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La violence basée sur le genre : la coopération internationale face à ses responsabilités

Overcoming cultural and structural barriers

**Challenges and perspectives in the
psychosocial management of victims of
gender-based violence in refugee camps**

De Achille Bapolisi

Psychological disturbance is highly prevalent among victims of gender-based violence who can present a complex and severe symptomatology. And very few such victims actually dare to seek care in the face of stigmatisation. The limited number of health professionals in the field, and the lack of mental healthcare training specific to the disturbances of this vulnerable group, make it very difficult for patients to access psychiatric care. Therefore, humanitarian programmes should include awareness-raising campaigns and psychological education in the communities alongside the training of primary healthcare professionals and reliable community members, as well as supervision provided by mental health specialists. A framework characterised by multidisciplinary collaboration needs to be chosen if a complex, trauma-informed care for victims of gender-based violence is to be achieved.



Psychotherapy session in the psychiatric clinic. Photo: © Achille Bapolisi

Gender-based violence has always been closely linked to war and armed conflict. Most specifically, in the Democratic Republic of Congo and neighbouring countries, rape has been used systematically by both rebels and government soldiers, with relative impunity (*Journal of Adolescent Health* 2015). Furthermore, in a considerable number of cases, civilians have been identified as perpetrators (*Social Science & Medicine* 2015). It is perhaps even more shocking that some previous reports also incriminate humanitarian workers and peacekeepers (*American University Journal of Gender, Social Policy & the Law* 2006) (*The Lancet* 2018). A study in eastern Democratic Republic of Congo reports that up to one-third of eastern Congolese adolescent girls have experienced sexual violence (*BMC Women's Health* 2014). Post-traumatic stress disorder, depression and other psychiatric disturbances are highly prevalent among victims of sexual assaults (*JAMA* 2010).

In our work with refugees from Nakivale camp, in south-western Uganda, more than three-quarters of the women seeking help at the psychiatric clinic reported gender-based violence either in their home country, or during their journey while fleeing from home, and sometimes even in the refugee camp itself. This article aims to present an overview of the challenges that we faced in our attempt to provide psychiatric and psychosocial assistance to refugees. Moreover, it strives to provide some practical guidance on how to fill the gap between the enormous mental healthcare needs in the field and the limited resources available.



House in Nakivale camp. Photo: © Achille Bapolisi

Acceptability of care

Many internal and external challenges need to be overcome before a refugee who has been a victim of gender-based violence will come forward for a consultation. First of all, survivors are not always aware that they have a mental health problem. They can present very disturbing symptoms that interfere with their daily lives, but they are usually not aware that these signs are symptoms of a well-defined mental illness which can be treated. For instance, from a community's perspective, a deeply depressed woman might be considered lazy by her family. Intrusive symptoms are more likely to be considered the result of spirit possession. Such misinterpretations lead to both a self and social stigmatisation which worsen the victims' mental well-being.

Besides being stigmatised for their disabling symptoms, survivors are also stigmatised by the rape itself. In most African cultures, a woman is honoured and respected for her virginity before marriage and for her fidelity afterwards (Mulumeoderhwa, M. 2018: Virginity Requirement Versus Sexually-Active Young People). Therefore, women who suffer rape are completely discredited, demeaned and humiliated. Many women who are raped are then rejected by their husbands, families and communities. This is a reason why many rape victims are unwilling to return to their home country even when peace is restored there. A 36-year-old woman who was raped and tortured in front of her family once told me: "There is no reason for me to go back there, there is no place for me there, there is no one waiting for me. I

know I am suffering in this camp, but at least no one knows what happened to me.” For such women, going to a psychiatric clinic means taking an additional risk of being identified as a raped woman.

Another reason that makes it challenging for these women to seek psychiatric care is the stigmatisation of mental illness in general. In Africa more than in other parts of the world, psychiatric patients are labelled and treated as marginalised members of the community. Words such as *mad*, *crazy* or *spiritually possessed* are commonly used to refer to people with mental disturbances.

The above highlights the crucial importance of implementing mental health awareness campaigns and psychological education in refugee communities and post-conflict areas. Well-designed campaigns could increase acceptance, decrease stigmatisation and legitimise mental disturbances as a normal reaction to the traumatic events that survivors have been through. Psychological education about the chief symptoms experienced by patients is key to helping people recognise who is in need of help. For this to be done efficiently and respectfully of the cultural settings, there is a need to involve not only women but also the main stakeholders of the communities such as traditional, religious and political leaders as well as teachers and traditional healers.

Accessibility of care

Healthcare facilities in Nakivale camp, as in many refugee camps around the world, are understaffed, underequipped and overwhelmed by the demand for the care of refugees. Therefore, it is difficult for victims of gender-based violence to find available healthcare professionals for sustained psychosocial assistance. Additionally, the few healthcare professionals available are overwhelmed by other vital emergencies such as heart failure, septicaemia, childbirth haemorrhages and many other issues. When selecting priorities, mental health is quite often left behind.

One of the practical ways to overcome the shortage of professionals in the camp is to train both primary care professionals and community members in basic mental health first aid. Integrating mental health into the primary level of the healthcare system has been prioritised by the World Health Organization (WHO 2008: Integrating mental health into primary care: a global perspective). It can be achieved by providing relevant and sustained training to primary healthcare professionals in the management of the most prevalent psychiatric disorders among refugees and the ethical aspects of care. The primary healthcare professionals can also be trained in the pharmacological treatment guidelines with an emphasis on the indication, dosage and side-effects of the most affordable medicines. They may also benefit from training in the main short-term, codified and effective psychotherapies. Techniques such as narrative exposure therapies, interpersonal therapies and cognitive group therapy have proven to be efficient even if used by trained non-mental healthcare professionals (KOBACH, A., et.al., 2015: Psychotherapeutic Intervention in the Demobilization Process). Kobach et al., 2015, Bass et al., 2013, O’Callaghan et al., 2013, Verdelli et al., 2003).



Health care facility in Nakivale camp. Photo: © Achille Bapolisi

The complexity of clinical care in precarious settings

Gender-based violence often leads to severe and complex forms of mental disorders. Besides the typical manifestation of post-traumatic stress disorder, patients often present a complex symptomatology including somatisation, dissociative features and pseudo-psychosis. These particular, and sometimes unusual, presentations of trauma-related disorders may lead to a misdiagnosis and sometimes mistreatment. Furthermore, patients quite often present physical and psychiatric comorbidities. In the survey we undertook in Nakivale, the most common psychiatric comorbidities with PTSD were depression, generalised anxiety and substance abuse disorders. The most common somatic comorbidities included gastritis, hypertension, HIV and urinary tract infections.

It is important to stress that the mental well-being of refugee patients is also affected by stressors in the camp. Unattended basic needs, such as sufficient food and water, the way aid is provided, sufficient healthcare, coupled with a low income and precarious livelihood, lack of care for family members and poor physical health, have all been associated with poor mental health outcomes among refugees in Nakivale camp.

The complexity of trauma-related disorders and their clinical presentation contrasts with the limited resources available in the camp. In terms of medication, the medicines available don't always offer the right balance between therapeutic effects and side effects. Besides, as

mentioned earlier, health professionals in the camp don't have enough time and/or training to provide psychotherapeutic help. And of course, there are still language and cultural barriers that need to be addressed with caution.

To fill the numerous gaps in the field, allocating mental health professionals to care for victims of gender-based violence would be an important step forward. Where this is not possible, we advocate the training of primary healthcare professionals in the basics of mental healthcare provision, including: diagnostic guidelines for trauma-related disorders, pharmaceutical care and basic therapeutic interventions. These tools can only be put to use if backed by technical and moral support and aided by a cooperative network of supervision and reference.



Refugees seeking for water Nakivale camp. Photo: © Achille Bapolisi

Need for multidisciplinary collaboration between professionals and organisations

The mental well-being of victims of gender-based violence depends on many factors. There is a complex link between mental well-being and physical health, justice and safety, economic development, social integration, education and human rights in general. Most of the time, these elements are instrumental in the predisposition, precipitation or perpetuation of mental

disorders. Thus, these multiple factors should be taken into consideration when addressing the psychological disturbances caused by gender-based violence. In our work with refugees, we have been able to address very challenging situations by using a network of professionals backed by the Mbarara Regional Referral Hospital, the office of the Prime Minister and other organisations such as the American Rescue Network and Medical Teams International.

Conclusion

In this article, I have outlined some of the practical strategies that can be used to efficiently address the psychological outcomes of gender-based violence among refugees. The stigmatisation and lack of knowledge about mental health may be addressed by involving different leaders and stakeholders in an awareness-raising campaign and psychological education. The shortage of mental healthcare professionals should be overcome by training selected healthcare givers in the efficient, adapted, culturally sensitive and evidence-based management of trauma-related disorders. Supervision by mental healthcare specialists and multidisciplinary collaboration is needed to sustain the psychosocial assistance provided to these highly vulnerable patients.

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