Article

Integrating mental health into primary health care in Rohingya refugee settings in Bangladesh: experiences of UNHCR

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Abstract

Hundreds of thousands of Rohingya refugees fled from Myanmar to Bangladesh. The greatly increased mental health needs are paired with limited resources for mental health care, particularly human resources. Therefore, UNHCR, the refugee agency of the United Nations, designed a programme to integrate mental health within refugee primary health care, using the Mental Health Gap Action Programme Humanitarian Intervention Guide (mhGAP-HIG) as the central tool. The aim was to scale up mental health services through capacity building of medical staff in refugee health facilities to enable them to identify and manage people with mental, neurological and substance use conditions. This paper is a process description of the programme, using direct experience of the authors, analysis of training evaluations and data from the refugee health information system and clinical supervision reports. Sixty-two primary health care workers were trained. Participants of the mhGAP training showed clear improvements in the post-training knowledge test. These trained staff started providing mental health and psychosocial services after the training in primary health care centres in the refugee camps. Fifteen of them participated in a bi-weekly supervision/on-the-job training visit. Within this period of time, almost 1,200 mental health consultations were realised in the primary health care facilities. Supervision reports of mhGAP-trained participants showed that in order to become effective mental health providers, the participants need to strengthen various skills including performing mental state examinations, providing psychoeducation and using psychosocial support techniques. In conclusion, the integration of mental health within the Rohingya refugee settings faced many challenges but proved to be feasible.

Key implications for practice

- Health system preparation and readiness is an important pre-requirement for integration of mental health into primary health care services. This is particularly significant in humanitarian settings in which the health system is fragile and struggling to keep services at a minimally acceptable level.
- Capacity-building efforts alone cannot guarantee the success of the integration process, that is, adequate attention should be paid to communication with health policy and decision makers especially on facility and local level to foster the process of integration and support scaling up.
- On-the-job supervision is a critical factor in mental health capacity building of non-specialist health providers. Without supportive clinical supervision, any plan for integration of mental health into primary care should be considered deficient and ineffective.

Keywords: Bangladesh, clinical supervision, integration, mental health gap action programme, mental, neurological and substance use conditions, Rohingya

Introduction

Rohingya in Bangladesh

Due to discrimination, exclusion and armed conflict, more than 910,000 Rohingya, an ethno-religious minority from Myanmar, fled in various waves to Bangladesh where most of them live in refugee camps in Cox's Bazar District in the

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Southwest of the country, close to the border with Myanmar (UNHCR, 2019). While significant improvements have been realised, the camps are still congested and living conditions for Rohingya refugees remain dire with overcrowded shelters, suboptimal hygiene conditions, significant food insecurity and high levels of interpersonal violence (Strategic Executive Group, 2019). Limited data exist about the prevalence of mental health conditions among Rohingya in Bangladesh (Tay et al., 2019) but the available assessments and reports indicate high mental health needs (International Organization for Migration, 2018; Riley, Varner, Ventevogel, Taimur Hasan, & Welton-Mitchell, 2017). The World Health Organization (WHO) estimates that populations affected by conflict and forced displacement, around one in five persons suffer from mental health conditions, a marked increase from non-emergency settings (Charlson, van Ommeren, Flaxman, Cornett, Whiteford, & Saxena, 2019).

Mental health conditions are common in refugee settings due to (1) the widespread exposure violence and atrocities, (2) the stress associated with forced migration leaving behind the ancestral lands and possession and (3) stressors in the refugee settings such as insolvency, differences in language and culture, disruption of social networks, harsh living conditions and insecurity about the future (Kirmayer, Narasiah, Ryder, & Guzder, 2011 Morina, Akhtar, Barth, & Schnyder, 2018; Silove, Ventevogel, & Rees, 2017; Steel, Chey, Silove, Marnane, Bryant, & van Ommeren, 2009).

While the mental needs of refugees are increased in comparison to non-refugee populations, the available resources are usually grossly insufficient, particularly in acute humanitarian settings in which local health systems are overwhelmed and not able to respond adequately to the influx of newly arrived populations (van Ommeren, Hanna, Weissbecker, & Ventevogel, 2015; Weissbecker, Hanna, El Shazly, Gao, & Ventevogel, 2019). This was certainly the case in Cox's Bazar district in Bangladesh. The health status of the people who arrived in the last four months of 2017 was appalling with high levels of malnutrition, infectious diseases and generally bad physical condition due to exhaustion (Action contre la Faim, 2017; MSF, 2017). A hospital assessment outside the camps in December 2017, just after the massive arrival of hundreds of thousands Rohingya, showed that the facilities were severely under-resourced and struggled to cope with the increased demands (Health Sector – Inter Sector Coordination Group, 2017). The report notices that '*since the new wave of people arriving from Myanmar, counselling, identification and management for mental health and psychosocial conditions and referral have been established in the hospital. However, there is no inpatient capacity in the hospital for acute and severe mental health case management. The center was closed at the time of visit*' (page 7). Similarly, an assessment by the WHO on mental health and noncommunicable disorders in the Rohingya situation in 2017 concluded that the '*capacity of the health system, particularly trained human resources, to detect, prevent and manage mental disorders and noncommunicable diseases is low and presents a fundamental challenge to providing such care during this emergency*' (Anwar, Huq, & Kessaram, 2017, p. 3).

In response to this grim reality, the United Nations Refugee Agency (UNHCR) scaled up its efforts to integrate mental health and psychosocial support (MHPSS) for Rohingya refugees. UNHCR's 2018 MHPSS strategy (UNHCR Cox's Bazar, 2018) has three components: (1) strengthening community-based psychosocial support (Sewe Uddin & Sumi, 2019), (2) introducing scalable psychological interventions (see Mahmuda, Awal Miah, Elshazly, Khan, Tay, & Ventevogel, 2019) and (3) making mental health services available in the refugee primary health care facilities that were under the responsibility of UNHCR and its health partners.

This article will focus on the third component and describe how UNHCR and health partners worked towards the integration of mental health into primary care. The first author (ST), a psychiatrist from Bangladesh, was involved in the programme as trainer and clinical supervisor. The second author (ME) is an expatriate psychiatrist who heads the MHPSS team of UNHCR in Bangladesh. He was directly involved in the mental health trainings for health staff. The third author (SH) oversees the refugee health programmes of UNHCR in Bangladesh, including the mental health components. The last author (PV) provided mental health trainings with the mhGAP Humanitarian Intervention Guide (World Health Organization & United Nations High Commissioner for Refugees, 2015) to medical staff in the refugee health centres in Bangladesh in 2014 and 2015, prior to the current crisis and was deployed to Cox's Bazar in November and December 2017.

Before describing the activities and results of the training programme, this article will provide a brief overview of mental health competency of general health staff in Bangladesh, describe the *mental health Gap Action Programme (mhGAP)*, particularly the humanitarian intervention guide, and will describe how this tool has been used in the Rohingya refugee camps since 2014. The discussion and conclusion will critically reflect on the achievements and challenges and formulate the lessons the authors have learned during the process.

Mental health services in Bangladesh

In the last decade, mental health received more attention from researchers and policy makers in Bangladesh (Hossain, Hasan, Sultana, & Faizah, 2019). However, the budget spent on mental health services was only 0.44% of the total national health expenditures. There are two mental hospitals and 56 psychiatric units in general hospitals. It takes four to five years to complete a full training to become a psychiatrist (Doctor of Medicine and Fellow of the College of Physicians and Surgeons (FCPS)) and only few doctors show interest in psychiatry as a specialisation. The country has one psychiatrist per 796,000 inhabitants and an equally low number of psychologists working in mental health care (World Health Organization, 2017a). There is no dedicated training for mental health nurses or psychiatric social workers. This number of mental health professionals is far too low to cover the full population in

need. Many psychiatric patients should therefore be taken care of by doctors who are not psychiatrists but have been trained in psychiatry (Karim, Shaheed, & Paul, 2005). However, in practice, many health workers have a very limited experience with mental health: During their general training, medical doctors do only a very short internship (seven to ten days) in the psychiatry department which is too short to gather enough knowledge about psychiatry. Pre-service medical training in mental health is strongly focussed on secondary care service rather than mental health service delivery in primary care. Consequently, the competency of general medical staff in Bangladesh is low and treatment of mental disorders in general health care rarely happens, while the referral pathways from general care to mental health care are grossly deficient (Giasuddin, Chowdhury, Hashimoto, Fujisawa, & Waheed, 2012; Hossain, Ahmed, Chowdhury, Niessen, & Alam, 2014). As a result, access to adequate mental health services is problematic in most parts of the country and especially at district level (World Health Organization and Ministry of Health & Family Welfare Bangladesh, 2007). There is an obvious need to strengthen the capacity of non-specialist doctors to identify and manage mental disorders.

The Mental Health Global Action Programme

In most countries, especially in low- and middle-income countries, the vast majority of people with mental health needs do not receive services (Demyttenaere et al., 2004). The World Mental Health Surveys suggest that for severe forms of mental disorders, the treatment gap in low- and middle-income countries can be as large as 75% (Wang et al., 2007). This enormous treatment gap is unlikely to be bridged by training more mental health specialist as this would require massive financial investments, and moreover, it will not bridge the 'credibility gap' (Patel, 2014) that is caused by stigma around mental health care and by the widespread use of alternative explanatory models around mental health conditions, such as beliefs around spiritual causation of severe mental disorders or views (Faregh, Lencucha, Ventevogel, Worku, & Kirmayer, 2019).

An alternative for specialist mental health care is its integration into general health services and to utilise specialist mental health staff in training and supervising roles. This idea is the backbone of the *Mental Health Global Action Programme (mhGAP)* by the WHO that seeks to address the lack of care for people suffering from mental, neurological and substance use conditions by enabling general health care settings particularly in low and middle income countries to become more responsive to the needs of this group (World Health Organization, 2008). Many primary health care systems in countries around the world focus on physical care, failing to provide mental healthcare to their population. Integration of mental health into the package will increase access to mental health care to their population because it is less stigmatising than visiting dedicated mental health facilities and will enable health workers to identify people with undetected mental health issues who visit the health facility for other reasons. While the integration of mental health into primary care is not without challenges, there are now many examples that show that it is possible to deliver primary mental health programmes in resource-poor and conflict-affected populations (Budosan, 2011; Budosan & Jones, 2009; Gureje, Abdulmalik, Kola, Musa, Yasamy, & Adebayo, 2015; Humayun, Haq, Khan, Azad, Khan, & Weissbecker, 2017; Rose, Hughes, Ali, & Jones, 2011; Ventevogel, van de Put, Faiz, van Mierlo, Siddiqi, & Komproe, 2012). The WHO has developed a range of tools to support mhGAP programming (World Health Organization, 2016, 2017b, 2018a). An adaptation for humanitarian settings (mhGAP-HIG) that is generally more concise but contains additional modules on acute stress, grief and post-traumatic stress disorder has been developed by WHO in cooperation with UNHCR (World Health Organization & United Nations High Commissioner for Refugees, 2015) which is widely used in refugee settings (Echeverri, Le Roy, Worku, & Ventevogel, 2018).

Mental health integration in the UNHCR supported health facilities for Rohingya in Bangladesh

Previous experiences

UNHCR has had an MHPSS programme for Rohingya refugees since 2014, which focused on around 30,000 officially recognised refugees who stayed for many years in '*registered camps*'. Before that time, doctors, nurses and health counsellors working in the Refugee Health Units had not received any specialised mental health training and lacked confidence and knowledge. In 2014 and 2015, UNHCR organised two three-day trainings with the mhGAP Humanitarian Intervention Guide for health staff (medical team leaders, physicians, senior staff nurses, medical officers, medical assistants, health educators) in the camps. The results of pre-and post-tests showed significant increases in knowledge and self-perceived competency to identify and manage people with mental disorders. However, due to issues with high staff turnover, major challenges with clinical supervision and shortages of medication, the effects of these trainings were not sustained.

Programme design and planning

UNHCR is responsible for health care provision in 24 health facilities. UNHCR provides health care through their partner organisations including the refugee health unit of the Refugee Relief and Repatriation Commissioner's Office and various non-governmental organisations such as Food for the Hungry/Medical Teams International (FH/MTI), Research, Training and Management International (RTMI), Relief International (RI) and Gonoshasthaya Kendra (GK). At the end of 2017, the newly expanded MHPSS team of UNHCR made the integration of mental health into primary care major objective. The programme was designed for health facilities covering the Rohingya population living in Kutupalong and Nayapara camps. The process started with assessment of primary health care centres using the 'Checklist for integrating mental health in primary health care (PHC) in humanitarian settings' (World Health Organization & United Nations High Commissioner for Refugees, 2012).

The MHPSS team visited the health facilities to assess the current capacity to deal with mental health problems. Essential psychotropic medicines were hardly available in the facilities, primary health care workers were not trained in mental health and the referral system was unclear. Particularly worrying was the absence of capacity for emergency response management to acute mental health issues.

Mental health services outside the camp are limited. There is only one public hospital in the district (the 250 beds Sadar Hospital) that has a psychiatric outpatient run by one psychiatrist with no inpatient ward. Some cases can be admitted to the general medicine ward when possible. A local organisation, NONGOR, operates a centre for substance abuse rehabilitation for adult men in the district capital, Cox's Bazar. In the humanitarian setting, one field hospital by the NGO Médecins sans Frontières has some beds dedicated for patients with mental health disorders and is described elsewhere (Dyer & Biswas, 2019).

As part of the wider public health response strategy, a programme was designed to build the capacity of non-specialist health care workers to identify and offer evidence-based treatment to persons with mental, neurological and substance use disorders. This was linked to the establishment of an effective referral system and advocacy for the overall wellbeing and inclusion of people with MNS conditions across multiple sectors and to training of health staff in protection principles.

Prior to the start of the integration programme, a series of meetings and consultations took place with key stakeholders in the healthcare system at different levels from primary health care facilities (unit managers and medical staff) and programme managers from the Refugee Health Unit of the Refugee Relief and Repatriation Commissioner (RRRC), UNHCR and health sector coordinators. These consultations were instrumental in (1) introducing the programme and explain the process and the outcome, (2) managing the expectations from the health actors and (3) mobilising more support and engagement.

UNHCR's activities complement those of many other actors, including those from the WHO who also organised capacity building activities with the mhGAP (Momotaz et al., 2019). An MHPSS technical working group (TWG) was established early after the influx in 2017 as a subgroup. Within the TWG, a taskforce for integration of mental health into primary health care is responsible for coordination of capacity-building activities and promotion of integrated services delivery.

Training

Two to three primary health care workers from each UNHCR supported health facility were selected for mhGAP training: a total of 62 primary health care workers. The selection of trainees was done in close consultation with the health management of the facility, prioritising those staff who: (1) indicated they were interested in mental health and motivated use the skills in their daily work, (2) had work schedules that would allow participation in supervision sessions and (3) were likely to stay long term in their duty station. The majority ($n = 36$) were doctors. Others were medical assistants ($n = 10$), psychologists ($n = 6$), health educators ($n = 7$), medical coordinators ($n = 2$) or nurses ($n = 1$).

Two three-day training workshops were facilitated by the expatriate psychiatrists (MES), a psychiatrist from Bangladesh (ST), a Bangladeshi psychologist who had been involved in mhGAP trainings of 2014 and 2015. Hard copies of the mhGAP manual were provided to the participants. The trainings followed the methodology as described in the mhGAP-HIG facilitator manual, with one day dedicated to introduction to mental health conditions and core communication skills, and to protection and human rights of people with mental health conditions, the second day to specific assessment of priority conditions and the third day to management of specific priority conditions (World Health Organization, 2018b). Each day included a range of discussions, role plays, case studies and video presentation. At the beginning of the three-day training, a pre-training test was conducted using a modified standardised assessment designed by the WHO for training on the mhGAP. Post-training tests were taken just after the training. In the pre-test, the average score was 55%, and in the post-test it went up to 75% [Figure 1].

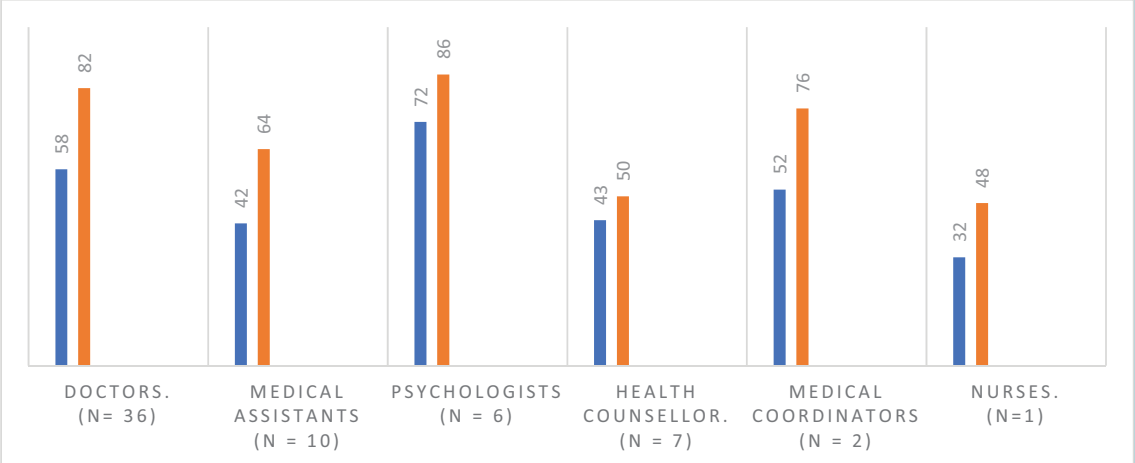

Figure 1: Comparison between pre-test and post-test mhGAP training (percentages of correct answers)

Supervision and monitoring

When a national psychiatrist (ST) joined the MHPSS team of UNHCR, she started to visit each facility once every two weeks just after the training. She observed clinical sessions of the health care providers who had received mhGAP training and reviewed facility supports such as medicines and other resources. Only 15 primary health care workers out of 62 regularly attended supervision. Some of the original participants of the mhGAP training had left their job, others were from organisations outside the UNHCR coverage area, and others did not attend supervision due to their heavy workload.

The supervision system used a graduation model based on individual progress. In those assessed as confident in applying the knowledge and skills, visits were reduced to once a month with emphasis on supporting staff in decision-making on diagnosis and treatment for complicated cases. The national psychiatrist was supervised and supported by the team leader (MAE), an experienced humanitarian psychiatrist, and was involved in informal peer supervision with other psychiatrists working on similar programmes (e.g. from the World Health Organization and the national NGO BRAC) through regular communication and consultation in the taskforce for mental health integration in primary health care.

The mhGAP trainees were assessed in various domains including: (1) adequate completion of mental health intake forms, (2) skills in history taking, (3) assessment of a person with a mental disorder, (4) performance of a mental state examination, (5) monitoring psychotropic medication, (6) regular follow up of patients, (7) provision of psychoeducation and (8) provision of psychosocial support. Figure 2 presents the mean supervision scores of mhGAP participants after seven months of training. The supervisor observed their practical skills and marked them, using a Likert scale from 0 to 5 points per item.

Most participants still had limited knowledge about psychiatry except those who were psychologists. We did not systematically assess patient impact, but the anecdotal evidence from the supervising psychiatrist is that many people with epilepsy and psychotic disorders significantly improved and that people with common mental disorders were successfully referred to psychologists in the health centres.

Three issues were most problematic: doing a mental state examination, providing psychoeducation and strengthening

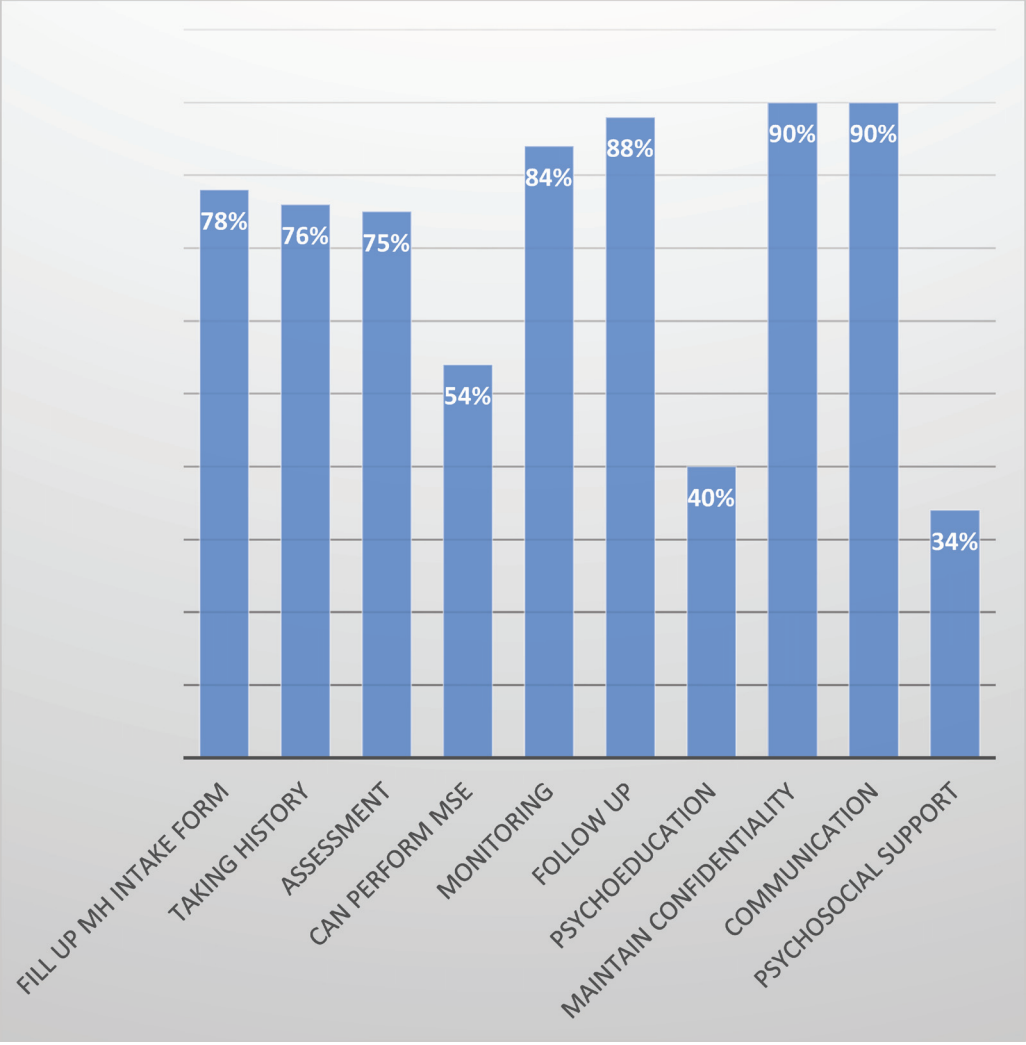

Figure 2: Percentages of participants who demonstrated certain skills during mhGAP supervision sessions ($n = 15$)

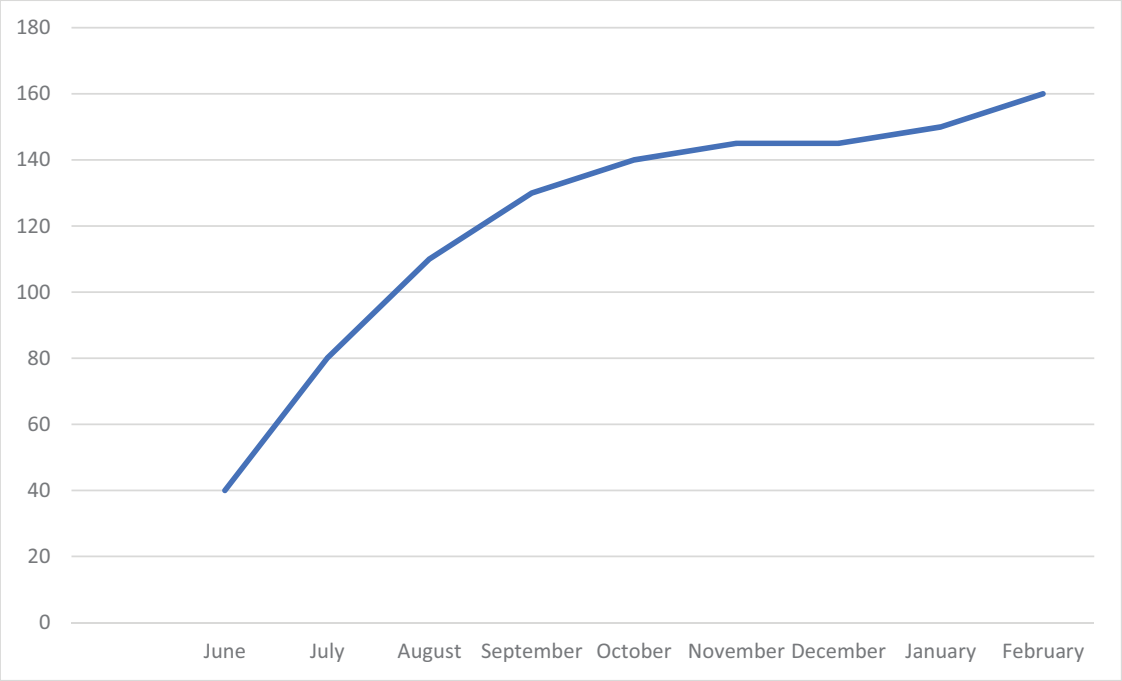

Figure 3: Monthly consultations of patients with mental disorders treated in UNHCR supported health services between July 2018 andto February 2019

psychosocial support. Participants found it hard to do a mental state examination, which is a structured assessment of a patient's psychological functioning. It proved difficult for participants to do this with the three days of training and some participants could not remember the terms in the mental state examination. A second issue is that participants struggled to give psychoeducation to people with mental health conditions and their caregivers. Such skills are essential because people with mental disorders and their caregivers are often stigmatised in their social networks. Participants also found it difficult to provide advice on how to improve psychosocial support. This is extremely important because the condition of people suffering from mental disorders can be influenced through support by family members and others in their communities. Throughout the supervision period, the psychiatrist noticed that participants were improving, but also felt the need for more formal training to the participants.

Programme outcomes

The number of consultations for MNS conditions in the health centres of the sites where trainings and supervisions happened increased in seven months from less than 40 consultations per month to around 160 per month [see Figure 3]. More patients, such as those presenting with psychosomatic symptoms and depression, were identified by the trained clinicians and provided with MHPSS support. Other patients were referred from the community to UNHCR supported clinics by community health workers and community psychosocial volunteers. Community health workers (CHWs) do outreach health visits and health counselling, and were trained in identification and referral of persons with mental health concerns to psychologists and counsellors located in primary health centres. Community psychosocial volunteers (CPVs) are responsible for group psychosocial activities such as peer support groups and community psychoeducational workshops and accompany patients when they visit secondary mental health services (see Uddin & Sumi, 2019). In the course of the project, community referrals increased significantly.

Primary health care physicians usually report their cases in UNHCR's Health Information System which in the project period had seven broad categories for mental health and related conditions (Ventevogel, Ryan, Kahi, & Kane, 2019). Figures 4 and 5 show the pattern of mental health conditions treated in primary care centres in Kutupalong and Nayapara camps. In both camps, the number of diagnosed female patients is higher than male patients. Medically unexplained somatic complaints and severe emotional disorder/depression are the most commonly diagnosed mental health conditions, particularly in women between eighteen and fifty-nine years. Epilepsy and intellectual disability are almost exclusively diagnosed in the age group of 5–17 years. Patients with substance abuse disorders are hardly diagnosed, probably because they tend to avoid health facilities and do not disclose their substance use problems due to shame and stigma. The pattern of diagnostic categories is broadly comparable with what is generally seen in the refugee health information system (Kane, Ventevogel, Spiegel, Bass, van Ommeren, & Tol, 2014).

Discussion

In a one-year period, significant improvements in mental health integration have been made in the Rohingya refugee camps. Within the first nine months of the mhGAP programme, health staff were trained who are now providing mental health support under supervision of a national psychiatrist of UNHCR. Within this limited period of time, nearly 1,200 clinical mental health consultations were

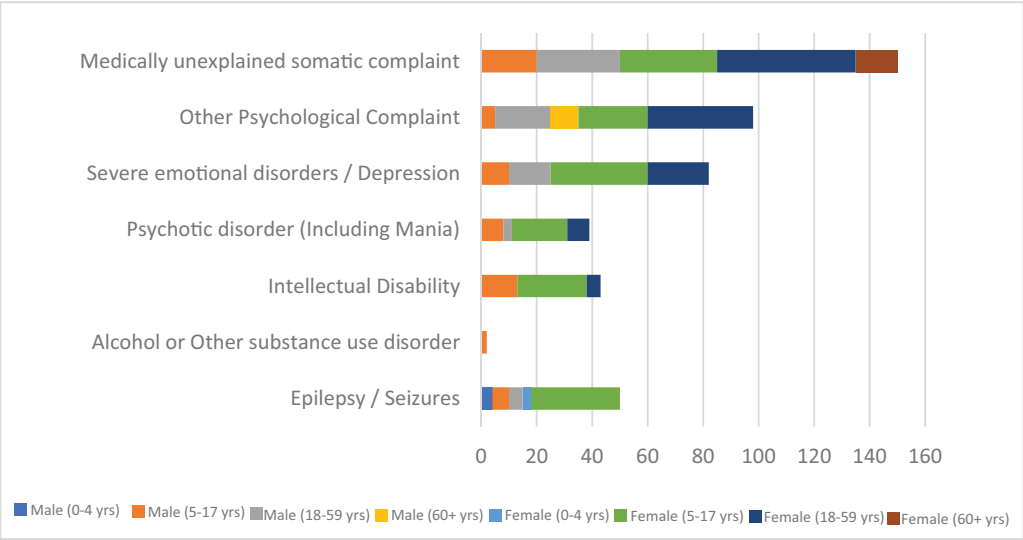

Figure 4: Consultations for mental, neurological and substance use conditions as registered in the health information system of Nayapara registered refugee camp (June 2018–Feb 2019)

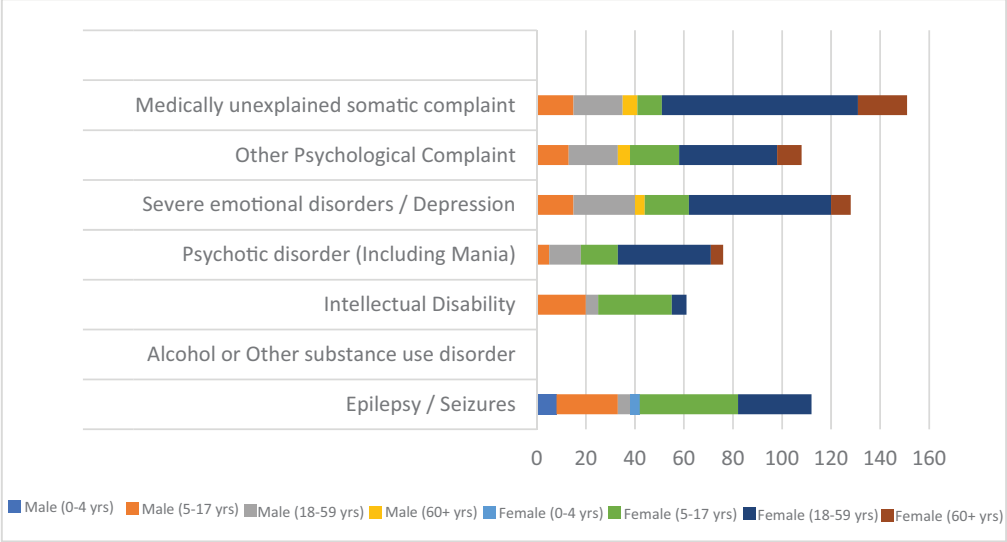

Figure 5: Consultations for mental, neurological and substance use conditions as registered in the health information system of Kutupalong registered and non-registered camps (June 2018 to Feb 2019)

delivered in UNHCR-supported health facilities. Essential psychotropic drugs are now available in most of the health facilities. Moreover, a referral system has now started to become functional: Patients are referred directly from the community to health centres and, where needed, from health centres to district-level hospitals. In collaboration with partners such as the WHO, mhGAP refresher sessions are being organised in Cox's Bazar District.

From a system perspective, the integration of mental health into primary health care relies to a great extent on utilising the resources (human, financial, physical space, medications) in provision of mental health services. This cannot be a 'one size fits all' approach. Careful assessment of the health system strengths and threats and the readiness of health care system is crucial for successful planning and implementation of integration efforts. Examples of readiness issues include: the capacity of the staff, the turnover rate, the availability of supervision system in place, the accessibility of drugs, etc. (International Medical Corps, 2017; World Health Organization, 2018a).

An important value of this paper is that we were able to follow the trainees over a period of time. It re-emphasises the importance of on-the-job supervision as a critical factor in building mental health capacity of non-specialised healthcare providers. Initial training must be followed by on-the-job supervision which is resource intensive but essential. Classroom trainings are not sufficient, as has been argued elsewhere (Budosan, O'Hanlon, Mahoney, Aziz, Kesavan, & Beluso, 2016; Echeverri, Le Roy, Worku, & Ventevogel, 2018).

While these are major achievements, the programme is also facing significant challenges that hamper its effectivity. First of all, human resources remain limited with only one psychiatrist to support many health facilities with a coverage area of hundreds of thousands of refugees. The physicians and other health workers in the facilities have shifting

duties and often there is only one doctor or medical assistant present in the health centre which made it sometimes difficult for them to make time for mental health supervision.

A second and related challenge is that it takes considerable time and effort to build effective working relations with the primary care physicians in the health centres. As in most humanitarian settings, the staff of health centres workers have temporary contracts. Limited job security compounded with the harsh working circumstances cause high attrition levels among the staff. This makes it difficult to build long-term relations with trained health workers.

Thirdly, doctors in primary care are used to doing their work independently and may perceive clinical supervision by a mental health specialist as interfering with their professional autonomy. In our case, this was complicated by the fact that the supervisor was a young female psychiatrist while many of the supervisees were male and older than the supervisor. What was also challenging was that the clinical supervisor was employed by UNHCR and worked with health care staff who were employed by different non-governmental organisations and consequently, there was no line supervision by the supervisor and the supervisees. The advantage of the absence of a formal power relation between the supervisor and supervisee is that all issues could be discussed by the supervisee without fear for reprisals. But it also led to some supervisees not following up on clinical advice. A complicating factor in our case was that the supervising psychiatrist was not from the same organisation as the clinic managers and programme leads.

A fourth challenge is that humanitarian emergencies, including the Rohingya emergency in Bangladesh, have huge logistical issues. For example, at times there are issues with supply of medication and not all health centres have the full range of essential psychotropic medications. There is a particular lack of injectable long-acting antipsychotic drugs which is often required for patients with chronic psychotic disorders and limited treatment adherence. There are also logistical challenges related to transport: Sometimes it is difficult for the psychiatrist to reach the camps due to bad weather and bad road conditions, particularly in the monsoon season. It is also challenging for patients and their caregivers to visit the health centres, as distances in the camps are considerable and there are only a few roads in the camp.

Fifth, there are challenges related to the language used in the mhGAP materials. Most of the health care providers are Bangladeshi professionals who originate from various parts of the country and are not able to communicate in the Rohingya language or the related Chittagonian dialect of Bengali. Some Bangladeshi health workers found it difficult to use the English language materials and if a translation of the mhGAP Intervention guide in the Bengali language had been available, this would have facilitated their learning.

Sixth, many people with mental health conditions can be assisted through integration of mental health into primary care, but some need more intensive care. UNHCR-supported primary health centres have essential psychotropic drugs and the possibilities to do brief hospitalisations. In some cases, referral to secondary mental health facilities is needed and this remains problematic: The district hospital in Cox's Bazar (Sadar Hospital) can admit people with an acute mental health condition to the general medical ward for a few days. The nearest hospital with a psychiatric ward is in Chittagong, about five hours' drive from Cox's Bazar. This greatly limits referral options.

Seventh, a major challenge in almost all humanitarian settings is an extreme lack of capacity for child and family-focused MHPSS services and a need for workforce capacity development in this field (Mind the Mind Now, 2019). There is no child psychiatrist in Cox's Bazar, so children with mental disorders are supervised by the general adult psychiatrist. UNHCR's MHPSS team includes a child psychologist who can assist psychologists and counsellors in the management of children with mental health conditions.

Lastly, despite major efforts to combat discrimination, people with mental health conditions are often stigmatised. The Rohingya language has different concepts for mental health conditions and these are often related to religious explanatory models (Tay et al., 2019). Rohingya have faith in their religious leaders and traditional healers. People with severe mental disorders and their caregivers are often not inclined to seek care in health facilities because many believe the solution to the problem is not medical.

Conclusions

The experiences with mhGAP programming in an acute emergency show that integration of mental health in primary care is possible, even in the context of a huge and chaotic acute humanitarian emergency such as the Rohingya refugee situation in Bangladesh. Our experiences highlight that integration of mental health encompasses much more than just training health workers for a limited period of time. Ongoing clinical supervision is essential, and this requires significant resources. Capacity building is a 'process' and not an 'event'; mhGAP trainings are only one element in a spectrum of activities aimed at integrating mental health into general health care. As has been observed in other emergencies, significant efforts need to be given to advocacy and liaison with stakeholders in the health care system to ensure that decision makers prioritise and support the addition of mental health components in the health system (International Medical Corps, 2016). Improving the capacity of medical staff to manage clinically significant mental health conditions is only one aspect of a comprehensive mental health system. Other elements include the introduction of psychosocial support and psychotherapy and community-based activities to provide mental health awareness and combat stigmatising attitudes towards mental health problems (Cohen et al., 2011; Faregh et al., 2019; Ventevogel, 2014). The experiences in Cox's Bazar demonstrate that it is feasible but not easy to integrate mental health into the health care system within a major humanitarian emergency.

Humanitarian emergencies can provide the impetus for mental health care reforms, in particular the decentralisation of services and the and strengthening of mental health into primary care (Epping-Jordan et al., 2015). In order to maximise such long-term effects on national level, it is important to use a long-term perspective from the outset (Pérez-Sales, Férnandez-Liria, Baingana, & Ventevogel, 2011). Much will depend on the political will of donor agencies to fund longer term mental health activities and of the possibilities to link the humanitarian services to national mental health care service development. We hope that our experience will be an encouragement to integrate mental health in the primary health care system of Bangladesh and in other humanitarian emergencies worldwide.

Supplementary file

Pre- and Post-test for mhGAP HIG Course (Training 1)

Financial support and sponsorship

All authors work for the United Nations High Commissioner for Refugees.

Conflicts of Interest

All authors have contributed to the manuscript and have read and approved the final version.

The manuscript represents honest work, and the information is not provided in another form.

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