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EMERGENCY MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR SURVIVORS OF POST-ELECTION VIOLENCE IN ELDORET, KENYA

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ABSTRACT

Objective: **To describe the design and delivery of emergency mental health and psychosocial support services for the survivors of Post-Election Violence in Eldoret, Kenya.**
Design: **A longitudinal intervention.**
Setting: **The North Rift Valley region in Western Kenya.**
Subjects: **A total of 80,772 survivors received mental health and psychosocial support services.**
Results: **Counselling and Psychological First Aid services were successfully offered to most survivors in the North Rift Valley region. Common issues addressed included looking for lost relatives, sudden traumatic death of relatives, anger at their attackers, feelings of revenge, fear of seeing the corpse, loss of all property and source of livelihood and denial.**
Conclusion: **It is possible and necessary to integrate a mental health and psychosocial support intervention into a disaster response even in limited resource settings. Further studies are recommended to evaluate the effectiveness of this approach.**

INTRODUCTION

Immediately after the December 2007 General Elections in Kenya, widespread violence erupted across the country. The violence was initially more severe in the North Rift Valley Province, but later spread to many urban centres in other provinces. Over 1000 people lost their lives in the violence while hundreds of thousands were displaced from their homes and were accommodated in comps all over the country (1). Many local and international organisations embarked on a humanitarian intervention that focused on provision of essential items for the internally displaced while a political solution was being negotiated by the political leaders. A mental health and psychosocial response was designed to be an integral part of the intervention in the North Rift Valley Province, with it is headquarter in Eldoret Town.

Many studies have found that large numbers of people are left with psychological scars after disasters of the magnitude described above. Norris and colleagues (2) in a review article, demonstrated that disasters inevitably affect all those they touch in profound ways. There are psychological, physical, social and environmental consequences that individuals and groups endure after a disaster.

Depending on the magnitude of the disaster and the individual demographic attributes, people are affected differently by disasters (2). It has been recommended that all disaster interventions build in a mental health component that is not limited only to the traditional one-on-one individual counselling, but also addresses family, community and societal needs (3). Among the recommended interventions in the emergency phase of a disaster, Psychological First Aid is one of the most comprehensive approaches (4, 5). It is intended to harness psychological and social resources available to survivors and use them to reduce more severe sequelae of potentially traumatic events.

The World Health Organisation also endorses this approach in its recommendations for disaster mental health interventions (6). The Inter-Agency Standing Committee comprising United Nations and Non-UN agencies involved in emergency response also came up with guidelines highlighting the usefulness of integrating psychosocial responses with the rest of the disaster response without necessarily concentrating on PTSD or other specific psychological morbidity (7).

Previous studies from Kenya, some on events that occurred more than 50 years ago, have demonstrated that psychological problems of significant magnitude

arise following traumatic events (8,9). The prevalence rates of psychiatric morbidity in these studies have routinely been reported to be higher than those in developed societies, raising questions as to the validity of measurement instruments and universal applicability of concepts developed in the west. Although it is suggested that specific interventions need to be tailored to the non-western population, the key intervention principles remain largely standardised in spite of continued controversies over underlying concepts (10, 11).

This paper discusses the design of the mental health and psychosocial support (MHPSS) programme as an integral part of the emergency humanitarian intervention in the North Rift Valley Province of Kenya after the violence following the disputed 2007 presidential elections.

MATERIALS AND METHODS

Intervention sites and population: The intervention was designed for the entire North Rift Valley, and a coordinating team comprising representatives from local and international organisations involved in mental health and psychosocial work was formed, based in Eldoret Town. Subsequently the team took on the broader responsibility of coordinating Protection activities in the North Rift and reporting to the Inter-agency Coordinating group comprising Government representatives and local and international humanitarian organisations.

For the purposes of the intervention, the North Rift Valley covered Uasin Gishu, Greater Trans Nzoia, Nandi North and South and contiguous areas affected by the post-election violence. According to Kenya Red Cross Society Statistics at the peak of displacement, this represented a total population of 117,475 internally displaced persons (KRCS report 15th April 2008). Major IDP Camps served included Burnt Forest, ASK Showground in Eldoret, Timboroa, Kitale ASK Showground, Endebess, Noigam Police Station and Turbo. Smaller camps were located in other areas in the districts of the North Rift, including Nandi, Trans Nzoia, Koibatek and even Turkana.

The chair of the cluster was a psychiatrist from Moi University with training and experience in Disaster Mental Health work.

Other members of the team included representatives from the United Nations High Commission for Refugees (UNHCR) which provided the secretariat, United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), the International Organisation for Migration (IOM), International Medical corps (IMC), Moi Teaching and Referral Hospital (MTRH), Kenya Red Cross Society, United Nations Development Programme (UNDP), United Nations Children's Fund (UNICEF), UNFPA, World Food Programme (WFP) and local NGOs

involved in protection activities.

The team met weekly to discuss events from the field and to plan intervention strategies as the emergency evolved.

Procedures and activities: The intervention began on 2nd January 2008, a few days after eruption of large-scale violence in the North Rift and was still ongoing by the end of April 2008, the period covered by this report. At the end of April the Government of Kenya initiated an operation to return the internally displaced persons to their homes, and the intervention changed in nature to offer support in a wide range of settings.

The target population initially focused on the internally displaced whose needs were more acute at the height of the violence, but as the intervention entered the return and reconsolidation phase the focus shifted to geographical locations affected. This meant targeting both the displaced and the non-displaced populations within a geographical area affected by the violence. All persons affected by the violence were offered different levels of support depending on need.

In the emergency phase, counsellors accompanied mobile medical teams to the areas where the internally displaced persons congregated or camped, and did a rapid assessment and addressed the psychosocial needs as they arose. The numbers of counsellors varied from day to day, ranging from 60 to 120 depending on the number of agencies providing their staff for the day.

The goal of the intervention was to provide mental health and psychosocial services to all those in need in order to reduce subsequent psychological distress and to facilitate more effective provision of other humanitarian assistance. The intervention was designed to address both the physical and psychosocial needs, without making a clear demarcation where one ended and the other began. The principles of the intervention were based on a variation of the principles 'Protect, Direct, and Connect' (5) as expounded below:
1. Protect- from further harm, counterproductive interventions, intrusive reporting
2. Direct- away from danger, towards safety and help
3. Connect- to necessary services, to lost relatives, to social support mechanisms.

To these three, this intervention further included Triage (assessment of level of distress and providing assistance accordingly) and Referral (for those in need of more specialised services away from the site). The deployed counsellors had a clinical background (most were nurses) and were able to perform triage and refer clients requiring medical or other clinical assistance.

The intervention was carried out at three levels:
1. Providing a safe place for expressing emotion for normal individuals with usual coping

mechanisms. This also included providing a link to other service providers and assessing other needs of the affected individuals

2. Providing on-site counselling for those with mild-moderate distress. This included individual, family and group counselling strategies at designated sites in the camps and shelters

3. Referral to clinical services for those with moderate-severe distress, or those displaying features of mental illness or in need of specialist assessment and management.

'Psychological First Aid' (4) was used as a key component of the intervention at all levels. The emphasis. in psychological first aid is supportive, unforced listening, gathering information about all needs and addressing them as appropriate. An important aspect of psychological first aid is the need for linkage to other service providers and to usual social support mechanisms.

RESULTS

The number of Internally displaced persons (IDPs) in camps and in the community in the North Rift rose from a trickle in early January to 117,475 in April 2008, before beginning a decline in late April as the government initiated a programme aimed at helping them to return to their homes.

Between 17th January and 21st April 2008, 80772 clients had been served by the team of counsellors. Table 1: shows the distribution of the served population by gender and month.

Some of the issues the survivors were dealing with in the early phase of the emergency included:

*   Looking for lost relatives- uncertain whether they are alive or dead.
*   Sudden traumatic death of relatives, anger at their attackers, feelings of revenge.
*   Fear of seeing the corpse- badly mutilated, decomposing.
*   Loss of breadwinner- need to keep the family together.
*   Loss of all property and source of livelihood
*   Denial- avoidance of grieving in belief that one has to be 'strong'.
*   Need to grieve- need for validation of grief.

At the end of April and beginning of May, numbers in the camps started fluctuating and it became difficult to continue planning for services in the camps. The service was redesigned to continue reaching out to people in the areas of return, including the non-displaced members of the community who needed mental health and psychosocial support services.

Some specific issues in the immediate post-emergency phase:

*   Continuity of care for patients with chronic conditions including HIV / AIDS and mental illness.
*   Missing relatives.
*   Returning home after receiving routine care at the referral hospital for example, delivery, treatment for acute illnesses.

Table 1
Number of Clients Served

Month	Children	Adult Female	Adult Male	Unclassified[a]	Total
January[b]	3375	4843	3464	4228	15910
February	16896	13537	9707	0	40140
March	7128	5489	4367	0	16984
April[c]	1578	3660	2500	0	7738
Total	28977	27529	20038	4228	80772

[a]Unclassified- These are clients seen in the first three days after data collection began, and they were not classified according to gender or age.
[b]The intervention began on January 2nd, but organised data collection and storage was only done from January 17 , 2008.
[c]The data used for this report concerns clients seen upto April 21st 2008.

Majority of those who received counselling and psychological first aid were children. Among the adults, more females than males received the services. A total of 4228 clients served in the first three days were not clearly identified as children, males or females. Most of those served were seen in the month of February, after which the numbers of clients declined significantly through the months of March and April.

*   Catastrophic reactions on returning to destroyed homesteads.

DISCUSSION

The mental health and psychosocial intervention after the Post-election violence in the North Rift Valley Province of Kenya represented an attempt at implementing best practices in dealing with the numerous social and psychological effects of a complex

emergency. Using validated recommendations and applying key principles of disaster mental health, it was demonstrated that it is possible to integrate the mental health and psychosocial response into the main disaster response with a measure of success even in limited - resource settings.

The design of this intervention is supported by van Ommeren *et al* (12), who recommend the integration of mental health services into all levels of healthcare. Further, the separation of 'mental health' from 'psychosocial services' or 'social services' is criticised because it unnecessarily 'medicalises' the mental health intervention by splitting the resources available for both arms of the intervention.

The Humanitarian Charter and Minimum Standards in Disaster Response (the Sphere Project) also endorses this approach and offers standards and indicators that address both the social and psychological aspects of an emergency (13).

The point of departure from these guidelines, however, is the location of the intervention outside of the health sector. This was informed by an assessment of the early phases of the intervention, where the health sector was more concerned with general medical conditions and hygiene than mental health issues. The Division of Mental Health in Kenya's health ministry is also understaffed and underfunded as noted by Jenkins *et al* (14), and did not have the capacity to mount a nationwide intervention at short notice.

Due to the cross-cutting nature of most mental health and psychosocial interventions, including Psychological First Aid (4), it was easier to integrate the mental health and psychosocial support team into the protection cluster. It was also fortunate that the chair of the protection cluster was a psychiatrist who was able to provide leadership and drive the mental health and psychosocial support agenda.

This approach needs to be evaluated in future interventions especially in resource limited settings due to its potential of mainstreaming mental health and psychosocial interventions in the early phases of any disaster response. It also highlights the need for mental health 'champions' to participate in disaster activities outside of the narrow clinical scope they are often restricted to.

The main limitations in this intervention were the shortage of qualified staff and limited resources to mount a long-term sustained intervention. Poor record keeping in the early phases of the intervention also interfered with the quality of the data collected, precluding any sort of statistical analysis on the dataset.

In conclusion, it is possible and necessary to integrate a comprehensive evidence-based mental health and psychosocial intervention in a complex emergency even in a limited resource setting. It is recommended that further studies be carried out to evaluate such interventions, and that future disaster responses should include a mental health and psychosocial support component.

REFERENCES

1. Commission of Inquiry into Post Election Violence, Report of the Commission of Inquiry into Post-Election Violence in Kenya (CIPEV). 2008, Nairobi: Government of Kenya.
2. Norris, F. H., *et al.*, 60,000 disaster victims speak: Part I. An empirical review 0/ the empirical literature, 1981-2001. Psychiatry, 2002.**65**: 207-239.
3. Norris, F. H., Friedman, M. J. and Watson, P. J. 60.,000 disaster victims speak: Part II. Summary and implications of the disaster mental health research. *Psychiatry*, 2002. **65**: 240-60.
4. National Child Traumatic Stress Network and National Centre for PTSD, Psychological First Aid: Field Operations GUide. 2nd ed. July, 2006: www.nctsn.org and www.ncptsd.va.gov.
5. Young, B.H., et al., Disaster Mental Health Services: A GUidebook for Clinicians and Administrators. 1998, Palo Alto: *The National Center for Post-Traumatic Stress Disorder.*
6. World Health Organisation, Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors. 2003, Geneva: *WHO Department of Mental Health and Substance Dependence.*
7. Inter-Agency Standing Committee, IASC GUIdelines on Mental Health and Psychosocial Support in Emergency Settings. 2007, Geneva: IASC.
8. Atwoli, L., Kathuku, D. M. and Ndetei, D. M. Post traumatic stress disorder among Mau Mau concentration camp survivors in Kenya. *East Afr Med J*, 2006. **83**:352-359.
9. Njenga, F. G., *et al.*, Post-traumatic stress after terrorist attack: psychological reactions following the US embassy bombing in Nairobl' Naturalistic study *Br. J. Psychiatry,* 2004. **185**: 328-333.
10. Bolton, P. and Tang, A. M. Using ethnographic methods in the selection of post-disaster., mental health interventions. *Prehosp Disaster Med*, 2004. **19**:97-101.
11. Bolton, P. A. and Weiss, W. M. Communicating across cultures: improving translation to improve complex emergency programme effectiveness. *Prehosp Disaster Med*, 2001. **16**:252-256.
12. van Ommeren, M., Saxena, S. and Saraceno, B. Mental and social health during and after acute emergencies: emerging consensus? *Bull World Health Organ*, 2005. **83**:71-75; discussion 75-76.
13. Sphere Project, Humanlfarian Charter and Minimum Standards in Disaster Response. 2004, Geneva:*www.sphereproject.orgj.*
14. Jenkins, R., *et al.*, Integration of mental health into primary care in Kenya. *World Psychiatry*, 2010. **9**:118-120.