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Exploration of the psychosocial wellbeing aspect of vulnerable populations at risk in Kakuma Refugee Camp

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Abstract

The refugee experience is characterized by exposure in one's country of origin to numerous traumatic incidents during migration and daily stressors after settlement in the camps as a result of natural disasters, wars and persecution on the basis of their race, religion, political beliefs and social identity, who cannot rely on their country of origin to protect them. Although numerous studies on deaths, illnesses and physical traumas resulting from wars and disasters have been performed, there are scanty longitudinal studies on how psychosocial issues influence refugees' mental health and the problem-specific interventions used to address mental ill health. The prevalence of mental illnesses among refugees keeps increasing in spite existing psychiatric treatment approaches used to resolve the particular concerns associated with mental health. The general objective of the study was to exploration of the psychosocial wellbeing aspect of vulnerable populations at risk in Kakuma refugee camp, Turkana County, Kenya.

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1.0 Introduction

War violence, the experience of fleeing and subsequent post-migration tribulations have been found to affect the psychological well-being of forcefully displaced populations (Thomas & Thomas, 2004). The level of mental distress among people in Kakuma is considerably high, and risk factors are abundant in the Kakuma context for developing mental health problems: loss of people, property and status, broken interpersonal relationships and social networks, serious and repeated traumatic experiences, relocation, vulnerability, potential instability, and misuse of drugs. Forcibly displaced populations typically report exposure to a high number of potentially traumatic events in their country of origin and during displacement (Farhat *et al*., 2018). Many refugees have already been traumatized in their country of origin, whether by war-related events, social violence, or abuse within their own families, and many have been further exposed to life-threatening situations during their flight, for example, surviving a perilous crossing of the Mediterranean, or encountering dangerous situations in the country of destination. In general, acts of violence such as rape, torture, and armed conflict have far more devastating effects on their victims than do natural disasters or accidents (Fegert *et al.,* 2018).

Persons with mental and psychosocial disabilities represent a significant proportion of the world's population. (WHO, 2010). Refugees are a particularly vulnerable population that is at risk for mental health problems for a variety of reasons: traumatic experiences in and escapes from their countries of origin, difficult camp or transit experiences, culture conflict and adjustment problems in the country of resettlement, and multiple losses—family members, country, and way of life. The prevalence and social distribution of mental health issues in countries with high incomes has been well established. Although the issue is increasingly being recognized in low- and middle-income countries, there is still a substantial gap in studies to quantify the problem, and in mental illness treatment measures, policies and services. The priority given to the prevention of mental illnesses and to the promotion of mental health by action on the social determinants of health needs to be increased considerably (WHO, 2014). It is understood that certain variables raise the risk of mental illnesses in refugees and migrants. Higher rates of mental disorders are associated with exposure to traumatic occurrences before departure or during flight and problems with settlement and integration in the host countries. Research in three separate countries (Germany, Italy and the United Kingdom) of long-term refugees from the former Yugoslavia found that these factors raised the risk of mental illness in refugees in all three countries (WHO, 2018). The objective of the study sought to explore the psychosocial wellbeing aspect vulnerable populations at risk in Kakuma refugee camp.

2.0 Theoretical framework

Trauma Theory

Contemporary trauma theory asserts that traumatic experience is defined as a situation that overwhelms the normal ability to cope (Ahearn e*t al,* 2017). Traumatic stressors cause neurological as well as biological reactions, causing the individual to shut down due to inability to integrate psycho-socio processes. Trauma theory focuses on self-healing through humor, spirituality and physical exercise, relaxation techniques and good nutrition, rather than depending on long term handouts (Mollica, 2006).

3.0 Designs and Methods

A research design is the 'procedures for collecting, analyzing, interpreting and reporting data in research studies' (Creswell & Creswell, 2018). A research design is a plan to answer a set of questions (McCombes, 2019). A descriptive design allows for the exploration of a wide range of variables that

affect mental health of vulnerable populations at risk. Descriptive design furnishes the researcher with an opportunity to gain insight into the problem itself and also helps the research team to see the need for the research (GradesFixer, 2019). Data instrument tools were questionnaires, interview guides and FGD guides. Data was analysed descriptively and inferential statistics. Quantitative data were coded and analyzed descriptively and inferential statistics using Chi-Square goodness of fit in order to establish the level of significance of correlation between study variables. The quantitative data were analyzed using SPSS 21 and presented in tables, pie charts and bar charts. Qualitative data were analyzed using thematic techniques analysis to support quantitative data and presented in form of verbatim reports.

4.0 Findings and Discussions

	5(SA)	4(A)	3(U)	2(D)	1(SD)	Mean	STD
I understand what the word mental health means	70(20.3%)	168(48.8%)	27(7.8%)	36(10.5%)	43(12.5%)	3.5407	1.27253
Mental health can be positive and it means psychological wellbeing	54(15.7%)	172(50.0%)	35(10.2%)	42(12.2%)	41(11.9%)	3.4535	1.23512
Mental health is negative it really only means psychological illness	35(10.2%)	65(18.9%)	32(9.3%)	73(21.2%)	139(40.4%)	3.1773	1.21960
To deal with trauma, it helps to think or talk about what happened	37(10.8%)	139(40.4%)	57(16.6%)	70(20.3%)	41(11.9%)	3.4593	1.10845
Mental health problems are shameful	28(7.9%)	87(25.3%)	37(10.8%)	81(23.5%)	111(32.3%)	2.5640	1.52586
It's good to talk to family about my mental health	56(16.3%)	204(59.3%)	31(9.0%)	32(9.3%)	21(6.1%)	3.7035	1.04387
I use healthy strategies to cope with negative thoughts	39(11.3%)	180(52.3%)	51(14.8%)	37(10.8%)	37(10.8%)	3.4273	1.15577
people with mental health problems are all crazy	29(8.4%)	66(19.2%)	44(12.8%)	86(25.0%)	119(34.6%)	2.4186	1.35281
I feel I can depend on my community to help me cope with challenges	39(11.3%)	173(50.3%)	49(14.2%)	49(14.2%)	34(9.9%)	3.3895	1.16033
A lot of people in the community are struggling with mental health issues	77(22.4%)	151(43.9%)	47(13.7%)	37(10.8%)	32(9.3%)	3.5930	1.21101

Table 1. Knowledge and attitudes about mental health
Source: Field Data (2021)

Respondents of the study were asked to state if they understood the term mental health and 48.8%agreed that they knew while 20.3% strongly agreed that they knew what mental health meant. it was also established based on the study findings that 10.5% of the respondents did not know what mental health was about. Respondents were asked if they knew that mental health can be positive and if it meant psychological wellbeing and 50.0% of the respondents agreed while 15.7% strongly

agreed. It was also notable that 11.9% of the respondents did not know that mental health meant psychological wellbeing and that it can be positive. As to whether respondents understood that mental health can be negative to imply psychological illness, 40.4% of the respondents strongly disagreed, 21.2% disagreed while 10.2% strongly agreed.

Respondents were also asked to indicate if they knew that dealing with trauma involves talking about what happened and 40.4% agreed, 10.8% strongly agreed while 20.3% disagreed. As to whether respondents were aware that mental health problems were shameful; 7.9% strongly agreed, 25.3% agreed while 32.3%strongly disagreed. As to whether respondents were aware that it was good to talk to family about my mental health; 16.3% strongly agreed, 59.3% agreed while 6.1% strongly disagreed. Respondents were asked if they use healthy strategies to cope with negative thoughts and 11.3% strongly agreed, 52.3% agreed while 10.8% strongly disagreed. Respondents were asked if in their opinion they felt that people with mental health problems were all crazy and 8.4% strongly agreed, 19.2% agreed and 34.6% strongly disagreed. As to whether respondents felt that they can depend on their community to help cope with challenges, 11.3% strongly agreed, 50.3% agreed while 9.9% strongly disagreed. Respondents were also indicate if they were aware that a lot of people in the community were struggling with mental health issues and 22.4% strongly agreed, 43.9% agreed while 9.3% strongly disagreed.

History of Torture

The researcher also sought to know whether respondents had experienced a history of torture and findings presented in.

Table 2. History of Torture

	1(NO)	2(U)	3(YES)
Sexual and Gender based Violence	155(45.1%)	20(5.8%)	169(49.1%)
Serious physical injury from combat situation	158(45.9%)	26(7.6%)	160(46.5%)
Imprisonment	100(29.1%)	28(8.1%)	216(62.8%)
Destruction of personal property	164(47.7%)	39(11.3%)	141(41.0%)
Forced evacuation under dangerous conditions	147(42.7%)	35(10.2%)	162(47.1%)
Murder, or death due to violence of spouse, child, family member or friend	148(43.0%)	29(8.4%)	167(48.6%)
forced to physically harm family member or friend	102(29.7%)	36(10.5%)	206(59.9%)
Forced labour	80(23.3%)	38(11.1%)	226(65.7%)
Extortion or robbery	150(43.6%)	42(12.2%)	152(44.2%)
Brainwashing	104(30.2%)	44(12.8%)	196(57.0%)

Source: Field Data (2021)

In a Focus group discussion with women and young girls, there were concerns about rape and sexual violence in the refugee camp. One respondent describe the situation as follows:

When we go to school very early in the morning sometimes when it's still dark, some men

hide in the bushes and wait for us…then they rape us. Some of these men are our family members so we can't report them.

Another respondent described his experience as follows:

Mimi kama mimi walibaka mke wangu huku naona… (For my case, my wife was raped as I watched).

Serious Physical injury from combat situation

As to whether respondents had experienced serious physical injury from combat situation, 46.5% agreed, 45.9% disagreed while 7.6% were undecided. The study findings agree with a study by (Shook et al., 2018) that the most frequently reported potentially traumatic events (PTEs) for both men and women included being in a combat situation. According to a Focus group discussion held, a participant who had experienced injuries from combat as was evidently seen from the healed scars on his face, hands and legs, described how he sustained serious injuries from an attack by his rivals who used weapons such as machetes to attack him.

Among others, armed conflicts cause psychological distress, behavioral disorders, and increased prevalence of mental illnesses and disabilities such as post-traumatic stress disorder, depression, and anxiety. The mental disorders in refuges can be classified according to their occurrence before the flight, during the flight, and after their resettlement (Fazel et al. 2012; Buchmüller et al. 2020).

Imprisonment

Regarding imprisonment 62.8% agreed that they had been imprisoned, 29.1% disagreed while 8.1% were undecided. According to a study by Steel *et al*., (2018), prolonged detention exerts a long-term impact on the psychological well-being of refugees. Previous studies examining the effects of detention concur with these findings (Reference Steel and SiloveSteel & Silove, 2001; Reference Sultan and O'SullivanSultan & O'Sullivan, 2001; Reference Keller, Rosenfeld and Trinh-ShevrinKeller *et al*, 2003).

Destruction of personal property

Pertaining to destruction of personal property 41% of the respondents agreed, 47.7% disagreed while 11.3% were undecided. The study findings indicate that a considerable number of the refugees have had their property destroyed and a study by Walter Kaelin (2006) concurs with this study's findings that one particular risk internally displaced persons and refugees face is the loss of property left behind and the inability to recover it. In fact, destruction of property has become an instrument of warfare or even ethnic cleansing in many civil wars, and resistance to return often takes the form of refusal to evict persons who have taken over their houses or apartments, or to refuse compensation for destroyed property. This correlates with interview respondent, who opined;

"They broke our houses during the war. We had nowhere to go".

Forced evacuation under dangerous conditions

Respondents were asked if they had experienced forced evacuation under dangerous conditions and 47.1% agreed, 42.7% disagreed while 10.2% were undecided. Based on these findings, it is evident that most of the respondents had experienced being evicted from their homes under dangerous conditions. As one participant put it during a focused group discussion;

"We were forced out of our home and they killed my wife. We had nowhere to go and it wasn't safe to go outside".

Roberts & Browne's (2011) literature review showed a strong negative influence of forced migration on mental health, and found that mental health risk factors for populations affected by war in low/ middle income countries are different from those who are in high-income countries. A meta-analysis of 56 reports on mental health among forced displaced people showed that socio-political conditions affect the mental health of refugees, and humanitarian intervention to address these effects does have a positive outcome (Porter & Haslam, 2005). These effects could also explain why substance abuse was found to be common in some communities of refugees of conflict (Ezard, 2012)

Witnessed murder or death

As to whether respondents had witnessed murder, or death due to violence of spouse, child, family member or friend, 48.6% agreed, 43% disagreed and 8.4% were undecided. The researcher also asked to know from respondents whether they had experienced situations where they were forced to physically harm family member or friend and 59.9% agreed, 29.7% disagreed while 10.5% were undecided. The study also inquired into aspects of forced labour and if respondents had witnessed the same and 65.7% agreed, 23.3% disagreed while 11.1% were undecided. They make us work here for long durations even up to six months without pay. They tell us we're volunteering. Respondents were also asked to indicate whether they had experienced extortion or robbery. Based on the study findings, 44.2% agreed, 43.6% disagreed while 12.2% were undecided. Respondents were asked if they had witnessed brainwashing and 57% agreed, 30.2% disagreed, and 12.8% were undecided.

Table 3. Emotional and psychological trauma

	1(SD)	2(D)	3(U)	4(A)	5(SA)	Mean	STD
Sadness	22(6.4%)	42(12.2%)	67(19.5%)	147(42.7%)	66(19.2%)	2.9971	1.45185
Irritable	15(4.4%)	40(11.6%)	83(24.1%)	153(44.5%)	53(15.4%)	2.8430	1.26805
Feelings of numbness or emotional emptiness	22(6.4%)	37(10.8%)	60(17.4%)	111(32.3%)	114(33.1%)	2.3721	1.42691
self-harming thoughts	23(6.7%)	49(14.2%)	38(11.0%)	97(28.2%)	137(39.8%)	3.1047	1.33601
Trouble sleeping	23(6.7%)	72(20.9%)	60(17.4%)	117(34.0%)	72(20.9%)	3.1337	1.26612
Feeling exhausted most of the time	27(7.8%)	41(11.9%)	89(25.9%)	116(33.7%)	71(20.6%)	2.5262	1.17278
Feeling a need for revenge	23(6.7%)	32(9.3%)	62(18.0%)	107(31.1%)	120(34.9%)	2.2180	1.28015
Sudden emotional or physical reactions	82(23.8%)	102(29.7%)	29(8.4%)	69(20.1%)	62(18.0%)	3.2122	1.46037
Feeling detached or withdrawn from people	82(23.8%)	102(29.7%)	29(8.4%)	69(20.1%)	62(18.0%)	3.2122	1.46037

Source: Field Data (2021)

Table 4. Anxiety symptoms

	1(SD)	2(D)	3(U)	4(A)	5(SA)	Mean	STD
Feeling tense	20(5.8%)	19(5.5%)	37(10.8%)	123(35.8%)	145(42.2%)	1.9709	1.12965
Heart pounding or racing	18(5.2%)	34(9.9%)	55(16.0%)	153(44.5%)	84(24.4%)	2.2703	1.09579
Suddenly scared for no reason	24(7.0%)	38(11.0%)	57(16.6%)	102(29.7%)	123(35.8%)	2.2384	1.24124
Spell of terror or panic	14(4.1%)	38(11.0%)	59(17.2%)	129(37.5%)	104(30.2%)	2.2122	1.11380
Nervousness or shakiness inside	12(3.5%)	43(12.5%)	69(20.1%)	131(38.1%)	89(25.9%)	2.2965	1.09032
Feeling fearful	26(7.6%)	45(13.1%)	70(20.3%)	123(35.8%)	80(23.3%)	2.4593	1.19697
Headaches	28(8.1%)	73(21.2%)	56(16.3%)	142(41.3%)	45(13.1%)	2.7006	1.17823
Feeling restless or can't sit still	31(9.0%)	47(13.7%)	61(17.7%)	125(36.3%)	80(23.3%)	2.4884	1.23830
Faintness, dizziness or weakness	31(9.0%)	44(12.8%)	42(12.2%)	94(27.3%)	133(38.7%)	2.2616	1.32969
Trembling	28(8.1%)	49(14.2%)	38(11.0%)	84(24.4%)	145(42.2%)	2.2180	1.33865

Source: Field Data (2021)

The findings in shows that majority of the respondents have had anxiety symptoms emanating from the impacts of the wars/conflicts. A whole range of psychological symptoms have been observed, such as posttraumatic stress disorder (PTSD), depression, anxiety disorders and behaviour problems (e.g., Derluyn, Broekaert, & Schuyten, 2008; Paardekooper, de Jong, & Hermanns, 1999).

Also, additional 'daily stressors' (e.g. Miller, Omidian, Rasmussen, Yaqubi, & Daudzai, 2008) following displacement – e.g., discrimination, dependency, socio-economic hardship – have been associated with depression in refugee children (Ellis, MacDonald, Lincoln, & Cabral, 2008; Heptinstall, Sethna, & Taylor, 2004). Furthermore, the loss of parental support also appears to be an important predictor of mental distress in displaced youths (Derluyn, Mels, & Broekaert, 2009). Among the individual child characteristics studied, female gender is generally an important factor negatively influencing psychological well-being, while findings on age remain inconclusive (Barenbaum et al., 2004).

Depression Symptoms

Table 5. How best do you describe your low moments? (Depression symptoms)

	4(Extremely)	3(Quite a bit)	2(A little)	1(Not at all)	Mean	STD
Thought of ending your life	189(55.0%)	65(18.9%)	43(12.5%)	47(13.7%)	1.8721	1.12015
Feeling of worthlessness	80(23.3%)	114(33.1%)	103(29.9%)	47(13.7%)	2.3488	1.00166
Worry too much about things	60(17.4%)	101(29.4%)	84(24.4%)	99(28.8%)	2.6512	1.08547

Feeling everything is an effort	44(12.8%)	113(32.8%)	71(20.6%)	116(33.7%)	2.7587	1.06764
Blaming yourself for things	87(25.3%)	124(36.0%)	61(17.7%)	72(21.0%)	2.3547	1.09695
Difficulty falling asleep	75(21.8%)	129(37.8%)	87(25.3%)	52(15.1%)	2.3663	1.00993
Feeling lonely	88(25.9%)	126(36.6%)	75(21.8%)	54(15.7%)	2.3808	1.99935
Feeling low in energy	75(21.8%)	146(42.4%)	65(18.9%)	58(16.9%)	2.3227	1.02047
Crying easily	149(43.3%)	99(28.8%)	58(16.9%)	38(11.0%)	1.9680	1.04512
Loss of sexual interest or pleasure	140(40.7%)	93(27.1%)	47(13.7%)	64(18.6%)	2.1192	1.15316

Source: Field Data (2021)

Relationship between Psychosocial wellbeing and mental health

Regression analysis was used to tell the amount of variance accounted for by one variable in predicting another variable. Regression analysis was conducted to find the proportion in the dependent variable (Mental health) which can be predicted by the independent variable (Psychosocial Factors).

Table 6. Model Summary for Psychosocial wellbeing and mental health

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	**.575[a]**	**.330**	**.328**	**.65249**	**.330**	**168.616**	**1**	**342**	**.000**	**1.395**

a. Predictors: (Constant), Psychosocial

b. Dependent Variable: Mental Health

Study findings in Table 5.6 reveal an R square value of 0.330 signifying that 33.0% of the changes witnessed in mental health status of refugees in Kakuma refugee camp was a function of psychosocial wellbeing. This implies that the remaining 67% unexplained variance in mental health status of refugees was a function of other factors that affect mental health but were not part of the study. Such factors are explained by the error term.

Table 7. Model coefficients for Psychosocial wellbeing and mental health

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
B		Std. Error	Beta			
1	(Constant)	**-.311**	**.205**		**-1.516**	**.130**
	Psychosocial	**.920**	**.071**	**.575**	**12.985**	**.000**

a. Dependent Variable: Mental Health

The results revealed a beta coefficient of 0.575 with a P value of 0.000 which was significant at 99% confidence interval. This implies that psychosocial wellbeing was a useful predictor of mental health among refugees in Kakuma Refugee camp. The regression equation to estimate the mental health as a result of changes in the psychosocial wellbeing was stated as: Y= -0.311+ 0.920 PSW +Ɛ where Y = Mental Health, PSW = Psychosocial Wellbeing and Ɛ = error term.

5. Conclusion

Study findings also revealed an R square value of 0.330 signifying that 33.0% of the changes witnessed in mental health status of refugees in Kakuma refugee camp was a function of psychosocial wellbeing. This implies that the remaining 67% unexplained variance in mental health status of refugees was a function of other factors that affect mental health but were not part of the study. Such factors are explained by the error term. The study concludes that, majority of the respondents have experienced emotional and psychological trauma thus influencing their mental well-being. Also, majority have experienced anxiety and depression as some have witnessed murder, forced eviction and disparity.

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