Psychosocial Challenges Faced by Internally Displaced Persons at Maai Mahiu Camp in Rift Valley Province, Kenya

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Abstract
Globally there is ample evidence that human conflicts are common worldwide and human beings who have been subjected to traumatic events associated with war, conflicts and collective violence experience serious psycho-social consequences. One such conflict was the 2007 Post Election Violence (PEV) that resulted in death, displacement, immense losses and traumatic events that caused serious psychological distress. This study was designed to explore the psycho-social challenges facing the Internally Displaced People (IDPs) in Maai-Mahiu camp in the Rift Valley, Kenya. Specifically, the study sought to establish the levels of depression among the IDPs and the psychosocial challenges that they were experiencing. The target population comprised of 277 adult male and female IDPs in Maai Mahiu camp. Respondent driven sampling strategy (RDS) was used to identify a sample size of 140 IDPs. To assess the levels of depression among the IDPs, Beck's Depression Inventory (BDI) was administered. Focus group discussions were used to obtain information on the psychosocial challenges they were experiencing. Findings indicated that the levels of depression were quite high: 82% of the respondents were depressed: 41% were severely depressed, 30% were moderately depressed while 11% had mild depression. In addition to being depressed, the IDPs were also experiencing other psychological distresses such as fear, despair, lack of sleep and isolation. Other identified challenges were lack of basic needs and social amenities. It was recommended that the IDPs be resettled as soon as possible to resume a semblance of normal life and psychological interventions be mounted to help those undergoing depression and other psychological disorders.

Key words: Depression, Psychosocial challenges, IDPs, Traumatic experiences

Introduction
Human conflicts are common worldwide, and their effects has been felt in many countries such as Afghanistan, Burundi, Chad, Colombia, Côte d'Ivoire, Peru, Rwanda, Sierra Leone, Chechnya in Russian Federation, Darfur, the former Yugoslavia Congo, Liberia, Cambodia, Bosnia, Somalia and Uganda. The conflicts are usually accompanied by a lot of suffering of those affected. The suffering includes rape and sexual assault, death, displacement of people from their homes and abduction of children and adults (Human Rights Watch, 1996). For example, during the Rwanda genocide, Tutsi women were raped after witnessing the torture and killings of their relatives and the destruction and looting of their homes (Nowrojee 1996). In times of conflict, individuals are exposed to traumatic events that leave the victims psychologically and emotionally scarred. The different types of trauma include sexual abuse/assault; physical abuse/assault; emotional abuse/psychological maltreatment; neglect (physical, medical or educational neglect); serious accident or illness/medical procedure; witness to domestic/ community violence; forced displacement; victim/witness to extreme personal/ interpersonal violence; traumatic grief/ separation for example death of a parent, primary caretaker or sibling (The National Child Traumatic Stress Network, 2008). Exposure to traumatic events can adversely affect survivors' psycho-social wellbeing. Among the documented effects are the Acute Stress Disorder (ASD) and the Post Traumatic
Stress Disorder (PTSD). PTSD is a common anxiety disorder following a traumatic event. According to DSM-IV-TR (2000), PTSD presumes that the person experienced a traumatic event involving actual or threatened death or injury to themselves or others, fear, helplessness or horror. The symptoms occur after one month after the event. ASD is diagnosed if a traumatic event occurred recently, then an individual might suffer symptoms similar to PTSD but without the one month duration requirement. Other effects of exposure to trauma include depression, anxiety, dissociation, substance abuse and adjustment disorders. In some cases, somatoform disorders and even hypertension were noted in some populations (Kessler, R., Sonne, A., & Bromet, E., 1995).

In addition, exposure to trauma leads to mixed feelings and reactions that include feelings of fear, guilt, vulnerability, helplessness, anger, rage, bitterness, sadness, moodiness, numbness, detachment and anxiety. Globally there is ample evidence that human beings who have been subjected to traumatic events associated with war, conflicts and collective violence experience dire psycho-social consequences (Derek, 1991; Hamber & Lewis, 1997; WHO, 2000; Pedersen, 2002). Other common personal and behavioral effects of emotional trauma include: substance abuse, compulsive behavior patterns, self-destructive and impulsive behavior, uncontrollable reactive thoughts, inability to make healthy professional or lifestyle choices, dissociative symptoms (“splitting off” parts of the self), feelings of ineffectiveness, shame, despair, hopelessness, feeling permanently damaged and a loss of previously sustained beliefs (American Psychiatric Association, 2000). In addition to the trauma, refugees and internally displaced people must also survive in contexts in which they feel uprooted, misunderstood and often discriminated against.

Kenya has experienced different types of violent and non-violent conflicts in its past and present history. According to Nyikuri (1997) the 1992 clashes and the subsequent psycho-social consequences, such as death, homelessness, abuse; mistrust, prejudice and psychological trauma left the victims with mental anguish and general apathy. The 2007 Post Election Violence (PEV) led to massive displacement of persons resulting to Internally Displaced Persons (IDPs), destruction of property, loss of lives and livelihoods and total disruption of social order. In all, over 1,200 people were reported killed, thousands more injured, over 300,000 people displaced and around 42,000 houses and many businesses were looted and destroyed (Harneit-Sievers / Peters, 2008; African Woman and child, 2009; Wambura, 2009).

A significant number of cases of sexual and gender based violence were reported. The Nairobi Women’s Hospital Gender Violence Recovery Center, noted that altogether they attended to over 650 cases of GBV related to the post-election crisis (CREAW, 2008, p 5). The long-term effects on survivors include psychological suffering, stigma, HIV and AIDS and other sexually transmitted diseases and probably unwanted pregnancies (Waki Commission, 2008).

According to the theory of loss-grief as by Kubler-Ross (1973) recovery from loss requires working through the various psychological stages: - denial, anger, bargaining, depression and acceptance which loss engenders as well as coping with various behavioral manifestations. In order to mourn one must be able to express anger, rage, and hatred. Victims of loss also experience a change in perception of self and others. One can never undergo loss and remain the same. From this perspective, the IDPs can be viewed as individuals who have experienced loss and hence who are in a grieving process hence having the need to mourn, as well as experiencing a change in self-perception.
WHO (2000) projected that as a result of a conflict, on average, in the long-term, the percentage of people with severe mental disorders increases by 1% above baseline, while the percentage of mild and moderate disorders increase, in the long-term, by 5-10% above baseline. These mental disorders include PTSD, depression, anxiety, dissociation, adjustment disorders and ASD. The small percentage (5-10%) of the population with newly developed disorders will continue to experience severe distress, and their functioning will continue to be impaired even after a few months. Even when a protective community and family environment has been restored, when disaster-related stressors (e.g., emergency-induced sudden poverty, lack of security and lack of good shelter) are no longer a major issue, this small percentage of the population will continue to be affected and requires more specialized and on-going interventions.

The 2007 PEV inflicted heavy psychological burdens on people. Although immediately following the violence there was intensive material and psychological interventions specifically debriefing, little psychological help is still going on. The Kenya Red Cross and other concerned parties identified lack of psycho-social support to the 2007 PEV victims. It is important to identify the psychosocial challenges that the IDP’s are experiencing in order to come up interventions that can address the challenges and prevent the victims from deteriorating to more severe mental disorders. It is in this light that this paper sought to establish the psychological challenges experienced by the IDP’s that may be interfering with effective functioning.

Specifically, the objectives of the study were to: (i) To determine the levels of depression among the IDPs in the camp, (ii) To find out whether there are relationships between depression and age, gender, marital status and educational levels of IDPs, and (iii) To identify the psycho-social challenges faced by the IDPs.

Research Methodology
A descriptive study design was used. The target population comprised of 277 IDPs in Maai Mahiu camp. The target population comprises both adult females and males from different parts of the country who were evicted from their homes after the 2007 PEV. Respondent driven sampling strategy (RDS) was used to identify the subjects. RDS is a way of sampling hard to-reach and sometimes hidden members of a population who are typically highly stigmatized and therefore “hidden through a technique similar to snowball sampling (Heckathorn, 1997). RDS is based on the belief that people are best recruited by their own peers due to greater trust, familiarity, or peer influence (Xin Lu, Bengtsson, Britton, Camitz, Jun Kim, Thorson & Liljeros, 2010). A sample size of 140 IDPs was used in the study.

To assess the levels of depression among the IDP’s, Beck’s Depression Inventory (BDI) was administered. Questions were read out for the participants who could not read and write. Focus group discussions were used to obtain information on the psychosocial challenges they were experiencing. The participants’ responses were transcribed and thereafter themes were derived from the information. Quantitative data was analyzed by means of descriptive and inferential statistics and were presented in tables of frequency distributions and percentages.

Before the commencement of the study the respondents were informed about the purpose and benefits of the study, the peer-recruitment procedure, the rights of participation or withdrawal from the research in order for them to make an informed decision to participate or not. Information was kept confidential and respondents were assured of anonymity and
confidentiality. Recommendations of seeking appropriate psycho-social support were made for those who may have suffered secondary trauma through responding to the questionnaires. After this research was over, debriefing was done in order to cater for the participants who may have been affected by the research experience.

Results and Discussion
The BDI was used to measure the intensity, severity and depth of depression among the IDPs. The findings are presented in table 1.

Table 1:
Levels of Depression among the IDP’s

<table>
<thead>
<tr>
<th>Gender</th>
<th>0-13 Normal</th>
<th>14-17 Mild</th>
<th>18-27 Moderate</th>
<th>&gt;27 severe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>11</td>
<td>7</td>
<td>23</td>
<td>25</td>
<td>66</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>8</td>
<td>19</td>
<td>33</td>
<td>74</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>15</td>
<td>42</td>
<td>58</td>
<td>140</td>
</tr>
</tbody>
</table>

The levels of clinically depressive symptoms ranging from mild to severe are shown in table 1 above. The proportion of those who were depressed from mild to severe were 115 or 82%; 58, or 41% were severely depressed; 30% were moderately depressed, and 11% had mild depression while 18% did not show any signs of depression. These results indicate that most IDPs had mild to severe levels of clinically depressive symptoms. Other forms of psychological distress were captured through the FGD’s as indicated by the following excerpts from the respondents.

“I live in constant fear and despair after getting threatening messages. I have developed negative attitudes towards people and any commotion scares me” (male, 54 years).

“The flash backs of burning houses affect me and I am not able to sleep at night fearing they might set me on fire....” (male, 37 years).

“I normally feel sad and unhappy. Some of us experienced loss and grief after displacement, rape, sexual mutilation, loss of body parts, contracting HIV/AIDS, and STDS. More so, after rape and sodomy, instead of comfort we got castigation and additional loss of abandonment by spouses and other family members” (female, 40 years).

“My husband was shocked to see our houses torched. Consequently, he died leaving me pregnant and with three other children. I am depressed and will never return to my pre-displacement home. I am so bitter and the social support of other IDPs is the only thing which has enabled me to survive” (female, 34 years).

“The people who committed the acts of rape and mutilation were known attackers, neighbors, relatives, friends and individuals working in the camps. The combined horror of PEV and sexual violence we experienced has destroyed our lives” (female, 34 years).

The above excerpts clearly show that the IDP’s are still suffering from fear, despair, insomnia, sadness, bitterness and breakdown of families. This is evidence that the respondents are still undergoing psychological distress. The figures of 82.1% for those who are depressed among survivors are higher than the figures found among similar populations. For instance, among newly displaced refugees seeking asylum living in reception centers in the Netherlands,
prevalence rates of 63% for depression were found (Steel, Z., Silove, D., Phan, T. et al. 2002). These figures are also higher compared to a study in Juba in November 2007 among Sudanese exposed to traumatic events which indicated the prevalence of depression among men to be 40.9% and among women 58.7%, (Bayard, R., Eliaba, Y., Olivia, Let al. 2009).

These findings are also comparable to the findings of Steel et al (2002) in Australia and De Jong, and Komproe (2002) which indicated high levels of psycho-trauma among resettled refugees and a high prevalence of psychiatric disorders and mental health problems. Njau (2005) found a prevalence rate of 80.2% of PTSD amongst the heads of households. However, there was no structured mechanism for documenting these situations in internally displaced persons living in Kenya. These results are also comparable to findings where the prevalence of mental disorders and factors associated with poor mental health have been shown to persist when the refugees are not settled even though they are allowed to live in camps for a long period of time (Beiser, M., Hou, F. 2001., Derrick, S., Zachary, S., Adrian, B., 2007).

The results of the study raise concerns about this high prevalence of depression among the IDP’s because they show that the respondents do not have access to fulfill their physical, social and psychological needs in their current situations of living. Conversely, these results lay emphasis on the fact that the degree of psychosocial disability associated with the respondents is clinically alarming.

It was investigated whether there was a relationship between gender, age, marital status and educational levels of the IDPs with depression. The findings are presented below:

### Table 2:

Relation of Depression and Demographic Characteristics

<table>
<thead>
<tr>
<th>Socio-demographic features</th>
<th>Beck Depression Inventory</th>
<th>Chi-Square test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-13 Normal</td>
<td>14-17 Mild</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>11</td>
<td>7</td>
</tr>
<tr>
<td>Female</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>Age distribution in years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>31-45</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>46-60</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td>61-85</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>Highest education level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>College/University</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Secondary level</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Primary level</td>
<td>18</td>
<td>13</td>
</tr>
<tr>
<td>Without formal education</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>15</td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Married</td>
<td>17</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>15</td>
</tr>
</tbody>
</table>

Out of those who were severely depressed, a higher percentage of females (57%) had severe symptoms of depression compared to 43% of males. However, the differences were not significant. The results also indicate a significant statistical difference (p=0.008 (p<0.05) between BDI scores and age. Respondents over 46 years showed more severe levels of depression as compared to those aged 45 and below (68% and 31% respectively). Traumatizing older persons who are in their last stages of the life cycle as indicated by Eric
Erikson will severely be disturbing emotionally (Harder, 2009). The analysis also showed that there was an association between levels of depression and educational level. A higher proportion of those with primary level of education were severely depressed (55%) followed by those with no formal education (33%). However, the association was not significant ($p=0.169$). When marital status was observed for the severely depressed category, a higher proportion of those who were married were depressed as compared to those who were not married (70% and 30% respectively).

It is possible that a higher proportion of women had higher levels of severe depression than men because women are likely to worry more about the condition of their dependants such as provision of food, water and other basic necessities. There were also more women than men in the camp. In relation to age, it seemed that the older persons experience higher levels of depression. This may be because they were already well established in their careers and family life according to Erikson’s theory and the disruption in their life led to stagnation and despair. This is especially because they do not have a lot of time to begin to build their lives again. In relation to education level, the findings may be explained by the fact that those who had higher levels of education from secondary level and above were not likely to be living in the camp as they were likely to be having some kind of jobs to do. From the data in table 2, there were only two graduates living in the camp and only 14 with secondary education. It therefore seems that the people who ended up in the camps were those with minimal formal education. For marital status, it is obvious that the married ones had more to worry about as compared to those who were single since a married person will most likely have more responsibilities such as taking care of a spouse, children, older parents and themselves.

Depression levels are also likely to be higher among the IDP’s because in addition to the life-threatening stresses experienced during the violence, IDPs continue to frequently experience recurring losses, challenges, and changes during the displacement and resettlement periods, IDPs are still forced to confront isolation, hostility and violence in their new locations. These survivors still face living situations that are, at times, over-crowded, rife with the threat of infectious diseases, and primitive in design (living in tents). These conditions are associated with chronic stressors which include socio-economic disadvantages, poor physical health and the collapse of social support that survivors must deal with.

The study explored the kind of challenges the IDPs were experiencing. Among those frequently mentioned were the following: Lack of adequate shelter, water, sanitation and hygiene; lack of food and non food items; lack of basic health care, i.e. lack of dispensaries and medicine; and lack of employment and education facilities for children. Their sentiments are captured in the following excerpts derived from focus group discussions:

“The available tents are inadequate to accommodate entire households. The tents are worn out leaking especially during this rainy season. Many families continue to share tents e.g. 10 people in one tent posing a lot of dire socio-economic and health challenges. Parents continue to share tents with children. We lack shelter materials, blankets, mattresses, household utensils, farm implements, mosquito nets, sanitary pads, cooking utensils and water storage containers among others” (male, 50 years).

“We lack clean water, soap, toilets and bathing facilities. In fact there is no distinction between male and female toilets in the sites which can cause insecurity. Some people may be raped or sodomised in such situations” (female, 45 years).

“Although the IDPs receive food rations from government i.e. one tin of maize, three
tins of beans and one liter of cooking oil per month it is not enough. Also, after the government’s filtering process of the genuine IDPs, some no longer get the relief food” (male, 50 years).

“The IDPs lack health facilities, dispensaries and medicines. Some sleep in the cold and have contracted diseases such as diabetes, asthma and T.B while others are malnourished, anemic and have no medication. Others have HIV/AIDS and STDs” (male, 56 years).

Concerning livelihoods the respondents had this to say:

“Most of the IDPs work as casual laborers. Some walk long distances (which has made them develop pain in the legs) searching for manual jobs such as working in the quarries, tilling land, washing people’s clothes or doing house chores. After all the tedious work, some are paid so little e.g. 50-100Kshs or given inadequate flour or food items, while others are verbally abused and chased away.... Some IDP households purchased small land for tilling, have prepared the fields but they have no seeds to plant. Local well-wishers also offered some 60 acres for farming, but the IDPs lack funds to have a tractor for ploughing. Life is difficult. If we got a tractor we would farm and sustain ourselves instead of relying on relief food. If people are to go fishing, give them the nets!” (Male, 37 years).

“We lack proper education facilities for our children e.g. nursery school and teachers. The children are congested in the nearby primary school where they are sometimes stigmatized. Even those who were KCPE candidates did not perform well because they are suffering from the psycho-social effects of the PEV. Some are languishing in the camps, hopeless and depressed and the vicarious process extends to their parents or guardians” (female, 52 years).

On the challenges facing the IDPs, it has emerged that they lack the basic needs such as physiological, safety and a sense of belonging. In addition, the conditions that they live in are a clear indication that they do not even think of their psychological needs as they are preoccupied with physiological needs. These conditions may be a major contributor to their psychological distress hence the high levels of depression.

Conclusion and Recommendations

It is evident that the IDPs are still hurting and need some assistance in order to heal, psychologically and spiritually. In conclusion, it can be reported that the IDPs are still experiencing severe physical, psychosocial and economic difficulties in their current living situations. They have no livelihood and therefore this contributes to the high levels of depression.

Therefore, the study recommended that:

(i) There is need to urgently resettle the IDPs who are continuously being re-traumatized in the camps. From the study’s findings the IDPs continue to live in dehumanizing conditions unable to fully regain their livelihoods. Life in the camp is difficulty since there are continuous reminders of the PEV and most people live in despair.

(ii) Due to high prevalence of depression among the IDPs there is need to provide explicitly psychological and medically therapeutic services. Periodic counseling needs to be organized for the IDPs. Counseling models such as long term individual, group counseling and social support systems should be emphasized and incorporated in the counseling programme in order to achieve comprehensive psychological healing for the IDPs. Emphasis should be laid on trauma counseling.
(iii) Psycho-social interventions such as provision of shelter, regular food distribution, improving sanitation and provision of clean water should be provided while bearing in mind that the best way to facilitate healing would be to resettle the IDP’s as soon as possible. The psycho-social as well as material needs must be addressed in a gender-sensitive manner.

(iv) Special attention should be paid to the older members of the group. The trauma, hopelessness and the distress they experience can graduate into more serious psychological conditions if not addressed. This is especially because they are likely to be affected by old age diseases, and combined with lack of medical attention may lead to serious conditions and complications.

References


Derrick, S., Zachary, S., Adrian, B., et al, (2007). Trauma, PTSD and the longer-term mental health burden amongst Vietnamese refugees a comparison with the Australian-born population


