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EXPLORING THE PERCEPTIONS OF REFUGEES AND ASYLUM SEEKERS REGARDING ACCESS TO MENTAL HEALTH SERVICES IN ZIMBABWE: A CASE STUDY OF TONGOGARA REFUGEE CAMP

Thesis submitted to:

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In partial fulfilment of the requirements for the degree Master of Arts (Migration and Displacement) by Coursework and Research Report

By Edward Govere

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Supervised by Professor Joanna Vearey

03 August 2017

Declaration

I hereby declare that this research report is my original and unaided work and that I have correctly referenced all the sources utilized. This research report has not been submitted previously for any degree or examination.

Edward Govere **Date**

edwardgovere..... …03/08/2017……..

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CHAPTER ONE: INTRODUCTION TO THE STUDY

1.1 Background and statement of the problem

Across the globe, the growing number of refugees is a great cause of concern with reports from the United Nations (2015) indicating that by end-2014, an estimated 60 million individuals were forcibly displaced as a result of conflict, human rights violation, persecution, or generalized violence. Among these, refugees amounted to 16.7 million the number of internally displaced people (IDPs) around the world, reached an all-time high of 33.3 million (UN, 2015). The biggest refugee producing countries were understood to be Afghanstan, Syria and Somalia – constituting half of the total refugee population in the world. Meanwhile, Pakistan, Iran, Lebanon, Jordan and Turkey were reportedly the major refugee-hosting countries in the world and 86% per cent of all refugees worldwide were hosted by developing countries compared with 70% a decade ago (UN, 2015). More so, a record high of nearly 1.7 million individuals submitted applications for asylum or refugee status in 2014 - mostly in developed countries (UNHCR, 2015).

In Zimbabwe, the last two decades have been marked by a significant influx of refugees into the country from other parts of the continent such as Burundi, Sudan, the Democratic Republic of the Congo (DRC), Congo Brazzaville, Rwanda, Ethiopia and Somalia (Chikanda & Crush, 2016). In response to the growing influx of refugees, in 1984, the Zimbabwean government established a refugee camp and named it after the late Josiah Magama Tongogara - Commander of the Zimbabwe African National Liberation Army (ZANLA) during Zimbabwe's liberation struggle (Chikanda & Crush, 2016). The UNHCR, in 2014 released a Joint Assessment Mission (JAM), indicating that an approximate total 150 individuals turn up at the camp every month seeking asylum, and that the total refugee population at Tongogara refugee camp rose from 4 500 in 2013 to over 7 000 in 2015 (UNHCR, 2014). The report further reveals that the majority of asylum seekers come from the DRC, Burundi and Rwanda while some come from as far afield as Bangladesh.

The prevailing biomedical model posits that refugees and asylum seekers are particularly vulnerable to developing mental health problems and are, therefore, in need of counselling and psychosocial services given their exposure to traumatic events and hardships during the pre-

migration period and the flight stage (Eastmond, 2000; Miller, Kulkarni, & Kushner, 2006; Watters, 2001). Premised on this traditional Western biomedical model, several studies conducted in the Global North establish that, compared to native citizens, asylum seekers and refugees are more vulnerable to mental health issues (Eastmond, 2000; Fazel, Reed, Panter-Brick, & Stein, 2012; Fazel & Stein, 2002; Huemer et al., 2009; Lustig et al., 2004; Porter & Haslam, 2005; Pumariega, Rothe, & Pumariega, 2005). However, there is a general lack of local literature to examine the prevailing notions on mental health issues and access to mental health care among refugees and asylum seekers in Southern Africa (Zihindula, Meyer-Weitz, & Akintola, 2015). This research was therefore prompted by the need to examine the perceptions of refugees regarding access to mental health care. Such research is not only relevant, but necessary for a critical examination of the prevailing discourses, as well as ensuring culturally sensitive mental health interventions.

The study identifies Tongogara Refugee Camp as the study site. The camp lies some 488 kilometres southeast of the country's capital - Harare, and nearly 60 kilometres from Chipinge. According to Chikanda and Crush (2016), the camp is located in a secluded, arid area which is mosquito infested and receives very little rainfall – making it hard for refugees to carry out any meaningful farming activity. Mufandauya (2015) observes that the camp takes the form of a desperately overcrowded village while wood and fuel are the main fuels for cooking, heating, and other domestic uses. According to Mapiko and Chinyoka (2013), in Zimbabwe – as in many other countries, the protection and care of refugees is the core mandate of the United Nations High Commissioner for Refugees along with the Department of Social Welfare, and a handful of non-governmental organisations with some being implementing partners while others are operational partners to UNHCR. These organisations assume different roles in service provision, which are mostly camp-based. Services rendered to refugees at Tongogara refugee camp encompass food service, health services (there is a clinic that deals with light ailments), accommodation, income-generating projects, agricultural inputs and nutritional supplements by Christian Care, primary and secondary education, refugee status, provision of return assistance by the Department of Social Welfare, sourcing and distribution of clothing to children and the bed ridden, vocational training, computer literacy by the JRS (Mapiko & Chinyoka, 2013).

1.2 Aim of the study

The aim of the study was to explore the perceptions of mental health and access to mental health care services among refugees and asylum seekers in Tongogara Refugee Camp.

1.3 Objectives of the study

1. To establish refugees' and asylum seekers' perceptions of mental health in Tongogara refugee camp.
2. To explore the experiences of refugees and asylum seekers when accessing mental health services in Tongogara refugee camp.
3. To describe the utilisation of mental health services by refugees and asylum-seekers in Tongogara refugee camp.
4. To inform recommendations for improving the accessibility of mental health services to refugees and asylum seekers particularly in Tongogara refugee camp.

1.4 Rationale of the study

Much to the continued dominance of the biomedical model, the rapidly accelerating figures and diversity of migration across the globe has led to a dramatic increase in the number of studies aimed at understanding mental health, illness and access to care. Within this perspective, it has been argued that such research is particularly important in the case of refugees and asylum seekers in order to address the needs of these categories of migrants and crucial to ensure that services are sensitive to these needs (Hartwell, 2011). On global scale, much recent academic research on refugees and mental health has focused on prevalence rates of certain so-called mental health problems among refugee populations (Cardozo, 2000; Fazel et al., 2005; Kirmayer et al., 2011; Norredam et al., 2009; Ringold, 2005; Sabin, 2003; Steel et al., 2002). While the significant and enduring effects of exposure to trauma on the mental well-being of refugees have been well-documented worldwide, little is known about refugees and mental health in Southern Africa – particularly in relation to their perceptions about mental health and access to care.

More generally, research carried out in Southern Africa on issues relating to the accessibility of health care services to migrants, although not extensive, has had a tendency to mainly focus on migrants in South Africa (Chikanda & Crush, 2014; Zihindula et al., 2015). This may in part be due to the widely held assumption that South Africa is the largest recipient of asylum seekers in

Southern Africa (Chikanda & Crush, 2014). The current study, however sought to draw attention to some other countries in the region by at least focusing on refugees in Zimbabwe. The study is thus one of the few in Southern Africa addressing the migration-health nexus through the lens of mental health. Also of major interest about this research is the fact that, unlike in countries like South Africa and Angola where refugees can easily go about their business without restrictions, the study examines the effects of encampment on refugee mental health and access to care thereof. It therefore carries the potential of contributing to the discourse of encampment in forced migration studies especially given that a human rights perspective has been adopted.

1.5 Delimitations of the study

The study was carried out at Tongogara Refugee Camp in Chipinge, Zimbabwe. Respondents were drawn from the refugee community as well as from various organizations operating in the camp. Engaging all stakeholders involved in the day-today operation of the camp helped ensure a balanced study and allowed for an objective analysis of the subject under consideration.

1.6 Definition of terms

Mental health and mental illness

Mental health is defined by the World Health Organization (2010) as a dynamic state in which in which an individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. Dadhania (2015) notes that mental health can be conceptualised as a level of psychological well-being of someone who is functioning at a satisfactory level of emotional and behavioural adjustment. It entails one's ability to perform mental function, resulting in productive activities, fulfilling relationships with other people, and providing the ability to adapt to change and cope with adversity (Power, 2010). Dadhania (2015) further establishes that mental health is much more than the absence of mental illness, and involves what makes life enjoyable, productive, and fulfilling, and it contributes to social capital and economic development in societies. From the perspective of positive psychology or holism, mental health may include an individual's ability to enjoy life, and create a balance between life activities and efforts to achieve psychological resilience (Dadhania, 2015; Power, 2010). Mental health is important at every stage of life, from childhood and adolescence through

adulthood and it affects how people think, feel, act, as well as determining the way in which people deal with stress, relate to others, and make choices (Power, 2010).

As defined by Crowley (2009), the term **mental illness** refers collectively to all diagnosable mental disorders or health conditions characterized by alterations in thinking, mood, or behaviour associated with distress or impaired functioning. According to Boyd and Nihart (1998), a mental health disorder is defined as 'the presence of psychological distress, impairment in psychological, social, or occupational functioning, or any disorder that is associated with an increased risk of suffering death, pain, disability, or loss of freedom' (p. 1129). A person struggling with his or her mental health may experience stress, depression, anxiety, relationship problems, grief, addiction, learning disabilities, mood disorders, or other mental illnesses of varying degrees (Crowley, 2009).

Refugee

The 1951 Convention Relating to the Status of Refugees (and its 1967 Protocol), to which Zimbabwe is a signatory, defines a refugee as:

Any person who owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his/her nationality and is unable, or owing to such fear, is unwilling to avail himself/herself of the protection of that country.

Asylum seeker

Lusher, Balvin, Nethery, and Tropea (2007) define an asylum seeker as a person who is seeking protection as a refugee and is still waiting to have his/her claim assessed.

1.7 Organisation of the report

Chapter one provided the background and orientation to the research. Chapter two of the research report focuses on literature review and examines theory and research relating to refugees and asylum seekers' perceptions regarding mental health and access to care in marginal spaces across the world. Meanwhile, the research design and methodology guiding the study are presented in chapter three of the research report, while the fourth chapter presents the analysis and discussion of data collected during the study. Chapter five presents a summary of the main findings, conclusions and recommendations that emerged from the study.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1 Introduction

Refugees have been the subject of a great deal of research over the past five decades (Hartwell, 2011). Some scholars suggest that until the Second World War, the majority of inquiries into the effects of war on individuals focused on combatants only (Kim, Wampold, & Bolt, 2006; Van der Kolk, 2003). The occurrence of the Holocaust in the mid-20th century however, witnessed a shift with some scholars beginning to pay attention to civilian war survivors, including refugees (Krippner & McIntyre, 2003). The experiences of refugees were not widely captured in the academic literature until the latter part of the 20th century (Kim et al., 2006; Van der Kolk, 2003), as much attention was being directed toward physical and social consequences of war on refugees. Only in the last three decades have researchers turned concerted attention to the psychological impacts of war on refugees (Hartwell, 2011; Ingleby, 2004; Krippner & McIntyre, 2003; Miller, 2008). A large body of literature related to the mental health 'needs' of asylum seekers and refugees exists, but most of it pays insufficient attention to access to mental health care for refugees and asylum seekers specifically (Hartwell, 2011).

The following section provides the literature review and theoretical background to the study and the main issues that are discussed are: the historical and policy context, refugees and mental health in general, risk factors for mental health problems, protective factors against mental health problems, the so-called mental disorders, alternative approaches to mental health care and barriers to accessing health care.

2.2 The historical and policy context of refugee protection in Zimbabwe

Before proceeding with the discussion on mental health issues and research related to refugee matters, it is more than worthwhile to consider the historical and policy context in which refugees in Zimbabwe find themselves.

The refugee problem has always been a matter of great concern in the political arena of the world (Anker & Posner, 1981; Chimni, 1999). Chalabi (2013) notes that the forced displacement of people in conflict situations can be traced back to at least 740 BC when people were quarrelling throughout all the tribes of Israel leading to the expulsion of ten tribes from their ancestral land.

Throughout the First World War, countless people fled to safer countries with the vast majority of survivors fleeing to England and other safer places (Musalo, Moore, & Boswell, 2003; Skran, 1992). During those times, there were no laid down statutes governing refugee matters (Ferris, 2011). The first bid by the international community to provide protection and come up with solutions to the refugee crisis started from the time of the League of Nations - formed in 1919 (Feller, 2001; Ferris, 2011; Loescher, 1996). This was followed by the formation of the International Refugee Organization (IRO) in 1946 with the UNHCR - whose main thrust was to help find durable solutions to the plight of refugees, being established on December 14, 1950 (Ferris, 2011).

A big step forward in the protection of refugee rights was taken with the coming of the Convention relating to the Status of Refugees, approved at a special United Nations conference on 28 July 1951 (Loescher, 1996). Mufandauya (2015) notes that subsequent colonial conflicts were topical in African countries and many countries ratified the Refugee Convention. This was achieved with reservations especially being made with regard to the right of freedom of movement - thereby leading to the adoption of the policy of encampment (Chikanda & Crush, 2014; Chitereka, 2008; Mapiko & Chinyoka, 2013). Mufandauya (2015) further notes that at that time, the political atmosphere in many African countries was extremely tempestuous and it led to the militarization of refugee camps for accountability and security purposes. At independence, most African countries adopted the encampment policy well in all its ruthlessness- which in many ways, led to the infringement of some fundamental rights of refugees as human beings (Ferris, 2011; Hovil, 2007; Mufandauya, 2015). That being the case, Zimbabwe was no exception either, with the country domesticating the 1951 and 1969 conventions on refugees as well as enforcing the policy of encampment (Chikanda & Crush, 2016).

Following an increase in the volume of global migration and the increased rates of human mobility, countries have adopted different policies in a bid to protect refugees (Chitereka, 2008; Hovil, 2007; Mapiko & Chinyoka, 2013; Sniderman, 2015). On the one hand, some countries such as Angola and South Africa adopted a liberal asylum and refugee policy that integrates all the essential principles for refugee protection including: access to basic social services, freedom of movement and the right to work. On the other hand, countries like Zimbabwe, Zambia and Kenya adopted the encampment policy (Abuya, 2007; Campbell, 2006; Darling, 2009). It is assumed that the

Zimbabwean government adopted the encampment policy on the grounds of national security (Mufandauya, 2015). Apart from those granted permission by the state to stay elsewhere for some special reasons, Chapter 4.03, Section 12 of the Refugee Act as provided in the Constitution of Zimbabwe, declares that refugees are to be kept in confinement within a camp designated by the government. In the case of any refugee who wants to travel, permission has to be sought from the authorities (Chikanda & Crush, 2016).

The current study sought to uncover and understand how refugees go about accessing health services under such a strict asylum and refugee legislation described above. Important to note is the fact that a lot of scholarly writing on the discourse of encampment, has lambasted the policy asserting that it only leads to the marginalization of refugees to the peripheral, miserable and high-risk rural borderline areas (Chikanda & Crush, 2014; Ferris, 2011; Hathaway, 2005; Hovil, 2007; Mufandauya, 2015). A common thread that runs through multitudinous studies is that after the traumatic experiences of war– which in many ways, will have forced the refugees to flee their homes, their mental and psychological state will be on the downside. Confining them to camps where they are isolated from the rest of the world therefore does nothing but compounds mental health issues among refugees (Bonanno, 2004; Hathaway, 2005; Hovil, 2007; Miller & Rasmussen, 2010; Mufandauya, 2015).

2.3 The legal framework for mental health in Zimbabwe

Access to mental health care is widely recognized as a fundamental right of every human being and health services for refugees are delivered with the guidance of internationally laid down procedures (Joop & De Jong, 2002; Tribe, 2002). The Jakarta Declaration on Health Promotion into the 21st Century reiterates the right of everyone to good health and particularly calls for the urgent need to pay attention to mental health needs. Article 12(1) of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which Zimbabwe ratified on May 13 1991 also states that, 'Everyone has a right to the highest attainable standard of … and mental health'. Zimbabwe also validated the Resolution 61.7 of the 61st annual World Health Assembly (WHA) on the Health of Migrants of 2008. The resolution urges member states to promote access to health care for migrants in a fair and just manner. In addition, Article 16 of the African Charter on Human and Peoples' Rights of 1981 emphasizes the right of everyone 'to enjoy the best attainable state of physical and *mental* health'. Lastly, the 1969 OAU Convention Governing the Specific Aspects of

Refugee Problems in Africa calls upon member states to urgently address the suffering and misery faced by refugees across the globe, including the provision of better living standards and future.

2.4 The refugee experience and mental health: A brief overview

Recent research on refugee matters has generally focused on the effects of mass violence and displacement on psychological functioning with special attention being given to exploring the impact of different types of trauma on the mental well-being of refugees (Fazel et al., 2005; Hartwell, 2011; Hodes, Jagdev, Chandra, & Cunniff, 2008; Kirmayer et al., 2011; Neuner et al., 2004; Ringold, 2005; Sabin, 2003; Steel et al., 2002; Vasilevska & Simich, 2010). It has been well-established by research that refugees experience multiple forms of stress before, during, and after their flight, and that they are more vulnerable to mental health problems (Bhugra, 2004; Bonanno, 2004; Cardozo, 2000; Sabin, 2003; Khawaja, White, Schweitzer, & Greenslade, 2008; Miller & Rasmussen, 2010; Neuner et al., 2004; Porter & Haslam, 2005; Ringold, 2005; Ryan et al., 2008; Zimmerman, Kiss, & Hossain, 2011; Simich, Beiser, & Mawani, 2003; Steel et al., 2002). The life-threatening stresses experienced by refugees across different migration stages are often labelled and pathologized through a disease or biomedical lens (Clark, 2014; Jacob et al., 2013).

Numerous studies have demonstrated that a strong dose-effect relationship exists between number of traumatic experiences and poor mental health outcomes, with those refugees who have experienced a greater number of traumas being at increased risk for mental health problems, including post-traumatic stress symptoms, depression, anxiety and somatic symptoms (Bhugra, 2004; Bonanno, 2004; Cardozo, 2000; Hartwell, 2011; Kirmayer et al., 2011; Miller & Rasmussen, 2010; Neuner et al., 2004; Porter & Haslam, 2005; Ringold, 2005; Sabin, 2003; Silove, 2000; Steel et al., 2002). A study conducted by Mollica, Cui, McInnes, & Massagli (2002) on Cambodian refugees indicates that the number of traumatic events experienced accounted for 45% and 50% of participants' depression and posttraumatic stress disorder scores, respectively.

The refugee experience is commonly divided into three phases: pre-migration, migration, and post-migration (Fazel, Reed, Panter-Brick, & Stein, 2012; Porter & Haslam, 2005). Each of these three phases is explained in detail below:

2.4.1 The pre-migration phase

The pre-migration period, also called the pre-flight phase, refers to the period of time before refugees flee from their country of origin (Ryan, Dooley, & Benson, 2008). Pre-migration risk factors refer to some of the traumas experienced by refugees before being forced to flee, and can lead to the development of mental health disorders (Chou, 2009; Collins, Zimmerman, & Howard, 2011; Fazel, Reed, Panter-Brick, & Stein, 2012; Ritsner, Ponizovsky, Nechamkin, & Modai, 2001; Ryan et al., 2008). During this phase, refugees are at increased risk for rape, torture, war injuries, substance abuse, depression, anxiety, and suicidal ideation (Hartwell, 2011). Porter and Haslam (2005) further establish that prior to their flight, refugees often face many challenges and these pre-migration stressors have been strongly associated with higher levels of psychological distress.

More generally, there are violence and threats to the safety of people and their families, and sometimes people may be taken into labour or forced to participate in violence, persecution, and exploited or kept in detention (Bhugra, 2004; Bonanno, 2004; Brewin et al., 2000; Crowley, 2009; Fazel et al., 2005; Ferris, 2011; Hodes et al., 2008; Khawaja et al., 2008; Miller & Rasmussen, 2010; Norredam et al., 2009; Porter & Haslam, 2005; Ryan et al., 2008; Vasilevska & Simich, 2010; Zihindula et al., 2015; Zimmerman et al., 2011). Other key stressors for most refugees during the pre-flight include insecurity and uncertainty as the majority of refugees flee under frantic, unpremeditated conditions, without any belongings, preparation or means for finding safety and basic survival needs (Hartwell, 2011).

2.4.2 The migration phase

Porter and Haslam (2005) note that the migration phase is the stage whereby refugees flee from their homes searching and journeying to the place of resettlement. Risk factors during flight stage include struggling to meet basic needs, having to cover long distances, violence, separation from family, as well as fear for the future (Fazel, Reed, Panter-Brick, & Stein, 2012; Kirmayer et al., 2011; Lindencrona, Ekblad, & Hauff, 2008; Pumariega, Rothe, & Pumariega, 2005). According to Hartwell (2011), for the majority of refugees, the flight ends as they enter a refugee camp and camps take time and means to develop. Numerous studies indicate that even in the larger, more established camps, conditions tend to be poor, hardly meeting survival needs while education, health care, and other basic services are neglected over time or absent (Chikanda & Crush, 2014; Chitereka, 2008; Hathaway, 2005; Mapiko & Chinyoka, 2013; Mufandauya, 2015; Sniderman,

2015). They often suffer from lack of adequate food and there is a high risk of contracting a range of infectious diseases resultant from overcrowding and the poor hygienic environment (Ferris, 2011; Hovil, 2007; Kirmayer et al., 2011; Steel et al., 2002). Refugee camps can also be dangerous places, with violence between groups within the camps as well as violence from the host community surrounding the camp (Chikanda & Crush, 2014; Hovil, 2007; Mufandauya, 2015).

2.4.3 The post-migration phase

While newfound hope and anticipation of a safe, prosperous life in their host country may help refugees postpone their grief in the immediate resettlement period, with time, the majority will mourn the loss of their homeland, family, friends, and material possessions (Coker et al., 2002; Hartwell, 2011; Lustig et al., 2004; Porter & Haslam, 2005). Lustig et al. (2004) assert that refugees often suffer from cultural bereavement – which refers to refugees' reactions to losing touch with the culture of one's country, of origin and is generally accompanied by feelings of anger, ambivalence and survivor guilt. Furthermore, during the post-flight phase, refugee families must confront everyday struggles, meet their basic needs of housing, employment, and health care, understand a new language, and obey laws of a new culture (Uba, 1992).

Nonetheless, some studies have ascertained that post-migration risk factors may lead to better psychological adjustment (Birman & Tran, 2008; Hyman, Vu, & Beiser, 2000; Kovacev & Shute, 2004; Miller & Rasmussen, 2010; Momartin, Steel, Coello, Schweitzer, Melville, Steel, & Lacherez, 2006). On the one hand, some scholars argue that most refugees adapt well to their new environments, though at different times and through various means, despite facing many challenges from the start (Bhugra, 2004; Khawaja, White, Schweitzer, & Greenslade, 2008; Schweitzer, Greenslade, & Kagee, 2007). Longitudinal studies conducted with refugees indicate that even though psychological symptoms of distress may persist for some years, these gradually decline overtime (Dinesh Bhugra, 2004; Hartwell, 2011; Krippner & McIntyre, 2003; Schweitzer et al., 2007; Steel et al., 2002).

On the other hand, several scholars contend that extended stays in refugee camps may have adverse effects on the mental health of asylum seekers and refugees (Fazel, Reed, Panter-Brick, & Stein, 2012; Fazel & Stein, 2002; Kirmayer et al., 2011; Lustig et al., 2004; Montgomery, 2008; Thomas

& Thomas, 2004). This, according to Hartwell (2011), is largely due to factors such as deprivation of food, water, medical care, and poor living conditions.

2.5 Coping and protective factors

Studies have found refugees to exhibit an incredible amount of resilience during all the three phases of migration described above (Crowley, 2009). The World Health Organization (2002) defines protective factors as the conditions that boost people's resistance to risk factors and disorders. Porter and Haslam (2005) establish that the protective factors have been shown to have a moderator effect on the impact of the traumatic events refugees come across. As is the case with risk factors, protective factors can be found in the individual, family or the social, political or economic environment (Hartwell, 2011), and in many ways, it is the cumulative effect of the existence of several risk factors in the absence of protective factors that makes individuals fall prey to mental health problems. Protective factors include spirituality, sense of commitment to a political cause, positive coping and communication skills, and access to family members and social support (Brune et al., 2002; Fazel et al., 2012; Johnson & Thompson, 2008; Lustig et al., 2004; Noh & Kaspar, 2003; Porter & Haslam, 2005). Many scholars suggest that most refugees do not develop mental health disorders and there is a the need for more research on factors associated with resiliency (Crowley, 2009). The present study recognises this gap in the literature and has incorporated it in the research questions.

2.6 Barriers to mental health care

Access to healthcare services – particularly difficulty in accessing primary care health services by asylum seekers has been a common theme across several studies (Abe-Kim et al., 2007b; Alegria et al., 2002; Hoge et al., 2004; Jenkins, Le, Leong & Lau, 2001; Wong et al., 2006). A number of factors are considered as barriers to mental health care and these include cultural and social barriers, lack of awareness of health services, language barriers, resource constraints and service fees, discrimination in provision of services, lack of documentation and mistrust (Abe-Kim et al., 2007; Alegria et al., 2002; Kirmayer et al., 2011; Leong & Lau, 2001; Uba; Watters, 2001; Wong et al., 2006).

2.7 The so-called mental illnesses

2.7.1 Posttraumatic Stress Disorder: PTSD

For the most part, the literature on mental health care revolves around the common assumption that, all forms of human distress or suffering can be medicalized (Bracken, 1998; Igreja, 2003; Kalksma-Van Lith & others, 2007; Pupavac, 2002; Summerfield,1999; Zarowsky & Pedersen, 2000). This medicalization paradigm has directly led to the development of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Common mental health disorders included under the DSM involve posttraumatic stress disorder (PTSD), depression, generalized anxiety disorder, bipolar disorder and somatization (Gamper et al., 2004). Many studies operating within the prevailing trauma paradigm have demonstrated that the most common of the so-called mental disorders, diagnosed among new migrants and refugees across the world is PTSD (Bhui et al., 2003, 2006; Crowley, 2009; De Jong, Komproe, & Van Ommeren, 2003; Hartwell, 2011; Kirmayer et al., 2011; Marshall, Schell, Elliott, Berthold, & Chun, 2005; Myer et al., 2008). Within this perspective or paradigm, PTSD is defined as a psychiatric disorder that can occur as a result of experiencing or witnessing a life-threatening event, and often leads to significant distress or impairment in functioning (Gamper et al., 2004). The three main types of PTSD symptoms identified are intrusive symptoms, avoidance, and increased arousal (Gamper et al., 2004; Karunakara et al., 2004; Momartin, Silove, Manicavasagar, & Steel, 2004; Neuner, Schauer, Klaschik, Karunakara, & Elbert, 2004; Nicholl & Thompson, 2004; Paunovic & Öst, 2001; Schulz, Resick, Huber, & Griffin, 2006).

Intrusive symptoms include upsetting memories, flashbacks, nightmares, as well as distress, following exposure to trauma-related internal and external reminders (Gamper et al., 2004; Nicholl & Thompson, 2004). Avoidant symptoms include attempts to avoid emotions, activities, thoughts, places, people, or places that remind individuals of the trauma, emotional numbness, and detachment from situations (Carlson & Rosser-Hogan, 1991; Gamper et al., 2004; Neuner, Schauer, Klaschik, et al., 2004). Arousal symptoms encompass outbursts of anger, sleeping disturbances, hypervigilance, and difficulty concentrating (Gamper et al., 2004).

2.7.2 The cross-cultural validity of PTSD

Despite the well-documented association between trauma exposure and the development of PTSD, there is considerable debate about the cross-cultural applicability of the PTSD category as presently described (Bracken, Giller, & Summerfield, 1997; Delic-Ovcina, 2010; Hinton & Lewis-Fernández, 2011; Marques, Robinaugh, LeBlanc, & Hinton, 2011; Paletti, 2007). Much concern has been raised about cultural bias and the usefulness of PTSD diagnosis in non-western societies (Hartwell, 2011). Several critics argue that the symptoms of PTSD, flashbacks included, are nothing more than a social construction – a Western construction with a hidden agenda (Bracken, 2001; Hinton & Lewis-Fernández, 2011; Pupavac, 2002; Summerfield, 1999; Young, 1997). Essentially, these scholars maintain that at the least, PTSD is a pseudo-condition that serves to glorify the Western agencies and their pundits who, from a distance, define what constitutes pathology and bring its cure (Pupavac, 2002; Summerfield, 1999). Kienzler (2008) states that the case of PTSD provides the perfect example of how society and politics have combined to help fabricate rather than discover a mental illness. In other words, psychological knowledge is merely the product of a particular culture at a particular point in time (Pupavac, 2002; Summerfield, 1999) – hence PTSD is considered the product of trauma and culture acting together rather than trauma *per se.*

Delic-Ovcina (2010) further asserts that even the researchers, instruments and exegesis of data are based on western cultural values. Along these lines, Hinton & Lewis-Fernández (2011) establish that despite the attempts by a handful of studies to enhance the validity of their assessment instruments by translating and back-translating into the language used among the study population - the instruments may still fail to accurately capture traumatic stress symptoms within non-western cultures or societies. Several scholars argue that the symptoms of PTSD may have different meanings across diverse cultures, and some symptoms may not be perceived as distressing (Bracken et al., 1997; Hinton & Lewis-Fernández, 2011; Igreja, 2003; Miller & Rasmussen, 2010; Paletti, 2007; Pupavac, 2002; Summerfield, 1999; Zarowsky & Pedersen, 2000).

Another criticism levelled against the PTSD category relates to its potential for medicalizing human suffering (Bracken et al., 1997; Hinton & Lewis-Fernández, 2011; Pupavac, 2002; Summerfield, 1999; Young, 1997; Zarowsky & Pedersen, 2000). From this point of view, psychological interventions for PTSD adopt a reductionist approach that decontextualizes human

suffering - restricting it to the individual's or family's private sphere, when the root causes of suffering appear to be collective and rooted in a socio-historic context of human rights abuses (Bracken et al., 1997; Igreja, 2003; Miller & Rasmussen, 2010; Pupavac, 2002). Thus, they reduce the broader social, political, economic and moral implications of traumatic events like war or genocide, to a strictly professional, even biological, set of consequences (Igreja, 2003b; Paletti, 2007). Further questioning the cultural appropriateness of trauma-focused interventions, this critique dismisses the assumption that PTSD is a universally applicable human phenomenon (Bracken, 2001; Delic-Ovcina, 2010; Hinton & Lewis-Fernández, 2011; Paletti, 2007; Pupavac, 2002; Schulz, Resick, Huber, & Griffin, 2006; Summerfield, 1999; Young, 1997). The aforementioned scholars caution against turning a blind eye to the enormous diversity of cultures, situations, and complex social, political, economic and historical configurations found in the world (Igreja, 2003; Paletti, 2007; Christina Zarowsky & Pedersen, 2000). Hinton and Lewis-Fernández (2011) contend that by placing more emphasis on PTSD as a universally applicable syndrome, research on PTSD may have unwittingly and paradoxically played a big part in diverting attention from the deeper, structural problems. Friedman, Keane, & Resick (2015) further assert that focusing too much on PTSD can lead researchers to neglect current stressors, security problems, traumas, as well as the causes of suffering.

In a similar vein, Litz (2014) posits that trauma-focused psychological interventions may be intrusive and impede natural recovery from trauma, particularly given their failure to leverage local resources – invaluable assets to healing and recovery. Thus, different cultural groups have different culture-specific syndromes that provide the basis for meaningful responses to trauma (Darghouth, Pedersen, Bibeau, & Rousseau, 2006; Hinton, Hinton, Eng, & Choung, 2012; Hinton & Lewis-Fernández, 2010; Kienzler, 2008; Patel, 2001). As such, many scholars argue that even though PTSD accurately describes some common reactions to trauma, its usefulness or clinical utility lags behind indigenous and local forms of expressing human suffering, including cultural syndromes (Amuyunzu-Nyamongo, 2013; Friedman et al., 2015; Kienzler, 2008; Litz, 2014). Friedman et al. (2015) note that local expressions are more 'experience near' and their clinical utility is rendered greater, particularly given their ability to promote empathy and reveal an association with general health status. In other words, they provide survivors with the perfect platform to express, in their own local terms and interpretations – specific details about their illness, particularly in terms of the cause and severity of illness (*ibid*).

Nevertheless, in their discussion of cross-cultural applicability and generalizability of PTSD treatments, Friedman et al. (2015) suggest that as currently specified, it is more difficult to draw meaningful conclusions about treatment outcomes across different cultures and ethnic groups. This is because there is a paucity and inconsistency of available data on the efficacy of cognitive-behavioural approaches for refugees and asylum seekers from all around the world (Arnold, 2005; Dana, 2007; Friedman et al., 2015; Murray, Davidson, & Schweitzer, 2010). Thus, the few studies which have been conducted to ascertain the importance of psychological interventions do not allow for a firm conclusion, but, some preliminary data suggest that underserved cultural groups can benefit from research-supported psychological treatments (Dana, 2007; Friedman et al., 2015). Along the same line, Hartwell (2011) suggests that even though objections to PTSD's cross-cultural applicability merit serious consideration and additional investigation, research on PTSD and traumatic stress have made very substantial contributions to the field of mental health and have been able to illuminate key aspects with respect to the most common symptoms of trauma and stressor-related disorders. The contributions include: advancing the understanding of human suffering, improving the ability to differentiate categories of trauma across cultures, as well as demonstrating linkages between trauma exposure and increased risk for mental distress (Dana, 2007; Friedman et al., 2015).

2.7.3 Depression

Another so-called form of 'mental illness' found among refugees across all ages is depression. A number of epidemiological studies have identified depression as a serious concern in refugee populations, indicating that rates of depression are as equally high as those of PTSD (Aroian & Norris, 2000; Başoglu, Kılıç, Şalcıoglu, & Livanou, 2004; Beckham et al., 1998; Boarts, Sledjeski, Bogart, & Delahanty, 2006; Carlson & Rosser-Hogan, 1991b; D. Hinton, Ba, Peou, & Um, 2000; Jordan et al., 1991; Keane & Kaloupek, 1997; J. David Kinzie, 1993; John David Kinzie et al., 2008; Mghir, Freed, Raskin, & Katon, 1995; O'Donnell, Creamer, & Pattison, 2004; Roussos et al., 2005; Shalev et al., 1998; Silove, Sinnerbrink, Field, Manicavasagar, & Steel, 1997; P. Smith, Perrin, Yule, Hacam, & Stuvland, 2002; Vega, Kolody, Valle, & Hough, 1986).

As in the case of PTSD, there is a strong link between depression, exposure to war trauma and post-migration stressors (Başoglu et al., 2004; Ellis, MacDonald, Lincoln, & Cabral, 2008; Hinton et al., 2000; John David Kinzie et al., 2008; Smith et al., 2002). Several studies indicate that there

is a high co-morbidity of depression and other so-called mental health problems such as PTSD (Fazel, Wheeler, & Danesh, 2005; Fazel, Khosla, Doll, & Geddes, 2008; Ginzburg, Ein-Dor, & Solomon, 2010; Marshall, Schell, Elliott, Berthold, & Chun, 2005; Mollica et al., 2001; Momartin, Silove, Manicavasagar, & Steel, 2004; Thabet, Abed, & Vostanis, 2004). Some scholars suggest that the simultaneous existence of two or more mental health conditions can have devastating effects (Brady et al., 2000; Fazel et al., 2005; Ferrada-Noli et al., 1998; Ginzburg et al., 2010), as it often creates a vicious cycle that seriously undermines the recovery process, refugees' ability to cope with the current living conditions, as well as depleting available resources.

However, several recent studies – conducted outside the Western power blocks have cast doubt on the validity of Western biomedical models of depression (Darghouth, Pedersen, Bibeau, & Rousseau, 2006; Deacon, 2013; Fenton & Sadiq-Sangster, 1996; Horwitz, 2011; Jadhav, 2000; Moncrieff & Timimi, 2013; Patel, 2001). Some anthropological research suggests that depression is a culture-bound syndrome – rather than a universal disorder (Darghouth et al., 2006; de Jong & Reis, 2010; Deacon, 2013; Patel, 2001; Ridge, Emslie, & White, 2011). There exists substantial literature showing that, as is the case with other diagnostic categories of mental illness – depression is not a global certainty, but a mere cultural construction (Darghouth et al., 2006; de Jong & Reis, 2010; Deacon, 2013; Fenton & Sadiq-Sangster, 1996; Horwitz, 2011; Jadhav, 2000; Moncrieff & Timimi, 2013; Patel, 200; Ridge et al., 2011). In the same vein, it has been shown in the literature that there is considerable difference over what constitutes depression – especially as evidenced by the ever-changing ways in which the category is conceptualised (Gattuso, Fullagar, & Young, 2005; Horwitz, 2011; Jadhav, 2000; Kitanaka, 2012). Further, several scholars argue that the current diagnostic criteria for diagnosing depressive disorder struggle to tell the difference between abnormal sadness and normal sadness (Durà-Vilà, Littlewood, & Leavey, 2013; Helén, 2011; Horwitz, 2007; Horwitz & Wakefield, 2007; Parker, Fletcher, & Hadzi-Pavlovic, 2012; Pies, 2009; Shorter, 2008; Stein et al., 2010; Wakefield, 2007).

2.7.4 Somatization

Somatisation is another so-called mental health problem commonly found among refugee populations (Kirmayer & Young, 1998; Laban, Gernaat, Komproe, Schreuders, & De Jong, 2004; Otto et al., 2003; Van Ommeren et al., 2001). Symptoms of somatization include chest pains, insomnia, headaches, stomach aches, gastrointestinal complains, such as nausea, diarrhea,

bloating, and reactivity to certain foods, as well as chronic fatigue (Kirmayer & Young, 1998; Lin et al., 1985; Otto et al., 2003). These symptoms may involve at least four different physical functions or parts of the body and individuals with somatic symptom disorder often undergo a number of medical tests, albeit with negative results – prior to the identification of the real cause of distress (Waitzkin & Magaña, 1997).

A number of criticisms have been levelled against the idea of classifying somatic symptoms as a form of mental illness (Creed & Barsky, 2004; De Gucht & Fischler, 2002; Duddu, Isaac, & Chaturvedi, 2006; Henningsen, Zimmermann, & Sattel, 2003; Mayou, Kirmayer, Simon, Kroenke, & Sharpe, 2005; Suvinen, Reade, Kemppainen, Könönen, & Dworkin, 2005; Whitehead, Palsson, & Jones, 2002). Mayou et al. (2005) argue that even though somatic symptoms that are unexplained by a general medical condition were, previously, one of the most neglected areas, the DSM neither provides a deep understanding nor any meaningful foundation for treating these symptoms.

Several scholars contend that the concept of somatization strengthens the mind-body dualism (De Gucht & Fischler, 2002; Grace, 1998; Meissner, 2006). It has been argued that the association between somatic symptoms and psychological factors cannot be proven (Fukuda et al., 1994; Grace, 1998; Henningsen et al., 2003; Mayou et al., 2005; Suvinen et al., 2005). Further, it has been shown in the literature that the terminology of somatisation – as is the case with other so-called categories of mental illness, on its own – is stigmatising (Mayou et al., 2005). Several critics contend that the different terms commonly used in the mental health field are offensive and unacceptable to most people around the world (De Gucht & Fischler, 2002; Duddu et al., 2006; Zbigniew Jerzy Lipowski & others, 1988; Mayou et al., 2005). Thus, the somatisation diagnostic category, has been found to be largely incompatible with diverse cultural settings around the globe (De Gucht & Fischler, 2002; Duddu et al., 2006; Mayou et al., 2005).

2.8 Alternative approaches to mental health care

Despite the prevailing dominance of the biomedical model in understanding and treating mental illness, there is a growing literature documenting culturally oriented interventions (Becker, 2010; Igreja, 2003; McNamee, 2015; Zarowsky & Pedersen, 2000; Chen, 2007; Miller & Rasmussen, 2010). Although a relatively small literature exists, the few studies available provide important

insights into the ways in which local cultures interpret and provide responses to human suffering in Southern Africa (Analyti, 2012; DeLoach & Petersen, 2010; Kienzler, 2008). A study conducted by Igreja (2003) in Mozambique, underlines the critical role traditional healers can play in helping people to recover from trauma. Further, a number of studies indicate that individuals and households from culturally diverse backgrounds seek treatment for mental illness from multiple sources, including faith healers, social support, self-help groups and traditional healers (Ae-Ngibise et al., 2010; Al-Krenawi & Graham, 2000; Dunn & others, 1999; Eisenbruch, 1992; M. Fazel & Stein, 2002c; Gong-Guy, Cravens, & Patterson, 1991a; Lustig et al., 2004e; K. E. Miller & Rasmussen, 2010d; Pumariega, Rothe, & Pumariega, 2005c; Steel, Silove, Phan, & Bauman, 2002c; Tempany, 2009; Tribe, 2002b; Westermeyer, Vang, & Neider, 1983).

Several scholars underscore the central role played by alternative healing methods such as the ones mentioned above – particularly given their sensitivity to context (Analyti, 2012; Anderson et al., 2006; Igreja, 2003; McNamee, 2015). In addition, alternative healing methods are generally applauded for their ability to locate the recovery process within people's indigenous history and context (Becker, 2010; Bracken et al., 1997; Igreja, 2003; Kalksma-Van Lith & others, 2007; McNamee, 2015). According to McLennan and Khavarpour (2004), indigenous conceptions of mental health are strongly positioned to address the interrelationships between the physical, spiritual and emotional environment. In that vein, several scholars note that one of the most important characteristic of indigenous healing methods is their recognition of the intersection among social and economic disadvantage, violence, discrimination, dispossession from land and culture on indigenous people, families and communities (I. Anderson et al., 2006; DeLoach & Petersen, 2010; Igreja, 2003c; K. E. Miller & Rasmussen, 2010e). Anderson et al. (2006) further assert that healing is a spiritual process that does not only involve therapeutic change, but cultural renewal. Thus the aforementioned scholars establish that the process of recovery from distress and human suffering is inherently embedded in the socio-cultural context (*ibid*).

Inspired by the above line of thought, several scholars maintain the argument that trauma-focused therapeutic interventions in war-torn regions of the different parts of the world are not helpful in aiding the healing process at all levels – from the individual to societal level (Bracken, 1998; Pupavac, 2002; Summerfield, 1999; Young, 1997). Essentially, these scholars argue against biomedical practice in non-Western societies and point to the dynamic and complexity of cultures,

situations, economic, political, social and historical configurations found in the world (Bracken, Giller, & Summerfield, 1997; Chen, 2007; DeLoach & Petersen, 2010; Gamper et al., 2004; Kienzler, 2008; McNamee, 2015; Petersen-Coleman & Swaroop, 2011; Summerfield, 1999; Zarowsky & Pedersen, 2000). More importantly, they call for a holistic approach to mental health that situates the individual within a broader historical, social, cultural, political and economic context (Igreja, 2003).

2.9 Gaps in the literature on refugees

A myriad of scholars have done research and written about various matters concerning refugees worldwide. A large body of literature focuses on examining prevalence rate and risk factors for mental health problems. With specific respect to the Zimbabwean academic fraternity, little if any, has been written about refugee and asylum seekers access to health care services in general. The review of literature uncovered hugely noticeable gaps in the existing literature. Mpwekela (2010), Mufandauya (2015), Mapiko and Chinyoka (2013), Chitereka (2008) and Reeler (1994) are among the very few scholars who have written about refugee related matters. None of these studies has paid a specific attention to refugee mental health needs and access to care. Given the lack of local literature and research on access to mental health services for refugees and asylum seekers in Zimbabwe, the present study could pioneer future research, specifically in relation to refugees and access to mental health services – at least in Zimbabwe. More so, on a more macroscopic scale, the current study could help fill big gaps in the literature available in Southern Africa. As highlighted earlier, it was discovered that little is generally known about access to mental health services for refugees and asylum seekers in the entire region (Zihindula et al., 2015).

2.10 Theoretical framework: Access to health care framework

Access is an important health concept that deserves a standardized and precise definition (Christian, 2014). No universally agreed definition of access exists however with the concept remaining a largely contested and loaded one (Hall, Lemak, Steingraber, & Schaffer, 2008; Oliver & Mossialos, 2004). It remains a complex notion as exemplified in the diverse interpretations of the concept across authors and its definition varies and changes with time as well as context (Levesque, Harris, & Russell, 2013). An extensive analysis of access therefore requires an exhaustive definition that serves as a reference point from which to build a theoretical framework (Ware, 2013).

In a bid to provide a comprehensive overview of access, the present study adopted the simplified version of the access to health care framework as described by Thiede, Aweongo, Mclntrye and Mooney (2007) and used by Mclntyre, Thiede and Birch (2009). The framework was originally developed by Penchansky and Thomas (1981). In their work, the aforementioned scholars considered access in three broad dimensions: availability, acceptability and affordability. According to Thiede et al (2007), there is a reciprocal connection between these three dimensions although each aspect addresses distinct issues. This is the framework that guided the present study and the following section describes each dimension discreetly and in much more detail:

Availability

Availability, is sometimes taken to mean physical access and has to do with the relationship between the quantity and type of existing services and the volume and type of needs of the client system (Penchansky & Thomas, 1981). Mclntyre (2009) establishes that the availability component of access mainly captures supply-side aspects of health resources and often enjoys the highest top of the mind recall when policy-makers evaluate access.

In Thiede et al (2007), the dimensions of accessibility and accommodation are merged into the dimension of availability, thereby expanding the latter beyond the simplex supply-side issues. Availability can be taken to imply that health services are located in the right place and found or reachable at the right time, when needed (Thiede et al., 2007). The accessibility aspect, as understood under the dimension of availability, seeks to determine the place of supply relative to the location of the client. It involves a set of varied issues ranging from client transportation resources, distance and travel time to health facilities, and transport cost (Penchansky & Thomas, 1981). Accommodation also falls under the dimension of availability and pertains to clients' perceptions of the appropriateness and suitability, particularly in regard to the way in which services are organized and delivered (Penchansky & Thomas, 1981). Examples encompass appointment systems, hospital/clinic details and operating hours, among many other factors rarely taken into account in literature (McIntyre et al., 2009).

Despite the dimension of availability being an essential aspect of access, it is does not suffice *per se* – to guarantee that individuals with health needs are empowered to utilize the existing services (Christian, 2014; McIntyre et al., 2009; Oliver & Mossialos, 2004). That being the case, the other

two main dimension of access may need to be taken into consideration to allow for a comprehensive understanding of the concept of access vis-à-vis any given health system.

Affordability

Affordability, sometimes referred as financial access, has to do with the costs of health care and medical aid in connection with the income of clients (Penchansky & Thomas, 1981). It concerns the client's perception of value-for-money and their understanding of prices, total costs and possible credit arrangements (Thiede et al., 2007). The affordability dimension has been found to be dominant in discussions surrounding the equity of health care (Thiede et al., 2007, p. 109). According Christian (2014) a relational aspect of the affordability dimension links health care costs and the household or individual's ability to pay for services, and is also linked to the broader topic of health care financing. The opportunity cost of ill health in terms of earning capabilities is another significant aspect of affordability, especially for the poor (Christian, 2014; Levesque et al., 2013; McIntyre et al., 2009).

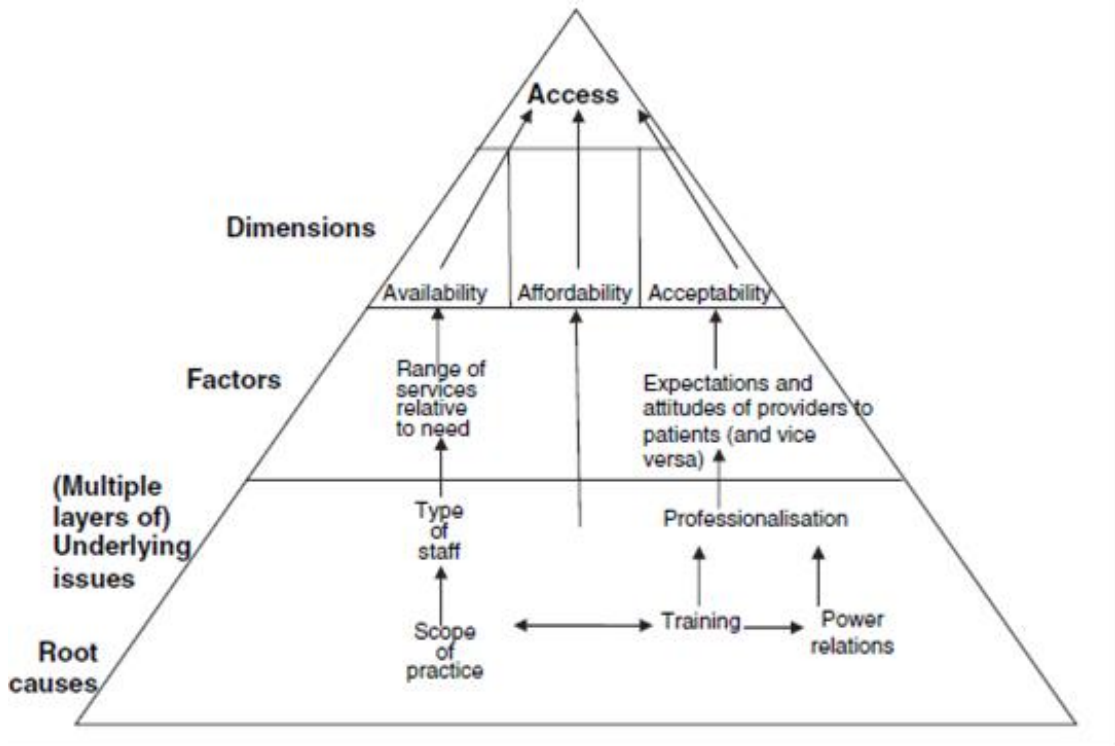
Acceptability

Lastly, acceptability– also referred to as cultural access, concerns client attitudes about the personal and professional characteristics of health care providers in comparison with the real characteristics of existing health care providers. Acceptability is often a more important dimension than availability when it comes to explaining whether clients seek health care or not (Ware, 2013). This relationship also works in reverse, capturing health care provider attitudes regarding what they consider acceptable client characteristics (Penchansky & Thomas, 1981).

The acceptability component is also linked to plural healthcare utilization, particularly the incorporation of traditional indigenous approaches to healing and western medicine. Unlike conventional frameworks of access, the theoretical framework underpinning the present study provides insights into a common phenomenon that most people experience – that is, how families navigate a plural health system in seeking health care. Several scholars note that health-seeking seeking behaviour is a socially negotiated process where individuals work within their cultural, financial, social, and geographical contexts, to determine the type of health services they need (Diaz et al., 2013; Geldsetzer et al., 2014; Scott, McMahon, Yumkella, Diaz, & George, 2014). In addition, a number of studies have shown that, in the absence of adequate health care, individuals

and families devise and seek care from multiple sources, including religious leaders, home treatment, facility-based providers, herbalists and drug peddlers (Giovanella, Vaitsman, Escorel, Magalhães, & Costa, 2002; Meurk, Broom, Adams, & Sibbritt, 2013; Moshabela, Schneider, Silal, & Cleary, 2012; Scott et al., 2014; Slikkerveer & others, 1990; Weerasinghe & Fernando, 2011).

Below is an illustration of the access to health care framework in the form of a triangle as extracted from (McIntyre, Thiede, & Birch, 2009, p. 190).



In conclusion, the current study was informed by the access health care framework. The three dimensions of access described in the framework: availability, affordability and acceptability– combined, proved vital tools for understanding the perceptions of refugees and asylum seekers regarding mental health and access to treatment.

2.11 Chapter summary

This chapter provided a detailed review of the literature related to the study. An introduction was provided, followed by a discussion of the historical and policy context of refugee protection in

Zimbabwe, the legal framework for mental health in Zimbabwe, an overview of the refugee experience and mental health from the pre-migration through to the post-migration phase, mental health disorders, coping and protective factors, as well as barriers to mental health care. The theoretical framework upon which the study hinges on – particularly, the access to health care framework, was presented in integration with the relevant literature.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

This chapter discusses the methodology that guided the study. It presents the research question, the aim and objectives of the study, research approach, design, sampling methods, research instrumentation, data collection method and as well as the method of data analysis employed for the study. Ethical issues that were considered are also explained.

3.2 Research question

What are the perceptions of mental health and access to mental health care services among refugees and asylum seekers in Tongogara Refugee Camp?

3.3.1 Primary aim

The purpose of this study was to explore the perceptions of mental health and access to mental health care services among refugees and asylum seekers in Tongogara Refugee Camp.

3.3.2 Secondary objectives

1. To establish refugees' and asylum seekers' perceptions of mental health in Tongogara refugee camp.
2. To explore the experiences of refugees and asylum seekers when accessing mental health services in Tongogara refugee camp.
3. To describe the utilisation of mental health services by refugees and asylum-seekers in Tongogara refugee camp.
4. To inform recommendations for improving the accessibility of mental health services to refugees and asylum seekers particularly in Tongogara refugee camp.

3.4.1 Research approach

This research utilized qualitative approach. Given the explorative nature of the current research, qualitative approach was adopted since it provides a rich foundation from which to gather meaningful findings (Berg, Lune, & Lune, 2004; Patton, 1990; Ritchie, Lewis, Nicholls, Ormston,

& others, 2013). Legard, Keegan and Ward (2003) maintain that qualitative research is considered most suitable for gaining insight into an unexplored situation, individual or phenomenon. It also allows for a rigorous investigation of phenomena from a holistic point of view that can lead to greater understanding of the experiences of the instrument of inquiry (Babbie, 2004; Creswell, 2013). As such, qualitative approach was considered as the befitting approach for exploring, in-depth, the perceptions of refugees and asylum seekers regarding the accessibility of mental health services in Zimbabwe.

The study sought to provide a detailed description of refugees and asylum seekers' access to mental health services examining their mental health needs, quality of mental health care, refugee experiences, utilization and recommendations. The researcher however, acknowledges one of the weaknesses of using qualitative approach in that research quality is heavily dependent on the individual skills of the researcher and more easily influenced by the researcher's personal biases (Barbour, 2001; Berg, Lune, & Lune, 2004; Opdenakker, 2006; Tuckett, 2004). More so, findings from qualitative research may not be generalizable due to the limited number of participants involved and is generally more time consuming (Horsburgh, 2003; Huberman & Miles, 2002; Schofield, 2002).

3.4.2 Research design

According to De Vaes (2001), research design constitutes the blueprint for the collection, measurement, and analysis of data. The function of a research design is to ensure that the evidence obtained enables one to effectively address the research problem as unambiguously as possible (Creswell, 2013). The current study employed the case study method. According to Baxter and Jack (2008), qualitative case study research facilitates exploration of a phenomenon within its context using a variety of data sources. The use of a case study design enabled the researcher to explore in-depth the perceptions of the respondents in the study. The explorative case study was used with the aim of examining mental health services for refugees in Zimbabwe and the real-life context in which these services are provided. The study however, acknowledges the disadvantage of using case studies in that, they are too long, difficult to conduct and produce a massive amounts of documentation (Yin, 2013).

3.4.3 Population and sampling procedures

According to Berg, Lune, and Lune (2004), a research population refers to a group of people upon which the study is conducted. The research targeted adult individuals aged 18 and above, residing in Tongogara camp, and officials from organisations such as the UNHCR, Christian Care, ICRC, JRS, Zimbabwean Ministry of Public Service, Labour and Social Welfare, faith-based leaders and camp clinic officials. The research population excluded refugee school children below the age of 17 for ethical reasons.

3.4.4 Participant Recruitment

Purposive sampling was used in the selection of participants. Bettmann, Penney, Clarkson Freeman, and Lecy (2015) define purposive sampling as a deliberate process of selecting respondents based on their ability to provide the needed information. The researcher targeted refugees and asylum seekers residing at Tongogara Refugee Camp who were openly communicative about their perceptions toward mental health and access to treatment in Zimbabwe as the main respondents of the study. Participants were recruited through a volunteer participant recruitment plan. The researcher approached potential study participants in person (face-to-face), introducing himself, and explaining the study verbally, informing all potential study respondents about the purpose, procedures, risks, benefits and alternatives to participation. This was achieved with the help of the camp administrator. The camp administrator appointed a multilingual interpreter – highly respected, experienced and well-known to residents in the camp. The interpreter provided translation services throughout the interviewing process. Interviews were conducted in the many local languages spoken by camp residents, including Swahili, Kifulero, Lingala and Kirundu. Potential participants were asked to decide whether they wanted the interviews to be conducted in their homes/compounds or inside the Social Welfare Offices (under the camp administrator's arrangement). With verbal consent, all interviews were carried out at the participants' compounds.

3.4.5 Sample

Onwuegbuzie and Leech (2007) define sampling as the procedure for selecting the required number and characteristics of a given population to be included in the research. The study was purposively focused on seeking individuals aged 18 and above, residing in the camp. To answer

the study's research questions, the researcher conducted semi-structured interviews with adult men (N = 4) and women (N = 14) who were from the Democratic Republic of the Congo (DRC) (N=10), Burundi (N = 4) and Rwanda (N = 4). The researcher also spoke with 2 nurses at the camp clinic, two representatives from Christian Care, teachers from the primary and secondary schools, an official from JRS, one social worker from the Department of Social Welfare, as well as several religious leaders in the camp.

3.4.6 Research tool

The study made use of a semi-structured interview schedule for data gathering. Questions on the interview schedule were open-ended and this ensured that the interviews undertaken were very interactive. An interview schedule allows the interviewer to be flexible, informal, and conversational during the interview (Brinkmann, 2014). Questions on the interview schedule were designed in such a way that they reflect the aim, objectives as well as the theoretical framework of the research study (Brinkmann, 2014; Kivnick & Murray, 2001; Turner III, 2010). The following issues were explored during the interviews: general understanding of mental health and illness, coping mechanisms in response to psychological distress, experiences when seeking mental health services and recommendations regarding to access to mental health care. A copy of the research tool is provided in Appendix D.

3.4.7 Pre-testing of the research tool

Pre-testing is the final stage in the construction of an interview guide (Larkin, de Casterlé, & Schotsmans, 2007; Synodinos, 2003; Williams et al., 2009). The above scholars note that pre-testing is conducted to ascertain the average time the interview process takes as well to obtain feedback from participants concerning potential problems with the interview questions and the interviewing process as a whole. In this regard, a pre-test of the research tool was conducted to assess the suitability of the research questions as well as to enhance the research tool's validity and reliability (Collins, 2003; Okoli & Pawlowski, 2004; Van Teijlingen & Hundley, 2002).

Rubin and Babbie (2011) further assert that no matter how careful one's research design might be, the possibility of error cannot be completely ruled out. Thus, the probability of making a mistake/s is very high, and this includes, the possibility of asking an ambiguous question to participants (p. 226). Although the researcher could not visit the fieldwork site before going there to conduct the

actual research – due to many factors, such as time, ethical, and financial constraints, a pilot study of the research was done upon the researcher's arrival at the camp. The researcher conducted a pre-test of the research tool with two persons who met the selection criteria but were excluded from participating in the final study. The results of pre-testing enabled the researcher to remove irrelevant questions on the interview guide (Williams et al., 2009). For example, the following question was removed from the interview guide following pretesting:

"Does taking part in this kind of study evoke any kind of emotions to you? What are they" This question was removed after respondents' discovery and suggestion that it a mere continuation of the previous question, which read as, "How did you feel during the interview". Thus the question was removed upon the suggestion of the participants. In addition, another respondent suggested that there was a need for the researcher to spend some time building rapport with the interviewee instead of going straight into the interview questions. This, according to the participant, was going to help 'break the ice' and encourage interviewees to open up, and make them feel comfortable during the interview.

3.5 Data Collection

The study made use of individual interviews for data collection, specifically in the form of semi-structured interviews. According to Whiting (2008) semi-structured interviews consist of predetermined questions with mostly fixed order but allow the flexibility for adding further questions for clarification during the interviews. Doody and Noonan (2013) note that semi-structured interviews allow much flexibility around the sequence of questions to be asked and often give more room for the interviewer to allow the respondent to speak more broadly about the topic under consideration. The choice of using semi-structured interviews was influenced by the fact that the researcher had a specific and clear agenda that was being sought to be understood (Cohen & Crabtree, 2006; Doody & Noonan, 2013; Noor, 2008; Pathak & Intratat, 2012; Whiting, 2008). More so, semi-structured interviews were chosen due to the fact that they allow the researcher to gain control during the interviewing process (Cohen & Crabtree, 2006; Doody & Noonan, 2013; Whiting, 2008). The researcher worked to ensure that the reliability of the of the study was enhanced by asking study respondents standardized questions throughout the entire interviewing process (Brinkmann, 2014).

Almost all interviews were tape-recorded (N=15). This helped ensure the use of direct and precise quotations during data analysis – thereby enhancing the trustworthiness research results (Bevington & Robinson, 2003; Elo et al., 2014). Tape-recording was only done upon receiving permission to do so from study respondents and the researcher made sure that the decision of the other three participants, to deny consent was treated with all due respect (Halderman, Waters, & Felten, 2004; Klasnja, Consolvo, Choudhury, Beckwith, & Hightower, 2009). Nonetheless, it also helped to protect their privacy and confidentiality (Whiting, 2008).

The researcher also made use of naturalistic observation as a way of gathering data. This provided the researcher with direct access to the social phenomena under consideration (Mehl, Robbins, & gro\s se Deters, 2012; Patton, 2005). Thus, instead of solely relying on some kind of self-report – that is, what participants had to say during the semi-structured interviews, the researcher sought to observe and record what he saw on the ground (Bordens & Abbott, 2002; Campos, Graesch, Repetti, Bradbury, & Ochs, 2009; Guba & Lincoln, 1982; Mehl et al., 2012). As such, the naturalistic observation method provided the perfect complement to the interviews given that no single research method can provide complete or enough information on its own (Cohen, Manion, & Morrison, 2013; Green, Camilli, & Elmore, 2012). Some significant observations made by the researcher during the data gathering phase include: the unbearable heat residents deal with on a daily basis, high idleness rates among camp residents, long waiting times and queues at the clinic, as well as the existence of several church buildings in the camp and many others currently being constructed. The full list of observations is provided in Appendix G.

3.6 Data analysis

According to Neuman (2005), data analysis is the process of bringing order, structure and meaning to the mass of collected data. Thematic content analysis was employed during data analysis. Neuendorf (2016) defines thematic content analysis as the process whereby the raw data is grouped into a list of common themes as expressed in actual words by the respondents in the study. Braun and Clarke (2006) further note that thematic content analysis involves organizing and describing one's research data set in detail and frequently goes further to interpreting various aspects of the research topic. According to Sgier (2012), it alludes to the process of reducing and making sense of large volumes of data and involves an attempt to identify core consistencies and meaning.

Thematic content analysis was deemed appropriate for data analysis as it allowed the researcher to organize raw data into tangible units of information and to group related categories and themes into subthemes. Braun and Clarke (2006) provide a detailed account of six different phases followed when conducting thematic content analysis. The first step is familiarization. It involves the process of reading through interview scripts and field notes, at the same time jotting down emerging new ideas about initial themes, concepts or questions. This stage was critical in helping the researcher to gain a comprehensive understanding of material from the interviews before it was split into different parts.

The second step is initial theme identification and data labelling. During this phase, the researcher identifies several key themes that initially emerge from the data. According to Kawulich and Holland (2012), the themes should be fairly broad but also somewhat exclusive or independent. It is also during this stage when the researcher gives each theme its unique code such as a number or a letter or a distinct highlighter/crayon color code. Deep reading and coding follows and this is whereby the researcher rereads each set of interview scripts or field notes thoroughly and rigorously, identifying each place where themes appear with the relevant codes. The fourth step is sorting data by theme which according to Ritchie and Spencer (2002), is a lengthy data management task that involves reorganizing data into the themes already developed. The fifth step is summarizing and synthesizing data. It involves reduction of data into something that is manageable usually done by writing a summary of each theme that details the general patterns, similarities, differences, silences, selected quotes used to illuminate the discussion. The final stage sees the researcher engaging in interpreting and checking for emerging themes and interconnections. It involves looking back at summaries on each theme, emerging themes, the significance, implications and interconnections between the themes (Braun & Clarke, 2006). All the above-mentioned stages were followed in the analysis of data.

3.7 Ethical considerations

Ethics has become a cornerstone for conducting effective and meaningful research (Neuman, 2005). The researcher was well aware of the many issues involved in refugee research (Ahearn, 2000; Jacobsen & Landau, 2003; Mackenzie, McDowell, & Pittaway, 2007) and at all times strived to maintain and adhere to the highest standards of professionalism and research ethic principles. Drawing from the guidelines for research in refugee and internally displaced people as described

by Leaning (2001), some of the ethics that were observed encompass the principle of informed consent, protection and welfare of participants, debriefing of participants, respecting participants' right to withdraw from research, maintaining confidentiality and anonymity of data, and approval of studies by institutional ethics committee.

The principle of informed consent

This principle emphasises the need for researchers to explain to participants, their obligations and responsibilities of participating in the research at the beginning of the study (Neuman, 2005). The researcher made sure that all pertinent information was provided to study participants before the start of each and every interview that was carried out. Participants were well informed and briefed about their rights, the purpose of the study, the nature and duration of participation, as well as the risks, benefits and alternatives to participation (Corrigan, 2003; Goodhand, 2000; Hugman, Bartolomei, & Pittaway, 2011; Mackenzie, McDowell, & Pittaway, 2007). Participants were informed that their participation was voluntary and that they were free to withdraw from the research at any time, as well as avoiding answering uncomfortable question/s. All this information was provided on the participant information sheet that was given to every participant at the beginning of each interview. A copy of the information sheet is provided in Appendix A.

Protection and welfare of participants

Drew, Hardman, and Hosp (2008) note that in the context of research ethics, the harm principle involves extreme physical pain or death, as well as other important factors such factors as psychological stress, personal embarrassment or humiliation. Babbie (2004) further establishes that protecting participants from harm is a key consideration in any research undertaken. Although this research had the potential of evoking trauma-related emotions, no one among the participants - was found to be in need of emotional counselling, or any other sort of intervention. Nevertheless, to ensure the protection and welfare of participants, arrangements for supportive counselling services were made with the camp clinic prior to the commencement of the study.

Maintaining confidentiality and anonymity of data

According to Mattison (2000), this principle entails that the researcher must keep confidential whatever information obtained in the research unless the participant has agreed and given consent

of publishing the information before the research begun. With the permission of respondents, interviews were tape-recorded and no one will have access to the information with the exception of the research supervisor. More so, pseudonyms were used in order to disguise the identity of participants during the process of data gathering and in raw data (Allmark et al., 2009; Bagnoli, 2009; Dearnley, 2005; Orb, Eisenhauer, & Wynaden, 2001; Richardson & Godfrey, 2003; Van den Hoonaard, 2003). The research data has also been stored in digital form with all identifying feature removed.

Approval of studies by institutional ethics committee

This study, particularly data gathering, was only conducted after the researcher had received the ethics clearance from the University of the Witwatersrand Human Research Ethics Committee (Non-Medical). In Zimbabwe, permission to conduct the study was sought and obtained from the Zimbabwean Ministry of Public Service, Labour and Social Welfare – where all research on refugee matters in the country are addressed for approval by the Commissioner of Refugees. Additional permission was also sought from Chipinge District Hospital, and all permission letters have been attached as part of the appendices in this report.

Publication of findings and feedback given to participants

With regard to the provision of feedback to research participants after the completion of the study, Tong, Sainsbury, and Craig (2007) establish that the final research report has to be made available to research participants upon their request. This principle plays a key role in ensuring that participants get acquainted to the findings of the research (Harriss & Atkinson, 2011; Johnson & Christensen, 2008; Tong et al., 2007). Accordingly, the researcher will send a copy of the research report to the camp administrator upon completion of the research project. The researcher has also done his utmost to ensure transparent and accurate reporting so as to minimize researcher bias (Burton-Jones, 2009; Podsakoff, MacKenzie, & Podsakoff, 2012).

3.8 Limitations of the study

Although this research was carefully planned, the researcher is still aware of its limitations and shortcomings and these are highlighted below:

- The study was expensive and time consuming. A lot of money was spent on food, travel, accommodation, and interpreting services during the data gathering phase. More so, the study was supposed to be completed within a one-year period and the researcher could not afford to gather as much information as he would have wanted due to that.

- It is hard to generalize the findings of the study to the broader refugee population in the camp given that refugee school-children under the age of 18 were excluded from the target population. A more representative sample could have drawn respondents from all age groups within the camp. Thus, the extent to which the sample is representative of all individuals and families from multiple countries is very limited.

- Some of the participants denied their consent to audio-recording. This might have led to a significant loss of data. The importance of this should however not be overemphasized since the researcher managed to take down some notes during the interviews.

- Another limitation of the current research is that the researcher was forced to engage the services of interpreters due to language barriers. Respondents were drawn from three different countries and there is a possibility that translation of phrases and concepts may have altered the themes that emerged from the analysis – and may therefore fail to provide a true reflection of what they said. Again, the significance of this should not be overstated as the researcher employed the services of trained professionals – currently employed by UNHCR.

- Given that qualitative analysis ultimately relies on the assessment and judgments of the researcher, there is the possibility of unintended researcher bias in spite of efforts to minimize it throughout the interviews and their analyses.

3.9 Strategies to ensure trustworthiness of the research

According to Shenton (2004) trustworthiness involves paying attention to four key aspects, namely, credibility, transferability, dependability, and confirmability.

Credibility

Patton (2005) notes that credibility points to the extent to which an authentic account of participants' experiences or understandings has been captured and reflected in the findings and conclusions. In this regard, the researcher enhanced credibility by collecting vast data on the research problem (Mays & Pope, 2000, 2000; Thurmond, 2001; Whittemore, Chase, & Mandle, 2001). More so, the researcher was prepared to move away from his original assumptions whenever the collected data suggested otherwise (Bradley, Curry, & Devers, 2007; Bruce, 2007; Mays & Pope, 2000; Sinkovics, Penz, & Ghauri, 2008; Thurmond, 2001; Whittemore et al., 2001).

Transferability

In addressing transferability, the researcher gets to examine the extent to which findings from a setting or sample can be applied to another setting or a larger population (Kuper, Lingard, & Levinson, 2008; Malterud, 2001; O'Reilly & Parker, 2013; Shenton, 2004). In that regard, the researcher enhanced the transferability of the study by providing a thick description of research findings to the reader (Shenton, 2004; Thomas & Magilvy, 2011; Tracy, 2010) as this could be useful in understanding other contexts, even though that was not the purpose of the current research.

Dependability

According Creswell and Miller (2000) dependability is based on the need for the researcher to account for the ever-changing context within which research occurs. In this regard, the researcher employed the strategy of explication (Creswell & Miller, 2000; Curtin & Fossey, 2007; Golafshani, 2003; Patton, 1990; Shenton, 2004). Thus, in this report, the researcher provides a clear and detailed explanation of how research was conducted, how data was gathered, how the research instrument was designed and utilised, and any other factors which impacted on data collection. More so, the researcher kept a reflective diary on how the research process panned out (Golafshani, 2003).

Confirmability

According to Shenton (2004), the researcher needs to follow certain steps in order to ensure that the findings from the study are a result of the experiences and ideas of the informants, rather than the preferences of the researcher. Drawing from Leininger (1994), the researcher documented the procedures for checking and rechecking the data throughout the study. Further, Carcary (2009)

notes that another way of ensuring confirmability is to have someone do an audit in one's research. The researcher provided enough information on the sources, evidence, data collection methods for the supervisor to trace the route to the conclusions, interpretations, explanations and recommendations.

3.10 Chapter Summary

This chapter provided a detailed description of the research design and methodology. It outlined the methods and procedures in the study and the following chapter provides a presentation and discussion of the findings.

CHAPTER FOUR: PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

The current chapter provides the presentation and the discussion of data collected. Descriptive statistics were used to analyze demographic information, while qualitative data were analyzed using thematic content analysis. The results presented in this chapter make use of constant and specific reference to verbatim quotations from the interviews conducted with the participants in the study. The presentation of results integrates the literature which was reviewed in chapter two of the research report. The data was gathered from refugees and camp officials.

4.2 Demographic profile of respondents

This section presents background information with regards to refugee respondents' age, gender, nationality and length of stay in the camp. As in the case of many other refugee camps across the world, Tongogara Refugee Camp consists of people from different backgrounds, and the following information was considered necessary in the analysis of the views of the respondents.

Table 1: Demographic details of refugee research participants (N=18)

Participant Pseudonym	**Gender**	**Age**	**Nationality**	**Length of stay - Years**
1. Besa	Female	47	Rwanda	7
2. Musa	Male	32	DRC	5
3. Mbombo	Female	35	DRC	3
4. Thandiwe	Female	26	DRC	6
5. John	Male	28	DRC	3
6. Faida	Female	38	DRC	12
7. Uwishema	Female	41	Rwanda	6
8. Uwimana	Female	41	Burundi	4
9. Franscine	Female	20	DRC	1
10. Dushi	Female	38	Burundi	1
11. Mary	Female	43	Rwanda	13
12. Jeremia	Male	30	Burundi	3
13. Kapinga	Female	30	DRC	5

14. Boanerge	Male	27	DRC	4
15. Mukanwiza	Female	50	Rwanda	9
16. Kubwimana	Female	48	Burundi	1
17. Abimana	Female	40	DRC	1
18. Kombo	Female	42	DRC	4

As the table above shows, the sample consisted of a total of eighteen respondents. Only four were male while fourteen were female. This is so because the majority of the refugee population at Tongogara camp is female. Six of the study respondents were between the age of twenty to thirty, while five of them were between thirty-one and forty years and seven were between the ages of forty-one and fifty. Ten study participants have been residing in the camp for four years or less, while the remainder had been staying in the camp for a period between four to thirteen years. Study respondents came from three different countries, with DRC having just over half the total number of participants in the sample. Meanwhile Burundi and Rwanda together constituted nearly half the total number of participants between them.

Table 2: Summary of key informants

Name of organisation	**Position types/titles**	**Number of informants**
Christian Care	Volunteer	2
Department of Social Welfare	Social worker	1
Religious organisations	Pastor	7
Jesuit Refugee Service	Counselling Coordinator	1`
Zimbabwe Republic Police	Police officer	3
St Michael's primary and secondary schools	Teacher	2

Table 3: Overview of themes that emanated from the study

Category	**Themes**	**Sub-themes**
Perceptions of mental health and illness	Perceived causes of mental illness	• Pre-migration trauma • Post-migration stress

	Expressions of mental distress	• Sadness • Wandering aimlessly through the camp • Craziness • Worrying • Insomnia • violence
Experiences when accessing medical-related mental health services	Barriers to accessing biomedical mental health care	• Language barriers • Lengthy waiting times • Ill-treatment at the camp clinic • Temporary solution to a long-term problem • Transportation barrier
Utilisation of mental health services by refugees and asylum-seekers	Biomedical mental health care	• Use of sleeping tablets • Individual counselling
	Local/non-medical mental health services	• Prayer and spiritual healing • Family and support systems • Substance abuse • Indulging in physical activity
	Fear of stigma	• Suffering in silence
Recommendations for improving mental health outcomes	The case against long-term use of sleeping tablets	• Addressing unmet needs among refugee families • Sports and recreational activities • The need for resettlement
	The need for language interpreter services at the camp clinic	

4.3 PERCEPTIONS OF MENTAL HEALTH AND ILLNESS

The first objective of the study was to investigate the perceptions of refugees and asylum seekers regarding mental health in Tongogara refugee camp. A range of interrelated themes emerged during the process of data analysis, namely: pre-migration trauma, post-migration stress, sadness, worrying, craziness, as well as violence. These themes were subsequently grouped into two broad categories: perceived causes of mental illness and expressions of mental distress.

Perceived causes of mental illness

4.3.1 Pre-migration trauma

Data collected from the sample revealed that all participants held the view that the signs and symptoms of mental health problems were prominent among residents in the camp. Although no direct questions were asked about the prevalence of mental health problems among refugees in the camp, some interviewees in the study impetuously volunteered that they thought everyone residing

in the camp as a 'refugee' - could potentially develop – or was actually suffering from mental illness, yet considerable differences existed regarding the severity of illness. Participants noted that psychological problems were inevitable, especially given their exposure to traumatic events and harsh living conditions in source countries, and in destination, respectively. This theme was captured in the following response:

> *"(laughs) most of us…we're traumatized, there's too much stress because to say that there's someone who's normal in this camp, there's none because we faced so many challenges, we faced so many emotions. So to say that…when you don't have something to do, you spend your day you see, you find me here sleeping, it doesn't mean I'm not able, or I'm not capable to work, so to spend the whole day doing nothing you know…sometimes you're just thinking nonsense, you're just traumatized, you're stressed. And you're wondering what is next, you know your past but you don't see your future, you're in a total confusion*" (Besa, female refugee, 47 years of age).

Another participant described the complicated manner in which most individuals in the camp had left their homes. She attributed distress to the several problems confronting most refugees during the flight stage.

> "*If you look at the way we left our country of origin, moving through different countries and passing through various camps, people are very much touched emotionally. As a result of thinking about all these problems, you develop sicknesses and diseases like BP and many other problems. Our health is hugely disturbed because we are thinking too much. Personally, given what I've been through I've suffered a lot emotionally and we are very distressed… it's impossible to feel good after all I've been through. What I know is that I am not alone in this camp, many others are facing the same problem as me*" (Dushi, female refugee, 38 years of age).

While a substantial body of literature reveals that the causes of mental disorders are generally complex and vary depending on the particular disorder and the individual (Almqvist & Broberg, 1999; Benson & others, 2004; Miller & Rasmussen, 2010; Mollica et al., 2004; Porter & Haslam, 2005), the above sentiments by participants shed light on the fact that refugees are at risk for a range of mental health issues, having experienced high levels of trauma. Majority of participants

reported witnessing several different traumatic experiences during the pre-migration stage and the flight stage and stated that such war-zone stressors were a major cause of mental problems. Nearly all of the participants suggested and provided vivid examples of how pre-migration trauma had impacted on their mental health. The above findings are consistent with the existing literature, as it is widely recognized that pre-migration trauma is a strong predictor of mental health outcomes in refugees and asylum seekers (Benson & others, 2004; Fazel, Reed, Panter-Brick, & Stein, 2012; Lindencrona, Ekblad, & Hauff, 2008; Mollica et al., 2004; Momartin, Steel, Coello, Aroche, Silove, et al., 2006; Takeuchi et al., 2007; Toar, O'Brien, & Fahey, 2009).

4.3.2 Post-migration stress

Another cause of mental problems that emerged was the theme of post-migration stress in the camp. All (N= 18) mentioned a wide range of post-displacement stressors ranging from everyday struggles, struggling for food, water, clothing, shelter, employment, and health care. They revealed that their struggle was further compounded by the fact that they must make ends meet with very little aid and a small amount of money. As if that were not enough, participants bemoaned the desert-like conditions in the camp, noting that the area is always hot, and receives little or no rain annually. Two participants had the following to say:

> "*Life is very tough here especially because the cash we receive is far from being enough. By the time we get to receive the money, you find out that you owe lots of people their money…you have been surviving through borrowing. $13 is a very small amount and it all goes to credits. There are also no jobs here in the camp. Most people spend their time doing nothing and some people engage in theft as a result*". (Mbombo, female refugee, 35 years age).

> "*I'm a widow…uhhhh, we don't get any extra assistance apart from the $13 dollars we get every month. There are food shortages and it's one of the biggest issues we are facing here. All these problems we face cause a lot of sicknesses and stress and everyone is suffocating here*" (Dushi, female refugee, 38 years of age).

It is evident from the views of participants that post-migration living difficulties affect the psychological functioning of refugees and asylum seekers. Participants were well-aware of the compounding effect of post-migration problems on their mental health and well-being. They

revealed that the most salient problems affecting their mental health were poor socio-economic living conditions and that these post-migration stressors were a significant contributor to mental illness. Thus, the interviewees in the study emphasized systematic structural constraints such as socioeconomic circumstances, lack of job opportunities, poor housing, and difficulties accessing healthcare in the camp.

The above finding is congruent with Bhugra's (2004) assertion about the existence of a significant relationship between psychological well-being and post-migration problems. Although it was conventionally believed that the psychopathology of refugees in their destination country was due to the trauma experienced in source countries (Ehntholt & Yule, 2006; Lustig et al., 2004; Silove, 1999), the above finding demonstrates the importance of taking into consideration post-migration and resettlement problems. In that vein, recent research reveals that the post-migration experience is equally important – if not more relevant – compared to the impact of pre-migration trauma and experience (Bhattacharya & Schoppelrey, 2004; Birman & Tran, 2008; Fenta, Hyman, & Noh, 2004; Froschauer, 2001;; Schweitzer, Brough, Vromans, & Asic-Kobe, 2011; Schweitzer, Melville, Steel, & Lacherez, 2006).

Expressions of mental distress

4.3.3 Sadness

Speaking from their own experiences, participants mentioned several ways of expressing their psychological distress. More than half of the participants in the sample spoke of experiencing overwhelming feelings of sadness. They reported experiencing extreme stress, feelings of irritability and anger, thinking too much, as well as 'sadness caused by suffering'. This theme emerged along with the themes of pre-migration trauma and post-migration stress as these two were reported to be the chief causes of sadness in the camp. Worrying was also identified by all as one the most common signs of mental distress. Their responses suggested that there was a strong connection between mental sadness and worry. Below are some of the sentiments that were expressed by the participants in the study:

> "*It especially gets serious when you start thinking about the things you witnessed in your home country. It's better to focus on the present and forget about the past because that is*

the root cause. It's difficult to eat, sleep, or even to talk to other people when your heart is broken…you feel the heat"(Uwishema, female refugee, 41 years of age).

"*Emotional problems are a big problem for majority of people who live here. Everyone is stressed and some people are developing behavioral problems due to the circumstances we find ourselves in… there are high levels of stress and less hope for the future. There is no hope at all...it's the reason some people are committing suicide. Life is very tough here...there was a time I had thoughts of committing suicide as well"*(John, male refugee, 28 years of age).

Previous studies indicate that sadness is one of the most common ways of expressing psychological distress (Beiser, 1985; Beiser & Fleming, 1986b; Carroll, 2004; Eisenbruch, 1991b; Felsman, Leong, Johnson, & Felsman, 1990; Fenton & Sadiq-Sangster, 1996b; J. H. Jenkins, 1991; Keyes, 2000; Mirsky, 1997; Rechtman, 2000)Although they did not mention or name it specifically, the responses of participants suggest common signs and symptoms of depression. A number of studies indicate that some of the key signs and symptoms of depression include feelings of hopelessness, persistent sadness, anxiety, emptiness, fatigue, insomnia, headaches, as well as suicidal ideation (Alexopoulos, Abrams, Young, & Shamoian, 1988; Barefoot & Schroll, 1996; Beck & Alford, 2009; Dantzer, O'Connor, Freund, Johnson, & Kelley, 2008; Tohen et al., 2003).

4.3.4 Craziness

Another key theme that emerged was that of craziness. The respondents of this study used the term 'crazy' in their descriptions of the signs and symptoms of psychological distress among residents in the camp. Participants spoke of 'thinking nonsense', 'talking without making sense, or talking to myself loudly', 'having a confused or disturbed mind', as well as wearing ragged clothes. Musa, a man who endured what he described as a 'very tough time' during his first days in the camp had the following to say:

"*Because of what, many people here in the camp, the old people, young people, they don't have the good mind that they have before they come to this country. All of the people here, they're crazy about what has happened and what they see…the way they survive…it's not good life. You can see somebody greet him…they cannot greet you…if you have a good*

mind, you can think that person is hating what what but noo… a lot is going on in their mind" (Musa, male refugee, 32 years of age).

Speaking from their personal experiences, two participants spoke of wandering aimlessly through the camp – a phenomenon they reported was very common among residents in the camp:

> *"This morning when I was going somewhere here in the camp, I was talking to myself out loud, complaining and there is this other person I came across, a neighbor who said, what is it that you are saying? And I replied I didn't say anything to you…I was talking to myself (shaking her head) We are tired and very disturbed in this camp"* (Kapinga, female refugee, 30 years of age).

> *"You see there is too much stress here in the camp. You find a woman like me walking around in the camp without having a clear plan as to where they are going"* (Mukanziwa, female refugee, 50 years of age).

Closely related to the theme of madness or craziness was the theme of violence. Three participants reported that persons afflicted with madness, sometimes, go around beating up people randomly, screaming, and displaying aggressive or violent behavior. As in the case of sadness and every other theme that emerged during the process of data analysis, participants attributed the aggressive behavior of certain individuals to extreme, traumatic stressors and the poor socioeconomic situation in the camp.

4.4 EXPERIENCES WHEN ACCESSING BIOMEDICAL MENTAL HEALTH CARE

The second objective of the study was to explore the experiences of refugees and asylum seekers when accessing mental health services in Tongogara refugee camp. Several themes were picked up from participants' interviews and these include: language barriers, lengthy waiting times, ill-treatment at the camp clinic, temporary solution to a long-term problem and transport barriers.

4.4.1 Language barriers

Language barriers emerged as one of the most important themes in participants' responses concerning their experiences when accessing mental health services in the camp. Participants reported that patient-provider communication was often rendered more difficult, particularly given

the fact that health care providers were attending to patients using languages the latter, had little or no understanding whatsoever – either English or Shona.

Table 4: Distribution of respondents by language skills

Language skills	**Number of speakers**
Swahili	13
French	5
Kinyarwanda	5
Kirundu	7
Kifulero	7
Lingala	3
Chewa	1
Shona	5
English	2

All but two participants in the study did not even possess the most basic skills of English at the time when the interviews were conducted, while only a fraction of respondents said they were able to speak Shona – albeit not so at a level approaching fluency during the interviews. The issue of language barriers was described by participants as one such serious hurdle to effective communication – necessary for a healthy helping or recovery process. Below are some of the sentiments in participants' own voices during semi-structured interviews.

> "*One of the biggest challenges we face is that most of us can't speak English or Shona. How can you get assistance from the clinic when you don't know the languages they speak? Even though some of the nurses speak Swahili, they know very little Swahili and some of the people in the camp can't even speak Swahili*" (Thandiwe, female refugee, 26 years of age).

> "*The clinic staff usually communicate in English or Shona as they can't speak our languages…I mean they don't know Swahili, Kirundu, Chewa among many other languages of foreigners in the camp. It's such a big problem except for those who have*

been here for long…long enough to have learnt Shona…same with English" (Uwimane, female refugee, 41 years of age).

This finding is consistent with findings from other studies investigating the impact of language barriers on the quality of health care (Bell & Mehta, 1980; Leong & Lau, 2001; Timmins, 2002). Language barriers can adversely affect quality of care as health professionals working with immigrant populations often fail to bridge the language gap.

4.4.2 Temporary solution to a long-term problem

Participants reported that those suffering from psychological distress in the camp were either given sleep medication or offered individual counselling services at the camp clinic. Although they did not completely rule out the short-term benefits of using sleep medications, over half of the participants revealed that taking sleeping tablets was creating more problems than solutions. It was leading to more stress and an ever-increased reliance on the tablets, thus producing a vicious cycle of dependency. This theme is exemplified in the following remarks made by two participants:

"*Some people when feeling down and struggling to sleep, they go to the clinic and get those injections for sleeping…myself I have never done as I just believe in prayer…those injections only work for a short period of time, they don't take away your struggles….at times they make you feel like you want to vomit and you once you start taking those, you start depending on injection until….I don't know…*" (Faida, female refugee, 38 years of age).

"*If you keep taking the tablets, you are likely to face several problems in the long run…better not to use them for a long time…these tablets…because you'll be in trouble*" (Uwishema, female refugee, 41years of age).

One such sub-theme that emerged under this theme was the theme of misdiagnosis. Several participants spoke of visiting the camp clinic only to receive misinformation or suffer from improper mental health treatment. Some reported that more often than not, service providers did not take the necessary time to assess their conditions before dishing out tablets – in part due to language related problems – a theme that has been discussed in detail, previously.

"*I think to better meet our health needs, they need to give us proper medication. They have to give medicine in accordance with the sickness the person is suffering from…A friend of mine used to go to the clinic for psychosocial services and was getting given the tablets but by the look of things it's not helping anything I think*" (Franscine, female refugee, 20 years of age).

4.4.3 Lengthy waiting times

Another recurring theme identified in the participants' responses during the interviews was lengthy waiting times. Participants bemoaned long waits and delays at the camp clinic and felt that the referral process often takes way too long – especially in cases that require urgent care. The theme of lengthy waiting times emerged in conjunction with the theme of transport barrier. Recounting their experiences, study participants described long waiting times as a significant barrier to accessing health services from the clinic and hospitals outside the camp. They reported that prolonged waiting time at the clinic had a compounding effect on psychological distress. The major causes of prolonged waiting times were reported to be high caseloads as well as clinical or healthcare staff shortage. Participants also called for an increase in the number of health professionals in the camp clinic and suggested that this was going to help reduce the lengthy waiting time they experienced – thus, ensuring increased rates of patient satisfaction and utilization of health services.

"*Suppose I go to the clinic today, they diagnose you but you have to wait for a very long time especially when it's a referral to Chipinge Provincial hospital or Mutare*"(Dushi, female refugee, 38 years of age).

"*The problem we face…especially as mothers, when you are about to give birth, the whole process sort of delays…it's like you're about to deliver a baby and then you're referred to Chipinge hospital. And the problem you are not going to get there anytime sooner as you have to wait whilst things like transport are being arranged. It takes time and it's such a stressful process"* (Franscine, female refugee, 20 years of age).

Several scholars note that the amount of time a patient waits to be seen is one factor which affects utilization of healthcare services as patients perceive long waiting times as an access barrier to health services (Bogart et al., 2013; Duff, Kipp, Wild, Rubaale, & Okech-Ojony, 2010;

Govindasamy, Ford, & Kranzer, 2012; Hardon et al., 2007; Miller, Ketlhapile, Rybasack-Smith, & Rosen, 2010; Mills et al., 2004; Van Dyk & Van Dyk, 2003). Long waiting times at clinics – especially in the Global South, has been shown to be an unnecessary – yet so common and a major cause of stress for patients at most hospitals and clinics (Blendon, Schoen, DesRoches, Osborn, & Zapert, 2003; Bogart et al., 2013; Derlet, Richards, & Kravitz, 2001; Govindasamy et al., 2012; Haraden & Resar, 2004; Hardon et al., 2007; Mills et al., 2004; Schwartz, 1974; Siciliani & Hurst, 2005).

More so, Oche and Adamu (2013) note that waiting time is one such key aspect of practice every client or patient uses to judge health personnel, even more than their knowledge and skill. It is an important indicator of the quality of services offered by health centers (Aldana, Piechulek, & Al-Sabir, 2001; Dagger, Sweeney, & Johnson, 2007; Pakdil & Harwood, 2005; Zineldin, 2006). Having to wait a long time in the clinic has also been shown to be a major source of dissatisfaction with health care for most clients, and a negative correlation has been found to exist between prolonged waiting time and patient satisfaction with health care (Oche & Adamu, 2013).

4.4.4 Ill-treatment at the camp clinic

Another theme that emerged, related to the themes of lengthy waiting times and ineffective treatment is that of ill-treatment at the camp clinic. More than half of participants complained of rough treatment by camp clinic service providers. They expressed their disgruntlement over the way nurses at the camp clinic handled patients seeking healthcare services and decried the 'refugee label' they were given. Participants felt that they were not receiving the same treatment as 'locals'(those considered Zimbabwean by nationality) especially in cases wherein referrals were made to the district hospital or any other hospital – outside the camp but within the country. This theme was captured in the following remarks by one of the participants:

> "*Another challenge about clinic, they must take human being as them because people they are not sheep, they're not a dog. If someone come to you, it means they need you. They need your assistance you understand. If they don't want you, they don't come to you. If someone go there and they need help, say I am sick you are not the one who come to him, it's him who come looking for you. Because he know if he sees you, he can get the issue..get answer. It means when someone says I am sick, listen to them and…you know..they used to*

say someone who is sick is like a baby, you know you must…cause him he's a nurse and know how to talk to somebody with. Talk to him nice, how do you feel in good voice not to shout him. If you shout him, can be scared to tell you… Yeah they shout…heeeeeeeey…you don't understand….heeeeey…go there…heeey…."(Musa, male refugee, 32 years of age).

Another participant expressed her concern over the usage of the term 'refugee' at clinics and hospitals in the country. She felt that the refugee label attached to people from different corners of the world – staying in the camp, was discriminatory and stigmatizing:

"*People are also dying even when they go to Chipinge hospital because there is a special name…marefugee. The use of this name by health professionals is not good. It has a negative way…to neglect and when you are known that you are a refugee from Tongogara, the treatment in hospitals is different, compared with locals*" (Kapinga, female refugee, 30 years of age).

The researcher sought to strike a balance between the views of refugees from their own perspective and that of service providers in the camp. The experiences of the former were largely discredited and discounted by the latter. In the words of one of the health professionals at the camp clinic

"*When you shout at these people, you're not doing it with the intention of causing any harm or damage to their broken egos. Working with them, you come to a point where you realize it's necessary and needed (shouting). Otherwise they won't take you seriously".*

Another camp official said,

"Look, when you came here, I was carrying her at my back…we were playing in a very friendly way. The same way we treat them all".

4.5 UTILISATION OF MENTAL HEALTH SERVICES IN THE CAMP

The third objective of the study was to describe the utilisation of mental health services by refugees and asylum seekers in Tongogara refugee camp. A number of common themes emerged during the analysis, including fear of stigma, suffering in silence, indulging in physical activity, use of sleeping tablets and counselling, prayer and spiritual healing, family and support systems,

substance abuse, and avoidance. The emergent themes can be grouped into two broad categories, namely – medical mental health treatment, and non-medical mental health treatment.

4.5.1 Use of sleeping tablets and counselling

The majority of participants reported that at some point in their lives, they have been to the camp clinic for sleeping tablets and/or counselling. They however appeared to downplay their use of sleeping tablets and contrasted its short-term benefits versus long-term impact. Many expressed concern over the potential side-effects of sleeping tablets on both mental and physical health. Two participants made the following remarks:

> "*Some people when feeling down and struggling to sleep, they go to the clinic and get those injections for sleeping…myself I have never done as I just believe in prayer"* (Faida, female refugee, 38 years of age).

> "*From my own personal experience, I went to the clinic when I was down emotionally, feeling so overwhelmed…they gave me sleeping tablets…just to make you sleep*" (Dushi, female refugee, 38 years of age).

An official from the camp clinic also revealed that day by day, long queues at the clinic for sleeping tablets and counselling had become the norm as the vast majority of refugees and new arrivals were suffering from a variety of mental health issues. She revealed that they were dealing with a range of common mental health problems, including PTSD, depression, anxiety, substance abuse, as well as some more rare mental problems such as bipolar disorder and schizophrenia. In addition, the researcher was shown some mental health care records wherein patterns of mental health service utilization for each disorder were kept. The most commonly used mental health services pertained to PTSD, which had 20 clients per day on average. It was however discovered that there were no permanent psychiatrists at the camp clinic – as they usually visit on a temporary basis all the way from the provincial hospital (Chipinge town).

4.5. 4 Prayer and spiritual healing

Although most participants claimed to have taken depressants at some point in their lives, all provided rich descriptions of their reliance on spirituality rather than mental health doctors or

drugs. Participants spoke of their strong belief and reliance in God, with all but two professing to be Christians:

> *"I'm Christian, I go to Rehoboth Church of God in Christ. Normally, we have prayer meetings Fridays and Sundays, so I make sure I attend every church service and when feeling overwhelmed, the pastor will call people as such to the front, he prays for you, and all of sudden I come back here feeling fresh and not thinking too much about my problems and I know God will visit us one day. So the pastor is there to give you hope when you feel like there's no tomorrow, to comfort you, and also to encourage you to pray all the time so as to avoid falling prey to evil spirits or anything that leads to misfortune*" (Faida, female refugee, 38 years of age).

Another woman described the pivotal role played by religious people in promoting recovery to mental health. She explained that faith leaders in the camp were offering a much needed message of hope and inspiration as they lead, guide and direct people – providing a ray of hope for distressed people:

> "*The pastor normally asks for those who are worrying too much and feeling hopeless about their tomorrow and how they are going to survive in the camp. He then guides you in prayer in making a short prayer along with him, saying a few words to God, and sometimes lays hands of people not feeling well. That is when you can start hearing some people giving testimonies about their healing and we thank God for every testimony any person gives to the church* (Mary, female refugee, 43 years of age).

In an interview conducted with one of the many religious leaders in the camp, it was reported that spirituality was playing a critical role in responding to the needs of the refugee population. According to the interviewee, the majority of refugees and asylum seekers in Tongogaga have been traumatized by horrific experiences and many of them have been left hopeless such that they desperately needed spiritual intervention. More so, numerous churches have opened in the camp as multitudes of desperate people believe that a spiritual life can deliver them from past trauma and current stressors in the camp. Camp officials noted that the vast majority of refugees residing in the camp belonged to some religious sect and were regular churchgoers who had placed their last hope on spirituality. Furthermore, an official from the camp clinic also revealed that despite

visiting the clinic for medications and counselling, the majority of residents in Tongogara were very religious and would rather seek help from their pastors than seeking formal mental health services.

The above findings are similar to those observed in previous studies focusing on the relationship between spirituality and mental health (Blanch, 2007; Carpenter, 2002; Dein, Cook, Powell, & Eagger, 2010; Fortinash & Holoday-Worret, 2008; Hill & Pargament, 2008; Pardini, Plante, Sherman, & Stump, 2000; Rippentrop, Altmaier, Chen, Found, & Keffala, 2005; Swinton, 2001). Several studies show that religion is one of the most common mechanisms for coping with psychological distress – nurturing 'broken hearts and wounded spirits', as well as healing the 'soul' (Duran, 2006; Duran, Firehammer, & Gonzalez, 2008; Gozdziak, 2002; Kohrt & Hruschka, 2010; Rogers, 2002; Struthers & Lowe, 2003; Walsh, 2008).

4.5.5 Family and support systems

The majority of participants described links between social support and health, and believed that support from family and friends had a positive effect on their physical and mental well-being. Nearly all participants spoke of social support as something that can always be counted upon especially when one was going through a hard time. Study respondents noted the interrelationship between their mental and physical health and the availability of support or lack thereof. They revealed that family and friends provided emotional support and helped them cope with several daily stressors more easily.

> "*I go to my neighbors, I share about the problems I am facing. As you can see, I am very young woman, I take my time to listen to their advice as there are some elderly women here and most of them are actually from DRC…and it's not just neighbors…I also have friends…I tell them how I feel and I usually start feeling better and keep going*" (Franscine, female refugee, 20 years of age).

The participants perceived that support from family and friends had a positive effect on their mental and physical health. Understanding and encouragement improved their confidence and alleviated distress. Sharing with friends and family was an effective strategy for relieving stress, even though the impact of support on wellbeing depended on the closeness of the relationship between the support provider and recipient:

"*Well, we just talk to each other, you talk to your neighbours about your struggles, you speak to the closest people around you, sometimes borrowing if you need something you know they have, but most of the time we just talk, as you can see, I'm widow and can't rely on my own to survive, I need people to share my struggles with, friends and people who can help me*" (Faida, female refugee, 38 years of age).

In this regard, study respondents described sharing and listening to family and friends as a form of informal therapeutic help. Participants noted that despite the pivotal role played by family and support systems in coping with psychological difficulties in the camp, it was still difficult because families and other support systems are often in the same position as those who might be in need of assistance.

There is ample evidence that social support acts as a buffer to stress and its destructive consequences (Lakey & Orehek, 2011; Taylor & Brown, 1988; Turner & Brown, 2010; Turner, Frankel, & Levin, 1983). Several studies show that support from family and friends helps prevent stress by making painful experiences seem less consequential (Ahern et al., 2004; Coker et al., 2002; Fozdar & Torezani, 2008; Glass, Flory, Hankin, Kloos, & Turecki, 2009; Goodman, 2004; Hsu, Davies, & Hansen, 2004; Lee, 2003; Lustig et al., 2004; Mollica, Cui, McInnes, & Massagli, 2002).

4.5.6 Substance abuse

Of all the participants who took part in this study, none of them claimed to be engaging in substance abuse. Participants however reported that even though most people in the camp relied on spirituality to cope with stress, some individuals in the camp were attempting to manage their stress through the use of alcohol or drugs. Study respondents described substance abuse as a form of self-medication for stress that some individuals were using in order to 'escape' their difficulties. They also highlighted the dangers of using alcohol and drugs to deal with stress suggesting that it was only good for masking people's problems, without solving any, and reported that it often makes people engage in violent behavior.

"*Some people drink a lot of beer and smoke cigarettes thinking they can forget about their troubles and reduce stress. It however depends with the person but as I said earlier, most people in the camp go to church and pray.*" (Jeremia, male refugee, 30 years of age).

A number of camp officials revealed that some individuals in the camp had developed an alcohol addiction as a result of trying to deal with psychological distress. There was what they described as 'urwaga' or 'kasiki' - a type of beer well-known as 'banana' – made from ripe, but not over-ripe bananas especially from countries such as Kenya, DRC, Uganda and Rwanda. It was also revealed that this type of beer was very cheap especially because it was one that was locally brewed or homemade. Camp officials claimed that 'banana' was a very unhealthy type of beer as it carried dangerous side effects to those consuming it. It was further reported during the interviews that only a handful of individuals relied on alcohol for managing their stress since the vast majority of camp residents were religious and heavily depended on spiritual support. The above findings largely contradict the assertion by some scholars that trauma exposure predicts alcohol and illicit drug dependence and abuse (McFarlane, 1998; Pierceall & Keim, 2000).

4.5.7 Indulging in physical activity

All participants in the study mentioned exercise as a common stress relief technique. When asked on how they were coping with stress on their own, respondents revealed that they engage in physical activity and hobbies that benefit both the body and the mind. Participants stated that physical activity was a popular way of managing and reducing stress in their everyday life in the camp and mentioned several activities, including participating in a sport, taking a walk, gardening, washing dishes and clothes, mopping, among others.

> "*So, when I'm like that I wash clothes, I find something to do, just to take out that energy….to take…just because…ahhh no…I wash, I clean, I mop, I just do it and when I see that everything is clean, I somehow feel I've cleaned up my mind…just because I was not used to live in such a dirty place thinking dirty, thinking nonsense, I clean I and feel just…(laughs) and I will feel the pressure is gone"* (Besa, female refugee, 47 years of age).

Research carried out to investigate the relationship between physical activity and mental health reveals that a positive correlation exists between the two variables (Biddle & Asare, 2011; Carless & Douglas, 2010; Harrison & Fredrickson, 2003; Paluska & Schwenk, 2000). Several scholars note that exercise and physical activity may help improve mental health and even prevent mental disorders by improving self-confidence, self-concept, cognition, or other psychological variables. Some scholars however suggest that the relationship between the improvement of mood and

exercise is one that should not be taken as a universally applicable phenomenon (Aly, Elmahdy, & Schrale, 2012; Peluso & Andrade, 2005).

4.5.8 Fear of stigma

Two participants revealed that they would rather suffer in silence than seeking mental health services from the camp clinic. Their responses pointed to the cultural stigma around mental health issues – that worked to keep them from taking a proactive approach in seeking mental health services. For these participants, even telling family and friends was never an easy thing as they feared beings judged or labelled as 'a crazy or disturbed person'. They expressed their discomfort talking to people about their problems and insisted that they would rather ask God for help or try to deal with their problems in their own space.

> "*So when you are aware of what is going on, you keep your emotions to yourself and other people…they spread it and when you spread your emotions, you give room to people to talk and personally, I don't like giving room to people to see or know what I'm going through*" (Besa, female refugee, 47 years of age).

Abundant theoretical and empirical literature shows that stigma is a significant barrier to care for many individuals suffering from mental illness (Corrigan, 2004; Golberstein, Eisenberg, & Gollust, 2008; Greene-Shortridge, Britt, & Castro, 2007; Gulliver, Griffiths, & Christensen, 2010; Hoge et al., 2004; Saxena, Thornicroft, Knapp, & Whiteford, 2007; Thornicroft, 2008).

Several studies demonstrate that mental health stigma - the prejudice and discrimination towards people with mental illness is just as debilitating as the illness itself (Hinshaw, 2005; Hinshaw & Stier, 2008; Link & Phelan, 2001; Sayce, 2000).

4.6 RECOMMENDATIONS FOR IMPROVING THE ACCESSIBILITY OF MENTAL HEALTH SERVICES

The fourth objective was to make recommendations for improving the accessibility of mental health services to refugees and asylum seekers particularly in Tongogara refugee camp. Participants made several recommendations for promoting mental health in the camp. The main themes that emerged in their responses during the interviews include: the case against long-term use of sleeping tablets, the need for language interpreter services at the camp clinic, addressing

unmet needs among refugee families, the need for improved engagement with refugee families, the need for resettlement, and recreational activities.

4.6.1 The case against long-term use of sleeping tablets

All participants in the study reported having experienced or experiencing numerous undesirable side effects as a result of using sleeping tablets. They reported insomnia symptoms, dry mouth, sleepiness during the day, nausea, profuse sweating, as well as dizziness. One participant commented:

> "*Yeah I never went back again, sleeping tablets are sometimes not good for our health. After taking the tablets, you start feeling tired, and you can't do anything…they eventually damage your health…bad for health. Everybody thinks the tablets don't work, they just don't and it's only short term*" (Dushi, female refugee, 38 years of age).

It was also revealed that sleeping tablets were creating a vicious cycle of addiction or dependency as users were less likely to function without them. Two participants had the following to say:

> "*If you keep taking the tablets, you are likely to face several problems in the long run…better not to use them for a long time…these tablets…because you'll be in trouble….and you will need to use them everyday…that's the problem*" (Uwishema, female refugee, 41 years of age).

> "*Some people they go to the clinic. Sometimes they're given those injections, sometimes you are even…you don't deserve that and you are given it. It is harmful to your health…*" (Besa, female refugee, 47 years of age).

The above sentiments highlight the most likely scenario when quick fix solutions are turned into long-term solutions. It is well documented in the literature that long-term use of sleeping tablets can cause unwanted and sometimes dangerous side effects (Ammassari et al., 2001; Barber, 1995; Linnoila & Viukari, 1976; Longo, Johnson, & others, 2000; Reynolds, 2000; Ulrich, 1984). This finding therefore calls for more durable solutions which will enable residents to live healthier lives. Rather than assuming that tablets can be a lasting solution to psychological distress, the main solution lies in prioritizing the social determinants of mental health – more specifically, issues to do with housing, employment, education, food security, access of health services, just to name a

few. Nonetheless, when handing out tablets as is currently the case at the camp clinic, it is important to explain to patients, all the risks and/or discomforts associated with the use of sleeping tablets.

4.6.2 Addressing unmet needs among refugee families

Study respondents expressed their desire to see the government and other role players involved in the day-to-day operations in the camp, supporting camp residents in setting up small-scale enterprises. Participants envisioned the initiation and development of small-scale agricultural projects such as pig, goat, and cattle rearing, poultry, irrigation schemes for small-scale farming, as well as flea markets:

> "*There are four ways of dealing with stress. The first one is finding a durable solution to people's hardships. The second one is initiation of money-making projects. Third, there is need to address the problem of malnutrition. The last one, which I certainly believe is the best, is to find a better resettlement area. Mental health does not exist in isolation with other areas of life as it entirely depends on the living conditions*" (John, male refugee, 28 years of age).

From a social determinants perspective, it is argued that there can be no better antidote to mental health problems, than improving daily living conditions – thus, ensuring healthy lives and promote well-being for all at all ages. Recent research indicates that psychosocial stressors – including failure to meet basic needs are more strongly related to psychological stress than war-related trauma (Beiser, 2009; De Jong et al., 2001; Fazel, Reed, Panter-Brick, & Stein, 2012; Miller, Worthington, Muzurovic, Tipping, & Goldman, 2002; Watkins, Razee, & Richters, 2012). Further, a growing body of literature on refugees and asylum seekers shows that post-migration stressors are related to high rates of distress (Beiser, 2009; Bhugra & Jones, 2001; Bronstein & Montgomery, 2011; Hyman et al., 2000; Miller, Weine, et al., 2002; Miller & Rasmussen, 2010).

Action must be taken to improve the daily life of the refugee population in the camp and this will go a long way to provide opportunities for enhancing mental health and well-being of the refugee population in the camp, as well as the risk factors for the development of mental health (World Health Organization, 2014). As reported by the participants in the study, residents in the camp are at higher risk of mental problems because of greater exposure to unfavorable social, economic,

and environmental circumstances. Close attention should therefore be paid to poverty reduction, human rights, access to education, employment, health care, housing, and the provision of services proportionate to the needs of the refugee population in the camp.

4.6.3 Sports and recreational activities

Participants expressed a strong desire to see a strengthened sports and recreation program. They bemoaned lack attention to sports and recreation and reported that this had significant negative consequences across a range of sectors, including mental health. Thus, both refugee respondents and camp officials attributed the prevalence of mental problems and substance abuse among residents to the limited opportunities to engage in sports activities. Furthermore, participants suggested that sport could be a very influential tool in promoting not only mental health – but job prospects for individuals. One participant made the following claim:

> "*I think there are so many things that can be done…things like games..sporting activities. These are the kind of things that can help reduce stress*" (Mbombo, female refugee, 35 years of age).

Although refugee children are engaged in sports activities within Tongogara primary and secondary schools, these activities are suffering from lack of funding and an ad hoc approach to sports – often failing to engage the services of sports professionals in the country. Outside the primary and secondary schools within the camp, adults organize together sports activities randomly – with little or no recognized sports committees that can help establish and sustain teams or competitions – at least locally. Even athletic fields available to residents in the camp are in a very poor state and it is no wonder many individuals in the camp, do not partake in sports activities.

Indeed, a large body of literature indicates that sports activities have been effectively used as a means of ensuring refugee participation in 'host communities', in many countries in the world (Alastair Ager & Strang, 2008; Alistair Ager & Strang, 2004; Amara et al., 2004; De Voe, 2002; Dryden-Peterson & Hovil, 2004; Guest, 2009; Ramon Spaaij, 2012; Ramón Spaaij, 2013), as well as a means to enhance mental health (Biddle & Asare, 2011; Carless & Douglas, 2010; Frederick & Ryan, 1993; Harrison & Fredrickson, 2003; Paluska & Schwenk, 2000).

It is proposed here, the need to organize matches between teams representing refugees and 'local hosting communities' outside the camp. This will go a long way in fostering peace and improve the local communities' perception of refugees – at the same time helping residents in the camp, keep a healthy body and mind (Beutler, 2008; Dyck, 2011; Farwell, 2001; Harris, 2007; Kidd, 2008; Levermore, 2008; Schulenkorf, 2010).

4.6.4 The need for language interpreter services at the camp clinic

Study respondents suggested the need for language interpreter services, as these would help health practitioners – including mental health professionals, to fully appreciate and understand their health needs. Most refugees in Tongogara speak multiple languages, including Kinyarwanda, French, Swahili, Kirundu, and Kifulero. They speak several languages and dialects, yet health professionals are only fluent in Shona – their mother tongue, and English. A camp official revealed that even though it was possible for health workers to learn the languages of the refugee population, their busy caseloads among many other commitments meant that it was something very unlikely. One participant made the following statement:

> "*One of the biggest challenges we face is that most of us can't speak English or Shona. How can you get assistance from the clinic when you don't know the languages they speak? Even though some of the nurses speak Swahili, they know very little Swahili and some of the people in the camp can't even speak Swahili"* (Thandiwe, female refugee, 26 years of age).

In order to communicate effectively with clients, service providers need to engage the services of interpreters as the latter's interpersonal skills can help create a much more comfortable atmosphere for patients (Burnett & Peel, 2001; Davidson et al., 2004; Feldman, 2006; Miller, Martell, Pazdirek, Caruth, & Lopez, 2005; Murray & Skull, 2005; Peisker & Tilbury, 2003; Raval & Tribe, 2014; Watters, 2001).

Consistent with the provision of many, if not all health services, communication is key to building a healthy relationship. Establishing effective therapeutic relationships requires the creation of a welcoming environment wherein clients feel at ease to express their 'felt needs' through both verbal and nonverbal means (Campbell, Davis, & Skinner, 2006; Claycomb & Martin, 2013; 2008; Grosse, 2002; Leach, 2005; Woodward, Abelson, Tedford, & Hutchison, 2004). It is argued that

the need for a welcoming environment for clients becomes even more important when working with refugee population – especially given the traumatic experiences they may have gone through, during different stages of migration (Century, Leavey, & Payne, 2007; Granger & Baker, 2003; Guhan & Liebling-Kalifani, 2011; Jones, Baker, & Day, 2004; Leach, 2005; Loewy, Williams, & Keleta, 2002; Margaret, 1994; Nguyen & Bowles, 1998; Weisman et al., 2005; Yakushko & Chronister, 2005).

4.6.5 The need for resettlement

Participants bemoaned living conditions in the camp and called upon the researcher to 'do whatever he could' to help them resettle into 'some better place', far away from the camp. The participants revealed that they felt marginalized especially given the desert-like conditions as well as the remoteness of the camp's location in Zimbabwe. They revealed that the long-term encampment of refugees under such severe and unfortunate conditions was doing more harm than good to their mental and psychological health and well-being. As such, study participants suggested that the best way to promote mental health was to be realized through resettlement away from the camp. Two participants commented:

> "*The conditions in the camp are terrible and our hope is that God may remember our sufferings. This place is for animals, not for human beings and many people are dying every passing day…this is a very unconducive living environment. Just find a way you can help us out of this place…it's too much.*" (Kapinga, female refugee, 30 years of age).

> *"Even food…we don't have enough food and lots of people are starving in the camp….there is so much suffering throughout the camp. It would be better if we were to be relocated away from here."*(Jeremia, male refugee, 30 years of age).

Consistent with the above finding, several scholars take a radical stance against encampment (Abdi, 2005; Bookman, 2002; Horn, 2010; Hovil, 2007; Hovil & Okello, 2008; Polzer, 2009; Smith, 2004; Sytnik, 2012; Turner, 2015). It is argued that the practice of encampment should be put to an end as it prevents refugees and asylum from interacting or developing connections with 'locals', as well as political, economic, and social institutions – critical for mental health and other areas of human development (Abdi, 2005; Brun, 2010; Harrell-Bond, 2002; Hovil & Okello, 2008; Phillimore & Goodson, 2006; Smith, 2004; Sytnik, 2012).

The fact that Tongogara is located in a very arid area – subject to desertification (if not a desert already), and prone to mosquitos and tsetse-infested ought to be a serious cause for concern amongst the government and other stakeholders working with the refugee population at Tongogara. There can be little doubt the encampment of refugees and asylum seekers is responsible for furthering many of the complications faced by refugees during the recovery process (Abdi, 2005; Bookman, 2002; Harrell-Bond, 2002; Hovil, 2007; Phillimore & Goodson, 2006; Sytnik, 2012).

4.7 Chapter summary

This chapter provided a detailed presentation and discussion of the findings that emanated from the study. Several themes were identified and discussed under the four study objectives, namely, perceptions of refugees regarding mental health in Tongogara Refugee Camp, refugees' experiences when accessing mental health services, utilization of mental health services in the camp, and recommendations for improving mental health outcomes among refugees in Tongogara. A summary of main findings, conclusions and recommendations are presented and discussed in the following chapter.

CHAPTER FIVE: MAIN FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of the main findings

This is the first study that examines the perceptions of mental health and access to treatment among refugees and asylum seekers in Tongogara Refugee Camp. The current chapter provides a summary of the main findings, conclusions and recommendations from the study. The summary is drawn from the themes that emerged during data analysis and recommendations are also made based on what participants revealed during the interviews.

The major findings of the study include the identification and description of the roots, symptoms and signs of mental illness among refugees and asylum seekers in Tongogara Refugee Camp. The study discovered that mental health problems among camp residents were caused by a combination of pre-migration traumatic experiences and post-migration living difficulties. Post-migration stressors included failure to meet basic needs such as food, water, clothing, shelter, education, employment, health care, as well as unbearable temperatures in the camp. Some study respondents attributed causes of psychological distress to evil spirits, demons and God – hence they placed strong emphasis on prayer and spiritual healing for recovery. Expressions of mental distress included sadness, wandering through the camp aimlessly, worrying, and talking to oneself loudly.

The results reveal that most refugees and asylum seekers rely on informal processes of coping with mental health. A key finding that emerged from the study is the critical role played by social support, religious leaders, and physical activity in helping people recover from trauma and cope with mental distress. The results also show that camp residents made use of sleeping tablets and counselling (biomedical mental health care) to cope with psychological distress, while a small minority of the refugee population was reported to be engaging in substance abuse.

When analysed in the light of the conceptual model undergirding the current study (McIntyre, Thiede, & Birch, 2009), the findings show that variation in access exists – depending on where care was sought. Although few participants expressed concern over lack of permanent

psychiatrist/s at the camp clinic (under availability), more generally, physical access to mental health care was not very problematic. The findings clearly demonstrate that residents had multiple options (plural health systems) at their disposal.

Since participants mainly relied on faith healing and social support for coping with mental health, problems of affordability of care were not reported except in cases where medical care was sought outside the camp, and for issues not necessarily linked to psychological distress. The findings of this study indicate that the preferred healing methods among residents in the camp were readily available and affordable – particularly their strong reliance on spiritual support – so visibly demonstrated by the multiplicity of churches and church architecture in the camp.

The findings show that there were acceptability issues for residents when accessing biomedical care for coping with psychological distress – specifically from the perspective of refugee patients. The results show lack of respect for clients by health professionals. For example, refugee participants reported being discriminated against and treated unfairly when seeking care from the camp clinic and hospitals outside the camp. This is a very important finding and a possible explanation of the health-seeking behaviour of individuals in the camp. The above finding also emerged in close relation to the dimension of accommodation, under the access to health care framework. Refugee participants underlined the need for health professionals to attend to patients in a manner that accommodates 'specific needs' of refugee populations. They emphasised the importance of being context-sensitive on the part of health practitioners – particularly given the different kinds of sufferings most refugees have been through. Additionally, with respect to the concept of accommodation, refugee participants questioned the appropriateness as well as effectiveness of sleeping tablets and counselling in treating psychological distress. Other key findings from this study (under accommodation) include lengthy waiting times and ill-treatment at the camp clinic.

A major finding that emerged under the dimension of acceptability was the issue of language barriers. Refugee participants noted that language played a central role in determining access to biomedical care, in and outside the camp. They noted that misdiagnosis and improper treatment had become the norm rather than the exception, primarily due to their inability to effectively communicate their health concerns to service providers.

Last, participants made several recommendations for improving mental health and wellbeing in the camp. One of the key findings from the study was the need to pay more attention to the prevention of mental health problems and the promotion of mental health through action on the social determinants of health. The results from this study indicate that mental health issues are largely shaped by the social, economic, and physical environments in which people live. Participants called for more action to improve their daily life in the camp, specifically, through the initiation and development of small-scale agricultural projects such as pig, goat, and cattle rearing, poultry, irrigation schemes for small-scale farming, as well as flea markets. Albeit very few, refugee participants also made recommendations directly related to the provision of mental health services in the camp. These include, among others, the need for interpreter services at the camp clinic.

5.2 Conclusions

The current study offers a number of unique contributions to the existing literature on refugees and asylum seekers' access to mental health treatment in Southern Africa. It was the first comprehensive study to explore the perceptions of mental health and access to treatment among refugees and asylum seekers, at least in Zimbabwe, and it was additionally one among the few studies to have been carried out in Southern Africa, exploring refugees' access to mental health services in general.

An interesting and peculiar aspect of the current study is the fact that an attempt was made to unpack the cultural interpretations of distress among refugees and asylum seekers in Tongogara. As demonstrated in the study findings, misdiagnosis and ineffective treatment were bound to occur as everyday mental distress was being mistaken for mental pathology. A culturally sensitive approach is therefore necessary if appropriate care is to be delivered. Understanding the interaction between indigenous forms of knowledge with Western health practices is essential if service providers want to ensure the 'felt needs' of service users are met.

The present study is different from many other studies on access to mental health services in that, the findings shed light on shortcomings of medicalizing distress. The results of the present study highlight the limitations of the biomedical model of mental illness treatment – particularly the fact that human suffering is restricted to the individual sphere, when the root causes of suffering appear

to be collective and grounded in a socio-historic context of human rights abuses (Chen, 2007; Igreja, 2003; Miller & Rasmussen, 2010). The study produced key findings that concur with previous studies (Afana, 2012; Tilbury & Rapley, 2004; Westoby, 2008) which noted that the medicalization of distress and human suffering often results in service providers continuing to label and treat refugee patients in terms of narrow prescriptive Western interpretations. The findings reveal that recovery from distress and human suffering is a spiritual process that goes well beyond therapeutic change, to involve a shift towards paradigmatic change and away from individual interventions. Rather than taking a narrow focus on access to 'formal mental health services' – that was severely belittled by the participants in this study, emphasis should be on key social and economic determinants of health and wellbeing. Accordingly, action on the social determinants of mental health demands public health and population-based strategies to prevent and manage common mental disorders in the community (Thangadurai & Jacob, 2014).

Another significant outcome of interest in the current study was that findings did not support previous literature on the link between psychological distress and substance abuse – particularly, the assertion that a direct causal link exists between the two (Fergusson, Boden, & Horwood, 2009; Kushner, Abrams, & Borchardt, 2000; Najavits, Weiss, & Shaw, 1997). The findings demonstrate that refugees and asylum seekers in the current study did not follow this pattern, as indicated by their strong reliance on spirituality in dealing with distress. More research is needed to further explain the complex relationship between mental health issues and substance abuse.

5.3 Recommendations

- The study recommends for the current encampment policy in Zimbabwe to be reviewed. It is argued that the status quo is an injustice and a disservice to the mental health and wellbeing of refugees and asylum seekers in the camp. Denying refugees and asylum seekers the right to freedom of movement, the right to work, or integrate with local people effectively renders them dependent on humanitarian hand-outs. The camp is located in an extremely arid region of the country and the government should consider reviewing the policy in view to resettling them in more productive areas than the Tongogara area. This will go a long way to ensuring that refugees and asylum seekers become producers, rather than consumers, at the same time enhancing their mental health and well-being.

- Although UNHCR proclaims voluntary repatriation to be the most desirable and durable solution to refugees, the present study urges the Zimbabwean government and other implementing partners to follow the example of South Africa, especially in promoting local integration of refugees in the country. It is abundantly clear that a large proportion of the refugee population in Tongogara Refugee Camp are destined to remain in Zimbabwe for long periods of time – given the protracted nature of conflicts in their countries of origin. The government should therefore promote local integration as that would allow refugees and asylum seekers to lead a meaningful existence within the country – thereby developing their human potential. This recommendation holds even for refugees from Rwanda, who, throughout the entire interviewing process, clearly expressed their unwillingness to be repatriated back to their native country for fear of the grave persecution they faced and might still face. Having witnessed the killings, many still suffer far more from what they saw. As such, these individuals cannot hide their much-needed protection outside their country of origin.

- The researcher makes recommendation for the government and other implementing partners to help camp residents in the initiation and development of small-scale agricultural projects such as pig, goat, and cattle rearing, poultry, irrigation schemes for small-scale farming, as well as flea markets.

- Sports activities should be promoted and supported for both refugee children in schools and adults in the camp. The researcher recommends for the organization of matches between teams representing refugees and local hosting communities outside the camp. This will go a long way in fostering peace and improve the local communities' perception of refugees – at the same time helping residents in the camp, keep a healthy body and mind.

- Mental health practitioners need to take a holistic approach to health, addressing psychological issues and focusing less on individual behavioral change and more on economic, social, environmental and cultural factors. Attention should be directed toward responding to much more practical issues, including employment, housing, food, as well as the provision of training opportunities.

- The researcher recommends for the promotion of an inclusive multicultural strategy addressing distinctive cultural and linguistic needs. Essentially, understanding the experiences of refugees and asylum seekers, as well as the meaning they attach to those experiences, is key to the provision of quality health services. Thus, refugees and asylum seekers should therefore be seen as best positioned to know what they want or need.

- The results of the current study indicate that the principal barrier refugees and asylum seekers face in accessing any service from the camp clinic or outside of it, is that of language. Inability to speak Shona and/or English for the refugee population is not only problematic during the clinical encounter, but also makes accessing services difficult. In response to this, the language interpreter services should be provided. The researcher recommends for the promotion of a holistic multicultural strategy addressing cultural diversity among camp residents.

- The study findings indicate that one of the biggest obstacles facing refugees and asylum seekers when accessing health services in the country is institutional discrimination. On a national scale, more work needs to be done to work towards curbing the multiple forms of discrimination experienced by refugees and asylum seekers in public health institutions.

- There is need for improved engagement with the refugee population. This will mean the establishment of the best and most appropriate approach and delivery of services. The findings of this study show that the majority of refugees and asylum seekers in the camp depend on religious intervention or social support to cope with mental distress. It is of paramount significance to avoid imposing ethnocentric assumptions to reduce such 'religious practices' in accordance with Western ideologies.

Recommendations for future studies

- This study was based on a small sample size which impeded generalization of the findings to the broader refugee population at Tongogara Refugee Camp. Further exploration regarding the differences in the experiences of subpopulations of camp residents, including adults and minors – both males and females is recommended. Larger or more representative samples should be considered in future studies in order to allow for the generalization of findings. More so, an investigation into differences that would otherwise result from other

important factors, such as length of stay and nationality may be needed before any firm conclusions can be drawn from the findings of the current study.

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Appendix A: Participant Information Sheet

Tittle of research project: Exploring the perceptions of refugees and asylum seekers regarding access to mental health services in Zimbabwe: a case study of Tongogara Refugee Camp

Research Protocol number: ……..

Student Name: **Edward Govere**

Student Email: **693192@students.wits.ac.za**

Student Contact Number: **+27 (0)71 794 6388**

Supervisor Name: **Prof Joanna Vearey**

Supervisor Email: **jovearey@gmail.com**

Supervisor Contact Number: **+27(0)72 392 7034**

University of the Witwatersrand Research Ethics Committee (non-medical) contact: Lucille.Mooragan@wits.ac.za

+ 27 (0) 11 717 1408

Hello! My name is Edward Govere and I am currently doing Masters of Arts (MA) in Migration and Displacement with the African Centre for Migration and Society, at Wits University in South Africa. I am conducting a research study on the perceptions of refugees and asylum seekers regarding mental health and access to care at Tongogara Refugee Camp. The research hopes to inform the University of the Witwatersrand and the African Centre of Migration and Society (ACMS) on perceptions of mental health among individuals in the camp and will consider recommendations for improving access to mental health care at least, in the camp.

I would like to invite you to take part in this study since it will help me to understand how individuals in the camp understand mental health and cope with stressful situations. Kindly be advised that your participation is entirely voluntary and if you agree to take part in the study, the interview will be conducted at a place most convenient and comfortable to you. The interview will be in the form of a semi-structured interview and will take a maximum of one hour.

With your permission, the interview will be tape-recorded. No one other than my supervisor will have access to the tapes. The tapes and interview schedules will be kept for two years following any publications or for six years if no publications emanate from the study. Pseudonyms will be used in order to protect your identity, and please, be assured that your name and personal details will be kept confidential and no identifying information will be included in the final research report.

Risks

There may be some risks from participating in this research study. I will ask some personal information about your life and this may evoke discomfort and negative emotions during the interview. If you do not feel comfortable answering some of the questions, you have the right to refuse to answer without any negative consequences. You are also free to withdraw from the interview should you feel uncomfortable with continuing. Should you feel the need for psychosocial assistance following the interview, this service is provided free of charge by the camp clinic.

Benefits

There are no direct benefits associated with your participation in this study. However this research will help me to understand individuals' perceptions about mental health and the accessibility of mental health services in the camp.

Costs

There are no costs associated with this research project.

The information that will be collected is purely for research purposes and to learn more about how individuals in the camp understand mental health as well as their perceived access to care. The information you share may also be written up in research reports. However I will anonymize your identity and it will be impossible to identify you personally in any of the research reports.

Participation is completely voluntary; you are under no obligation to take part in this project. You may withdraw from this project at any stage and this will not harm you in any way.

- **Do you have any questions?**
- **Would you like to go ahead taking part in this project?**

Appendix B: Consent form to participate in the study

I hereby consent to participate in the research project. The purpose and procedures of the study have been explained to me. I understand that my participation is voluntary and that I may refuse to answer any particular items or withdraw from the study at any time without any negative consequences. I understand that my responses will be kept confidential.

Psedonym for Participant: _____

Date: _____

I, Edward Govere, herewith confirm that the above participant has been fully informed about the study and has given verbal consent to participate as indicated above.

Name of Researcher: **Edward Govere**

Date: _____

Signature: _____

Appendix C: Consent form for Audio-tape recording

I hereby consent to tape-recording of the interview. I understand that my confidentiality will be maintained at all times and that the tapes will be destroyed two years after any publication arising from the study or six years after completion of the study if there are no publications.

Psedonym for Participant: _____

Date: _____

Name of Researcher: **Edward Govere**

Date: _____

Signature: _____

Appendix D: Interview Guide

Demographic Questions

1. Pseudonym:
2. Gender:
3. Country of origin:
4. Languages spoken:
5. Length of stay in the camp

Main Questions

- What do you think are some of the biggest issues facing the residents of this community at present?
- Do you think emotional problems are a concern for residents here?
- What support for health is normally provided for new arrivals in the camp?
- Personally, how do you cope with emotional problems?
- What are your thoughts about doctors, nurses, social workers, psychologists or other health professionals in Zimbabwe?
- Apart from receiving formal mental health services, how do people deal with stress?
- What is your experience with support surrounding mental health issues within the camp?
- What types of barriers do people face when trying to access health services within and outside the camp?
- What, if any, advice would you give to your doctors and clinic staff in order to better meet your needs?

Reflection Questions

- How did you feel during the interview?
- Is there anything else you would like to discuss or share to help me better understand your experience with health care in Zimbabwe or your health concerns?

Appendix E: Permission to carry out the research

Reference: RF/50/8

DEPARTMENT OF SOCIAL SERVICES

PERMISSION IS HEREBY GIVEN TO GOVERE EDWARD

OF: UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

TO VISIT TONGOGARA REFUGEE CAMP **ON:** JULY TO DECEMBER 2016

FOR THE PURPOSE OF UNDERTAKING AN ACADEMIC REASEARCH ON REFUGEES

4/7/16

S Soko
ACTING/COMMISSIONER FOR REFUGEES

COMMISSIONER FOR REFUGEES
01 JUL 2016
P. O. Box CY 429, Causeway, Harare
Tel: 700894 / 251000 - 1 / 251016

Signature of the Camp Administrator R M Zengelfa

NB Please return duplicate to Commissioner for Refugees after the visit.

REMARKS

He came and carried out his research.

2016 -11- 07

Appendix F: Ethics clearance certificate

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Govere

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H16/09/07**
PROJECT TITLE	Exploring the perceptions of refugees and asylum seekers regarding the accessibility of mental health services in Zimbabwe: A case study of Tongogara refugee camp
INVESTIGATOR(S)	Mr E Govere
SCHOOL/DEPARTMENT	Social Science/
DATE CONSIDERED	23 September 2016
DECISION OF THE COMMITTEE	Approved
EXPIRY DATE	26 October 2019

DATE 27 October 2016 **CHAIRPERSON** _____ (Professor J Knight)

cc: Supervisor : Professor J Vearey

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

_____ _____/_____/_____
Signature **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix G: List of Observations

- the unbearable heat residents deal with on a daily basis
- high idleness rates among camp residents
- long waiting times and ques at the clinic
- the existence of several church buildings in the camp and many others currently being constructed – church architecture much nicer and actually incomparable to refugee compounds
- most refugees spend their time singing, praying and trumpeting in churches and mosques.
- the camp is becoming more and more overcrowded
- there are a few residents engaging in small scale enterprises, including flea markets, goat and chicken rearing and gardening
- severe water scarcity in the camp
- unhealthy looking and illnesses among children in the camp
- many residents live and share their compounds with domestic animals.