Rapid Mental Health Situational Analysis

Central African Republic

Ouaka	**Haute-Kotto**	**Ouham**
Bambari & PladamaOuaka Refugee Camp	Bria, Konengbe, Issamazengue, Bornou, Dangbatro, Aigbando, Ngoubi, Boungou	Bossangoa & Bouca

Mental health priority conditions, community practices and available services and supports

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TABLE OF CONTENTS

1. Introduction

2. Methodology

3. Socio-political context

4. International Medical Corps in CAR

5. Mental Health policies and strategies in CAR

6. Who is doing what and where regarding mental health and psychosocial support

7. Health facility staffing and MHPSS capacity

8. Current problems and stressors among IDPs

9. Prevalence, identification and management of mental health and psychosocial problems

10. Psychotropic medications and supported basic laboratory services

11. Referral pathways and Health Information System (HIS) on Mental Health

12. Anticipated challenges in Mental Health PHC integration

13. Summary and recommendations

14. List of acronyms

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1. Introduction

This assessment was planned to identify the needs in mental health after the escalation of the emergency in December 2013. The last multi-sectorial assessment that was carried in November 2013 by IMC CAR[1] included mental health components. The recommendations from this assessment were to start providing training in psychological first aid and the management of mental health priority conditions for health care staff at the different health posts. The current assessment is specifically focussing on mental health and has partly a different regional focus than the multi-sectorial assessment from 2013.

The field work for this assessment was conducted from the 7th to the 14th March 2014 in the districts of Ouaka and Haute Kotto and from March 18th to 21th 2014 in the district of Ouham. Desk study, attendance of cluster, working group meetings and interviews at the central level took place in Bangui before, in between and after field visits in the period from March 1sh to 24th 2014.

The overall goal of this situational analysis was to inform planning and potential mental health programming in Bambari, Bria, Bossangoa and Bouca under the current emergency response. The assessment is mainly addressing the following aspects:

1. Community priorities, perceptions and practices regarding mental health under the current crises

2. Level of integration and quality of mental health services as part of health facilities and current practice

3. Scope and reach of current mental health services provided to the people affected by the conflict including IDPs', refugees and local communities

The rapid assessment is focusing on the analysis of the current needs as well as the capacity at community and individual level to cope with the current crisis and respond. The final section provides

[1] Rapid Multi-Sectorial Assessment Report Central African Republic, IMC, 2013

[2] World Health Organization & United Nations High Commissioner for Refugees (2012). *Assessing Mental Health and Psychosocial Needs and Resources*

[3] Multi-cluster/sector initial rapid assessment CAR, OCHA, 2014

recommendations to inform IMC for programming as well as mental health coordinating bodies and shed light on further program needs opportunities and synergies with other programmes.

2. Methodology

International Medical Corps conducted the mental health assessment in 4 areas: Bambary (host community, IDPs and Sudanese refugees), Bria, Bossangoa and Bouca. In the latter three areas both host community and IDP's were targeted. The selection of these 4 areas was based on areas were IMC was already operational and where recently programming was opened. Other essential selection criteria where: access, security and secondary information on the needs of services. The assessment was carried out by the IMC Mental Health Emergency officer with support from the IMC CAR country teams.

The situational analysis made use of both quantitative and qualitative methods to ensure triangulation of information. Methods included: review of secondary data, interviews with key informants, participation in coordination meetings, observation and field visits, structured questionnaires, and focus group discussion.

At community level data was collected from service providers and health facilities through field visits, interviews and focus group discussions (FGDs) with community members as well as community health workers. To provide space different gender perspectives on the mental health situation FDG's were as much as was possible separated by sex and age. Community dynamics did not always make it possible to follow this division strictly.

The tables below provide an overview of the interviews carried out at field level.

IDPs and community key informant interviews and FGDs	
Ouaka	• 1 regional hospital representative in Bambari • 2 FGDs, community members, Bambari (5 males, 8 females) • 3 FGDs, community members, Pladama (7 males, 10 females, 8 f youths, 3 m elders)
Haute Kotto	• 8 community leaders from Bria and surrounding communities • 1 local government representative in Bria • 3 FGDs, general community members, Bria (8 females, 9 males, 1 m/ 3 f elders) • 3 FGDs, community volunteers, Bria and axes (21 males, 12 females)
Ouham	• 2 FGDs, community leaders, Bouca (11 males, 2 females, 2 m youths, 1 f elder) • 1 FGD, community leaders, Bossangoa (7 males) • 2 FGDs, general community leaders, Bossangoa (5 males, 3 females)

Interviews with representatives from agencies and service providers	
Ouaka	• Mercy Corps: 1 protection agent, 1 psychosocial agent in Bambari • Save the Children: 1 doctor, 1 psychosocial coordinator in Bambari • ICRC: 3 coordination team members in Bambari • IMC: 1 doctor, 3 Nurses, 1 Midwife, 1 protection agent in Pladama Ouaka
Haute Kotto	• Regional Hospital: 1 assistant director, 1 clinical officer, 1 nurse in Bria • MSF- France: 1 project manager, 1 doctor, 1 nurse in Bria • IMC: 2 doctors, 1 psychosocial agent, 2 nurses, 1 midwife, 12 aid nurses in Bria
Ouham	• COOPI: 1 psychologist, 2 psychosocial assistants in Bossangoa • MSF- Holland: 1 medical director, 5 psychosocial agents in Bossangoa • Caritas CAR: 1 program director, 1 psychosocial animator in Bossangoa

	• IMC: 1 protection agent, 1 protection focal point, 2 nurses in Bouca

Health Facilities	
Ouaka	• MoH Regional Hospital in Bambari • Save the Children PHC x 11 in Bambari and surrounding area • IMC PHCC in Pladama Ouaka
Haute Kotto	• MoH & MSF-France Regional Hospital in Bria • IMC PHCC in Bria • IMC PHCU x 5 in surrounding communities
Ouham	• COOPI Listening Center in Bossangoa • MoH & MSF-Holland Regional Hospital in Bossangoa • MoH & IMC Regional hospital in Bouca

The assessment at field level was complemented with interviews at central level with among others IOM, Bangui psychiatric hospital, MOH, WHO, MSF Holland, MSF Spain, MSF France, Ministry of Health, Mercy Corps and ICRC. Moreover in Bangui "Hospital de la Amitie", "Hospital Communitaire" and the "Hospital Pediatrique" were visited to interview the psychosocial agents present and assess the level of service provision and capacity for referral.

Desk review of current data, policy documents, and previous assessments included:

- MHPSS minimal emergency response, MoH, Bangui, 2014
- Multi-cluster/sector initial rapid assessment CAR, OCHA, 2014
- Rapid Multi-Sectorial Assessment Report Central African Republic, IMC, 2013.
- Evaluation report on mental health and care practices. Kemo region, CAR, ACF, 2013.
- ABC Analyse des besoins de crise Republique Centre Africaine, Acaps, 2014
- Vinck & Pham. Association of exposure to violence and potential traumatic events with self-reported physical and mental health status in the Central African Republic. JAMA. 2010 Aug 4; 304 (5):544-52.
- Guerchet et al. Prevalence of dementia in elderly living in two cities of Central Africa: the EDAC survey. Dement Geriatr Cogn Disord. 2010; 30 (3):261-8.
- OCHA (CAR): Situation Report No.14-19, 2014

International Medical Corps used instruments from the WHO/UNHCR (2012) "Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings"[2] including an IMC specific comprehensive version of the "Checklist for integrating mental health in primary health care (PHC) in humanitarian settings" and "Participatory assessment: perceptions by general community members".

While the situational analysis contributes to a deeper understanding of mental health in CAR the scope of the assessment is limited by various factors. One of the mayor limitations for analysis is the limited data available on mental health at health centre level; including the absence of mental health categories in the health centre registers. Due to the on-going emergency response at the time of this assessment, there was a limited time for interviewing of the various actors and get an in- depth understanding of the knowledge and practices among health staff regarding mental disorders. However, the assessment took place by key informant interviews as well as group discussions with the health staff. This was further

[2] World Health Organization & United Nations High Commissioner for Refugees (2012). *Assessing Mental Health and Psychosocial Needs and Resources*

complemented by observation of consultations as well as brief 'mini' orientation workshops of IMC health staff with an overview of mental health and basic skills of psychosocial support.

Security did not allow assessing all locations of interest. For example in Bria the surrounding rural communities could not be visited due to security constraints while IMC does operate here. To still capture relevant information, interviews were carried out with health staff active in these areas as well as community health workers from these villages.

Limited interaction took place with traditional healers and other community health practitioners with the exception of traditional birth attendants in two locations. Due to the importance of traditional healers in the Central African Communities this would have been a relevant assessment point. However due to security and time constraints it was not possible to mobilize the same. For development of interventions it would be essential to find ways of including these actors.

3. Socio-political context

In March 2013, a rebel coalition seized power in CAR's capital city, Bangui, resulting in violent confrontations, attacks and widespread looting throughout the city. With the ongoing conflict in the country, approximately 4.1 million people, almost half of whom were children, were directly affected by the crisis, and 1.2 million people were cut off from essential services. Unprecedented violence and widespread killings have taken place throughout the capital, Bangui, and several provinces around the country, mainly in Ouham and Ouham Pende. The human toll is over 1,000 deaths and more than 300,000 people displaced in the first month following the unrest in December 2013 in Bangui only. With an estimated total of 935,000 persons currently displaced in the country, more than one in five Central Africans is not living in their own home. Many of them are residing in safe shelters at night and returning home during the day[3].

As a result of the political and military situation outside of Bangui, most of the people had fled into the bush, while others remained in the villages to protect their property. Many of the displaced communities are mobile and largely remain unaccounted for, living with host families and communities, or in makeshift settlements in the bush few kilometres from their village of origin where they are less exposed to violence. These population movements have led to changes in the normal and healthy functioning of the community and their daily activities are deeply impacted.

According to OCHA (March, 2014) there are currently 2.6 million people in CAR in need of humanitarian assistance, which is more than half the total population. This includes 604,000 in Bangui and 2 million persons in other urban and rural areas. Insecurity in displacement sites and communities is rampant, exposing vulnerable groups (notably women and children) to protection-related threats, in particular youth are exposed to forced recruitment and women and children to multiple forms of gender based violence. The on-going violence and continued increase in displacement has severely diminished the population's access to basic health care. The entire health system in the country has effectively collapsed, and less than half of the country can access basic health services including medicines.

Despite the large needs for mental health and psychosocial support, mental health is rarely considered within primary health interventions except for the efforts of a few international organisations supporting the government to build up the health capacity. Mental health is still often disregarded as important

[3] Multi-cluster/sector initial rapid assessment CAR, OCHA, 2014

component of other interventions such as nutrition interventions or sexual and reproductive health programs.

In general, there are major limitations in the distribution of human resources, capacity and quality of care in the country and this is even more evident in mental health services. There is a strong centrum periphery inequality in the availability of services and practically the only functional services in mental health are available at Bangui level. Yet, the needs for mental health are equally spread throughout the country. The absence of formal training programs in psychiatry is also striking and at the same time the faculty of psychology at the University of Bangui was closed in 1990 due to budget cuts. Psychologists are considered more as counsellors and under the new law on public health, psychology is considered a traditional medical practice, which may lead to the possibility of being perceived as witchcraft[4] and forms a barrier for scaling up the profession.

At the level of the communities there are deep misunderstandings about the causes, explanations and care related to mental health and mental disorders. Traditional beliefs related to sorcery and religion constitute the main frame of reference for dealing with relatives presenting with behavioural troubles. Families tend to hide these family members and avoid consulting health services and fear the shame it can bring to their families according to their system of values and beliefs. The limited access and stigmatisation constitutes a serious concern in terms of respect for human rights of those who are experiencing mental disorders. Those concerns are especially significant in the context of the current crisis where people with severe mental health conditions were killed during confrontations, reflecting their particular vulnerable position during violent episodes.

4. International Medical Corps in CAR

IMC works primarily in the insecure Northern and Eastern provinces of CAR, namely Haute-Kotto, Vakaga, Bamingui-Bangoran, and most recently, Ouaka. Since 2007 IMC have provided assistance and protection to Darfurian refugees living in Sam Ouandja, approximately half of whom have recently been transferred to Bambari town due to conflicts with local armed groups. International Medical Corps provides curative and preventive consultations, maternal and child health care, child protection, therapeutic and supplementary nutrition services, HIV/AIDS prevention, health education, gender-based violence (GBV) prevention and response, and hygiene promotion activities to refugees and host communities.

In 2013 IMC has been able to expand its area of intervention through its mobile medical units to incorporate an additional 20 remote and underserved communities in Haute-Kotto and in Vakaga. In other areas, they also support government health facilities with medicines and supplies, the provision of health care services and the rehabilitation of health posts.

The ongoing conflict is intensifying the need for emergency relief services. To provide primary health care services to these vulnerable populations, IMC rebuilt and re-equipped two health centres in the isolated north-eastern border region. The assessment at the end of 2013 found that IDPs, refugees and host populations are extremely vulnerable to malnutrition and disease, as access to clean water, sanitation, food, and health care were limited, if not completely non-existent.

[4] Evaluation report on mental health and care practices. Kemo region, CAR, ACF, 2013

As violence continues across the country, IMC has been able to continue presence on the ground addressing the urgent health needs of affected communities. The health teams are providing outpatient consultations, prioritizing testing and treatment for malaria; antenatal consultations and safe deliveries for pregnant women; nutritional screening and treatment for severely malnourished children; measles and polio vaccinations; support for survivors of sexual violence; and promotion of key health, hygiene and nutrition messages.

Working in two clinics in Bangui, IMC provided 1,288 consultations from February 15-February 25, of which 48% of presented cases were related to malaria. The team have seen more than 100 cases of moderate malnutrition and 13 cases of severe malnutrition. In Bouca, IMC has been able to provide drugs and essential supplies to the health centre in town. This contributed to the capacity of the health centre and as a result, 734 consultations were provided from February 15-25, with 16 cases of moderate malnutrition and 8 cases of severe malnutrition were attended to. In Bria, IMC has finalized a measles campaign and nearly 14,000 children, aged 6 months to 15 years, were vaccinated against the disease February 15-19.

As precedents to this assessment, in November 2013 a rapid multi sectorial assessment conducted by IMC in Haute Kotto revealed significant mental health and GBV related needs related to common experiences of violence and trauma, .among all the sectors and ages in the community. Women and particularly young girls were especially vulnerable at the domestic level and more acutely during the present conflict. Later in January 2014 a GBV specialist was deployed to support the IMC staff and GBV programming with a set of activities and recommendations that are being implemented by the local teams in the field.

5. Mental Health policies and strategies in Central African Republic

So far mental health has been a highly neglected area in Central African Republic and is a very weak developed area in the overall health response and policies. Policy documents and the Basic Package of Health Services (BPHS) are practically non-existent or not accessible.

The only location where mental health was practised before the crisis was in Bangui in the Psychiatric Hospital. The hospital offered psychotherapy, individual therapy, group therapy and medication for severe conditions. The national capacity was practically limited to the team available in the psychiatric hospital, including one psychiatrist, 2 psychologists and 2 mental clinicians. Since the crisis their capacity has deteriorated further due to lack of medication supply. Before the crisis several NGO's such as MSF and ACF were undertaking mental health activities with a limited scope.

The psychiatrist leading the psychiatric hospital was also appointed by MOH to develop the mental health strategy. The "National programme on mental health" is under development since 2011 but so far has not been consolidated and could not be shared by the MOH in its current draft stage. Nonetheless a 'crisis minimal response plan' was developed to address the needs in the current emergency and to mobilise funds for the same. Early March WHO has appointed a mental health specialist to collaborate with MOH on this strategy and to support the minimal response plan with funding and technical capacity.

The key elements of this government response plan include in the mid and long term the reinforcement of the capacity of the health staff starting within Bangui and progressively including other health districts

to train doctors, nurses and psychosocial agents with different levels of responsibility. In the short run they want to create an emergency unit as specified in the table below.

Proposal for an emergency MHPSS unit	
General objective	• Case management for people with psychological troubles as a consequence of the recent political military crisis in CAR • To facilitate their integration in the communities
Specific objectives	• Reestablishment of mental wellbeing of beneficiaries • Reduction of normal and pathological post-traumatic stress • Reestablishment of social cohesion
Beneficiaries	• IDPs, children, people with disabilities, pregnant women, people suffering from mental and neurological disorders and substance abuse
Activities	• Basic psychological assistance by the NGOs present in the sites with the capacity of psychologists and psychosocial agents and with the technical support from Bangui psychiatric institutions. Training of the psychosocial agents of the NGOs present in the sites and with the competences or human resources and the technical support from Bangui psychiatric institutions. Mobilization and support of the communities by the NGOS present at the field sites, to empower and promote intra- community social support in coordination with MOH at central level.

Early March, at the start of the assessment no formal mental health working group was established neither was this a priority agenda for the health cluster meetings. However during the period of the assessment IMC in collaboration with ACF has been promoting the establishment of regular meetings on mental health between the actors, forming the basis of an informal working group. The MOH focal point of mental health (director of the Bangui psychiatric hospital) took the lead as chair while IMC and ACF provided continued support to establish the coordination of both local and international NGO's. For now there does not exist a formal relation with the health cluster and the chair is in close contact with WHO and the cluster.

6. Who is doing what and where regarding mental health and psychosocial support

At the end of March 2014 the "who what where matrix" for mental health services in the Central African republic was not developed. An overview for Bangui was under construction under leadership of MOH and the psychiatric hospital of Bangui. The information below was collected in the general field work as well as in desk study, and might not be exhaustive.

Due to the new emergency some of the established organisations in the assessment area had to withdraw because of insecurity and limitations in provision of services, some others are planning to scale down activities. Several organisations indicated that there presence does not suffice in full coverage of the needs of the population, for example COOPI in Bossangoa indicated that they feel overwhelmed by the number of cases they receive through their GBV and psychosocial interventions and MSF Holland is

prioritising service provision to new cases of sexual violence and do not have capacity to provide a similar package to older cases.[5]

The following table provides an overview of the organizations that are delivering services in the current emergency in the area of MHPSS in the districts of Ouaka, Haute Kotto and Ouham.

Who? (Agency)	**What?** (Types of activities)	**Where?** (Location)
WHO	Continued support to MoH in developing a mental health strategy including technical and financial support. Planning to establish a listening centre and an occupational therapy centre for people affected by the current crisis to be reintegrated in socio economic activities	All CAR
Save the Children	Child friendly spaces, family tracing and reunification and child combatants reintegration program	Bambari, Ouaka
Mercy Corps	Psychosocial support for cases of S/GBV, child protection and social cohesion activities	Bambari, Ouaka
IMC	Protection and psychosocial assistance related to GBV	Pladama Ouaka, Ouaka, Bria, Haute Kotto, Bouca, Ouham
MSF-Holland	Psychosocial counselling through expat psychologist and local psychosocial workers	Bossangoa[6], Ouham y Bangui
COOPI	Psychosocial support and case management for GBV survivors and trauma (2 psychologists in CP and GBV)	Bossangoa, Ouham and Bangui
Caritas CAR	Child friendly spaces	Bossangoa, Ouham
MOH	Psychiatric Hospital in Bangui/General Hospital – case management and hospitalisation of common and severe cases of mental disorders, pharmacological treatment, individual anger therapy and family support (1 Psychiatrist, 2 mental health clinicians, 2 psychologists and 2 social workers)	Bangui
MOH	'Hospital Communitaire' and 'hospital de la Amitie' - 20 psychosocial agents and counsellors mainly focussing on HIV/AIDS patients and outreach activities	Bangui
IOM/COOPI/DRC	Coordination, capacity building in mental health facilities and of community health workers, focus areas GBV, protection and mental health	Bangui[7/8]
MSF Spain	Psychosocial counselling through 2 expat psychologist and local psychosocial workers, they are affiliated with hospital Castor	Bangui
ACF	Mental health and care practices, psychosocial support	Bangui

[5] While new cases of sexual violence should receive priority for life saving services, older cases are still in need in medical care.
[6] MSF Holland is anticipating withdrawing the mental health programme in May 2014, however they will continue with provision of medical services. This is related to the reduction of expats in the field due to safety reasons.
[7] Anticipated to start in April – anticipated for 6 months
[8] Bangui is not part of this assessment, however it is included here as it can be anticipated that some of these actors will widen their scope of intervention is security allows and thus coordination with these actors remains central.

MSF France/ICRC	Provide psychiatric and psychological support for their staff	Bangui
French Red Cross	Ambulatory treatment centre psychosocial Support for HIV patients	Bangui
Several local NGO's	Community work, sensitisation and referral as well as basic psychosocial support to HIV patients and people with substance abuse difficulties as well as prevention of substance abuse and screening for psychosocial disorders and behavioural problems for referral.	Bangui

7. Health facility staffing and MHPSS community capacity

The overall staffing capacity at the various locations of the assessment was minimal to insufficient, based on quantity of human resources as well as capacity and knowledge on mental health. However there were slight variations at each different site of the assessment. In rural locations many qualified staff was temporarily withdrawn due to continued instability and insecurity. Even in urban locations the access varied day by day and thus also the continuity is service delivery remained an ongoing challenge. In various locations IMC has recently opened primary health services and is still building up the teams and the capacity, both increasing the number of staff and training them.

Another issue that is affecting the coverage of medical staffing in health centres is related to the religious/ ethnic background of the staff, in areas where the majority of the target population is Christian it is not recommended to have Muslim staff providing services and the other way around. The swapping of staff contributes to continuation of service provision and is a security necessity, however this mitigation action is also affecting the staffing levels.

The table below gives the overview of staffing in the month March 2014. The table shows a gap in staffing at all levels related to the coverage and function of the health facilities. Specifically there is understaffing in the number of doctors and in some locations also in nurses. A setback in community outreach and follow up is the limited availability of community health workers in all the health centers, with the only exception in Bria. Limited capacity is available in psycho-social support. In the locations where IMC is operative the psychosocial support is focussing on protection needs and GBV, in Bossangoa the focus is all related mental health cases. Overall there is lack of psychologists at health centre level.

Health Facility Staffing[9]	**Location and Health Facilities**					
	Ouaka		**Haute Kotto**		**Ouham**	
	PHC IMC Pladama	**Hospital Bambari (Safe the Children & Mercy Cops)**	**Hospital Bria (MSF-Fr)**	**PHCs IMC & axes**	**Hospital Bossangoa (MSF-Hl)**	**Hospital Bouca (IMC)**
Doctors	1	3	3	1	1	1
Clinical Officers	1	2	1	1	25	3
Nurses	2	6	11	1	6	2
Midwives	1	1	2	1	2	2
CHWs	1	2	9	2	0	0
Psycho-social workers	1	2	0	1	5	2

[9] Due to differences in catchment populations at the sites included in the assessment, it is not possible to compare directly the number and composition of the staff, this should be seen in relation of health center size and needs.

Psychologists	0	0	0	0	0	0

The assessment included gaining an understanding of the capacity and knowledge of the health staff in the area of mental health and psychosocial support. Results change according to the role and position of the health staff but they are similar in the various locations of the assessment. Therefore the observations below are applicable to the different sites included in the assessment.

For medical doctors knowledge on identification and diagnoses of common and severe mental health disorders was basic but sufficient for patient identification. Their knowledge on differential diagnosis was varying according to specific background and training. Most of them went through psychiatric rotations during their education but they didn't have any specialized training or significant practice with psychiatric patients and psychopharmacological treatments.

In the case of general health staff including clinical officers, nurses and midwifes the knowledge of typologies and diagnoses was lower than that of doctors but they are able to recognize that there might be a problem in the sphere of mental health in general. From their training and background they have a better understanding of patient care and basic understanding of psychosocial support skills, however at the same time a gap was observed between their knowledge and the actual practice and application in daily work. When it comes to more specialized techniques for counselling there is a strong need of further training and support to acquire the necessary skills and tools.

Psychosocial workers, including protection agents, have received in the past specific training on MHPSS by international NGOs, mainly on techniques of psychological first aid and basic counselling. Nevertheless at the moment of this assessment there was no regular follow up and supervision by a specialist, which constitutes an obstacle due to their limited autonomy and capacity on case management.

Among the facilities' staff nobody was trained on the WHO mhGAP intervention guidelines and they were not aware of the existence of these materials, tools and framework.

Community health workers showed very limited understanding of mental health conditions although some of them were acknowledging the negative impact of traumatic experiences on the wellbeing of their communities and could identify and refer individuals presenting with adjustment difficulties. Others in the communities were relating such conditions to traditional, religious or magic beliefs.

Besides the CHWs interviewed at the health facilities, some people were identified who had received some training in psychosocial support in the past but where currently not employed as staff or volunteers. Their continued presence can be a valuable resource to tap in for future programs. In Bouca some CHW were trained by MSF-Spain when they were in charge of the regional hospital and were conducting a community based program of psychosocial support; in Bria also some key youth leaders were trained by COOPI; and in Bossangoa five psychosocial workers have been trained by MSF-Holland.

Traditional healers and key members of the community have been approached in all the sites by the health staff to establish links to collaborate in terms of awareness, health promotion and referral. For instance in Bria IMC has been training community leaders and traditional birth attendance in subjects related to primary health, nutrition and sexual and reproductive health. When asked about mental health they recognized it as a problem in their communities and they indicated that these cases are often handled through a traditional response based on a system of beliefs related to religion, magic or superstitions. Traditional healers are perceived as the main resource for such type of cases instead of seeking out modern health services. Although it is just the beginning of this contact with the traditional

healers, there are already some signs of a fruitful potential collaboration with them and the health system. They seemed receptive to work together and try to build a common framework of understanding to address those problems and symptoms within the community and strengthen possible referral of severe cases.

Another asset at the community level are the religious institutions that have taken a major role in the crisis to provide safe grounds to the affected population. For example in Bouca Catholic priests, Nuns and Protestant pastors work together to reach out to the people hiding in the bush and provide reassurance and accompaniment to return to their villages. They are also anticipating becoming involved in reconciliation processes. In Bossangoa a priest of the national Caritas is focusing on psychosocial support to children and their families.

8. Current problems and stressors among target communities

The constant threat of sectarian violence represents the main stressor and concern among the general population. This is part of the ongoing unstable and unpredictable environment since March 2013. The large number of casualties left by the attacks against both Christian and Muslim communities, implicate that nearly every family has lost one or more members or close acquaintances, including women and children and an unresolved process of grief where in many cases the families don't have access to the bodies of their beloved ones.

Bria and particularly Bambari have a tradition of peaceful and collaborative coexistence of communities from different religious and ethnic backgrounds and represent a very important resource for the entire country to promote understanding of tolerance and reconciliation. The stressors at these sites for the host community composed by both Christians and Muslims, come from the current general insecurity but also from a more chronic situation of lack of services and respect for the rights of vulnerable groups.

Women express concern about how to support their families, particularly in the cases where they have lost their husbands or they were separated due to displacement or the need to travel to find a job or to try to recover some of their belongings. Men regret that in the current situation they can't fulfil their role as provider and ensure good living conditions for their families. They talk about their properties and valuables that they have lost and are worried about the future for them and their relatives. The current conditions are causing a lot of tension and stress within the families. Men and women have a different perceptions about the importance of the different stressors, where men had the tendency to minimize the family conflicts; women were highlighting this dimension sometimes as a concern over the general insecurity situation.

Refugees in Pladama Ouaka camp near Bambari have been fleeing from Sudan and have voiced concerns about the uncertainty they are facing, the fear for the future and wondering when the next episode of violence will take place. They expressed a deep sense of hopelessness and helplessness.

Young boys and men expressed despair about their own perspectives, particularly when their families have been displaced and have lost their houses and belongings. They regret having lost their inheritance and the possibility to start or continue with their education or any business.

Young girls complain about the vulnerable position they have in their families with little autonomy and being exposed to aggressions. They fear to be married at a very early age, and to have to discontinue

their education (in case they were still attending) while being married off. With the current threat of violence young women also express fear for loosing their partners and families and the support for their children.

In Bouca and Bossangoa the communities have faced extreme violence during the current crisis, they witnessed killing of beloved ones and burning of their houses. Moreover there are continued regular incursions of armed groups looking for supplies and intimidating the people, representing a constant risk and source of stress. Even those families whose houses were not destroyed have left their homes to look for refuge at the centre of the town in the case of Bossangoa or in the bush like in Bouca, living in a very difficult environment with a lot of limitations in terms of sanitation, hygiene, food and water. The delay in the assistance for these sites has also reinforced the feeling of helplessness, frustration and isolation. This is particularly the case in Bouca where very few actors have made presence due to the security threats to reach the area. The coming raining season is already a source of worry in terms of food security worsening the access and communication and leaving the communities in a more vulnerable position towards further attacks against civilians.

The following table summarizes the main stressors reported by the community and service providers.

Stressful experiences faced by the IDPs	
Threat and actual extreme violence	• Organized and spontaneous eruptions of violence • Selective murders • Mutilations and multiple atrocities
Loss & separation	• Relatives killed as a result of violence • Death of family members due lack of services • Forced family separation and loss of properties
Conflict and violence	• Current tribal and religious conflicts • Past experiences of inter-communitarian violence • Torture of children, women and domestic violence
Protection issues	• Orphaned and kidnaped children • Delayed development among children • Child labour and early marriage • Health and education infrastructure not functional
Health issues	• Sickness, malaria, diarrhoea, malnutrition, convulsions, spread of STDs
Environmental issues	• Hygiene and sanitation conditions • Access to water and food insecurity • Coming raining season, risk of floods and affected planting and harvest
Psychosocial related concerns	• Cases of GBV and SGBV, • Reported problems with the host communities, harassment, • Unemployment and poverty

A main issue found during the assessment was the problem of substance abuse as a consistent source of concern for the population, health providers and authorities. The most widely used substances are alcohol and marihuana but since the last 5 years there is an increasing consumption of Tramadol which is easily found at public markets and at a very low price accessible to anyone. It has been reported that the drug is used frequently among men, women and even children. People indicate that the main reasons for the abuse are either to be able to work harder and longer or to mitigate the fear and distress from the exposure to or witness of extreme violence. This problem was highlighted at all assessment sites.

The community recognizes that the consumption of drugs and alcohol is creating a serious problem of dependence and it is perceived as a factor of social disintegration. Reports indicate that in the current and past crises tramadol has been used by the fighters among the multiple groups involved in sectarian, religious and ethnic confrontations. People highlighted that in many cases, extreme violence and atrocities are executed under the effects of such substances. At the same time it appears that the drugs play a role in escalation of incidents in the family atmosphere, for example in the area of intimate partner violence against women and children as well as at community level in instigating attacks towards people from different ethnic or religious groups, riots and looting.

Local NGO's (like 'Asociacion Coer Amour', 'Education pour la Sante', 'Aid Social') also highlight the fear in relation with ongoing kidnapping of woman and children. This is a stressor that is particular affecting the people in IDP sites.

9. Prevalence, identification and management of mental health and psychosocial problems

WHO estimates that in the context of humanitarian crises, the prevalence of common mental disorders, such as depression, doubles from a baseline of 10 to 20%, while there are about 2-3% of people with severe mental health problems such as psychotic disorders and major depression who are especially vulnerable in such crises. Based on the catchment population for the four sites (91167), an estimated 18233 (20%) suffer from common mental health problems, and 2735 (3%) suffer from severe mental health disorders. The table below shows estimated prevalence per location according to this standard.

Estimated prevalence for common and severe mental health disorders					
	Bambari	**Bria**	**Bossangoa**	**Bouca**	**Total**
Catchment population	11552 people	16437 people	42949 people	20229 people	91167 people
Estimated prevalence of common mental health disorders (10-20%)	1155-2310 people	1644-3287 people	4295-8590 people	2023-4046 people	9117-18233 people
Estimated prevalence of severe mental health problems (2/3%)	231-347 people	329-493 people	859-1288 people	405-607 people	1823-2735 people

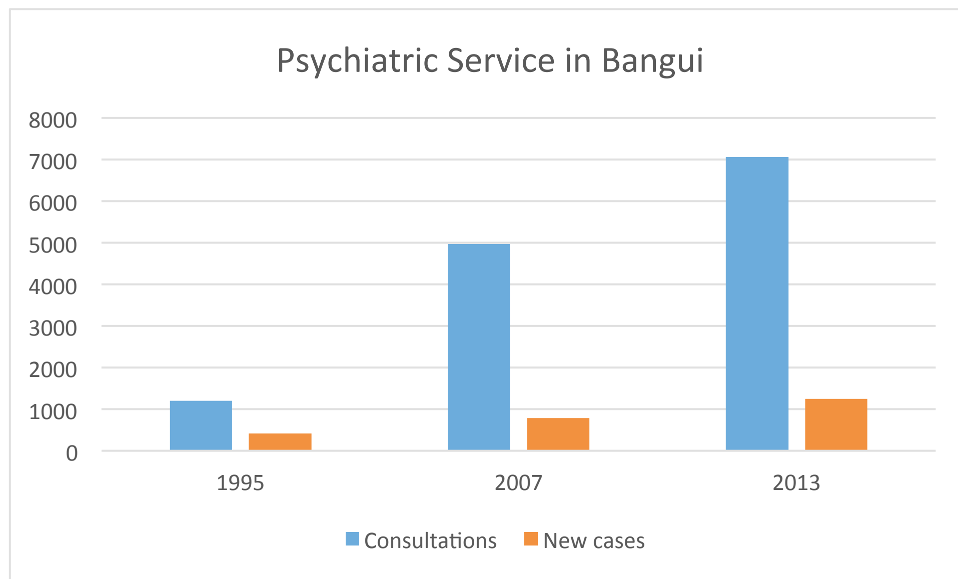
A study of Vinck & Pham in 2010 in the prefectures of Lobaye, Ombella M'Poko, Ouham, and Ouham Pende and Bangui, accounting for 52% of the total population of CAR, estimated a prevalence of 55.3% of symptoms of depression and 52.5% of anxiety and concluded that the exposure to violence and self-reported physical health were statistically associated with those mental health outcomes.

Due to the long and repetitive history of conflict in the region it is possible to find chronic and acute cases of common and severe mental health disorders associated with the exposure to traumatic events. This information comes from the interviews and group discussion with key informants and from visits to the affected communities. There are no official registers for these cases in the health facilities because people are not aware that such types of symptoms can be addressed through modern healthcare but also because the health staff lacks capacity to identify and treat those patients. The gap in registration of mental health disorders clearly causes a structural lack of case identification and reporting of mental illnesses.

Main complains that were reported in focus group discussions and interviews at health facilities are related to headache, palpitations, lack of energy and motivation, changes in behaviour and aggression. These reports may be indicative of a large distribution of acute stress related problems or adjustment disorders and in some cases of depression and post traumatic stress disorder. Epilepsy was also reported repeatedly among children and adults. Also in the case of epilepsy, it is associated with local beliefs related to a mix of religion, magic and superstitions, which keep families from seeking medical assistance and management is limited to traditional methods. Even if case identification of epilepsy and other disorders would take place at the moment there is limited medication or staff capacity at the health service level to provide care and pharmacological treatment.

The communities also indicate frustration with their capacity to support people that are suffering from isolation or aggression that refuse their support.

While the assessment does not include Bangui, this is the location with advanced registration of mental illnesses and can be seen as relevant to understand the overall mental health context. According to the information obtained from the psychiatric hospital in Bangui, there are near 300 cases of homeless people with mental illness in the city of Bangui and the periphery. The figure below shows that the numbers of consultations at the psychiatric service have increased 400% during the last 10 years and the number of new cases has increased from 416 in 1996 to 1246 in 2013.



The most common causes of consultation are stress and trauma related disorders and gender based violence. Increase in service usage can in general be clarified by various factors and does not necessarily mean an increase of cases. It could also be explained by increasing knowledge on available services, improved access and improved registration and acknowledgement overall.

10. Psychotropic medications and supported basic laboratory services

During an emergency it should be expected that agencies make essential medicines and medical supplies available according to the minimum standards of the Interagency Emergency Health Kit (IEHK). Overall in CAR there is extreme limited availability of medicines and medical supply for treatment of mental health conditions.

Before the crisis only Bangui had psychotropic medication and adequate drug management available at the psychiatric hospital. However during this assessment there was no psychotropic medication available at the psychiatric hospital. WHO has committed to support with the provision of essential medicines in the current response plan. Some of the hospitals which were part of this assessment had occasionally Diazepam and some antipsychotic and antiepileptic medication available, although there was no capacity among the facilities staff for the administration and management of psychotropic medications and their use was limited to stabilize acute states.

Besides the need of a reliable drug provision system and adequate drug management, available laboratory services are required to support initiation and monitoring of psychotropic medications. Hospitals in Bambari, Bria and Bossangoa have basic lab services although they don't have a regular supply of the materials necessary to perform the appropriate tests for the follow up of the use of psychotropics. The capacity of the lab staff is also very limited to perform the lab tests with that purpose.

At Bangui level there exists a national laboratory with limited analysing capacity due to lack of resources such as materials and instruments. Moreover there is a Pasteur Institute in full technical capacity but due to security reasons they have temporarily limited their service provision. NGO's work closely together with the Pasteur institute, however the referral for laboratory services for analysis of mental disorders is not established.

Availability of psychotropic medication at health centre level according to the WHO essential drug list for IEHK, as well as available laboratory services are listed below.

	Laboratory services available at health facilities		
Laboratory Service	**Ouaka**	**Haute Kotto**	**Ouham**
Complete blood count	Hospital, Bambari	Hospital, Bria	Hospital, Bossangoa
Liver function test	None	None	Hospital, Bossangoa
Thyroid function test	None	None	Hospital, Bossangoa
Rapid Blood sugar test	Hospital, Bambari	Hospital, Bria	Hospital, Bossangoa
Toxicology screening test	Hospital, Bambari	None	Hospital, Bossangoa
Creatine clearance test	Hospital, Bambari	None	Hospital, Bossangoa
Serum lithium level	None	None	None

Psychotropic medication WHO essential drug list for Interagency emergency health kit	Location and Health Facilities					
	Ouaka		Haute Kotto		Ouham	
	PHC IMC Pladama	Hospital Bambari	Hospital Bria	PHCs IMC Axes	Hospital Bossangoa	Hospital Bouca
Antidepressants (amitriptyline/fluoxetine)	Never	Never	Never	Never	Usually	Never
Anti-anxiety (diazepam tab and inj)	Never	Usually	Usually	Never	Usually	Never
Anti-psychotics (haloperidol tab and inj)	Never	Usually	Usually	Never	Never	Never
Anti-epileptics (phenobarbital, diazepam)	Never	Usually	Never	Never	Never	Never
Bipolar disorder (valproic acid, carbamazepine)	Never	Never	Never	Never	Never	Never
Generic antiparkinsonian (biperiden)	Never	Never	Never	Never	Never	Never

11. Referral pathways and Health Information System (HIS) on Mental Health

According to the strategic plan in elaboration at MoH and WHO, the regional hospitals in Bambari, Bria, Bossangoa and Bouca represent the referral facilities for the PHCs and PHCUs in their respective districts but they don't have the capacity at the moment to receive complex and severe cases of mental disorders.

The psychiatric hospital in Bangui is the only specialized referral institution in the country for mental health services. This service has been the only structure in charge of training and tracking mental disorders in the past and during the current crisis. Their capacity is limited to 24 beds for inpatient care distributed in two buildings separated for men and women. Activities include outpatient consultations, family interview, psychological support, psychotherapy group sessions and occasionally domiciliary visits. There is only one psychiatrist and two paramedical specialists in charge of drug management and one psychologist and two social workers. The hospital has very limited resources although the authorities were committed to allocate to mental health services at least 15% of the resources designated to health in the country as part of the decision of the member states of WHO.

They received cases from the three general hospitals in Bangui, but at the time of the assessment there were no cases from the province due to the restrictions on movement related to insecurity in the main roads. At the same time there is a general gap in referral from distant rural communities due to the high transportation costs.

When zooming in on referral at the community level it is notable that mental health cases do not come naturally forward through the established linkages and collaboration between community leaders and health centres. As these networks do exist for protection issues there is opportunity to start disseminating information on mental health and sensitizing the community about the relevance of bringing people with mental health problems to the health posts and at the same time strengthening the knowledge of community health workers concerning symptoms and case identification.

Apart of the records kept by the clinical team at the psychiatric hospital in Bangui, there is no systematic monitoring of information at the other health facilities in Bangui except for the cases referred as

psychosocial cases by the general hospitals in Bangui and even less in the areas of the assessment in the other districts.

12. Anticipated challenges for integration of Mental Health at PHC level

Administrators and staff from the health facilities were asked to identify the main obstacles for introducing mental health services at the primary health care level at the facilities and in the communities.

Besides the clear need for training and medical supplies, the list below highlights the concerns in terms of well-being, supervision and support of the staff. Particularly the staff from one or other ethnic or religious groups who are exposed to constant threats depending on the region and its socio-political circumstances, may need special measures of protection or relocation. The instable environment in which activities and services take place can lead to the need for evacuations or it would force members of the staff to leave on short notice. Other challenges that were mentioned by the staff are listed in the table below:

Main challenges on MHPSS programming
• Lack of human resources both in quantity and quality, including nurses and community health workers for the identification and management of common and severe conditions
• Psychotropic medication is not available in most of the facilities
• There are no lab services to check for complications and to balance the right dose for prescription
• Appropriate spaces and infrastructure would be needed in the outpatient facilities for the management of difficult cases
• Adequate inpatient services are needed for admitted patients who could be unstable and run away
• Close follow up at the community level is necessary to ensure families accept and support patients, and to ensure good caregiver practices, protection of human rights, drug compliance and attendance
• A lot of work to do in terms of attitudes, beliefs and practices related to mental health both at the community level as well as at service provision level; for instance the stigma associated and the role of traditional healers
• Staff well-being and motivation it is also a concern given the basic conditions of practice, the amount of work and the type of cases they might be facing
• An adequate and functional referral system is missing to handle complications or severe cases

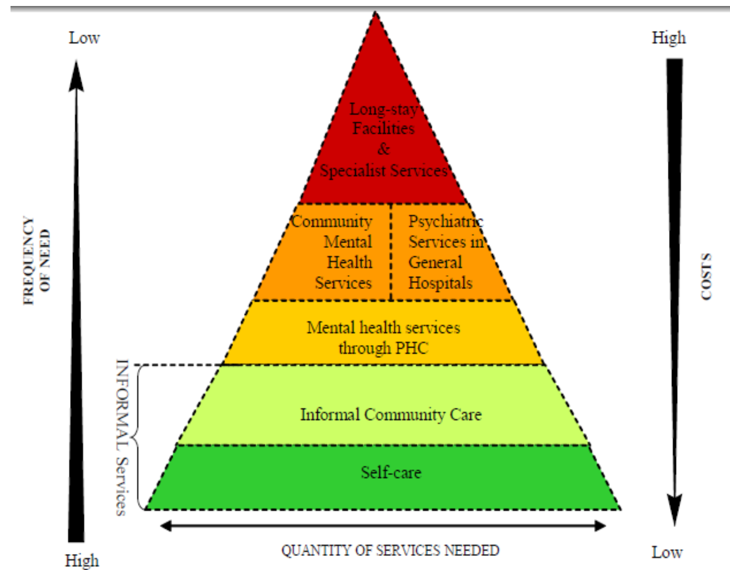
13. Summary and recommendations

- The already fragile health services that were available before the current crises in CAR are continuously depending on programs and activities by international organizations and agencies which is clearly not sufficient to respond to the needs of the affected population, particularly for mental health. The current insecurity has caused further deterioration of services as well as withdrawal of staff.
- At the national level there is a need for strong leadership and coordination of the national mental health response. While initial steps for coordination have been made at Bangui level; linkages with

the local level service providers also have to be made. There is an MHPSS working group in Bangui organized at the level of the psychiatric hospital and under the health cluster to discuss strategies and planning of activities among the ministry of health, NGOs and agencies. Integration with the efforts at the level of the protection cluster it is highly recommended to maximize resources and avoid duplication and overlapping. Currently WHO is making an effort to push the mental health coordination further but it is still highly dependable on a few individuals and structural support of one or more INGO's would be essential.

- Although clinical data is very limited and restricted to Bangui, a community based assessment shows that acute stress reactions, adjustment and common mental disorders are largely distributed among the population of Bambari, Bria and its axes. In Bouca, Busangoa and their axes the extreme violence experienced by the population represents a particular concern for suspected cases of mood, anxiety disorders (including PTSD) and psychosomatic complains which seem recurrent regardless of the condition as IDPs or host communities.
- The most important stressful experiences that the population is facing is the fear for continued sectarian violence and loss and separation of family members. Women indicate specifically their concerns to provide for the families as well as stress and violence at the household level. In some locations people fear to resume their normal lifes and are still hiding in the bushes. Besides those inherent stressors from displacement and conflict, people face conflicts with the host communities and are exposed to repeated displacement due to the instable and volatile situation and also due to the threat of the coming rainy season.
- Children and women without husband or relatives represent an important group in terms of protection and psychosocial support. Direct exposure to stressors and violence during the current internal conflict but also during the past, has left mid and long term consequences affecting the normal processes of grief and the cognitive and emotional development of children, which are risk factors for the development of mental disorders. People with severe mental disorders have been reported as a particularly vulnerable group being killed during the confrontations.
- Another group that needs specific attention are youth and other groups vulnerable to substance abuse. It became clear from the various interviews that the usage of tramadol is affecting the level of violence and escalation of conflicts. Moreover the exposure of young men being part of armed groups and risks for recruitment is another cause for chronic distress in society.
- So far MSF-Holland is providing psychosocial care at the facility level in Bousangoa but it might discontinue this activity by May. Coopi is also present in Bousangoa and Mercy Corps in Bambari with a more limited capacity to respond to the needs. Other organizations and agencies are more restricted to activities of mental health promotion, and awareness. Although important, these activities should be extended to the level of case management and specialized services, including psychosocial support, targeted psychosocial interventions and pharmacological treatment. Currently Bouca and Bria have no actors providing any type of mental health support. At the moment IMC has programmes in the area of protection and GBV that include components of counselling and psychosocial support. This programing provides space for further elaboration towards psychological support and mental health programming at the health facility level.
- A comprehensive approach for Mental Health and Psychosocial Support is needed including the integration of more specialized mental health services at the health facility levels but also a strong community based component in order to identify, refer and follow up people in need. IMC is planning to introduce MHPSS professionals in its teams and is currently exploring funding alternatives and partnerships to cover this gap.

In line with the "Optimal Mix of MH Services (WHO)" IMC should develop programs that support the holistic approach of coping at the community level as well as providing specialized services. This would include activities that strengthen coping and understanding at the community level as well as strengthening of referral from community to local service providers and upwards referral to the highest level of the pyramid for severe and complex cases of mental disorders. This would require strong coordination at central and regional levels and IMC could work closely with WHO and MoH to take the lead in this regard as well as set up linkages to and between the protection and health clusters.



Programming for longer term impact and influence would also include capacity building at MoH level and possibly a push for the revision of the mental health strategy and investment in curriculum building for the longer term. The specific role of IMC in this regard could be one of advocacy, training and capacity building. Closely liaising with UN agencies will be required for large scale investments in capacity building at the Ministry level and educational programmes.

IMC could work in the lower part of the pyramid by linking to other programmes with a strong community outreach components such as nutrition, GBV, child protection, education services and general community health workers or community services. The key goal here would be to build the capacity of these community actors in providing basic emotional support as well as information on services and referral. House to house visits as well as initiating community dialogues could be a useful approach in this regard.

Community group activities as well as peer to peer support can be a useful approach to strengthen community support and enhance community coping mechanisms. This could fit with local systems and build on local customs. Possible tea-talk sessions could be a useful approach here, if identified as a cultural acceptable practice.

The third level would target the strengthening of services at the PHC level through training of general health staff in identification and support of mental health cases as well as the staffing through psychologists and psychiatric experts in management of psychotropic medication. This could include temporary deployment of a psychiatrist to focus on capacity building of the medical doctors and other general health care staff. IMC could collaborate with government counterparts to upgrade the in facility services, including stocking of medication and management of medicine stocks.

Nurses in nutrition should be trained in basic psychosocial support as well as mother to child care and nurturing. Due to the distress and conflict the natural bonding of mother and child might be affected and there is a need for special attention to address the malnutrition aspects as well as mitigate long term consequences for psychosocial problems among children. IMC's current programming provides space to strengthen families' ability to cope with the crisis.

The fourth and the 5th levels require IMC to collaborate on strengthening the upward referral system, including downward monitoring of the use of medication and follow up on clients. IMC's role should focus here on capacity building of community volunteers as well as regional and national actors on referral.

Possible components for programming are outlined below:

Programming model on MHPSS	
Main objective	Strengthen the capacity of the mental health services in the general health service delivery and strengthen community coping as well as access to a dignified basic mental health package at the community level and specialized care through efficient and adequate referral networks.
Activities	Intensive training of health staff in WHO mhGAP guidelines at the PHC level and in IMC clinics as well as other relevant counterparts – this would include training, on the job supervision and curriculum development
	Training of medical staff at the national and referral levels (this is anticipated through the national mental health plan with funding from WHO – IMC should link with this training plan to complement the additional needs)
	Support supervision at the facility level by specialized mental health experts in service provision and client support as well as the administration of medication
	Provision of psychotropic medications and training on stock keeping as well as strengthening the ministerial capacity in monitoring of availability of medication. The latter should be linked to overall initiatives in medication management.
	Training of psychosocial workers on case management skills as well as basic psycho social interventions
	Provision of mental health services at the health facility level including the administration of psychotropic medication
	Strengthen the capacity of laboratory services with capacity building and provision of equipment and materials for the follow up of psychotropic administration and management at national level and regional level
	Training of nurses and psychosocial support workers in the IMC nutrition programmes on mental health and nutrition as well as mother and child relationships and Early Childhood Education (ECD)
	Training of CHWs and community volunteers in the IDP and host community setting (where IMC has access) on general mental health, PFA, case identification, referral and awareness raising as well as group psychosocial support activities.
	Train / sensitise traditional health practitioners, TBA's and community leaders in identification and referral of mental health cases as well as PSA.
	Provision of community outreach services and follow up of clients
	Setting up of recreational activities as well as peer to peer group work and vocational training or other supportive activities, this could include the creation of support centres as well as general community activities. The main target group should be youth at risk while additional areas would include strengthening the psychological support in women centres and GBV programmes as well as in child protection programmes.
	Mental health advocacy and coordination – NGO leads should be identified in close collaboration with the cluster leads and the MOH
	Strengthen evidence based programming by improved data collection systems and harmonization between actors through the MHPSS working group – leadership in

	the roll out of a data management system is required.
	Strengthening of the referral pathway and collaboration between province and national psychiatric hospital through exchange and common training of medical practitioners.
	A long term programme area for the mental health component would focus on rebuilding of community trust. This should be done in coordination of reconciliation programming and clearly at this stage this would be too soon.
	During a potential post-conflict phase, IMC could strengthen their current programme with demobilized youth and scaling up of psychosocial support programmes to youngsters that have been fighting during the conflict and became part of gangs. Besides vocational training and other recreational activities it would be essential to include an intensive psychological programme with individual and group sessions. Moreover it would be relevant to target youth that is specifically affected by substance abuse.

14. List of acronyms

BPHS	Basic Package of Health Services	**MC**	Mobile Clinic
CHWs	Community Health Workers	**MHPSS**	Mental Health and Psychosocial Support
DRC	Danish Refugee Council	**MoH**	Ministry of Health
FGD	Focus Group Discussion	**MSF-Fr**	Medecins Sans Frontiers – France
GBV	Gender Based Violence	**MSF-Hl**	Medecins Sans Frontiers – Holland
IASC	Inter-Agency Standing Committee	**MSF-Sp**	Medecins Sans Frontiers – Spain
ICRC	International Committee of the Red Cross	**PFA**	Psychological First Aid
IDP	Internally Displaced People	**PHC**	Primary Health Care
IMC	International Medical Corps	**PHCC**	Primary Health Care Centre
IOM	International Organization for Migration	**PHCU**	Primary Health Care Unit