaching hospital as a tertiary psychiatric inpatient facility and to ensure that mental health patients are not being kept in Juba Central Prison. Further engagement with development oriented actors, perhaps even Private Foundations and possibly UNDP is required in the absence of an Early Recovery cluster in South Sudan.

1. Identification of MHPSS indicators for the OCHA 5Ws reporting system. Drafting of information sharing tools template where possible.

Below is a list of the current MHPSS indicators in the HRP under the respective clusters. Indicators written in italics are additional indicators that I requested to be included in the 5Ws, or are amendments to an existing indicator. All indicators should be age and sex disaggregated.

**Protection:**

1. General Protection: # of persons with specific needs (disabled, elderly, chronically ill) who receive targeted support/ assistance
2. Child Protection: # of individuals reached with PSS services (sum of sub-indicators)[[1]](#footnote-1)
3. GBV: # of GBV survivors who receive at least one of the GBV services in the GBV SC Minimum Package (GBV case management, CMR and/or PSS/PFA).

**Health:**

1. # of health care personnel trained on mental health.
2. *# of persons who receive clinical management of mental, neurological or substance use disorders through medical services (primary, secondary or tertiary health care).*

**Education:**

1. # of teachers trained on psychosocial support.

**Nutrition:**

1. *# (or %) of parents/ caregivers of malnourished children receiving early child development and parenting skills awareness sessions.*

**CCCM:**

1. # (or %) of persons living in camps receiving psychosocial services (recommend changing to the below):

*% of camp staff trained in guidance (e.g., MHPSS & CCCM booklet) on how to avoid causing harm and psychosocial distress.*

This ‘new’ list of indicators needs to be included in the OCHA 5Ws reporting system through the respective clusters. The expanded list of indicators and the advocacy with Cluster Leads on the 5 priority clusters, should ensure that all MHPSS actors’ activities are able to be represented through existing reporting mechanisms. In the past, MHPSS actors were struggling to find a space to report their good activities such as providing mental health care for persons with mental health conditions, community-based PSS activities for youth, parents/ caregivers and restoring family links activities conducted by the Red Cross. MHPSS activities have thus far been poorly reflected in the HRP process with many INGOs not reporting at all through the 5Ws-mainly because they are not receiving funds through the CHF or the Cluster mechanism. This often means that examples of good community based PSS programmes were not being well captured. This is not the case, however for the UN agencies and particularly for local NGOs (working in community based PSS) who are implementing projects with UN agencies or with INGOs.

The priority 5 clusters will collect the activity related information related to their specific MH or PSS activity. The Coordination of the MHPSS group, will then liaise with OCHA to extract the relevant indicators across all 5 clusters and collate into one document that can be discussed, reviewed and analysed at the regular monthly MHPSS coordination meetings. It is not enough for the Clusters to simply collect the 5Ws information, this information needs to be brought into one document representing the whole breadth and depth of MHPSS programming in South Sudan. This responsibility is included in the ToR for the Coordinator of the MHPSS group (see annex).

1. Creation of an inter-agency referral form to facilitate access to services for persons of concern.

It was not possible to create a referral form specific for MHPSS actors in South Sudan during this field support mission. A version of a referral form in use by other MHPSS coordination groups was shared with the Board of the coordination group. Historically, referrals between agencies has proven very difficult, mainly because agencies are not able to commit to receiving referrals from other organisations as they are already working at capacity and cannot guarantee provision of services or support in communities or areas outside of Protection of Civilian camps (PoCs) or refugee camps. The split coordination structures have also made it very difficult to activate referrals for psychiatric patients requiring family tracing initiatives or more community based psychosocial support, and similarly for persons requiring access to mental health care or more focused/ non-specialised support. The overall density of referrals is quite low between agencies and it is currently not possible to rely on the Government to provide many services. If the MHPSS coordination group agrees, it could be added to the workplan as a task for 2016.

Juba Central Prison and Juba Teaching Hospital

In **Juba Teaching Hospital** there is one ward allocated to providing inpatient psychiatric care to persons with mental health problems. This ward is managed by Dr. Atong the Director of Mental Health Services in South Sudan; she is also a female Psychiatrist (one of only two Psychiatrists in the country). There are some 30+ staff members who are more ‘volunteers’ with some form of Psychology background or Counselling skills (there is no professional accreditation for Psychologists in South Sudan and they do not receive clinical experience and supervision as part of their teaching) working on the psychiatric ward, in addition to some general nurses. Some organisations (e.g., UNHCR for refugee response) are in the process of developing MoUs with the hospital to accept patients who require tertiary (inpatient) level psychiatric care for a period of time. I am not aware of the bed-capacity within this ward as I was unable to conduct a visit during this mission, however key informants report that it is usually full! Juba Teaching Hospital in the only acceptable tertiary level psychiatric facility within the Republic of South Sudan.

**Juba Central Prison**: Unfortunately, there are over 110+ males, females and children with mental, neurological and substance use disorders that are being kept (detained) in one section of Juba Central Prison. The conditions in which these individuals with mental health problems (and their children) are being kept is deplorable and a grave violation against their human rights. Patients are often chained, are naked, are severely malnourished, are beaten by guards who are not trained to work with the mentally ill but are trained to be prison guards, patients are unable to access the appropriate psychiatric care (many are not on sustainable and managed medication regimes and there are very few group therapy sessions), and they have been abandoned by their families (often due to community pressure) and are incarcerated. Many patients have been incarcerated in these conditions for many years. The diagnostic profiles for the patients is unknown – almost all are classified as having some form of psychosis, but this has also been questioned by MHPSS actors with access to the prison. It is by no means certain that all patients are suffering from a form of psychosis. The children are often born in prison to a parent with a mental health problem and spend all their time within the prison – denied access to school, to recreational activities and a healthy environment in which to develop – so there are associated child protection concerns too. A trend has developed in South Sudan, where by a person with a severe mental health disorder is sent to the local prison (in towns and villages outside of Juba) in addition to Juba Central Prison itself, rather than referring them to appropriate mental health care (however far away this may be) and offering support to their families. Prisons are not appropriate spaces for the care and treatment of persons with mental health problems in the Republic of South Sudan or any other country around the world.

A Psychiatrist (Dr. Atong) visits the Prison once a week to provide some psychiatric care to the patients, however this is minimal given the needs and the demands on her time. Some of her other staff at the Juba Teaching hospital also attend, but they are understandably not comfortable in working in a prison environment. Some MHPSS actors such as Handicap International are supporting with activities in the prison such as group sessions for some of the patients, conducting awareness raising and sensitisation sessions on mental health and communication skills with the prison guards, and renovating parts of the building to create a small consultation room and a room for group activities. ICRC is currently supporting the prison with food supplements to some patients who are severely malnourished. Of note is that the Health cluster were, reportedly, unaware that persons with mental health problems were being detained in Juba Central Prison – despite this issue being discussed within the Mental Health platform and the issue being raised to me by a variety of MHPSS actors. Other organisations are interested to take part in recreational activities for patients but they do not wish to be associated with supporting the conditions in the prison, or to be seen as agreeing to the incarceration of persons with severe mental health disorders.

The Director of Mental Health Services- Dr. Atong – has sketched a plan to move the patients from the Central Prison to Juba Teaching Hospital in a phased 4 month approach. A space has been identified in Juba Teaching Hospital to establish another psychiatric ward and also a space to conduct group therapy activities as well as activities such as gardening. However this project is a very large undertaking and it is perhaps too large for any individual agency/ organisation to manage. My recommendation is for a group of agencies/organisations to come together in a Consortium, to work with the Government to detail out the various stages and levels of the plan and to cost/ draw up a budget. The MoH does not have the technical capacity to produce such as document alone, it needs the technical support from WHO, Unicef and from other INGOs working in this area. Once the plan is detailed and costed, then individual agencies can identify the roles and tasks that they wish to take on and play to their strengths e.g., capacity building of Doctors, nurses, pharmacists and psychologists at Juba Teaching Hospital, transportation costs to move the patients, food and NFI items for patients, psychotropic drug supply, restoring family links and community based psychosocial support to reintegrate patients back to their families as much as possible, family and community sensitisation sessions on mental health, care & access to education for children of psychiatric patients, and renovation costs of Juba Teaching hospital building amongst others tasks. A consortium is also more likely to attract funding from more development focused donors, or Private Foundations – although the urgency of this activity should not be under-estimated. There is considerable interest from MHPSS actors to better support the patients at Juba Central Prison and this interest should be capitalised on where possible.

Psychotropic drug supply

Just a cautionary note to agencies or organisations who may wish to roll out the mhGAP approach in South Sudan or other mental health care initiatives (e.g., Juba prison). The Government of South Sudan has an acute shortage of drugs at all levels within the health system and there are extreme difficulties in delivering medications to facilities around the country. There is no domestic production of medication, 100% of drugs are imported and managed by agencies within their own programmes (e.g., UNHCR for refugee response and IMC). The 2007 version of the essential drug list for the country can be found in the annex. I understand that the drug list is being updated and Dr. Atong and other MHPSS actors have advocated for psychotropic medication to be included within this list, however I was unable to access a more updated list. Of note, is that having an essential drug list is important, but in the case of South Sudan it does not equate to these drugs being available in-country. This was also noted by Dr. Iman Ahmed, the WHO desk officer for South Sudan in Geneva during her filed mission to Juba (out missions overlapped by one-week). MHPSS actors need to be mindful of these constraints and to budget medication procurement, cold chain, delivery and storage into their MH programmes as it will not be possible to rely upon Government resources for this, or to hand this responsibility fully over to the MoH.

**Recommendations and Action Points**

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| **Recommendation** | **Responsible person** | **Date** |
| Coordinator of the MHPSS group to have a seat at the ICWG. Endorsement from HCT. | Gemma Connell, Deputy-OCHA | 10 July 2016 |
| Nutrition Cluster to include an indicator on PSS in their 5Ws reporting. | Isaac - Nutrition Cluster Coordinator + Unicef | 31 July 2016 |
| CCCM Cluster to re-phrase their indicator on PSS in their 5Ws reporting | Martha Kow D, CCCM Cluster Coordinator + IOM/ UNHCR | 31 July 2016 |
| Health Cluster to include an indicator looking at access to mental healthcare services for persons with MH disorders-see above section for suggestion. | Magda, Health Cluster Coordinator + WHO | 31 July 2016 |
| Recruit Coordinator for MHPSS group | IOM South Sudan and HQ level | 1 August 2016 |
| Share ToT material on the IASC Guidelines with Key focal persons in Juba and with Donors. | Sarah Harrison, Coordinator IASC MHPSS RG | 1 July 2016 |
| Share final drafts of MHPSS coordination group ToR with Board members. | Sarah Harrison, Coordinator IASC MHPSS RG | 1 July 2016 |
| Appoint an MH focal point or deploy additional MH capacity in Juba to support the MoH and other MHPSS actors. | Dr. Iman Ahmed, WHO South Sudan Desk (Geneva) | 31 Oct 2016 |

**Annexes**

1. Annex 1: Draft ToR for MHPSS Coordinator position – to be finalised by IOM.
2. Annex 2: Draft ToR for MHPSS coordination group in Juba.
3. Annex 3: Proposed coordination structures for MHPSS activities within the humanitarian architecture.
4. Annex 4: A document listing the commitments between the priority Clusters and the MHPSS coordination group. This document includes the indicators listed under the priority clusters (proposed and existing indicators).
5. Annex 5: Essential drug list for South Sudan (last updated 2007 to our knowledge!)
6. Annex 6: ToT package on the IASC MHPSS Guidelines – drop box link: <https://www.dropbox.com/sh/zpq35y8mnxwjvvv/AAB8uKl7H9YsRJ4o9LevxLQQa?dl=0>
7. Annex 7: Referral form for MHPSS-GBV-CP services (developed by Jordan MHPSS WG)

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1. CP indicators include: # of children reached with community-based PSS, # of children reached through non-community based PSS, # of care-givers reached with community-based PSS, # of caregivers reached through non-community based PSS, # of adult caregivers reached with capacity building on PSS, # of community members (other than care-givers) reached with capacity building on PSS. [↑](#footnote-ref-1)