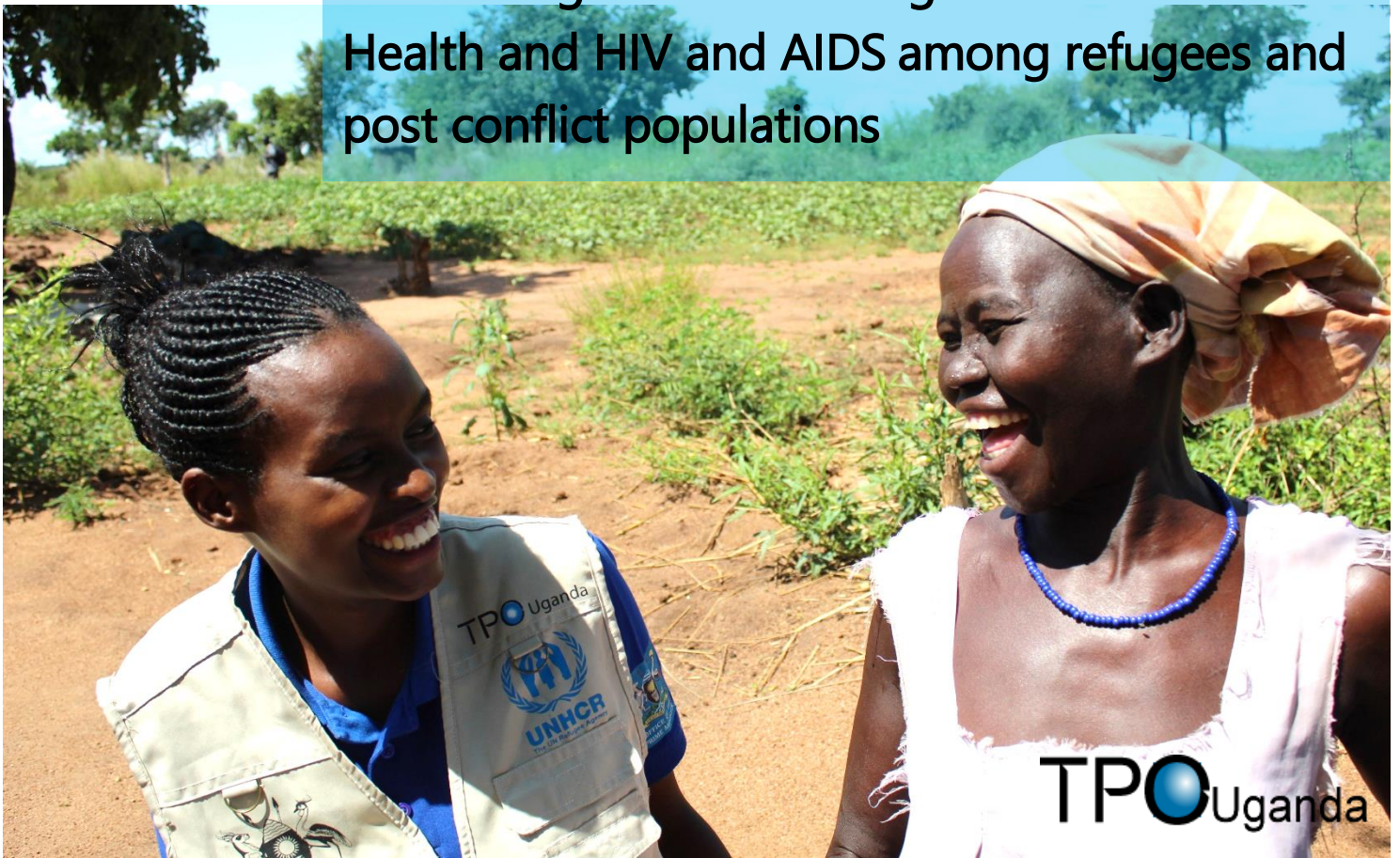


# Addressing the intersecting burden of Mental Health and HIV and AIDS among refugees and post conflict populations



Regina Dipio is a 50-year-old South Sudanese refugee living in Bidi Bidi. Regina and her neighbor friend Rose, were simultaneously raped by a soldier while they were in transit from South Sudan. Upon getting to Uganda, Rose fell sick and opted to test for HIV after which she shared her positive results with Regina urging her to test since they were raped by the same soldier.

To their surprise, Regina's results were negative. She started to test multiple times with the hope that she can be confirmed positive in vain.

'This whole process clouded me with memories of the rape incident. I lost trust in all the medical facilities I visited because I believed they were lying to me. With five children of my brother to take care of, it was fair I started HIV medication earlier. Since no one understood me, I started to

contemplate suicide because I knew I would die soon anyways. One day as I had gone to the base camp for additional medical check-up, I interacted with a Social Worker from TPO Uganda who was talking to people about 'problems of the mind'. I shared my story and the plans to end my life. The social worker made an appointment to talk to me when others left.

She later visited my home several times to see how I was managing to relate with other family members. I learnt that it was possible for two people who have been raped by one person to pose different results. The Social Worker helped me to understand that there are married couples like that too. And that not accepting my status would continue to depress me and affect my commitment to supporting my brother's children. I started to trust the results I had been receiving health workers'.

Like Regina, the intersection between HIV and Mental Health and Psychosocial support (MHPSS) continues to affect populations within humanitarian and post conflict settings in Uganda. The needs range from gaps in information, stigma and discrimination and strengthening services. While there has been significant national progress on HIV and AIDS programming, reducing the prevalence from 7.3% in 2011 to 6.3% in 2017, in August 2018, UNHCR noted that 35% of refugees and 65% of host community populations were receiving treatment for HIV and AIDS in the country. Moreover, over one-third of Uganda's population is affected by mental health needs, less than half of whom access intervention due to inadequate personnel, psychotropic medicines; psychosocial interventions; and psychotherapies (Murray 2015). A high burden of these statistics lies with populations in fragile and emerging settings like post conflict

North and North-Eastern Uganda and refugee areas West Nile, Northern and South-Western Uganda<sup>1</sup>. Similarly, a 2016 risk factors cross section survey conducted on a countrywide sample in Uganda using the WHO STEPS tool, Kabwama et al found that residents in Northern Uganda had a higher prevalence of alcohol use compared with other regions. This was largely attributed to traumatic stress resulting from the over 20years long civil conflict, victims using alcohol as a coping mechanism (See; Roberts and Sondorp, 2011; UNHCR and WHO, 2008).

According to the In Charge at Mucwini Health Center in Kitgum district, cases of depression are common among HIV and AIDS clients attending the Anti-Retroviral Therapy (ART) clinic. Through administering the PHQ9 tool, it was found that 400 of the 700 clients receiving HIV and AIDS services at the health center manifested mild to grave MHPSS needs. These also struggled with adherence often shaped by stigma, discrimination and self-blame which exacerbate psychosocial wellbeing. It was however noted that the PHG9 form is not adequately used by attendants at the health facility due to capacity gaps. Thus, integrating HIV and AIDS services in MHPSS responses within such vulnerable settings remains essential.

Through interaction with health workers in Palorinya and Bidi Bidi settlements, it was noted that HIV and AIDS response for MHPSS clients was critical. The misconception that staying with someone who has HIV and AIDS or MHPSS needs leads to transmission is still widely held which leaves most coinfecting people abandoned and unable to openly seek support. Due to coping hardships in the settlements, these are also most vulnerable to sexual exploitation and abuse which exposes them to the increased risk of contracting HIV. Some of the vulnerabilities highlighted include increased survival sex and prostitution in the refugee settlements, gender-based violence, sociocultural dynamics around uptake of services such as condom use and limited HIV and AIDS services. Integrating packages for HIV and AIDS and MHPSS for us means strengthening the capacity health workers, supporting outreach programs to deliver awareness and services to the most vulnerable groups and investing in supplies.

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**Elisaru Lillian, Nurse, Palorinya Health Center III**

**We have some members in our group who are living with HIV and AIDS. They were very bitter when it comes to talking about issues of HIV and AIDS because some of them think they did not deserve it. During the sessions, our Social Worker encouraged us to talk about it. This information encouraged me to voluntarily test for HIV and AIDS.**

**Akandu Celina, Member, Ngogita CBT Group, Bidi Bidi settlement**

In addition to the case management through which the needs of clients like Regina are identified and supported through continuous follow up, TPO Uganda conducts clinical outreaches through which information on MHPSS needs is disseminated to community members, screening is undertaken to identify affected individuals who are enrolled into the cognitive behavior therapy (CBT) group for specialized care. The therapy groups have also been used as a space to strengthen individual members' ability to openly discuss HIV and AIDS in the context of the MHPSS support being received.

<sup>1</sup> The 2015 Global Burden of Disease study shows that 15-20% of crisis-affected populations develop mild-to-moderate mental disorders such as depression, anxiety, and post-traumatic stress disorders (PTSD).