

“OUR HEARTS HAVE GONE DARK”

THE MENTAL HEALTH IMPACT OF SOUTH SUDAN’S CONFLICT

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Cover photo: Military tank in Upper Nile state, South Sudan, 2009. ©Tim McCulka

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CONTENTS

ACRONYMS	4
GLOSSARY	5
1. EXECUTIVE SUMMARY	7
2. METHODOLOGY	11
3. WAR, TRAUMA AND MENTAL HEALTH	13
South Sudan's Long Legacy of War	13
Renewed Conflict in 2013	14
The Mental Health Impact of Armed Conflict	16
South Sudan: A Traumatized Nation	17
4. SURVIVORS SPEAK OF TRAUMA	19
"Sometimes i dream that I died with those who were killed": Targeted killings in Juba	20
"I am still scared because of what happened": Attacks on civilians in Malakal	22
"People are traumatized": Attack on the Bor UNMISS PoC Site	25
"I am never happy": Detention and torture in Juba	26
"I am nothing": Sexual Violence Outside Bentiu PoC Site	29
"We are all alone": Death, Abduction, and Disappearance of relatives	32
5. LACK OF ACCESS TO MENTAL HEALTH CARE SERVICES	36
Government Mental Health Services: Practically Non-Existent	36
Government Mental Health Policies	39
International Assistance and Cooperation	40
6. SOUTH SUDAN'S LEGAL OBLIGATIONS	44
The Right to Mental Health Care Services as part of the Right to Health	44
Violence as A Violation of the Right to Mental Health	48
The Right to Mental Health Care Services as part of Victims' Right to Reparations	49
7. THE WAY FORWARD	51
End Violations and Abuses of Human Rights and Humanitarian Law	51
Improve the availability, accessibility and quality of mental health services across the country	52
Ensure integration of Mental Health and Psychosocial Support into Emergency Response Programming	55
Provide Reparations For Psychological Harm	55
8. CONCLUSION: THE IMPORTANCE AND URGENCY OF MENTAL HEALTH SERVICES	57
9. RECOMMENDATIONS	59

ACRONYMS

ARCSS	Agreement on the Resolution of Conflict in South Sudan
AU	African Union
AUCISS	African Union Commission of Inquiry on South Sudan
CPA	Comprehensive Peace Agreement
IASC	Inter-Agency Steering Committee
IDP	Internally displaced person
IGAD	Intergovernmental Authority on Development
IMC	International Medical Corps
IOM	International Organization for Migration
IRC	International Rescue Committee
MI	Military Intelligence
MSF	Médecins Sans Frontières (Doctors Without Borders)
NGO	Non-governmental organizations
NSS	National Security Service
POC	Protection of Civilians
PTSD	Post-traumatic stress disorder
SDG	Sustainable Development Goal
SPLM/A	Sudan People's Liberation Movement/Army
SPLM/A-IO	Sudan People's Liberation Movement/Army-In Opposition
TGoNU	Transitional Government of National Unity
UN	United Nations
UNMISS	United Nations Mission in South Sudan
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
UNPOL	United Nations Police
WHO	World Health Organization

GLOSSARY

DEPRESSION

A mood disorder characterized by sadness, social isolation, inactivity, difficulty with thinking and concentration, a significant increase or decrease in appetite and time spent sleeping, feelings of dejection and hopelessness, increased irritability, and/or suicidal thoughts or attempts to commit suicide.

MENTAL HEALTH

The World Health Organization (WHO) defines mental health as “a state of well-being in which an individual realizes 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.”

MENTAL HEALTH DISORDER OR CONDITION

A medically defined condition associated with pain or distress that negatively impacts a person’s thinking, feeling, or mood and affects his or her ability to relate to others and function on a daily basis.

MENTAL HEALTH SERVICES

The means by which interventions for mental health care are delivered. This includes outpatient facilities, mental health day treatment facilities, psychiatric wards in a general hospital, community mental health teams, supported housing in the community, and mental hospitals. It includes non-biological (also referred to as psychosocial support, treatment or rehabilitation) or clinical interventions to support psychosocial well-being, also referred to as psychosocial support services. It may also include traditional or religious healing practices.

MENTAL OR PSYCHOLOGICAL DISTRESS	A term used to describe a range of psychiatric symptoms, such as sadness, anxiety, rage and depression, that are troubling, confusing or disrupt activities of daily living. Mental or psychological distress is broader in scope than mental health disorders or conditions, in that a person may exhibit symptoms of psychological distress without reaching the threshold of suffering from any medically defined disorder or condition.
POST-TRAUMATIC STRESS DISORDER (PTSD)	A clinical mental disorder that arises after experiencing or witnessing a very stressful, frightening, or distressing event. An individual suffering from PTSD exhibits: 1) intrusive symptoms such as nightmares and flashbacks, 2) avoidance of reminders—such as thoughts, feelings, people, and places—associated with the trauma, 3) negative changes to thoughts—such as negative beliefs about oneself or others, self-blame, anger, shame guilt or fear, and 4) changes in physiology and reactivity—such as irritability, aggression, reckless behaviour, poor concentration and sleep issues. Symptoms must be present for more than one month and create significant distress/impairment to daily functioning.
PROTECTION OF CIVILIANS (POC) SITE	Camp-like settlement for internally displaced people established within existing United Nations Mission in South Sudan (UNMISS) compounds and guarded by UN peacekeepers.
PSYCHOSOCIAL SUPPORT SERVICES	Subset of mental health interventions which are generally non-biological or non-clinical in nature and include help with social, emotional, psychological and practical needs.
PSYCHOLOGICAL TRAUMA	A distressing emotional response resulting from experiencing or witnessing a very stressful, frightening or distressing event, in which a person's capacity to cope and/or integrate his emotional experience is overwhelmed.
PSYCHOSIS	A serious mental disorder characterized by defective or lost contact with reality, often involving hallucinations or delusions.
TRAUMATISED	A term used in this report to describe individuals experiencing longer-term psychological distress as a result of experiencing a very stressful, frightening or distressing event and whose capacity to cope is overwhelmed and ability to manage daily life activities is compromised.

1. EXECUTIVE SUMMARY

Parties to South Sudan's internal armed conflict that erupted in December 2013 have violated international human rights and humanitarian law, with a devastating impact on civilian populations. Both the Government of South Sudan and the Sudan People's Liberation Movement/Army-In Opposition (SPLM/A-IO), together with their respective allied forces, deliberately attacked and killed civilians, abducted and raped women, committed acts of torture, destroyed and looted civilian property, and attacked humanitarian personnel and assets. Such acts have led to an unknown number of deaths, physical injuries, the displacement of over two million people, loss of livelihoods, and high levels of food insecurity. They have also had less visible, but no less significant, repercussions on people's mental health—the state of emotional and psychological wellbeing in which individuals can realize their potential, cope with the normal stresses of life, work productively, and be active members of their community.

This report describes the serious and significant mental health impact of South Sudan's conflict to highlight the urgency for more attention and resources to improve the availability, accessibility, and quality of mental health services in the country. It is based on interviews with 161 internally displaced people living in United Nations Mission in South Sudan (UNMISS) Protection of Civilians (PoC) sites in Juba, Malakal and Bentiu and in an informal settlement at Mahad School in Juba. Amnesty International researchers also interviewed government and UN officials, donors, representatives of non-governmental organizations (NGOs), and international and South Sudanese mental health professionals—including psychiatrists, psychologists and psychosocial workers.

Internally displaced South Sudanese impacted by the conflict described experiencing a range of symptoms commonly associated with mental health disorders such as post-traumatic stress disorder (PTSD) and depression—having nightmares, getting angry easily, feeling unable to concentrate, and considering suicide. Many spoke of headaches, stomach pains, backaches, and heart palpitations—common physical manifestations of psychological stress. They also told of feeling unable to work, study, carry out basic daily tasks, care for children, or maintain relationships with friends and family. They attributed these mental, physical, emotional, relational, and spiritual impacts to their experiences as victims of, or witnesses to, torture, arbitrary detention, sexual violence, killing, and forced displacement.

The dire mental health situation in South Sudan is not surprising. Studies in conflict-affected regions across the world have consistently demonstrated that armed conflict has a serious negative impact on mental health. Due to armed conflict, people are more likely to suffer a range of mental health issues: a minority will develop new and debilitating mental disorders, many others will experience psychological distress, and those with pre-existing mental disorders often will need more help than before. The World Health Organization (WHO) estimates that in situations of armed conflict and other emergencies, the proportion of the population suffering from mild or moderate mental disorders rises from approximately 10% to 15-20%.

In South Sudan, decades of conflict have left a legacy of psychological distress. The renewed violence since December 2013 has further exacerbated the situation. While there are no official national

statistics on mental health, the Director of the Ministry of Health's Department of Mental Health acknowledged that there has been an increase in the number of patients with mental health conditions since the start of the conflict. This conclusion is reinforced by independent research. A 2015 study by the South Sudan Law Society (SSLS) and the United Nations Development Programme (UNDP) found that 41% of 1,525 respondents across six states and Abyei exhibited symptoms consistent with a diagnosis of PTSD. A 2015 survey by SSLS in Malakal PoC site found that 53% of respondents exhibited symptoms consistent with a diagnosis of PTSD. The African Union Commission of Inquiry on South Sudan (AUCISS) noted in its final report that "trauma appears to be a key consequence of the conflict." These findings are borne out by Amnesty International's own research.

The overwhelming majority of people interviewed who were experiencing psychological distress felt they would benefit from mental health or psychosocial support services and programmes, but few had. Interviewees spoke of how neighbours, friends, relatives and church members advise, counsel, and comfort them, providing some relief. Conflict and displacement have, however, severely weakened and stretched these traditional support networks and their ability to help people cope. Often the people to whom individuals facing distress would turn for support are either absent or are themselves suffering from heavy psychological burdens. People with mental health problems are also subjected to social stigma, and family members generally have limited information about mental health and trauma or what constitutes appropriate care and treatment.

Despite significant and widespread needs, the availability and accessibility of mental health and psychosocial support services in South Sudan is extremely limited. Juba Teaching Hospital—the only public medical facility that provides psychiatric care—has only 12 beds in its psychiatric ward. The availability of psychotropic drugs is inconsistent and limited. There are only two practising psychiatrists in the country, both of whom are in Juba and neither of whom sees patients on a full-time basis. As a result of the lack of appropriate services and facilities, people with mental health conditions are routinely housed in prisons, even if they have committed no crime.

Though South Sudan's health sector policies and plans since 2006 have recognized the need for improved mental health services, stated goals have not been reached. Objectives for increasing the number of trained mental health staff, for example, have not been achieved. Mental health services have not been integrated into the primary health care system, and there is no dedicated mental health policy, strategy, or legislation. Part of the problem is explained by the government's chronic underinvestment in health care generally, and its failure to make the financial commitments necessary to improve the availability and accessibility of mental health services. This is mirrored by the fact that international assistance and cooperation to the health sector, though substantial, has overlooked mental health.

In this context, services provided by international NGOs are insufficient to fill the gap and meet the tremendous needs of the population. In Juba, Malakal, and Bentiu PoC sites, some NGOs offer mental health and psychosocial support services, but their interventions are insufficient given the size of the populations they are intended to serve. There is a particular gap in the availability of specialized mental health services, such as psychotherapy, group therapy, or pharmacologic intervention, for people with severe mental disorders. There are only a few international organizations with programmes supporting the improvement of mental health services within the public health sector. Some churches and smaller NGOs carry out community-based interventions that seek to address trauma, but these are limited and uncoordinated. The WHO office in Juba has not provided substantial technical or financial support to expanding mental health services in South Sudan.

South Sudan has committed itself to respect, protect and fulfil a range of human rights including the right to health and has assumed a range of relevant obligations under international law. This requires South Sudan to ensure access to mental health services; refrain from acts such as torture that cause psychological harm; and prevent such acts by third parties. South Sudan must also ensure that victims of serious human rights or humanitarian law violations or abuses receive compensation for mental harm and rehabilitation, including psychological care, in fulfilment of their right to reparations. Amnesty International's findings lead to the conclusion that South Sudan is failing to live up to these commitments and obligations.

The government should urgently prioritise guaranteeing access to essential mental health care and treatment, including information and services. South Sudan should work to provide mental health treatment through primary health care; provide care at the community level; make psychotropic drugs available; educate the public; establish national policies, programmes and legislation; support research and monitoring; develop human resources; increase funding to mental health services; and mainstream mental health interventions across other sectors. The government should also make financial and programmatic contributions to mental health services in emergency settings and should facilitate and encourage international cooperation and support for implementation of the Inter-Agency Steering Committee Guidelines (IASC) on Mental Health and Psychosocial Support in Emergency Settings.

South Sudan is facing a severe economic crisis due to high inflation and a sharp decline in national oil revenues as a result of reduced production and a drop in international oil prices. Even in this challenging context, there are steps the government could take to improve mental health services that require political commitment more than funds. The development of a mental health policy and legislation, for example, could go a long way towards galvanizing greater attention to mental health in South Sudan. The Ministry of Health could also more effectively seek international cooperation and assistance to support mental health care services by making specific requests to donors for such support and by working with donors to ensure that general support to the health sector does not neglect mental health needs. The Ministry of Health could also call on other government ministries, international donors, and NGOs to mainstream mental health and psychosocial support initiatives into all development and humanitarian interventions.

The Agreement on the Resolution of the Crisis in South Sudan (ARCSS), signed by parties to the conflict in August 2015, should signal the turning of a new page. The new Transitional Government of National Unity (TGoNU) must take steps to end the serious violations and abuses of international human rights and humanitarian law that continue to traumatize the people of South Sudan, as well as the longstanding impunity for such violations and abuses. The government must provide all forces with clear orders detailing conduct that is prohibited under international law; establish mechanisms to adequately monitor conduct of forces; and initiate prompt, effective and impartial investigations to bring those credibly suspected of criminal responsibility to justice.

The ARCSS offers an important opportunity for fulfilling the right of victims to reparations, including compensation and rehabilitation for mental harm. The TGoNU should work with the AU to ensure the speedy establishment of the Hybrid Court for South Sudan (HCSS), the Commission on Truth, Reconciliation and Healing (CTRH), and the Compensation and Reparations Authority (CRA) provided for in the peace agreement. The TGoNU should ensure these bodies give appropriate consideration to the mental health consequences of the conflict and the resulting need for mental health and psychosocial support as an element of individual or collective reparations programmes and initiatives.

International bodies must also do their utmost to prevent and deter future violations of humanitarian law and violations and abuses of international human rights law. The AU Commission should quickly establish the HCSS to investigate and prosecute genocide, war crimes, crimes against humanity, and other crimes under international law committed during the conflict, as required in the August 2015 peace agreement. The UN Security Council should impose a comprehensive arms embargo on South Sudan and targeted sanctions, including travel bans and asset freezes, against civilian and military officials who have engaged in violations of international humanitarian law and violations and abuses of international human rights law.

Doing more to address mental health needs is not only essential for individual well-being, it is also critical for South Sudanese to effectively rebuild their communities and country. Poor mental health negatively impacts people's ability to carry out day-to-day activities and pursue livelihoods or education. Poor mental health among parents also has an inter-generational impact on child health, development, and growth. Restoring mental health can play a vital role in contributing to sustainable economic growth and poverty reduction. This is reflected in the fact that, in September 2015, the UN included mental health as an element of the new global Sustainable Development Goal (SDG) on health.

Many South Sudanese and international observers identify poor mental health as a destabilizing force that has contributed to violent behaviour at family, community, and national levels—an observation

supported by studies showing the links between poor mental health, anger and desire for revenge. South Sudan, together with the AU, the UN and other international partners, must therefore prioritize efforts to heal the thousands of South Sudanese affected by conflict in order to ensure that poor mental health does not continue to undermine peacebuilding efforts in South Sudan. Restoring mental health is a prerequisite for achieving and maintaining peace, stability, and reconciliation.

2. METHODOLOGY

This report is based primarily on research conducted by Amnesty International in April and May 2015, and in May 2016, in the cities of Juba, Malakal, and Bentiu, which have all been affected by the internal armed conflict. It also draws on research carried out since the outbreak of the conflict in December 2013.

The conflict has resulted in the internal displacement of approximately 1.7 million South Sudanese. Of these, 200,000 are living in six Protection of Civilians (PoC) sites across the country. PoC sites are the camp-like settlements for internally displaced people established within existing United Nations Mission in South Sudan (UNMISS) bases and guarded by UN peacekeepers. Other internally displaced people have settled in host communities, live in informal settlements, or have fled to remote, hard-to-reach areas of the country. Amnesty International researchers interviewed 161 internally displaced people living in PoC sites in Juba, Malakal and Bentiu. Researchers also conducted interviews in an internally displaced people's settlement at the Mahad School in Juba. Researchers selected these locations because they were accessible and host large concentrations of individuals affected by the internal armed conflict.

Researchers selected for interviews internally displaced people who were victims of or witnesses to violations or abuses of international human rights and humanitarian law, individuals who showed signs of psychological distress, and their family members. Those interviewed were generally referred by non-governmental organisations (NGOs) or community members. Researchers also interviewed community leaders, women leaders, church leaders, elders, and traditional leaders about community perceptions of and responses to psychological distress.

Interviews with internally displaced people focused on the violations and abuses interviewees had experienced or witnessed, other sources of stress and trauma within their lives, behaviours and symptoms associated with psychological trauma, and the impact of these behaviours and symptoms on their day-to-day lives. Most interviews lasted approximately one hour. Interviews were conducted in private or semi-private settings, such as homes, NGO offices, or meeting spaces.

Researchers took care to ensure that interviewees represented a cross section of the population with respect to gender, age, and ethnicity. Given that the conflict has, in many instances, pitted ethnic communities against each other, with armed actors deliberately targeting civilians based on their ethnicity and perceived political allegiance, it was important for the research to reflect experiences of people from different ethnic groups. However, because the vast majority of individuals who have taken refuge in Juba and Bentiu PoC sites are from the Nuer ethnic group, all internally displaced people interviewed in these locations were Nuer. The population of the Malakal PoC site is mixed, so researchers were able to interview individuals from the Nuer, Shilluk, and Dinka ethnic groups. At the Mahad School, interviewees were from the Dinka, Murle, and Anyuak ethnic groups.

Amnesty International researchers also interviewed government and UN officials, donors, representatives of NGOs, and international and South Sudanese mental health professionals—including psychiatrists, psychologists and psychosocial workers—to further understand the impact of the conflict on mental health. In particular, interviews focused on mental health issues arising in the context of

widespread violations of human rights and humanitarian law, and the availability of services for those suffering from psychological distress.

Researchers informed interviewees of the purpose of the interview, the kinds of issues that would be covered, its voluntary nature and the fact that they could discontinue the interview at any time. All interviewees verbally consented to being interviewed and for their testimony to be included in this report. Interviews were conducted in English, Arabic, Anyuak, Dinka, Murle, Nuer, and Shilluk languages with assistance from interpreters. To respect confidentiality and protect victims and witnesses from reprisal, all internally displaced people interviewed have been assigned pseudonyms. Most representatives of international NGOs also requested that their names be withheld, due to fear of reprisal by government officials for speaking out about human rights issues.

Amnesty International consulted mental health experts in designing the research methodology and throughout the research process. A medical doctor with significant experience working with internally displaced people and survivors of human rights violations accompanied Amnesty International researchers to Juba and Bentiu. In addition, South Sudanese mental health or psychosocial support workers offered counselling as needed during and following interviews, to help avoid re-traumatization. Amnesty International researchers referred interviewees to relevant organizations providing mental health services as appropriate and with the consent of individuals interviewed. A psychologist and a psychiatrist with experience in South Sudan reviewed this report, and their feedback was incorporated.

This report seeks to portray the mental health impact of South Sudan's conflict, based on the understanding that mental health is "a state of well-being in which an individual realizes 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."¹ Amnesty International, therefore, understands mental health impacts to encompass both specific mental health conditions as well as more general psychological distress and trauma. Researchers sought to identify and describe commonly recognized psychiatric symptoms experienced by interviewees, but did not attempt to determine the specific mental health conditions that may affect them.

The term mental health care or services is used to refer to a broad range of interventions designed to support mental health. It should therefore be understood to include non-biological interventions, also referred to as psychosocial support, treatment or rehabilitation.

Amnesty International would like to thank all the survivors of human rights violations and abuses who courageously described their intimate thoughts and emotions, as well as the officials, health professionals, and aid workers who shared their views and experiences.

¹ World Health Organization (WHO), Mental Health Action Plan 2013-2020, 2013, p. 38, available at: http://www.who.int/mental_health/publications/action_plan/en/

3. WAR, TRAUMA AND MENTAL HEALTH

SOUTH SUDAN'S LONG LEGACY OF WAR

The armed conflict that erupted in December 2013 is only the most recent episode of violence in South Sudan's history. From 1956 to 1972 and again from 1983 to 2005, the Government of Sudan and pro-government militias fought against armed groups who sought greater equality and autonomy for the southern regions of Sudan. Both periods of civil war were characterised by extreme violence against civilians, gross human rights abuses, and massive forced displacement. During the second civil war from 1983 to 2005, an estimated 1.9 million people—one out of every five southern Sudanese—were killed or died from disease and famine, and some four million people were internally displaced.²



A woman cries following a deadly attack by cattle raiders. Chukudum, Eastern Equatoria state, 2007 © Tim McCulka

² United States (US) Committee for Refugees, "Sudan: Nearly 2 million dead as a result of the world's longest running civil war," 2001, available at: <http://web.archive.org/web/20041210024759/http://www.refugees.org/news/crisis/sudan.htm>

In 2005, the Sudanese government and the rebel Sudan People's Liberation Movement/Army (SPLM/A) signed a Comprehensive Peace Agreement (CPA) which granted regional autonomy to South Sudan. But the CPA did not bring an end to internal violence, nor did South Sudan's secession from Sudan in 2011 following a referendum on self-determination. From 2005 to 2013, fighting between government forces and armed insurgent militias, intercommunal violence often linked to land and cattle, and the widespread availability of arms after years of war continued to result in repeated population displacements, destruction of civilian property, and a high number of civilian deaths.³

RENEWED CONFLICT IN 2013

In December 2013, growing political tension between President Salva Kiir and Dr Riek Machar mushroomed into a brutal internal armed conflict.⁴ Fighting started in Juba, the capital, where government forces engaged in targeted killings, primarily of Nuer men. Security forces across the country split—with some maintaining allegiance to the government and others defecting to support the armed opposition under Machar, which came to be known as the Sudan People's Liberation Movement/Army-In Opposition (SPLM/A-IO). By the end of 2013, the conflict had engulfed parts of Jonglei, Unity, and Upper Nile states.⁵



The conflict resulted in the destruction of homes, hospitals, and other buildings. Bentiu, South Sudan, March 2014. ©Amnesty International

³ See for example, Amnesty International, *Overshadowed Conflict: Arms Supplies Fuel Violations in Mayom County, Unity State, 2012* (Index: AFR 65/002/2012) available at: <https://www.amnesty.org/en/documents/afr65/002/2012/en/>; Amnesty International, *Destruction and Desolation in Abyei, 2011* (Index: AFR 54/041/2011) available at: <https://www.amnesty.org/en/documents/afr54/041/2011/en/>; Small Arms Survey, *My Neighbor, My Enemy: Intertribal Violence in Jonglei, 2012*, available at: http://www.smallarmssurveysudan.org/fileadmin/docs/issue-briefs/HSBA-IB21-Inter-tribal_violence_in_Jonglei.pdf; and Small Arms Survey, *The Pendulum Swings: The Rise and Fall of Insurgent Militias in South Sudan, 2013*, available at: <http://www.smallarmssurveysudan.org/fileadmin/docs/issue-briefs/HSBA-IB22-Pendulum-Swings.pdf>

⁴ Riek Machar served as Vice-President from 2005 to July 2013, when President Kiir removed him from the position. In February 2016, Kiir issued a presidential decree reappointing Machar as Vice-President, in accordance with the August 2015 Agreement on the Resolution of the Crisis in South Sudan (ARCSS).

⁵ For background on the first months of the conflict, see UN Mission in South Sudan (UNMISS), *Conflict in South Sudan: A Human Rights Report, May 2014*, available at: <http://unmiss.unmissions.org/Portals/unmiss/Human%20Rights%20Reports/UNMISS%20Conflict%20in%20South%20Sudan%20-%20A%20Human%20Rights%20Report.pdf>; Amnesty International, *Nowhere Safe: Civilians under Attack in South Sudan, May 2014* (Index: AFR 65/003/2014), available at: <https://www.amnesty.org/en/documents/AFR65/003/2014/en/>

Both government and opposition forces have committed serious violations of international humanitarian law and serious human rights violations and abuses. They have deliberately killed civilians including children, women and elderly people, often targeting them based on ethnicity or perceived political allegiance. They have abducted and raped women and girls; ravaged hospitals and schools; destroyed and looted civilian property, including means of livelihood; attacked humanitarian personnel and assets; recruited child soldiers; and killed captured soldiers and other fighters placed hors de combat. Warring parties have also obstructed humanitarian assistance, including medical and food supplies, preventing them from reaching civilian populations displaced by the conflict.⁶ These acts amount to war crimes and some may constitute crimes against humanity.

The conflict has had a devastating impact on civilians. Thousands of people have been killed and entire towns and villages have been left in ruins. Over 2.3 million South Sudanese have fled their homes since the outbreak of fighting, with some 1.7 million internally displaced and another 600,000 living in neighbouring countries as refugees. An estimated 2.8 million people—close to one quarter of the population—are facing acute food and nutrition insecurity.⁷

In August 2015, following almost two years of on-and-off peace negotiations mediated by the Intergovernmental Authority on Development (IGAD), parties to the conflict and other stakeholders signed the Agreement on the Resolution of the Conflict in South Sudan (ARCSS).⁸ The agreement provides for the formation of a Transitional Government of National Unity (TGoNU) and for national elections after two and a half years. It also envisages broad security sector reform, the establishment of a Hybrid Court for South Sudan (HCSS) by the African Union (AU) Commission to provide accountability for crimes under international law, a Commission on Truth, Reconciliation and Healing (CTRH), a Compensation and Reparations Authority (CRA), and for a permanent constitutional development process.⁹

On 26 April 2016, Dr Riek Machar, leader of the SPLM/A-IO, returned to Juba and was sworn in as First Vice President, marking an important milestone in implementation of the ARCSS. Ministers of the TGoNU took oaths of office a few days later. As of May 2016, however, numerous aspects of the ARCSS have not been implemented, in some cases due to outstanding disagreements between the parties.¹⁰

The country also continues to be affected by significant violence, despite the permanent ceasefire orders issued by President Kiir and Machar following signing of the ARCSS.¹¹ Fighting in southern Unity state continued through December 2015, and on 25 April 2016, a rocket-propelled grenade landed inside the perimeter of the United Nations Mission in South Sudan (UNMISS) compound in Bentiu.¹² On 17 and 18 February 2016, violence in the Malakal Protection of Civilians (PoC) site

⁶ Ibid. For additional documentation of human rights and humanitarian law abuses, see Amnesty International, “South Sudan: Escalation of violence points to failed regional and international action,” 21 May 2015, available at: www.amnesty.org/en/press-releases/2015/05/south-sudan-escalation-of-violence-points-to-failed-regional-and-international-action/; UNMISS, *The State of Human Rights in the Protracted Conflict in South Sudan*, December 2015, available at: [http://unmiss.unmissions.org/Portals/unmiss/Human%20Rights%20Reports/Human%20Rights%20Update%20Report%20of%204%20December%202015%20\(final\).pdf](http://unmiss.unmissions.org/Portals/unmiss/Human%20Rights%20Reports/Human%20Rights%20Update%20Report%20of%204%20December%202015%20(final).pdf); Human Rights Watch, *They Burned it all: Destruction of villages, killings and sexual violence in Unity State, South Sudan*, July 2015, available at: <https://www.hrw.org/report/2015/07/22/they-burned-it-all/destruction-villages-killings-and-sexual-violence-unity-state>; African Union Commission of Inquiry in South Sudan (AUCISS), *Final Report*, October 2015, available at: <http://www.peaceau.org/uploads/auciss.final.report.pdf>; http://reliefweb.int/sites/reliefweb.int/files/resources/2016_hrp_SS_Final_WEB.pdf

⁷ United Nations Office for the Coordination of Humanitarian Affairs (OCHA), *Humanitarian Bulletin: South Sudan*, 10 February 2016, available at: http://reliefweb.int/sites/reliefweb.int/files/resources/160210_OCHA_SouthSudan_humanitarian_bulletin.pdf

⁸ Signatories to the ARCSS include: 1) The Parties (the Government of South Sudan, the Sudan People’s Liberation Movement/Army-In Opposition (SPLM/A-IO), the former detainees, and the political parties), 2) Stakeholders (civil society, faith based leaders, women’s bloc, and eminent personalities), 3) Adherents, 4) The Guarantors (Intergovernmental Authority on Development (IGAD), Heads of State and Government, the AU, the IGAD-led Mediation, and international partners).

⁹ ARCSS, available at: southsudan.igad.int/index.php/91-demo-contents/news/299-agreement-on-the-resolution-of-the-conflict-in-the-republic-of-south-sudan. Riek Machar, leader of the SPLM/A-IO, signed the agreement on 17 August 2015 while President Salva Kiir signed the agreement on 26 August 2015.

¹⁰ For an account of failures to implement the peace agreement between August 2015 and January 2016, see: Report of the Chairperson of the Joint Monitoring and Evaluation Commission (JMEC) for the Agreement on the Resolution of the Conflict in the Republic of South Sudan to the African Union Peace and Security Council (PSC), 29 January 2016, available at: <http://jmecsouthsudan.org/uploads/AUPSCreport.pdf>

¹¹ For accounts of fighting following the signing of the peace agreement, see UNMISS, *The State of Human Rights in the Protracted Conflict in South Sudan*, December 2015; Final report of the Panel of Experts on South Sudan established pursuant to Security Council resolution 2206 (2015), January 2016, UN Document: S/2016/70, available at: http://www.un.org/ga/search/view_doc.asp?symbol=S/2016/70

¹² UNOCHA, *South Sudan Humanitarian Bulletin*, 9 May 2016, available at: https://gallery.mailchimp.com/f2c222dd83de60ecbebe45951/files/160509_OCHA_SouthSudan_humanitarian_bulletin.pdf

left approximately one-third of the camp burnt to the ground.¹³ There were incidents of insecurity and fighting in Western Equatoria between May 2015 and March 2016, during which government soldiers attacked civilians and burned civilian homes.¹⁴ In February 2016, fighting in Pibor county of Jonglei state between government soldiers and forces loyal to former Pibor administrator David Yau Yau displaced 30,000 people.¹⁵ In Western Bahr el Ghazal state, government soldiers killed, tortured and raped civilians and looted and burned down civilian homes between December and February 2016. According to the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), between January and March 2016¹⁶ approximately 100,000 South Sudanese fled the country as refugees.¹⁷ Despite the peace agreement, therefore, real respite from two years of displacement, death, and destruction is still far off for many South Sudanese.

THE MENTAL HEALTH IMPACT OF ARMED CONFLICT

Studies in conflict-affected regions across the world have consistently demonstrated that armed conflict has a negative impact on mental health—the state of emotional and psychological wellbeing in which individuals can cope with the normal stresses of life, work productively, and be active members of their community.¹⁸ Due to armed conflict, people are more likely to suffer a range of mental health issues: a minority will develop new and debilitating mental disorders, many others will experience psychological distress, and those with pre-existing mental disorders often will need more help than before.¹⁹ The World Health Organization (WHO) estimates that in situations of armed conflict and other emergencies, the proportion of the population suffering from mild or moderate mental disorders rises from approximately 10% to 15-20%.²⁰

Studies also indicate that people who experience more episodes of trauma during conflict are more susceptible to mental health problems.²¹ Traumatic events shown to be positively correlated with mental health problems include witnessing or experiencing rape, torture, abduction, forced displacement, and loss of property—all human rights and humanitarian law violations that have been endemic in South Sudan's internal armed conflict. Other traumatic experiences, such as lack of adequate food, shelter or medical care, though to some extent an assumed consequence of war, have, in South Sudan, been exacerbated by the intentional destruction of civilians' means of livelihood²² and obstruction of humanitarian aid by warring parties.²³

¹³ Center for Civilians in Conflict, *A Refuge in Flames: The February 17-18 Violence in Malakal PoC, 2016*, available at: http://civiliansinconflict.org/uploads/files/publications/CIVIC_-_Malakal_Report_-_April_2016.pdf

¹⁴ Human Rights Watch, "South Sudan: Army Abuses Spread West, 6 March 2016," available at: <https://www.hrw.org/news/2016/03/06/south-sudan-army-abuses-spread-west>

¹⁵ UNOCHA, South Sudan Humanitarian Bulletin, 28 March 2016, https://gallery.mailchimp.com/f2c222dd83de60ecbebe45951/files/20160328_OCHA_SouthSudan_humanitarian_bulletin.pdf. The fighting erupted following President Kiir's appointment of Baba Medan Konyi as Governor of the recently created Boma state, replacing David Yau Yau as administrator of the area. Sudan Tribune, "South Sudan President Summons Boma Governor over Clashes," 28 February 2016, available at: <http://www.sudantribune.com/spip.php?article58158>

¹⁶ Human Rights Watch, "South Sudan: Civilians Killed, Tortured in Western Region: Provide Justice for Army Abuses in Western Regions," 24 May 2016, available at: <https://www.hrw.org/news/2016/05/24/south-sudan-civilians-killed-tortured-western-region>

¹⁷ UNOCHA, South Sudan Humanitarian Bulletin, 9 May 2016, available at: https://gallery.mailchimp.com/f2c222dd83de60ecbebe45951/files/160509_OCHA_SouthSudan_humanitarian_bulletin.pdf

¹⁸ WHO, Mental Health Action Plan 2013-2020, p. 38.

¹⁹ WHO, Building Back Better: Sustainable Health Care after Emergencies, 2013, p. 4, available at: http://apps.who.int/iris/bitstream/10665/85377/1/9789241564571_eng.pdf

²⁰ WHO, Building Back Better, p. 17.

²¹ R. F. Mollica et al., "Mental health in complex emergencies," *The Lancet*, 2004, p. 2059, available at: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(04\)17519-3/fulltext?refuid=S0840-4704\(10\)60254-2&refissn=0840-4704](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(04)17519-3/fulltext?refuid=S0840-4704(10)60254-2&refissn=0840-4704) For example, the number of human rights violations suffered by individuals during the Balkan conflict was positively correlated with risk of post-traumatic stress disorder (PTSD), major depression and other symptoms of mental health disorders. Stefan Priebe et al, "Experience of Human Rights Violations and Subsequent Mental Disorders: A Study Following the War in the Balkans," *Social Science and Medicine*, 2010, p. 5, available at: <http://www.ncbi.nlm.nih.gov/pubmed/21041008>

²² For example, between April and December 2015, government forces looted and burned food and stole cattle and other livestock from civilians in southern and central Unity state. UNMISS, *The State of Human Rights in the Protracted Conflict in South Sudan*, December 2015, para. 43.

²³ In March 2016 alone, UNOCHA recorded 60 incidents affecting humanitarian access. Of these, 43 were cases of violence against humanitarian personnel or assets. UNOCHA, *South Sudan Humanitarian Access Situation Snapshot*, March 2016, available at: http://reliefweb.int/sites/reliefweb.int/files/resources/access_snapshot_20160407.pdf

Common conditions triggered by conflict include post-traumatic stress disorder (PTSD) and other anxiety disorders, depression, and psychosomatic problems such as insomnia, or back and stomach aches.²⁴ Symptoms associated with these mental health conditions and psychological distress more broadly include feelings of shame, self-blame, fragmented memories, a lack of concentration, intrusive memories, the avoidance of circumstances associated with the stressor, sleep disorders, nightmares, flashbacks, irritability, anger, anxiety, and mistrust of other people. People suffering from poor mental health, particularly depression, may also consider, or carry out, suicide, and are more prone to poor physical health, risk-taking, and harmful behaviours such as substance abuse.²⁵

SOUTH SUDAN: A TRAUMATIZED NATION

There is no doubt that decades of war have exacted a heavy toll on South Sudanese people and contributed to widespread mental health issues. While there are no national statistics on the prevalence of mental health conditions in South Sudan, surveys assessing rates of post-traumatic stress disorder and depression in limited populations have consistently illustrated high levels of psychological distress. A 2004 study found that 50% of surveyed residents of Southern Sudan and 44% of Southern Sudanese refugees in Uganda suffered symptoms of PTSD.²⁶ A study conducted in 2007 found high levels of mental distress in the population surveyed in Juba. In this study, 36% of respondents met symptom criteria for PTSD and half (50%) of respondents met symptom criteria for depression.²⁷ This study's results showed a direct relationship between experiencing traumatic events—such as forceful separation from family and being injured—and the likelihood of PTSD and depression.²⁸ Research among South Sudanese ex-soldiers in 2010 found that 15% reported wishing they were dead or thinking about suicide.²⁹

Quantitative studies carried out since the renewed eruption of conflict in 2013 have reported similar findings. A 2015 study by the South Sudan Law Society (SSLS) and the United Nations Development Programme (UNDP) found that 41% of the 1,525 respondents across six states and Abyei exhibited symptoms consistent with a diagnosis of PTSD. The data also indicated high levels of exposure to trauma in the sample population, with 63% of respondents reporting that a close family member was killed at some point in their lives and 41% reporting that they had witnessed a friend or family member being killed.³⁰ A 2015 survey by SSLS in Malakal PoC site found that 53% of respondents exhibited symptoms consistent with a diagnosis of PTSD.³¹

²³ In March 2016 alone, UNOCHA recorded 60 incidents affecting humanitarian access. Of these, 43 were cases of violence against humanitarian personnel or assets. UNOCHA, South Sudan Humanitarian Access Situation Snapshot, March 2016, available at: http://reliefweb.int/sites/reliefweb.int/files/resources/access_snapshot_20160407.pdf

²⁴ R. Srinivasa Murthy and Rashmi Lakshminarayana, "Mental Health Consequences of War: A Brief Review of Research Findings," *World Psychiatry*, 2006; WHO, *World Report on Violence and Health*, 2002, p. 224, available at: http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf

²⁵ For full descriptions of mental disorders, see *International Statistical Classification of Diseases and Related Health Problems*, 10th Revision (ICD-10), available at: <http://apps.who.int/classifications/icd10/browse/2016/en>

²⁶ Unni Krishnan Karunakara et al., "Traumatic events and symptoms of post-traumatic stress disorder amongst Sudanese nationals, refugees and Ugandans in the West Nile," *African Health Sciences*, 2004, p. 88, available at: http://kops.uni-konstanz.de/bitstream/handle/123456789/11366/Karunakara_et al2004.PDF;jsessionid=9B57C94F7346EF5000577E9024A0F3E2?sequence=1

²⁷ Bayard Roberts et al., "Post-conflict mental health needs: a cross-sectional survey of trauma, depression and associated factors in Juba, Southern Sudan," *BMC Psychiatry*, 2009, p. 5, available at: <http://www.biomedcentral.com/content/pdf/1471-244X-9-7.pdf> A survey of populations in Abyei found that 37.8% of respondents met symptom criteria for PTSD. See also Belkys López and Hazel Spears, *Stabilizing Abyei: Trauma and the Economic Challenges to Peace*, Kush, 2013, available at: <http://server2.docfoc.com/uploads/Z2015/12/20/zXgw5Bj4vM/7032e8dd1043bb97e5251705dce7182c.pdf>

²⁸ It found that respondents who had experienced eight or more of the 16 trauma events included in the questionnaire were more likely to exhibit symptoms of PTSD and depression. Bayard Roberts et al., "Post-conflict mental health needs: a cross-sectional survey of trauma, depression and associated factors in Juba, Southern Sudan," *BMC Psychiatry*, 2009, p. 6.

²⁹ Nina Winkler, "Psycho-social intervention needs among ex-combatants in Southern Sudan," *Bonn International Centre for Conversion*, 2010, p. 14, available at: http://www.ssddrc.org/uploads/SSDDRC_Psycho_Social_Assessment.pdf

³⁰ The survey used the Harvard Trauma Questionnaire (HTQ) to assess 16 types of traumatic events and PTSD symptoms. South Sudan Law Society (SSLS) et al, *Search for a New Beginning: Perceptions of Truth, Justice, Reconciliation and Healing in South Sudan*, October 2015, p. vii, available at: [file:///kenb0-vs-dc1ro/users\\$/elizabeth.deng/Downloads/Perception%20Survey%20Report%20Transitional%20Justice%20Reconciliation%20and%20Healing%20-.pdf](file:///kenb0-vs-dc1ro/users$/elizabeth.deng/Downloads/Perception%20Survey%20Report%20Transitional%20Justice%20Reconciliation%20and%20Healing%20-.pdf)

³¹ David K. Deng et al, *A War Within: Truth, Justice, Reconciliation and Healing in Malakal PoC*, 2015, p. v, available at: https://radiotamazuj.org/sites/default/files/SSLS_A_War_Within_Dec_2015_.pdf



A woman whose husband was killed by an unknown armed group the previous night. Gumbo, Central Equatoria state, 2006 © Tim McCulka

Mental health experts and service providers believe the conflict has had a significant and widespread impact on mental health. According to Dr Atong Ayuel, Director of the Ministry of Health's Department of Mental Health, there has been an increase in the number of patients with psychosis, depression, substance abuse problems, and dementia.³²

The African Union Commission of Inquiry on South Sudan (AUCISS) noted in its final report that "trauma appears to be a key consequence of the conflict."

"The Commission heard multiple stories of loss of close family members, children, husbands, wives that left survivors traumatized. The brutality of atrocities witnessed or survived haunts many victims. For mothers, separation from or abduction of children has left emotional and psychological scars and that manifest in various [ways] including sleeplessness and stress-induced illness."

The AUCISS recommended further inquiry into the scope of trauma and the need for psychosocial interventions in the country.³³

³² Amnesty International interview with Dr. Atong Ayuel, Director, Mental Health Department, Ministry of Health, Juba, South Sudan, 10 April 2015.

³³ AUCISS, Final Report, para. 895.

4. SURVIVORS SPEAK OF TRAUMA

“I hear a lot of noise at night. I dream that I am still in jail...I wake up and I can’t go back to sleep.”

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Of the 1.7 million South Sudanese internally displaced by the current conflict, approximately 200,000 are living in six PoC sites located on UNMISS bases across the country. Displaced people seeking refuge and protection have converged on these sites over the course of the conflict. There are some 28,000 living in Juba PoC site, 47,000 in Malakal, and almost 120,000 in Bentiu.³⁴

The residents of South Sudan’s PoC sites have, without exception, been profoundly impacted by the human rights and humanitarian law abuses and violations that have characterized South Sudan’s conflict. Their homes have been looted or destroyed, their livestock stolen, their businesses ruined. Many have witnessed family members or neighbours being killed or are themselves victims of physical or sexual violence.³⁵ Though the protection of UN peacekeepers has undeniably saved lives, PoC sites have themselves been scenes of mass killing: an April 2014 attack on Bor PoC site resulted in at least 47 civilian deaths while a February 2016 attack on Malakal PoC site resulted in at least 25 deaths and 120 injuries.³⁶ There have also been incidents of shelling and gunfire penetrating PoC sites as well as numerous cases of killings, rapes, and abductions of internally displaced people who venture outside of PoC sites.³⁷

Internally displaced people interviewed by Amnesty International described having nightmares, getting angry easily, feeling unable to concentrate and considering suicide—common symptoms associated with PTSD and depression. Many also spoke of headaches, stomach pains, backaches and heart palpitations—common physical manifestations of psychological stress. They attributed these mental, physical, emotional, relational and spiritual impacts to the human rights and humanitarian law abuses and violations they had witnessed or experienced. They also described how these impacts affected

³⁴ UNMISS update, 22 February 2016, <http://unmiss.unmissions.org/Portals/unmiss/UNMISS%20Update/2016/February%202016/22.02%20-%20Update%20No.%20114.pdf>

³⁵ For an overview of conflict related rights violations, see, for example, UNMISS, *The State of Human Rights in the Protracted Conflict in South Sudan*, December 2015.

³⁶ UNMISS, *The State of Human Rights in the Protracted Conflict in South Sudan*, December 2015, para. 43; UNOCHA, *South Sudan Humanitarian Bulletin*, 3 March 2016, available at: https://gallery.mailchimp.com/f2c222dd83de60ecbebe45951/files/160303_OCHA_SouthSudan_humanitarian_bulletin.pdf

³⁷ UNMISS, *The State of Human Rights in the Protracted Conflict in South Sudan*, December 2015, paras 43-53.

their ability to work, study, carry out basic daily tasks, care for children, and maintain relationships with friends and family. Their testimony is a stark illustration of the mental health repercussions of the conflict.

In addition to conflict-related abuses and violations, the generally difficult living conditions within the PoC sites present an additional challenge. Limited access to education and medical care including psychosocial services, a monotonous diet, cramped and sometimes flooded shelters, and poor sanitation exacerbate psychological stress and also impede recovery from trauma.

Family and community members play an important role in supporting individuals experiencing psychological distress, but conflict and displacement have severely weakened and stretched these traditional support networks and their ability to help people cope. Interviewees spoke of how neighbours, friends, relatives and church members advise, counsel, and comfort them, providing some relief. But often the people to whom individuals facing distress would turn for support are either absent or are themselves suffering from heavy psychological burdens. People with mental health problems are also subjected to significant social stigma, and family and community members have limited information about mental health, trauma, and what constitutes appropriate care and treatment. Many individuals experiencing psychological distress felt they would benefit from mental health or psychosocial support services and programmes, but given the limited availability and accessibility of such services within the PoC sites or in South Sudan generally, very few had.³⁸

“SOMETIMES I DREAM THAT I DIED WITH THOSE WHO WERE KILLED”: TARGETED KILLINGS IN JUBA

In December 2013, following the outbreak of fighting in Juba, members of the Presidential Guard, the military, and other security forces targeted Nuer soldiers and civilians on the basis of their ethnicity and perceived political affiliation to Riek Machar. Government security forces conducted house-to-house searches in Juba, killing people in or near their homes or taking them to other locations. According to the South Sudan Human Rights Commission (SSHRC), more than 600 people were killed and 800 injured in Juba and its suburbs between 16 and 18 December 2013.³⁹

One of the worst single incidents of killing in Juba was the murder of approximately 300 men from the Nuer ethnic group in a facility in the Gudele neighbourhood used by several security forces as a joint operations centre, during the night of 16-17 December 2013.⁴⁰ Government soldiers and other security officers gathered the men in a building and opened fire on them, killing most. Malith, one survivor, spoke of what happened.

“We were put in a house with four windows and people shot at us. They shot from the windows. They also opened the door and shot inside... I had fallen against the wall and was covered by the weight of others who had died.”

Malith and other survivors who spoke with Amnesty International described experiencing psychological distress as a result of the deaths they witnessed and barely survived. The memory of what happened, Malith said, disturbs his sleep. He also has difficulty concentrating.

“Sometimes I dream that I died with those who were killed. I wake up sweating and trembling. Sometimes I think those people who died are here with me, alive. The situation is hard. I think about how I survived. Why did these others die? It makes me feel bad...”

³⁸ The availability of mental health and psychosocial support services within the Protection of Civilians (PoC) sites and generally in South Sudan is described in the Chapter “Availability and Accessibility of Mental Health Services.”

³⁹ South Sudan Human Rights Commission, Interim Report on South Sudan Internal Conflict, December 15, 2013 - March 15, 2014, p. 6, available at: www.gurtong.net/ECM/Editorial/tabid/124/ctl/ArticleView/mid/519/articleId/15078/SSHRC-Interim-Report-on-South-Sudan-Internal-Conflict-December-15-2013--March-15-2014.aspx

⁴⁰ The AUCISS confirmed this incident and conducted a forensic analysis of the building where the massacre took place. AUCISS, Final Report, paras 470-494. See also UNMISS, Conflict in South Sudan-A Human Rights Report, paras 70-78.



UNMISS PoC site in Juba, South Sudan. 2014 © Amnesty International

I tried to go to school here but found that I could not concentrate even on the easy things. They just opened a school here, but my thoughts distract me. When I sit still, my mind just goes to other things like my children.”

Malith said that NGOs, journalists, and researchers had interviewed him about what happened. But, he said, “*Nobody has come to give me any counselling or support.*”⁴¹

James, who also survived the massacre in Gudele, said he has difficulty remembering things related to his daily life. He suffers from headaches and dizziness when he recalls the heat of the house where he was confined with others before the massacre. He also feels increased aggression and avoids other people.

“Sometimes I get confused. I lost a lot of things. The other day I had 2000 SSP [South Sudanese pounds]. I don’t remember what happened to that money. After 28 days a man here in the PoC came and gave me the money saying ‘Did you forget about this money? You said I should keep it for you.’

I prefer to sit by myself quietly. When people make noise or talk around me, I feel hot and dizzy and hear voices. I remember in that building it was so hot. We were dizzy and others died because it was too hot... I don’t talk too much. I easily get angry. My temper has become so bad. When I feel my body getting hot and I start getting headaches, I just go and sit by myself.

You don’t know when you will die. The same people who killed us are still out there. People are confused, stressed, and traumatized.”

James stated he had not received any psychological care: “*I never got any kind of support or counselling,*” he said.⁴²

⁴¹ Interview with Malith (pseudonym), Juba, South Sudan, 25 April 2015.

⁴² Interview with Peter (pseudonym), Juba, South Sudan, 2 May 2015.

When the soldiers and security officers who carried out the killings in Gudele found Phillip, another survivor, unharmed under a pile of bodies, they forced him to drink the blood and eat the flesh of those killed, in exchange for his life. He feels a different person than before.

“They found me, tied my arms behind my back and forced me at gunpoint to drink blood and eat flesh. I was told that if I didn’t do this I would be killed. At night when I sleep, those who were killed come back in my nightmares.

You may think I’m normal, but my mind is not good...I use a wheelbarrow to carry goods to give myself less time for thinking, to try to delete what happened from my memory, but that can never happen. I spend little time sleeping, mostly I stay awake. I can’t eat, I don’t want anything I’m offered. I don’t think the way I am feeling will ever change.”⁴³

Peter told Amnesty International that government soldiers captured his 18-year-old son, Duol, on 16 December 2013 in Nyakuron neighbourhood, then took him to Gudele, where they tied his arms and legs and beat him. Peter recounted that, after Duol managed to make his way to the PoC site on 23 December 2013, he suffered from hallucinations and showed other signs of psychological stress, including difficulty sleeping and eating.

“They [soldiers] beat him until they thought he was dead. His legs were tied with chains or ropes—when he came back, he had marks on his hands and ankles...He was mad completely. He used to walk around, boxing in the air...He punched in the air because he was trying to defend himself. He had a perception that someone was trying to fight him, and that he needed to protect himself.

He’d walk around all day and all night. He didn’t sleep. He’d go and lie down in the drainage pits. Sometimes if you gave him a bed to sleep on, he’d prefer to sleep on the ground... He would not eat. If you forced him to eat, he’d only have a little... We had to force him to take a bath. Four of us would come and force him to bathe... He would talk to himself in English and Arabic, mostly about his friend who got killed.”

Peter told Amnesty International that there was no appropriate doctor available at the PoC site and he was too afraid to take Duol to see a doctor within Juba. With assistance from a family member, Duol was able to leave Juba and travelled to Khartoum where he saw a psychiatrist and was given medication. According to Peter, the doctor said Duol was “traumatized.”⁴⁴

“I AM STILL SCARED BECAUSE OF WHAT HAPPENED”: ATTACKS ON CIVILIANS IN MALAKAL

The city of Malakal, in Upper Nile state, has been heavily contested since December 2013, changing hands between government and opposition forces at least a dozen times. During the attacks and counter-attacks on the city in the first few months of fighting, both sides killed civilians and looted and destroyed civilian homes, offices, and other buildings.⁴⁵ Amnesty International spoke with women who witnessed killings and sexual violence in Malakal, before they took refuge at the UNMISS PoC site between December 2013 and February 2014.

⁴³ Interview with Phillip (pseudonym), Juba, South Sudan, 27 April 2015.

⁴⁴ Peter did not know what, if any, specific diagnosis was made. Interview with Peter (pseudonym), Juba, South Sudan, 2 May 2015.

⁴⁵ UNMISS, Conflict in South Sudan: A Human Rights Report, May 2014, para. 151-160.



A view of the deserted streets in Malakal, Upper Nile state in January 2014 after residents fled violence between government and opposition forces. © UN Photo/Isaac Billy

Ajak fled to the Malakal UNMISS base on 25 December 2013, during the first attack on Malakal by opposition forces.

“As I was running, I saw Nuer soldiers and one tried to shoot me. I saw people dead on the roads—men, women and children... The Nuer soldiers stopped us on the road to UNMISS and said, ‘Give money or mobiles, or we’ll shoot you.’”

The psychological burden of what she witnessed was still with her, over 18 months later.

“I started suffering as soon as I arrived at UNMISS—I could not sleep or eat. If I found people quarrelling, I would leave immediately, I could not accept it. I like to be with people, but if they are talking, I sometimes don’t follow as I can’t concentrate. I can’t sleep, and when food is brought, I can’t eat. I only remember the war and what happened to me.”⁴⁶

Ajak’s daughter explained that her mother showed increased aggression, affecting her relationships with others.

“Before, she was good. But then she saw many people die and she became abnormal. She is always angry if someone she does not like talks nearby. She quarrels with me and with other people, not like before. She cries to God that she is dying. Her problem is her increasing suffering.”⁴⁷

Nyachot took shelter in a Catholic church in the Medina neighbourhood of Malakal on 24 December 2013, along with many other civilians. She said government soldiers would come to the church to abduct, kill and rape people who had taken shelter there. Nyachot witnessed a soldier kill one woman who resisted rape. She came to the Malakal PoC site on 18 January 2014. She described to Amnesty International persistent signs of distress, including nightmares.

⁴⁶ Interview with Ajak (pseudonym), Malakal, South Sudan, 6 May 2015.

⁴⁷ Interview with the daughter (name withheld) of Ajak (pseudonym), Malakal, South Sudan, 6 May 2015.

“My head is bad, I just think about the bad things I saw...The things that happened in the church, I still remember and see them in my mind...At night I don't sleep well. I get nightmares and remember the dead bodies that were around us. I was scared. I am still scared because of what happened...When I talk to people, and they talk about the conflict, I feel bad and just cry.”⁴⁸

Nyachoat also said she used to go for days without speaking to anyone, until a neighbour took her to the PoC medical centre run by International Medical Corps (IMC), where she met with a mental health officer who provided counselling and gave her medicine, which she said helped her sleep and gave temporary reprieve from nightmares.⁴⁹

Nyadeng, a mother of five children aged 14 and under, fled to the Malakal UNMISS PoC site in February 2014, after opposition forces took control of the city for a third time. She had been in Malakal Teaching Hospital, where Amnesty International visited in March 2014 and documented killings by opposition forces.⁵⁰ Nyadeng's sister described the changes she has seen in her behaviour, including memory loss:

“She can't manage—she's not normal. She can talk but it's senseless. She quarrels with the children. She cooks, but like a child, she burns things. She knows the children's names, but she does not know their ages. It is the children who tell her to do the things she should do. She can't identify what is happening...Sometimes I pray to God to help her.”⁵¹



A ward in Malakal Teaching Hospital, where patients and displaced people who had taken refuge were killed by opposition forces in late February 2014. Malakal, Upper Nile state, March 2014. © Amnesty International

⁴⁸ Interview with Nyachoat (pseudonym), Malakal, South Sudan, 2 May 2015.

⁴⁹ She did not know the name of the medication she received.

⁵⁰ Amnesty International, South Sudan: Nowhere Safe: Civilians under Attack in South Sudan, p. 24-27.

⁵¹ Interview with sister (name withheld) of Nyadeng (pseudonym), Malakal, South Sudan, 6 May 2015.

“PEOPLE ARE TRAUMATIZED”: ATTACK ON THE BOR UNMISS POC SITE

Control over the city of Bor, in Jonglei state, changed hands three times in the first month of the conflict, until government forces, supported by the Uganda People’s Defence Forces (UPDF), regained control on 18 January 2014. During the early days of fighting, thousands took shelter in the Bor UNMISS PoC site. Though the population of the Bor PoC site was initially ethnically mixed, Dinka who had taken shelter there progressively left after the government gained control over Bor. By February 2014, the population residing inside the PoC site was almost entirely Nuer, surrounded by a predominantly Dinka population residing in Bor. Tensions between those within and outside the PoC site were high. In March 2014, Amnesty International documented cases of killings and sexual violence against individuals who ventured outside the PoC site. As a result of such incidents, many chose never to leave the camp.⁵²

On 17 April 2014, a group of armed Dinka youth attacked the PoC site, at the time home to 4,800 displaced civilians.⁵³ Some fired into the PoC site from outside while others breached its perimeter and opened gunfire from within. At least 47 internally displaced people were killed as a result.⁵⁴ The attack was a flagrant violation of international humanitarian law, which prohibits attacks on UN peacekeeping missions as well as on zones of refuge. Esther was in the Bor PoC site on 17 April and witnessed the attack.

“It started with a small demonstration by local youth. They had guns and other weapons. They wanted to try to break in, but the UN didn’t let them. Then they went around to the other side, started shooting and broke in. The UN officers were overwhelmed and couldn’t stop them. They ran for their lives. After 30 minutes, many UN forces came and the attackers ran away.

The attackers killed over 100 people [UN figure is 47] including women and children. They even killed small infants and pregnant women and they set fire to tukuls [thatched roof homes] with people inside of them. UNMISS collected all of the dead bodies in two bulldozers.”

Esther’s sister and her two children, ages 13 and 9, were among those killed.

According to UNMISS, for months following the attack, people in the camp expressed fear of future attacks and said that their children were still traumatized by what they had experienced.⁵⁵ The South Sudan Law Society’s February 2015 survey of displaced people living in the Bor PoC site found that almost all of the approximately 100 respondents interviewed had symptoms consistent with a diagnosis of PTSD.⁵⁶

Esther described experiencing a number of signs of psychological distress since the attack, including poor memory and feelings of anger.

“My memory is not as good as it was before. I’ve become forgetful. I might know you, but I forget your name. I’ve become absent-minded. I cannot remember things. I’ve even gotten lost in Juba... Now I’m fearful and don’t want to go out...”

⁵² Amnesty International, South Sudan: Nowhere Safe: Civilians under Attack in South Sudan; UNMISS, Attacks on Civilians in Bentiu and Bor, April 2014, para. 77-78, available at: unmiss.unmissions.org/Portals/unmiss/Human%20Rights%20Reports/UNMISS%20HRD%20-%20Attack%20on%20Civilians%20in%20Bentiu%20and%20Bor%20-%20January%202015.pdf.

⁵³ UNMISS, Attacks on Civilians in Bentiu and Bor, April 2014, para. 18.

⁵⁴ UNMISS, Attacks on Civilians in Bentiu and Bor, April 2014, para. 105.

⁵⁵ UNMISS, Attacks on Civilians in Bentiu and Bor, April 2014, para. 112.

⁵⁶ South Sudan Law Society (SSLS) et al, Search for a New Beginning: Perceptions of Truth, Justice, Reconciliation and Healing in South Sudan, p. 25.

I am very bitter. I get angry because of small things. I'm not as tolerant as I was before. Little things make me angry. I feel very violent. I want to fight someone so that person might kill me."

"Little things make me angry. I feel very violent. I want to fight someone so that person might kill me."

Esther

Before the conflict, Esther ran a restaurant in Bor town and used her profits to support her grandchildren. But the mental impact of her experiences has affected her ability to work and pursue livelihood activities. She feels unable to start any business or even carry out usual household tasks. *"I can't do that anymore because I can't focus...My way of thinking is distorted,"* she said.⁵⁷

Elizabeth, who also survived the attack, said that people at the Bor PoC site were not the same afterwards. She herself has difficulty sleeping and complained of physical pains she says she didn't have before the conflict.

"People are traumatized...They have become fearful. If I hear a loud bang, even if it isn't a gun, I want to run away...I don't sleep at night. I stay awake thinking about the hopelessness of our situation...The future always looks bleak...I have nightmares. The image of people being killed, including infants, is stuck in my mind..."

My heart beats quickly, and I have headaches and joint pains. I have kidney problems and stomach bloating. Sometimes I get malaria. I also have swollen feet—they call it ratuba [arthritis]. I have pains in the back. I didn't have these physical pains before. All this came as a result of the fighting, compounded by the fact that I don't have money to do a proper check-up. I was healthy before the crisis."

She said she is not as active as she used to be, and is unable to carry out day-to-day activities like fetching water.

*"Everything is about motivation. There is nothing to motivate me. I'm depressed. I have no motivation to do work like I used to."*⁵⁸

"I AM NEVER HAPPY": DETENTION AND TORTURE IN JUBA

Since the start of the conflict, government security forces, particularly the Military Intelligence (MI) and National Security Service (NSS), have frequently arbitrarily detained perceived government opponents.⁵⁹ Dozens of former detainees interviewed by Amnesty International over the past two years have said security officers accused them of supporting opposition forces, but did not formerly charge them with any offence or present them before a court as required by South Sudan's constitution and international human rights law. Former detainees described security officers beating them with sticks,

⁵⁷ Interview with Esther (pseudonym), Juba, South Sudan, 24 April 2015.

⁵⁸ Interview with Elizabeth (pseudonym), Juba, South Sudan, 28 April 2015.

⁵⁹ For more on arbitrary detention and the use of torture in South Sudan, see: Amnesty International, Denied Protection of the Law: National Security Service Detention in Juba, South Sudan, April 2016 (Index: AFR 65/3844/2016); Amnesty International, "Dozens of Detainees at Risk of Death in Shipping Containers," 27 May 2016; Human Rights Watch, "South Sudan: Arbitrary Detention, Torture; Military, National Security Service Routinely Beat Detainees," 18 May 2015, available at: www.hrw.org/news/2015/05/18/south-sudan-arbitrary-detention-torture

whips, and metal bars, and giving them insufficient food and water. Some remained in detention for many months, often in horrific conditions. Three former detainees interviewed for this report told of trouble sleeping and other manifestations of psychological stress, which they said resulted from their time in detention.

John, a shop owner, said soldiers captured him in Munuki neighbourhood of Juba on 16 December 2013, when he was on his way to the UNMISS PoC site. They took him to the Giyada barracks and put him into an underground detention cell where he counted 69 other detainees, most of them Nuer. He recounted that soldiers subjected him to routine beatings, and that he did not have enough to eat.

“They beat me every day. They wanted me to say that I am a rebel. At around 10pm they would bring me out and start beating me. They punched and kicked me. They kicked me till my tooth came out. They would hit me with the butt of a gun and a long metal rod...”

Every two nights we were given rice and beans at 11am. Water was put in a small jerry can once a week. If the water finished, we weren't given more until the following week. Some people drank their urine.”

John escaped from the Giyada detention facility on 5 March 2014 during a lapse in security that occurred when fighting erupted among soldiers, reportedly over their salaries.⁶⁰ Living in the Juba PoC site over a year after his escape, John had lingering fears of being re-captured and was tormented by the memory of being detained.

“I am not ok. Even now I am still afraid that they'll come looking for me...I have a quick temper. Little things annoy me. I can't calm down easily. When I talk to people, I just find myself shouting for no reason...”

I don't sleep well. I get nightmares. When I first arrived, I could barely keep my eyes closed. My mind would not relax. Even now I am very alert. I always look at the people around me carefully, you cannot trust people. Nowadays, I can sleep, but not all night. I get dreams. Bad dreams about my capture, about the torture and the way we used to stay in that cell. We were like animals. Dirty and filthy. Sometimes I wake up at night and just start walking. I just walk around the PoC without knowing where I am going.”⁶¹

Amnesty International spoke with the uncle of Pal, a father of four who committed suicide in the Juba PoC site in March 2015. Before the conflict, Pal was a trader living in the New Site neighbourhood of Juba. He fled to the UNMISS PoC site in December 2013. According to his uncle, soldiers caught Pal when he left the site to get water in January 2014 and detained him at a facility in New Site. He escaped during the fighting among soldiers on 5 March 2014. “When he returned,” said Pal's uncle, “he wasn't normal.”

“He was emaciated and very desperate. His life was a mess. He was beaten badly with metal bars and sticks, and they kicked him a lot. One of his arms was fractured as a result. When he came back, he had many wounds on his body...”

He couldn't concentrate or focus...At night, he wouldn't sleep. He used to have nightmares. He'd dream that those people who caught him had come back again, and he would jump up and shout... He would walk around and talk to himself, in an uncoordinated way...He used to tell me, 'Uncle, I don't have a choice except to die as well.' He said he would rather die than live a miserable life...”

⁶⁰ Amnesty International has interviewed three other Nuer men who were detained in Giyada and escaped during the March fighting. Following the fighting, the SPLA spokesperson, Colonel Philip Aguer, said that 100 security forces officers arrested on suspicion of responsibility for atrocities in December 2015 in Juba also escaped. Interview with Philip Aguer, former SPLA spokesperson, Juba, South Sudan, 26 March 2014.

⁶¹ Interview with John (pseudonym), Juba, South Sudan, 27 April 2015.

Before Pal was detained, his wife and children had left Juba and moved to Kakuma refugee camp, in Kenya. Pal's wife died in February 2014 while he was in detention. Then, in March 2015, Pal got news that his daughter was sick and might not recover.

"The following day, after he was told his daughter was sick, he left us in the house at around 3pm and took a rope that is used for tying the tukuls, and he hanged himself."

Pal's family members did their best to support him. His uncle explained, "We counselled him all along. That's why he survived [as long as he did]. But none of us are in good health mentally."⁶² Pal did not receive any professional mental health services.

Simon, another former detainee, told Amnesty International he was captured by NSS personnel at the end of February 2014, when he left the UNMISS PoC site in Juba to withdraw money from his bank account. He was first detained at an NSS office near the Ministry of Justice and then transported to the NSS headquarters near Jebel market in Juba.

"I found about 70 people [other detainees]... They [NSS officers] didn't say anything about why they had arrested me. Most of the people were Nuer. They were just arrested on the streets but they would say they captured them in war, that they are rebels."

Simon remained in NSS detention for over two months, in poor conditions. He described being beaten and other forms of torture sustained by fellow detainees.

"The rooms where we were kept were completely dark – no windows. There was a small hole where the light would come through. That's just how you know it is day or night. We were given rice in a plastic sheet only once a day at 3 o'clock..."

They beat me with pipes. They would say, 'tell us what you have done'... Others were pierced with needles. They would strip you naked and pierce your sensitive parts like the penis with needles."

Simon said that in May 2014, NSS personnel transported him to an office to meet with a senior military official. At one point, he was left unguarded and was able to run, get on a motorcycle taxi, and escape. Now living in the Juba PoC site, he can't shake off the memory of his detention.

"I am suffering a lot. I am going insane. I have nightmares all the time. At night I feel as if I am being attacked and captured and tortured again. I also get annoyed easily. I was not like that before."⁶³

Lual told Amnesty International that NSS officers arrested him in September 2014 and detained him in a facility in Juba along the Nile River, where they chained his hands and feet.

"They beat us every day at 6pm. They used a bicycle lock – with plastic in the middle and metal locks at the end... We defecated within the cell and then were forced to clean it. They didn't give us cleaning supplies, we just used our hands."

They gave us one piece of bread a day and water with a hosepipe. They would spray it into the room and we'd have to use our hands to drink it. They would do this for five minutes and we'd have to scramble to drink. Then they would take it away."

According to Lual, security officers killed over 60 detainees during his time at the riverside detention facility.

⁶² Interview with the uncle (name withheld) of Pal (pseudonym), Juba, South Sudan, 25 April 2015.

⁶³ Interview with Simon (pseudonym), Juba, South Sudan, 25 April 2015.

“At eight every evening, they would come and take some to be killed, with electric shocks. They didn’t shoot you or use crude weapons. Then we prisoners would have to take them to the river.

Whenever they would kill people, we would be taken to dissect the stomachs of those who were killed, so they could be thrown into the river and wouldn’t float. Once your stomach is cut, you don’t float, you just rot under the water. Because if you float, your body will litter the river and it will be evidence that people were killed.

I myself had to cut the stomachs of four people. I was given a knife... We cut the stomachs and then removed the internal organs and put them in a paper bag. They were disposed of separately, to avoid floating. Then the officer would take you deep into the river, up to your chest, to drop the body. We were the ones carrying the bodies.”

Lual spent a total of five months in detention. He eventually escaped and made his way to the UNMISS PoC site in Juba. He told Amnesty International that he is still haunted by his experience in detention.

“I hear a lot of noise at night. I dream that I am still in jail. I am haunted by the cutting of the stomachs of the victims. I wake up and I can’t go back to sleep.

I feel hopeless. I’m not interested in talking to people. I prefer to stay alone... I feel depressed, I am never happy. I am only thinking about how I can leave Juba... And sometimes I start going somewhere and then all of the sudden, I forget where I’m going and just go home. I think about committing suicide. My dignity is challenged. I can’t go beyond this fence. All of this makes me feel bad, and I hate myself.”⁶⁴

“I AM NOTHING”: SEXUAL VIOLENCE OUTSIDE BENTIU POC SITE

South Sudan’s internal armed conflict, particularly the violence in Unity state, has been characterised by a shocking frequency of sexual violence. Bentiu, the capital of Unity state, hosts the largest PoC site in the country, with approximately 120,000 internally displaced people living there. While the site is a critical source of protection for its residents, many of whom have witnessed killings and destruction in their home areas, reaching the PoC site has not brought an end to their experience with violence. Displaced people in Bentiu must often leave the site to collect wood for fuel, food, or to grind grain. They have faced continuous threats when doing so; women have faced the particular risk of sexual violence or abduction. UNMISS has documented numerous incidents of sexual violence occurring within the perimeter of UNMISS sites. According to UNMISS, in January and February 2015 alone, at least 35 women were raped by government soldiers near the Bentiu PoC site.⁶⁵

⁶⁴ Interview with Lual (pseudonym), Juba, South Sudan, 25 April 2015.

⁶⁵ UNMISS, The State of Human Rights in the Protracted Conflict in South Sudan, December 2015, paras 46, 53.



Aerial view of the UNMISS PoC site in Bentiu. June 2016. © UN Photo/Isaac Billy

Nyawal sought refuge in the Bentiu PoC site in early 2015, escaping an attack on her village in Guit county. She was raped by an SPLA soldier a few months after arriving at the PoC site when she ventured out to buy medicine.

“That day, we were eight people on the road. Four men, and in front of me two elderly women, and another woman. We were stopped by two Dinka SPLA soldiers. The men ran and one SPLA soldier shot at them. The other pointed his gun at me and the other women. They caught one man and took him to the bush. I heard gunshots. Maybe he died, I don’t know. They took all our money, and the flour and sorghum one woman was carrying. For the two older women, they just took their money. For me and the second girl, Nyatuong,⁶⁶ they took us to the bushes in Rubkona and they raped us. This was at 4pm.”

On their way back to the PoC site, Nyawal and Nyatuong were stopped by another pair of SPLA soldiers, this time from the Nuer ethnic group. For the second time in the same day, they were raped.

“They called us and asked for money. We said we didn’t have money, that our property was taken by other Dinka soldiers. We were afraid. They were speaking Nuer and said ‘we are your people but we fight for government’. They took us and led us to the bush. Nyatuong was crying. I did not feel anything, I knew what they would do. They told us to take off our clothes. They then tied my eyes with a cloth. I think even Nyatuong was tied. I don’t know why they were tying our eyes. We had already seen their faces and it was dark. They were only two men and they had guns. They wore SPLA uniforms. They then raped us. One took me, the other took Nyatuong; I could hear her crying. Her man also came to me, I think the other one also went to Nyatuong. They raped us until around 11pm or midnight. It was very dark when we went back to UNMISS.”

⁶⁶ A pseudonym.



Women returning with collected firewood to the UNMISS PoC site in Bentiu, January 2015. © UN Photo/JC McIlwaine

Nyawal was treated for her rape by Médecins Sans Frontières (MSF) and also received support from the International Rescue Committee (IRC), which provides counselling for survivors of sexual violence in the Bentiu PoC. Her experience caused her significant mental anguish.

“Initially I could not sleep, I was feeling terrible, I felt dirty. I cry all the time when I think about it. It is better now. What I think about most is if there was no war, nobody could have forced themselves on me. Nobody would have done this to me.

I am very angry about what happened...It has changed my life. I am nothing. I have nothing good. My body was good but now it is not. I had been married only three months. And then this happened. My husband and I are OK. He understands. He says it is the way of war, it has happened to all women.

I am ashamed. It is not a good thing to happen to somebody. Some people think I wanted it to happen, that I went outside to look for soldiers to get money. They think it is my fault. Life in the PoC is hard. Women live in fear here. They have to provide for their families. It is so hard. If you don't go outside, your family will suffer, if you go outside, something will happen to you. Some women go outside and they never come back. When you go to get firewood, you get raped.”⁶⁷

⁶⁷ Interview with Nyawal (pseudonym), Bentiu, South Sudan, 16 May 2015.



Newly arrived internally displaced people register at UNMISS PoC site in Bentiu, Unity state, May 2015. © Amnesty International

“WE ARE ALL ALONE”: DEATH, ABDUCTION, AND DISAPPEARANCE OF RELATIVES

Many displaced people are tormented by the loss of wives, husbands, children, and other family members who have been killed or abducted. Sometimes individuals may have disappeared, leaving relatives to wonder whether they are alive or dead. Funeral rites can provide survivors an important sense of closure, but these have often not been performed because survivors don't know the precise fate of their relatives, because they don't have access to their remains, or because the scale of death makes individual funeral ceremonies impossible.

Sara was living in Terekeka, Central Equatoria state, in December 2013. She told Amnesty International that her husband was tied up by security forces on 18 December, taken away and killed with several other men from the Nuer ethnic group. Now living in the Juba PoC site, she cried as she described how his death has affected her life.

“At night my body aches everywhere, like something is piercing my body... I usually think about how my husband died, and it hurts a lot. I cry and I tremble a lot when I think about what happened... I get confused... Sometimes, I will walk and forget where I was going. The day before yesterday I went to buy something in the market, and I just walked and kept walking till I realised I was lost.”⁶⁸

Lam's wife was killed in Juba on 16 December 2013, only a day after she gave birth to their third child. He had run away from their home, assuming she would not be harmed. He came back to find the baby alive, and his wife killed. He keeps going over the incident and blames himself for leaving her. Lam told Amnesty International that he can't stand thinking of the past and has no hope in the future.

⁶⁸ Interview with Sara (pseudonym), Juba, South Sudan, 24 April 2015.



A child at the UNMISS PoC in Juba. 2015 © UN Photo/JC McIlwaine

"I am unable to sleep. My wife appears in my dreams. Sometimes she blames me for not performing the required funeral rites...I didn't go to church; I blamed God. When I would go to church I would just cry. My wife used to sing in church. I would remember her voice, how she used to sing."

His three year old daughter also has nightmares: *"She woke up one night screaming that she had seen her mother in her dream. Another day she also cried saying she heard her mother's voice."*

Lam has found some relief from his mental distress through working in the community and helping others.

"The community here made me a leader in charge of the welfare of orphans. It distracts me from my own problems... When the community started the cultural dances it helped me relax, and reduced tension in the community. It reminds me of when I used to court my wife. We used to dance together. I am happy that this dance has made people in the community get along. It has reminded people who they are."⁶⁹

The psychological toll of not knowing the fate of a close relative is particularly acute. Rebecca was living in the town of Rubkona in Unity state in December 2013. She lost contact with her husband, a government soldier, after the conflict started. She fled first to Yida in northern Unity state and then to Juba.

"We here we are all traumatized. Our minds are lost, our hearts have gone dark. Even now I want to cry. People who are separated from family are unhappy and depressed... Our lives depend on the UN and other NGOs. I have no hope... My children are now sleeping in a flooded tent. We are all alone."

⁶⁹ Interview with Lam (pseudonym), Juba, South Sudan, 25 April 2015.

Rebecca reached out to members of her church and friends in the PoC site for support, but found that they too were suffering.

"I speak with the Catholic sisters, but confiding in others who have problems like yours does not help. They have the same problems as I do. I just pray as only God can help. I have a friend, but she has her problems too. I don't want to burden her."⁷⁰

On 10 October 2014, government-allied militia abducted three UNMISS contractors who were working at Malakal airport. While two were later released, the fate of the third individual is unknown.⁷¹ Amnesty International spoke with Emmanuel, a relative of the missing man, who believes he was killed the night of his abduction. His wife died of tuberculosis in May 2014. According to Emmanuel, their three young sons, whom he cares for in the Malakal PoC site, "have no hope."

"They miss their parents. At night they wake up screaming because of bad dreams. They think and cry a lot. They don't talk much. When I tell them something harshly they just cry. One of them is now fighting with other children. He was not like that before. I think it's because they don't have anybody to talk to about the things that disturb them most."⁷²

"They miss their parents. At night they wake up screaming because of bad dreams."

Emmanuel

Rachel is caring for the four children of Nyayang, her former neighbour in the Juba PoC site. According to Rachel, Nyayang's husband, a soldier, disappeared during the December 2013 fighting in Juba. Rachel said that, as a result of her husband's disappearance and the conditions in the PoC site, Nyayang started to show psychological distress.

"She would stay awake at night and take a chair and sit in front of her house for a long time. People would ask her, 'why are you sitting like that for so long' and she'd respond that she was thinking. She talked to herself a lot. It was as though she was speaking to someone else over the phone... She also wasn't attentive, and she didn't eat. If she was called to eat, she would take two spoons and then abandon the food. She lost a lot of weight. She cried a lot, every day. She was forgetful and absent-minded. You could discuss a lot of things with her, but all of a sudden she'd just forget what you were talking about."

Rachel explained that Nyayang also showed increased aggression and violent behaviour, including beating her children.

"She'd use sticks and beat [them] with the rope that was given to us to tie the rakubas [thatched shelters]. The kids were bruised, and sometimes she beat them until they bled. She beat all of them, even the one-year-old. She would even pick them up and throw them violently. She would say that she didn't want children and threaten to go away and leave them."

On three occasions in October 2014, Nyayang attempted to commit suicide by drinking poison. Rachel stopped her twice.

⁷⁰ Interview with Rebecca (pseudonym), Juba, South Sudan, 25 April 2015.

⁷¹ UNMISS, "UN demands safe release of abducted personnel in South Sudan airport," 17 October 2014, available at: www.un.org/apps/news/story.asp?NewsID=49103#.Vhd_gPmqpBc

⁷² Interview with Emmanuel, Malakal, South Sudan, 2 May 2015.

“When I caught her about to drink the poison, I asked her why she wanted to do this. She said she wanted to die because she’s helpless and her children have become destitute and she couldn’t support them.”

Nyayang did not receive psychological support or care for her mental distress. In October 2014, she disappeared, leaving her three children behind in the Juba PoC site.⁷³

In the Malakal PoC site, Amnesty International interviewed three women who were grieving for their daughters they believed had been abducted by opposition forces. Nyamum was running to the UNMISS base in Malakal during the fighting in December 2013, when her 15 year-old daughter disappeared behind her. Nyamum believes she was abducted by opposition forces. She said she has no appetite because she thinks only of her missing daughter. She also has trouble concentrating, has headaches, and her heart and hands tremble.⁷⁴

Ayen stayed in a church compound in Malakal until 18 February 2014, when she and her 18 year-old daughter were abducted by opposition forces. They were beaten and forced to carry things. Ayen told Amnesty International that opposition forces later released her, but not her daughter.

“I’m angry thinking of what happened...Even if I’m hungry I cannot eat, thinking of my daughter. When she was taken she was in P8 [the final year of primary school]. I miss her. I have no hope that she will return. The rebels kill people everywhere. They killed people in the church in Malakal...I don’t go to church because of what happened in church... Now there is nobody close to comfort me.”⁷⁵

Nyaban took shelter in the Malakal Hospital in December 2013. She witnessed opposition fighters come to the hospital and kill women and children. They also abducted her young cousin, Joy. She said that since the abduction, she suffers from nightmares and lives with constant fear and anxiety. She spends her time grieving and has become forgetful.

“Until now I have not heard whether Joy is alive or not. There is a rumour that she was taken by the Lou Nuer and is near the Ethiopian border... So many thoughts are mixed up in my mind. I worry about Joy, about what happened and where she can get food...When they came and took her it was at night, and only in the morning we saw the gate was open...There is no support, but to pray to God to help me.”⁷⁶

⁷³ Interview with Rachel (pseudonym), Juba, South Sudan, 5 May 2015.

⁷⁴ Interview with Nyamum (pseudonym), Malakal, South Sudan, 6 May 2015.

⁷⁵ Interview with Ayen (pseudonym), Malakal, South Sudan, 6 May 2015.

⁷⁶ Interview with Nyaban (pseudonym), Malakal, South Sudan, 6 May 2015.

5. LACK OF ACCESS TO MENTAL HEALTH CARE SERVICES

When South Sudan gained regional autonomy under the terms of the 2005 Comprehensive Peace Agreement (CPA), the government started to build a health care system from scratch. Over ten years later, South Sudan still does not have adequate healthcare facilities, services, treatment or staff to adequately support those in need of mental healthcare. The current conflict has dealt a significant blow to an already struggling health care system, with the complete or partial destruction and looting of several health facilities, including the Malakal and Bentiu hospitals.⁷⁷ Even where available, government mental health services are very limited in scope and often of poor quality. While mental health has been included in South Sudan's policies and plans for the health sector since 2006, stated goals have not been reached. The government has not committed adequate attention, or funding, to improve the availability or accessibility of mental health services, while support from international organizations and donors is also minimal.

Services available in conflict-affected settings, including in the UNMISS PoC sites, are almost entirely provided by international NGOs. In Juba, Makal, and Bentiu PoC sites, some NGOs offer mental health and psychosocial support services, but their interventions are insufficient given the size of the populations they are intended to serve. One major gap is in the provision of specialized mental health services for people with severe mental disorders. Additionally, due to the ethnic and political divides created by the current conflict and the persistent security risks in some locations, many people living within the PoC sites are afraid to leave. In Juba, for example, many PoC site residents are reluctant to seek out the limited mental health services available at Juba Teaching Hospital. In Bentiu and Malakal towns, there are no mental health services even if those living in the PoC sites leave.

GOVERNMENT MENTAL HEALTH SERVICES: PRACTICALLY NON-EXISTENT

Few communities in South Sudan live in reach of the even most basic health care services. The Ministry of Health itself has described the availability, accessibility and management of health facilities as generally poor.⁷⁸ There is an insufficient number of health facilities and a deficit of health professionals. According to the Ministry, in 2012 there were only 1.5 physicians and 2 nurses/midwives

⁷⁷ Médecins Sans Frontières (MSF), "Medical Care in South Sudan Under Fire," 24 February 2014, available at: www.msf.org/article/medical-care-under-fire-south-sudan. According to UNOCHA, as of September 2015, 55% of health facilities in the Greater Upper Nile region were not functioning. UNOCHA, Humanitarian Needs Overview, 2016, available at: http://reliefweb.int/sites/reliefweb.int/files/resources/2016_HNO_South%20Sudan.pdf

⁷⁸ In the 2009 Basic Package of Health and Nutrition Services for Southern Sudan (BPHS), the Ministry of Health estimated that overall access to health care was below 25%. Government of Southern Sudan, Ministry of Health, Basic Package of Health and Nutrition Services, 2009, p. 11.

for every 100,000 citizens, all of them disproportionately based in urban areas.⁷⁹ Geographical distances, poor roads, the absence of ambulance services, and socio-cultural and financial barriers all contribute to the inaccessibility of medical care.⁸⁰ Even where accessible, the lack of qualified health workers, insufficient material resources, equipment, and medicines, as well as dysfunctional referral mechanisms compromise the overall quality of basic health services in the country.⁸¹

Whilst the health system as a whole in South Sudan is in a deeply worrying state, mental health services remain practically non-existent. The Juba Teaching Hospital is the only public medical facility that provides psychiatric care. During a visit to this hospital in April 2015, Amnesty International found just 12 beds in the facility's inpatient psychiatric ward. Due to inadequate resources, the ward itself is run down and in dire need of renovation and new equipment. There are no therapeutic activities, home visits, or community outreach.⁸² The availability of psychotropic drugs is inconsistent and limited.⁸³ Even when the drugs are available, families can rarely afford them, particularly for long-term use.⁸⁴ While some patients travel from across the country to access treatment in Juba, the cost of travel and the low awareness of services available make this an unrealistic option for the vast majority of those in need of care.⁸⁵

There is a dire shortage of trained mental health professionals. There are only two practising psychiatrists in the country, both of whom are in Juba and neither of whom see patients on a full-time basis. One is the Dean of Juba University's College of Medicine and the other divides her time between the Juba Teaching Hospital and leading the Mental Health Department in the Ministry of Health. The psychiatric ward at Juba Teaching Hospital is staffed by one clinical psychologist and a number of psychiatric medical assistants, counsellors and nurses.⁸⁶

Outside of Juba, the availability and accessibility of mental health services is even more grim. There is no psychiatric ward in either of the country's other two major hospitals, in Wau and Malakal. The Upper Nile state Ministry of Health said it tried to establish special units in Malakal and elsewhere in the state, but was unable to do so due to the conflict and lack of funds.⁸⁷ There are no mental health specialists in public facilities outside of Juba. Primary health care providers are not sufficiently trained to diagnose mental health cases. Even if they were, there would be no clear referral pathways or reasonably accessible treatment options.⁸⁸

The inadequate number of mental health professionals in South Sudan is due in part to the limited opportunities for training in mental health in the country. There is no specialized training available in psychiatry, psychiatric nursing, or clinical or counselling psychology.⁸⁹ Medical students often graduate without completing psychiatric rotations and as a result aren't trained to identify or address mental health issues in patients. The head of the Mental Health Department lamented that, "*most of our doctors don't know anything about mental health.*"⁹⁰ To its credit, the Ministry of Health has taken the small step of sending four staff for training outside of the country. The head of the Mental

⁷⁹ Government of South Sudan, Health Sector Development Plan, 2012-2016, p. 11, available at: <https://extranet.who.int/nutrition/gina/sites/default/files/SSD%202012%20HEALTH%20SECTOR%20DEVELOPMENT%20PLAN%202012-2016.pdf>

⁸⁰ Richard Downer, Center for Strategic and International Studies, The state of public health in South Sudan: Critical Condition, November 2012, available at: http://csis.org/files/publication/121114_Downie_HealthSudan_Web.pdf

⁸¹ According to the 2012-2016 Health Sector Development Plan, 33% of health facilities required complete replacement and 18% required major renovation. Government of South Sudan, Health Sector Development Plan, 2012-2016, pp. 10, 15.

⁸² International Medical Corps (IMC), Mental Health Facilities: Situational Analysis and Strategy, 2013, p. 9.

⁸³ IMC, Mental Health Facilities: Situational Analysis and Strategy, 2013, p. 11.

⁸⁴ Interview with NGO staff member, Juba, South Sudan, 10 April 2015. Interview with family member of mental health patient, Juba, South Sudan, 4 May 2015.

⁸⁵ Interview with Dr Atong Ayuel, Director, Mental Health Department, Ministry of Health, 10 April 2015.

⁸⁶ Interview with Dr Atong Ayuel, Director, Mental Health Department, Ministry of Health, Juba, South Sudan, 10 April 2015. IMC, Mental Health Facilities: Situational Analysis and Strategy, 2013, p. 9.

⁸⁷ Interview with Upper Nile state Minister of Health, Malakal, South Sudan, 9 May 2015.

⁸⁸ Interview with NGO staff member, Juba, South Sudan, 10 April 2015.

⁸⁹ IMC, Mental Health Facilities: Situational Analysis and Strategy, 2013, p. 10.

⁹⁰ Interview with Dr Atong Ayuel, Director, Mental Health Department, Ministry of Health, 10 April 2015.

Health Department also told Amnesty International that she is working to integrate mental health in the university curriculum and teaches some modules in colleges of medicine across the country.⁹¹

The routine use of prisons to house individuals with mental health conditions is a stark manifestation of the inadequacy of mental health treatment, stigma about mental disorders and the deficit of facilities and trained staff. Individuals with mental health conditions deemed to pose a danger to themselves or others often end up arbitrarily detained in prison, even if they have not committed any crime. They may be transferred to prison from medical facilities or taken directly to prison by family members who feel unable to care for them. In May 2016, there were 66 male and 16 female inmates in Juba Central Prison categorized as mentally ill, more than half of whom had no criminal files.⁹² According to a former health worker at Malakal Hospital, prior to the conflict, there were 27 people with mental health problems in the Malakal prison. *“Some were brought to prison by family members because they were violent, aggressive, and suicidal,”* he explained.⁹³



People with suspected mental conditions are routinely detained in prisons. Juba Central Prison, Juba, South Sudan, 2011. © Robin Hammond

In prison, people with mental health disorders receive insufficient medical care, if any at all.⁹⁴ Although general living conditions in South Sudan's prisons are extremely poor, inmates with mental disorders are often naked, chained or held in solitary confinement.⁹⁵ Between January and May 2016, four inmates with mental disorders died in Juba Central Prison due to insufficient food and treatable illnesses such as malaria and diarrhoea.⁹⁶ The detention of individuals with suspected mental disorders

⁹¹ Interview with Dr Atong Ayuel, Director, Mental Health Department, Ministry of Health, 10 April 2015.

⁹² Thirty-six of the mentally ill prisoners had criminal files, while 36 did not. Interview with prison officials, Juba, South Sudan, 6 May 2016.

⁹³ Interview with former Malakal hospital health worker, Malakal, South Sudan, 2 May 2015.

⁹⁴ In Juba, psychiatric staff from the Teaching Hospital do visit the inmates in the prison. Provision of medication depends often on availability and ability of family members to pay. Interview with Juba Teaching Hospital staff, 10 April 2015. See also Human Rights Watch, "Prison is not for Me": Arbitrary Detention in South Sudan, June 2012, available at: https://www.hrw.org/sites/default/files/reports/southsudan0612_forinsert4Upload.pdf

⁹⁵ In May 2016, five women with mental disorders were in solitary confinement in Juba Central Prison. Amnesty International observations during visit to Juba Central Prison, Juba, South Sudan, 6 May 2016. See also Human Rights Watch, "Prison is not for Me:" Arbitrary Detention in South Sudan.

⁹⁶ Interview with prison officials, Juba, South Sudan, 6 May 2016.

violates a host of rights, including the prohibition of arbitrary detention, the right to non-discrimination, to health, to due process as well as to be free from cruel, inhuman and degrading treatment or punishment.⁹⁷

GOVERNMENT MENTAL HEALTH POLICIES

In its 2006-2011 Health Policy, the first articulation of the vision and principles of the health sector following the signing of the CPA, the Government of Southern Sudan indicated that it saw mental health as “an essential component of public health.” The policy promised the development of a strategic approach to protecting and promoting mental health and well-being, and the development of a flexible range of post-conflict, integrated mental health support and care services at all levels of the health system, particularly at the community level. It specified that services should be “appropriate, accountable, accessible and equitable, and ensure that the dignity of people is respected.” The policy further promised the development of a mental health strategy and appropriate legislation.⁹⁸

Mental health is also included in South Sudan’s Basic Package of Health Services (BPHS), which provides service norms and standards to primary health care service managers and providers at the Village, Boma, Payam, County and State levels.⁹⁹ The 2012-2016 Health Sector Development Plan, intended as a road map for improving health services, recognized the human resource gaps in the mental health sector and recommended that the number of psychiatrists should increase from 0 in 2012 to 11 by 2016, and that the number of psychiatric technicians should increase from 0 to 112.¹⁰⁰

Though these policies and plans foresee some relevant improvements to mental health services, there has been little or no implementation. Human resource objectives—conservative as they are—have not been met.¹⁰¹ Nor have mental health care services been integrated into the primary health care system. The establishment in June 2014 of a Department of Mental Health in the national health ministry was a positive step, but it remains under-staffed and under-resourced. The Director’s goal to oversee the development of a specific mental health policy is, as of May 2016, yet to be realized.¹⁰² Nor is there any legislation concerning mental health issues, including on the existing practice of incarcerating people with suspected mental health disorders.

In addition to failing to adequately integrate mental health into the national legal and political framework, South Sudan has also failed to make adequate financial commitments to improve the availability and accessibility of mental health services. The health sector budget as a proportion of the national budget declined from 7.9% in 2006 to 4.2% in 2011.¹⁰³ In the 2015-2016 budget plan, the health sector received only 3% of the total budget and only 1% was allocated to social and humanitarian affairs. Meanwhile, the security sector received 44%, the highest amount in the budgetary allocation.¹⁰⁴ While there is no specific requirement under international human rights law for the percentage of national budget a government is required to spend on the health sector, in the 1991 Abuja Declaration, African governments pledged to allocate at least 15% of their annual budget to improving the health sector.¹⁰⁵ It is unclear how much of the government’s health sector budget is spent on mental health services.¹⁰⁶

⁹⁷ There is no legislation governing the forced commitment of individuals to mental health or any other institution where they are deprived of liberty. Thus there is no clear legal basis for these detentions.

⁹⁸ Government of Southern Sudan, Ministry of Health, Health Policy for the Government of Southern Sudan, 2006-2011, pp. 38-39. http://www.africanchildforum.org/cfr/policy%20per%20country/south%20sudan/ssudan_health_2006-2011_en.pdf

⁹⁹ Government of Southern Sudan, Ministry of Health, Basic Package of Health and Nutrition Services for Southern Sudan, 2009.

¹⁰⁰ Government of South Sudan, Health Sector Development Plan, 2012-2016, p. 40.

¹⁰¹ Even if implemented fully, this would still mean that there would only be one psychiatrist per 700,000 in the population.

¹⁰² Interview with Dr Atong Ayuel, Director, Mental Health Department, Ministry of Health, 10 April 2015.

¹⁰³ Government of South Sudan, Health Sector Development Plan, 2012-2016, p. x.

¹⁰⁴ Ministry of Finance and Economic Planning, Approved Budget Tables: Fiscal Year 2015/16, October 2015, p. 14, available at: <http://www.grss-mof.org/wp-content/uploads/2015/10/RSS-Approved-Budget-Book-2015-16.pdf>

¹⁰⁵ Abuja Declaration on HIV/AIDS, Tuberculosis and other Infectious Diseases, OAU/SPS/ABUJA/3, 27 April 2001, available at: http://www.un.org/ga/aids/pdf/abuja_declaration.pdf

¹⁰⁶ Amnesty International wrote to the Ministry of Health in April 2016 requesting this information, but did not receive a response.

INTERNATIONAL ASSISTANCE AND COOPERATION

INSUFFICIENT MENTAL HEALTH SERVICES IN PoC SITES AND OTHER EMERGENCY SETTINGS

A number of NGOs have established psychosocial support interventions in PoC sites. Interventions include the establishment of child-friendly spaces, group recreational activities, and psychosocial first aid or support to survivors of sexual violence. The International Rescue Committee (IRC), for example, runs a women's protection and empowerment programme in Bentiu PoC that includes five women's centres offering psychosocial support and individual case management.¹⁰⁷ The International Organisation for Migration (IOM) has established and trained psychosocial mobile teams in the Bentiu and Bor PoC sites which provide services aimed at strengthening family and community support, such as recreational activities, discussion groups and focused, non-specialized services through peer support groups, lay counselling and home visits.¹⁰⁸ Handicap International has a programme designed to improve the psychosocial situation of internally displaced people in Juba that includes psychosocial counselling and the establishment of support groups.¹⁰⁹ While important contributions, these programmes are still insufficient given the large populations they are intended to support.

There is also a specific gap in the availability of specialized mental health care services, such as psychotherapy, group therapy, or pharmacologic intervention, for people who have significant difficulties in basic daily functioning and have not been helped by more basic community interventions. Few NGOs in South Sudan provide such services. According to one NGO staff member, *"everyone is doing psychosocial support, but it doesn't help to put people with severe problems into a child-friendly space."*¹¹⁰ The concern expressed by multiple NGO workers is that there is no ability to refer cases identified through psychosocial support programmes. *"Demand is being created and there is an awareness, but where can people go to seek treatment?"* asked one NGO staff member.¹¹¹

International Medical Corps (IMC) is the only NGO offering more specialized mental health services in the Juba and Malakal PoC sites. IMC has one expatriate psychiatrist who oversees mental health officers stationed at IMC-run primary health clinics in the Juba and Malakal PoC sites.¹¹² Through the mental health officers, specially trained community health workers, and the staff of the primary health clinics, IMC provides treatment, counselling, and case management for individuals with mental, neurological and substance use disorders. They also offer community awareness-raising and sensitization through home visits, community support groups, and local radio programming.¹¹³ But the IMC's single mental health officer in Juba serves a population of over 28,000, while the officer in Malakal serves 47,000 people. In Bentiu, where 120,000 internally displaced people live at the UNMISS PoC site, there are no specialized mental health services available for people with severe mental disorders.

While there are gaps in mental health service provision within the PoC sites, the situation is far worse in other areas of the country affected by conflict, including where internally displaced people have settled informally, outside of the PoC sites. They have little access to any form of mental health support.

SCARCE SUPPORT TO PUBLIC HEALTH SECTOR

There are only a few international organizations with programmes supporting the improvement of mental health services within the public health sector. Handicap International initiated a mental health

¹⁰⁷ Interview with International Rescue Committee (IRC) staff, Bentiu, South Sudan, 14 May 2015.

¹⁰⁸ Interview with International Organization for Migration (IOM) staff, 1 May 2015.

¹⁰⁹ Handicap International, Urban Juba Project, 2016 (on file with Amnesty International).

¹¹⁰ Interview with NGO staff member, Juba, South Sudan, 7 April 2015.

¹¹¹ Interview with NGO staff member, Juba, South Sudan, 10 April 2015.

¹¹² IMC also has mental health officers in Minkaman internally displaced persons site, in Akobo and at Gendrasa and Kaya refugee camps in Maban County and one expatriate clinical psychologist based in Maban. Interview with IMC staff, Juba, South Sudan, 10 April 2015.

¹¹³ Interview with IMC staff, Juba, South Sudan, 10 April 2015.

project in 2014 that includes work to support and build the capacity of staff in the psychiatric ward of Juba Teaching Hospital and the staff and authorities at Juba Central Prison in issues relating to mental health. They are also hoping to support the health ministry in the development of a national mental health policy.¹¹⁴ HealthNet TPO has recently worked on a pilot project to integrate mental health care into three primary health care centres in Jur River county in Western Bahr el Ghazal state. The project, which ended in December 2015, faced numerous challenges, including the absence of a guiding mental health policy, insufficient human resources, insufficient funding, and high turnover of the staff in the primary health care centres.¹¹⁵

Saint Bakhita Health Centre in Yei, Central Equatoria state, run by the Catholic Diocese of Yei, provides direct services to individuals in need of mental health care. In 2014, it provided in or outpatient services to 206 patients with a range of mental health conditions.¹¹⁶ They, however, lack specialized staff, only have one psychiatric nurse and no separate ward for mental health patients.¹¹⁷

LIMITED AND UNCOORDINATED COMMUNITY-BASED TRAUMA PROGRAMS

Some churches and smaller NGOs carry out community-based interventions that seek to address trauma. Morning Star, for example, is a trauma awareness program funded by the United States Agency for International Development (USAID) whose vision is to create opportunities for people to learn about trauma, begin to heal, and come together as a community to support further healing and reconciliation.¹¹⁸ Morning Star has trained facilitators who have held community conversations about trauma. They are currently working to revise training materials and to conduct additional trainings, including with primary health care workers.

Solidarity with South Sudan, a Catholic NGO, has provided a number of healing from trauma workshops to teachers, church members, soldiers, and prisoners, using a method called *Capacitar*. The trainings are designed to enhance individuals' ability to cope.¹¹⁹

The South Sudan Psychosocial Support Programme (SSPP), a community-based organization founded by South Sudanese psychosocial counsellors and psychiatric nurses, specializes in providing mental health and psychosocial support for survivors of war and organized violence in Eastern Equatoria state. Their activities include community awareness raising on mental health, training government health workers on mental health, running mobile mental health outreach clinics and carrying out individual and group counselling.

Such community-based trauma programmes can help reduce stigma related to mental health symptoms, assist people to better understand difficult experiences, increase healthy coping, and strengthen support systems. They therefore play an important role in the spectrum of mental health services. But, in the absence of a clear mental health strategy, there is no overarching vision of how these interventions should be carried out, including best practices or professional and ethical standards they should adhere to or of how they relate to other mental health interventions. As a result, community-based trauma interventions are largely uncoordinated and unlinked to the more formal mental health sector.

INADEQUATE SUPPORT FROM WHO

With its publication of the 2001 World Health Report, which focuses on mental health, the WHO sought to dispel the historical neglect of mental health and increase attention to mental health because it is "critical to the overall well-being of individuals, societies and countries."¹²⁰ Since then, the WHO

¹¹⁴ See www.handicap-international.us/south_sudan

¹¹⁵ Interview with Health Net TPO staff, 10 April 2015.

¹¹⁶ Presentation by Coordinator, Saint Bakhita Health Centre, 10 March 2015.

¹¹⁷ Presentation by Coordinator, Saint Bakhita Health Centre, 10 March 2015.

¹¹⁸ Interview with Morning Star staff, Juba, South Sudan, 9 April 2015.

¹¹⁹ Interview with Solidarity with South Sudan staff, Juba, South Sudan, 6 May 2015.

¹²⁰ WHO, The World Health Report, Mental Health: New Understanding, New Hope, 2001, p xi, available at: <http://www.who.int/whr/2001/en/>

has developed or contributed to a number of mental health tools, including the Inter-Agency Steering Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings and the mental health Gap Action Programme (mhGAP) which focuses on how to expand services for mental health in low resource settings such as South Sudan.¹²¹ The WHO has also emphasized that countries can make substantial gains in mental health services during and following emergencies. In fact, according to WHO, despite their adverse effects on mental health, emergencies—often accompanied by an increase in humanitarian aid and focused attention on mental health—present an important opportunity to transform mental health care for the long term.¹²²

According to its constitution, the WHO is responsible for providing leadership on global health matters, shaping the health research agenda, setting norms and standards, articulating evidence-based policy options, providing technical support to countries, and monitoring and assessing health trends.¹²³ In 2013, the WHO published a global Mental Health Action Plan that recommends the following actions for the WHO: building capacity in the development and implementation of policies, plans and laws relevant to mental health; offering technical support for resource planning, budgeting and expenditure tracking for mental health; providing technical support for expanding mental health treatment and support; providing technical advice and guidance for policy and activities related to mental health in humanitarian emergencies; supporting countries in the formulation of a human resource strategy for mental health; and providing guidance and training on the development of information systems to capture information about core mental health indicators.¹²⁴

Unfortunately, the WHO office in Juba has not provided substantial technical or financial support to expanding mental health services in South Sudan—a fact acknowledged by the WHO Country Representative.¹²⁵ The WHO office is, however, hoping to improve its support for mental health through the recruitment of a staff person responsible for non-communicable diseases, including mental health. The WHO is also planning to conduct an assessment of non-communicable diseases, including mental health, in June 2016. Findings would be used to shape interventions and strategies on mental health.¹²⁶ The WHO South Sudan work plan for 2016-2017 foresees support for the development and implementation of a mental health policy in line with the WHO Mental Health Action Plan 2013-2020 and support for the development of integrated mental health services, but these activities are not yet funded.¹²⁷

LIMITED DONOR FUNDING

Donor support to South Sudan's health sector since 2005 has come primarily through bilateral grant support as well as pooled donor funding mechanisms intended to support the implementation of the Basic Package of Health Services (BPHS) and the Health Sector Development Plan.¹²⁸ Although mental health is included in the BPHS and an increase in the number of mental health professionals was one objective of the Health Sector Development Plan, according to mental health workers in South Sudan, little donor funding has made its way to support the improvement and expansion of government-provided mental health services.

¹²¹ WHO, Mental Health Gap Action Programme (mhGAP): Scaling Up Care for Mental, Neurological, and Substance Abuse Disorders, available at: http://www.who.int/mental_health/evidence/mhGAP/en/

¹²² WHO, Building Back Better: Sustainable Mental Health Care after Emergencies, 2013, available at: http://apps.who.int/iris/bitstream/10665/85377/1/9789241564571_eng.pdf

¹²³ WHO Constitution, 1946, Article 2, available at: <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1>

¹²⁴ WHO, Mental Health Action Plan 2013-2020, pp. 13-19.

¹²⁵ Interview with WHO Country Representative, Juba, South Sudan, 3 May 2016.

¹²⁶ Interview with WHO Country Representative, Juba, South Sudan, 3 May 2016.

¹²⁷ WHO Country Office, South Sudan, Approved WHO Work Plans for 2016-17 Biennium (on file with Amnesty International). Interview with WHO staff member, Juba, South Sudan, 28 April 2016.

¹²⁸ The Multi-Donor Trust Fund managed by the World Bank, ran from 2005 to 20013. Since 2013, the World Bank has supported the Rapid Results Health Project (RRHP) managed by IMA World Health (IMA). The Basic Services Fund, supported by the United Kingdom (UK), Canada, Norway, Sweden, the European Union (EU) and the Netherlands, ran from 2005 to 2012. The first Health Pooled Fund, supported by Australia, Canada, the European Commission, Sweden and the UK ran from 2012-2016. The second Health Pooled Fund, supported by Australia, Canada, the European Commission, Sweden, the UK and the US will start in 2016.

There are multiple explanations as to why donor support to the health sector, though substantial, has not resulted in an improvement of mental health services.¹²⁹ For one, the absence of a national mental health policy or strategy, or of clear government commitment to mental health—either political or financial—means there is little to inspire or guide donor support for mental health. Also, the paucity of mental health professionals in South Sudan means that there are few advocates for improved mental health services. The Ministry's Department of Mental Health—the would-be champion of mental health services—does not have the human or financial resources to effectively coordinate national and international players or to rally donor support. The Department in fact has only one staff person—the Director.

Another issue is that, though donor funding purportedly supports implementation of the Basic Package of Health and Nutrition Services, certain interventions are prioritized. The objectives of the Health Pooled Fund for example (which in fact mirror those laid out in the Government's Health Sector Development Plan 2012-2016) include to “increase the utilisation and quality of health services, with an emphasis on maternal and child health.”¹³⁰ Given that South Sudan has the highest maternal mortality rate in the world, this emphasis is appropriate. But the Health Pooled Fund's 101-page instructions to implementing partners, which outline essential primary health care activities, make no mention at all of mental health and psychosocial support.¹³¹ This is one illustration of how service specific prioritizations may overshadow other critical elements of health care, such as mental health care.

The failure to deliberately ensure that mental health and psychosocial support programmes are integrated into health interventions, as well as into work in other sectors, crosscuts the government, the donor community, and national and international NGOs. A South Sudanese mental health worker said, “Most donors have little understanding of mental health. They focus on emergencies like food distribution and physical health, neglecting mental health and psychosocial support which are crucial during moments of conflict.”¹³² On a positive note, in August 2015, USAID's Conflict Advisor in Juba began developing a strategy to integrate trauma interventions into programs in each of USAID's development sectors (health, education, governance, food security, livelihoods, and conflict mitigation).¹³³

Initiating mental health and psychosocial support programming is complex, especially given cultural differences and an absence of qualitative or quantitative research to guide programme design. It is also difficult to measure the impact of mental health services—unlike other forms of humanitarian assistance like water or food distribution.¹³⁴ According to one NGO staff member, “Mental health and psychosocial support programmes impact things that aren't tangible—quality of life, security, happiness. Because the change is difficult to measure, it is sometimes pushed out of the hard core humanitarian work.”¹³⁵ Individuals with mental health conditions, once diagnosed, may require long-term treatment and care and, as a result, an expectation of a long-term commitment to funding.¹³⁶ National and international NGO workers felt that all of these factors contributed to the perceived reluctance among donors to fund mental health services.

¹²⁹ In 2014-2015, for example, international donors provided US\$230 million in support to the health sector. Ministry of Finance and Economic Planning of the Government of the Republic of South Sudan, South Sudan Annual Aid Report 2014/15, 2016, available at: <http://www.grss-mof.org/wp-content/uploads/2016/06/South-Sudan-2014-15-Annual-Aid-Report.pdf>

¹³⁰ See “Key objectives of the HPF,” available at: [http://www.hfpsouthsudan.org/background/Health Sector Development Plan, 2012-2016](http://www.hfpsouthsudan.org/background/Health%20Sector%20Development%20Plan,%202012-2016), p. xi.

¹³¹ Ministry of Health and Health Pooled Fund, Call for Proposals, April 2013, available at: http://www.hfpsouthsudan.org/download/hpf_key_documents/management_of_hpf_mechanism/Request%20for%20Proposals%20-%20Eastern%20Equatoria,%20Western%20Bahr%20el%20Ghazal%20and%20Unity%20States.pdf

¹³² Email communication with mental health worker, May 2016.

¹³³ Interview with United States Agency for International Development (USAID) staff, Juba, South Sudan, 5 May 2016.

¹³⁴ Interview with expatriate psychologist, Juba, South Sudan, 7 April 2014.

¹³⁵ Interview with NGO staff member, Juba, South Sudan, 8 April 2015.

¹³⁶ Interview with NGO staff member, Juba, South Sudan, 7 April 2015.

6. SOUTH SUDAN'S LEGAL OBLIGATIONS

South Sudan is bound by international law to respect, protect and fulfil the right to health, which the WHO defines as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”¹³⁷ This requires the government to ensure access to mental health services; refrain from acts such as torture that cause psychological harm; and prevent such acts by third parties. South Sudan must also ensure that victims of serious human rights or humanitarian law violations or abuses receive compensation for mental harm and rehabilitation, including psychological care. Amnesty International’s findings lead to the conclusion that South Sudan is failing to meet these obligations in a number of respects.

THE RIGHT TO MENTAL HEALTH CARE SERVICES AS PART OF THE RIGHT TO HEALTH

The right to health is enshrined in numerous international and regional human rights instruments including the Universal Declaration of Human Rights (UDHR).¹³⁸ The Convention on the Rights of the Child (CRC), to which South Sudan is a party, recognizes the right of the child to “the highest attainable standard of health” and requires that children with mental disabilities have access to health care services.¹³⁹ South Sudan is also bound under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) to ensure access to health services for all women.¹⁴⁰ As a signatory to the African Charter on Human and Peoples’ Rights (the African Charter), South Sudan has indicated an intent to be bound by its content, including Article 16 which provides that “every individual shall have the right to enjoy the best attainable state of physical and mental health.”¹⁴¹

The Transitional Constitution of the Republic of South Sudan (TCRSS), in place since 2011, also recognizes the government’s obligation to provide health services. It states that: “All levels of

¹³⁷ WHO Constitution, 1946, Preamble.

¹³⁸ Universal Declaration of Human Rights (UDHR), 1948, Article 25.

¹³⁹ UN Convention on the Rights of the Child (CRC) 1989, ratified by South Sudan in May 2015, Articles 23 and 24.

¹⁴⁰ UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), 1979, ratified by South Sudan in May 2015, Article 12.

¹⁴¹ African Charter on Human and Peoples’ Rights (African Charter), Article 16(1). South Sudan signed the African Charter on 24 January 2013. South Sudan’s National Legislative Assembly approved ratification of the African Charter in October 2013. The only remaining step to complete the ratification process is for the government to deposit the instrument of ratification with the AU. Since South Sudan has signed the treaty, it is bound by the Vienna Convention on the Law of Treaties to refrain from acts that would defeat its object and purpose. Vienna Convention on the Law of Treaties, 1986, Article 18.

government shall promote public health, establish, rehabilitate and develop basic medical and diagnostic institutions and provide free primary health care and emergency services for all citizens.”¹⁴²

South Sudan is not party to the Convention on the Rights of People with Disabilities (CRPD) or to the International Covenant on Economic, Social and Cultural Rights (ICESCR)—two key treaties with respect to mental health.¹⁴³ However, the treaty monitoring body of the ICESCR, the Committee on Economic, Social and Cultural Rights (CESCR), has provided useful and authoritative guidance on how states should implement the right to health, including mental health. Even in the absence of ratification of the ICESCR, South Sudan should take cognisance of the CESCR’s guidance in order to effectively comply with its obligations under other treaties and its own constitution to implement the right to health.

According to the CESCR, though fulfilment of the right to health is to a great extent dependent on the availability of resources, all countries, notwithstanding their economic situation, have a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of health services.¹⁴⁴ Core obligations of states include the provision of essential primary health care and essential drugs.¹⁴⁵ According to the WHO, the provision of primary health care should include the detection and treatment of common mental and behavioural disorders.¹⁴⁶ States are also required, as a minimum core obligation, to adopt and implement a national public health strategy and plan of action.¹⁴⁷

In addition to providing minimum levels of services, implementing the right to health provided in CRC, CEDAW, the African Charter, and South Sudan’s constitution requires the government to improve and expand upon health services over time, in accordance with the principle of progressive realisation. Progressive realization requires states to take deliberate, concrete and targeted steps, as “expeditiously and effectively as possible” and to the maximum of their available resources with a view to progressively realizing the right to health over time.¹⁴⁸ Such steps might include adopting legislation or administrative, economic, financial, educational or social reforms, or establishing action programmes, appropriate oversight bodies or judicial procedures. Available resources refer to those existing within a State as well as those available from the international community through international cooperation and assistance.¹⁴⁹ The context of armed conflict does not dilute South Sudan’s immediate obligation to take steps to ensure full realization of the right to health.¹⁵⁰

According to the CESCR, fulfilment of the right to health means that health services, including mental health services, are available, accessible, acceptable, and of good quality. Availability means that there are enough mental health-related facilities and services as well as sufficient trained medical and other professionals. Accessibility means that mental health facilities are affordable, geographically accessible and available without discrimination; it also comprises the right to seek and receive information about health services. Acceptability means that facilities respect different cultures and medical ethics. Services of good quality meet medical and scientific standards of quality.¹⁵¹

An important principle regarding mental health services, provided for in the 1991 UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health, is that every individual has the right to be treated and cared for, as far as possible, in the community in

¹⁴² Transitional Constitution of the Republic of South Sudan (TCRSS), 2011, Article 31.

¹⁴³ See Committee on Economic, Social, and Cultural Rights (CESCR), General Comment 3: The Nature of State Parties Obligations (art. 2(1) (General Comment 3), 1990, UN Doc E/1991/23, para 10.

¹⁴⁴ CESCR, General Comment 3, para. 10.

¹⁴⁵ CESCR, General Comment 14: The Right to the Highest Attainable Standard of Health (General Comment 14), 2000, UN Doc E/C.12/2000/4, para. 43.

¹⁴⁶ WHO, The World Health Report, Mental Health: New Understanding, New Hope, 2001, p. 59.

¹⁴⁷ CESCR, General Comment 14, para. 43.

¹⁴⁸ CESCR, General Comment 3, para. 2.

¹⁴⁹ CESCR, General Comment 3, para. 4.

¹⁵⁰ See Anand Grover, Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, 2013, UN Doc A/68/297.

¹⁵¹ CESCR, General Comment 14, para. 12.

which he or she lives.¹⁵² Patients also have the right to be treated in the least restrictive environment and with the least restrictive or intrusive treatment appropriate to the patient's health needs and the need to protect the physical safety of others.¹⁵³ The WHO calls for people with mental disorders to be moved out of prisons and for all institutional-based care for people with mental health conditions to be phased out. According to the WHO, until all patients can be discharged into the community with adequate community support, psychiatric institutions should be downsized, the living conditions of patients should be improved, and procedures should be set up to protect patients against unnecessary involuntary admissions and treatments.¹⁵⁴

Fulfilling the right to mental health further requires that mental health services be designed to fulfil a wide range of mental health needs. According to the UN Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health (Special Rapporteur on the right to health), “[States] should take steps to ensure [the availability of] a full package of community-based mental health care and support services conducive to health, dignity, and inclusion, including medication, psychotherapy, ambulatory services, hospital care for acute admissions, residential facilities, rehabilitation for persons with psychiatric disabilities, programmes to maximize the independence and skills of persons with intellectual disabilities, supported housing and employment, income support, inclusive and appropriate education for children with intellectual disabilities, and respite care for families looking after a person with a mental disability 24 hours a day.”¹⁵⁵

The WHO similarly recommends that providing comprehensive mental health care requires a variety of services. These services should include a balanced combination of medication (or pharmacotherapy); psychotherapy; and psychosocial rehabilitation.¹⁵⁶ The WHO's optimal mix of services pyramid framework (**figure 1**) indicates that the majority of mental health care can be managed through self-care and informal community mental health services. Where additional expertise is needed, more formalized services are required. In ascending order these include primary care services, followed by specialist community mental health and psychiatric services based in general hospitals, and lastly by specialist and long stay mental health services.¹⁵⁷

¹⁵² UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health, 17 December 1991, A/RES/46/119, Principle 7.

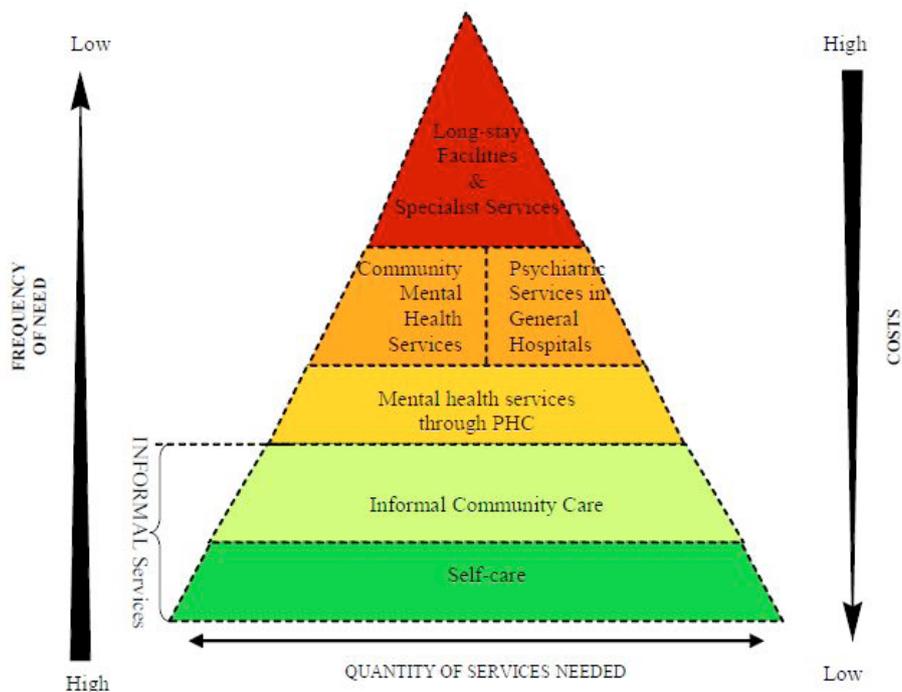
¹⁵³ UN Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health, Principle 9.

¹⁵⁴ WHO, *The World Health Report, Mental Health: New Understanding, New Hope*, 2001, pp. 87, 114.

¹⁵⁵ Paul Hunt, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, 2005, UN Doc.E/CN.4/2005/51, para. 42.

¹⁵⁶ WHO, *The World Health Report, Mental Health: New Understanding, New Hope*, 2001, p. 59.

¹⁵⁷ WHO, “The Optimal Mix of Services for Mental Health,” available at: http://www.who.int/mental_health/policy/services/2_Optimal%20Mix%20of%20Services_Infosheet.pdf



WHO optimal mix of services pyramid framework. ¹⁵⁸

The Inter-Agency Steering Committee (IASC) guidelines on the provision of mental health and psychosocial support in emergency settings, such as the UNMISS PoC sites, recommend the availability of a similar, layered system of complementary supports to meet the needs of different groups.¹⁵⁹ (See **figure 2**) The IASC pyramid framework calls firstly for basic needs, such as food, shelter, and water to be provided in a socially appropriate manner that promotes mental health and psychosocial wellbeing. The second layer represents responses that seek to strengthen community and family supports, through for example, discussion groups, child-friendly spaces, and cultural and recreational activities. The third layer represents supports necessary for a smaller number of people who require additional, more focused individual or family interventions by trained and supervised workers. This layer includes basic mental health care by primary health care workers. The top layer represents the additional psychological or psychiatric supports needed for people whose suffering is intolerable and who have difficulties with basic daily functioning that exceed the capacity of any primary health services available. Though such specialised services are needed only for a small percentage of the population, according to the IASC, in most large emergencies this amounts to thousands of individuals.¹⁶⁰

¹⁵⁸ WHO, "The Optimal Mix of Services for Mental Health."

¹⁵⁹ The Inter-Agency Steering Committee (IASC) Guidelines on mental health and psychosocial support during emergency settings were developed in 2007 with the participation of mental health practitioners, universities and numerous humanitarian and human rights organizations. The guidelines are considered the general reference for organizations providing mental health or psychosocial support services in the context of humanitarian programming in South Sudan. IASC, IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007, available at: http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

¹⁶⁰ IASC, IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, pp. 11-13.

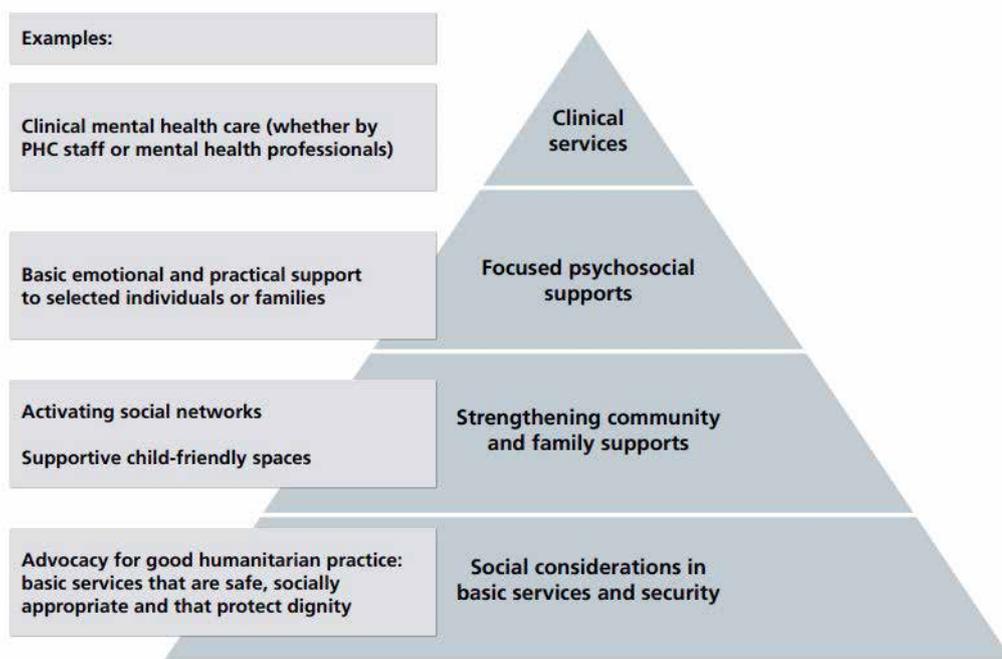


Figure 2: IASC intervention pyramid for mental health and psychosocial support in emergencies, as adapted by the WHO.¹⁶¹

While South Sudan is not expected to provide the same level of mental health services as a developed country, it has failed to guarantee even minimum essential mental health services, such as the detection and treatment of common mental and behavioural disorders and the availability of essential psychotropic medicines. In addition, the government has failed to make any identifiable progress towards improving the availability and accessibility of mental health services over the past years. Notably, it has failed to adopt a mental health policy or to pass mental health legislation—steps that don’t require significant resources. The WHO describes the absence of a mental health policy as indicative of a “lack of expressed commitment to address mental health problems.”¹⁶² The lack of progress in improving mental health services over the past few years indicates insufficient political will and financial commitment to address mental health. For the above reasons, South Sudan is violating a number of obligations with respect to the right to health.

VIOLENCE AS A VIOLATION OF THE RIGHT TO MENTAL HEALTH

It is widely accepted that acts such as torture, sexual violence, and unlawful killing will often have a negative impact on the mental health of “victims”—people who have individually or collectively suffered human rights violations as well as their immediate family or dependants who have suffered harm in intervening to assist or prevent victimization.¹⁶³ In addition to being serious violations of civil and political rights in and of themselves, such acts can, therefore, also constitute violations of the right to health.

¹⁶¹ WHO, UNHCR, Mental Health Gap Action Programme Humanitarian Intervention Guide, 2015, p. 11, available at: http://apps.who.int/iris/bitstream/10665/162960/1/9789241548922_eng.pdf

¹⁶² WHO, The World Health Report, Mental Health: New Understanding, New Hope, 2001, p. 77.

¹⁶³ The term “victim” for the purpose of reparation includes those who have individually or collectively suffered harm, including “the immediate family or dependants of the direct victim and persons who have suffered harm in intervening to assist victims in distress or to prevent victimization.” UN Basic Principles and Guidelines on the Right to a Remedy and Reparations for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law (UN Basic Principles and Guidelines), 2006, UN Doc A/RES/60/147, Principle 8.

Torture and other cruel, inhuman or degrading treatment are prohibited under South Sudan's Constitution as well as under the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), to which South Sudan is a state party. The infliction of severe pain or suffering, whether physical or mental, is a key element of the definition of torture. It follows, therefore, that acts of torture are also violations of the right to health. Indeed, the CESCR has stated that the right to health includes the right to be free from interferences, such as torture.¹⁶⁴

The Special Rapporteur on the Right to Health has affirmed that violence has a direct impact on the enjoyment of the right to health, since it results in “significant physical, psychological and emotional harm to individual victims and contributes to social problems for individuals, families and communities.”¹⁶⁵ Respecting the right to health as provided in the CRC, CEDAW, and the African Charter therefore requires South Sudan to refrain from acts that interfere with individuals' mental health. South Sudan must also protect individuals from acts that cause mental harm by preventing such acts by third parties. According to the CESCR, violations of the right to health include, “the failure to regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others” and “the failure to protect women against violence or to prosecute perpetrators.”¹⁶⁶ South Sudan must therefore exercise due diligence to prevent, investigate, and prosecute acts that cause negative mental health impacts, whether perpetrated by State actors or private persons.

In the context of South Sudan's current internal armed conflict, government forces have committed torture, rape, enforced disappearances and arbitrary killings—which have terrorized civilian populations. South Sudan has also failed to investigate and prosecute such acts, contributing to a culture of impunity that allows them to continue unabated. Both by committing and not addressing these deliberate targeted acts, South Sudan has failed to respect and protect the right of its population to the highest attainable standard of health.

THE RIGHT TO MENTAL HEALTH CARE SERVICES AS PART OF VICTIMS' RIGHT TO REPARATIONS

In addition to refraining from and preventing acts that cause psychological harm, the government has an additional specific obligation under international law to provide necessary mental health services to victims. This obligation stems from the right of victims to an effective remedy, which includes effective and prompt reparation for harm suffered.¹⁶⁷ Whilst it is recognised that the provision of effective remedies, including reparations, does have resource implications, this obligation is not subject to progressive realisation and therefore requires immediate and concrete measures.

Reparation encompasses the concrete measures that should be taken to address the suffering of the survivors and victims and to help them rebuild their lives. The aim of reparation is to “as far as possible, wipe out all the consequences of the illegal act and re-establish the situation which would, in all probability, have existed if that act had not been committed.”¹⁶⁸ Forms of reparation include restitution, compensation, rehabilitation, satisfaction, and guarantees of non-repetition.¹⁶⁹ While all forms of reparation would likely contribute to alleviating psychological harm suffered by victims, mental health services are specifically considered as an element of states' obligations to provide compensation

¹⁶⁴ CESCR, General Comment 14, para. 8.

¹⁶⁵ Report of the Special Rapporteur Paul Hunt to the Commission on Human Rights, The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, 2004, UN Doc E/CN.4/2004/49, para. 84, available at: <https://documents-dds-ny.un.org/doc/UNDOC/GEN/G04/109/33/PDF/G0410933.pdf?OpenElement>

¹⁶⁶ CESCR, General Comment 14, para. 51.

¹⁶⁷ The right to an effective remedy is included in Article 8 of the UDHR as well as in the CAT, CEDAW, CRC, and the African Charter, all of which bind South Sudan.

¹⁶⁸ Permanent Court of Arbitration: Chorzow Factory Case (Germany v. Poland), 1928.

¹⁶⁹ The UN Basic Principles and Guidelines recognize five forms of reparation: restitution, compensation, rehabilitation, satisfaction and guarantees of non-repetition.

for economically assessable damage, including mental harm and the costs of medical and psychological care, and to ensure rehabilitation, including psychological care and social services.¹⁷⁰

South Sudan bears the primary responsibility for providing reparation to victims of human rights violations in the country. There is an express legal obligation on South Sudan to provide reparation when violations are committed by agents of the state or under the state's authority. When crimes are committed by agents of other states or non-state actors—for example, the Sudan People's Liberation Army-In Opposition (SPLA-IO)—South Sudan has an obligation to ensure that victims can claim reparation against those responsible, including by making claims through the national justice system.¹⁷¹ When obtaining redress from other states or non-state actors is not possible, such as where the person responsible cannot be identified or located, or where there are obstacles that will delay vital measures of assistance required by survivors or victims, South Sudan should step in and provide reparation to survivors and victims, including through administrative programmes, and then seek to reclaim any costs from those responsible.

The scope of mental health services that South Sudan must make available to has been elaborated in relation to victims of torture. According to the UN Committee against Torture, compensation and rehabilitation should cater for treatment of trauma and psychological assistance.¹⁷² The UN Voluntary Fund for Victims of Torture, established to contribute to the rehabilitation of torture victims, defines psychological assistance to entail “individual therapy, whether based on clinical, psychoanalytical, behavioural or other therapy...to assist victims with their gradual reintegration into society. Psychiatric therapy may be combined with medication to alleviate physical and psychological symptoms.”¹⁷³

Psychological rehabilitation has also been recognized as particularly critical for victims of sexual violence. As a state party to CEDAW, South Sudan is required to establish or support services for victims of rape, sexual assault and other forms of sexual violence, including “rehabilitation and counselling.”¹⁷⁴ According to the UN Declaration on the Elimination of Violence against Women, South Sudan should also “ensure, to the maximum extent feasible in the light of their available resources and, where needed, within the framework of international cooperation, that women subjected to violence...have specialized assistance, such as rehabilitation...treatment, counselling, and health and social services...and should take all other appropriate measures to promote their safety and physical and psychological rehabilitation.”¹⁷⁵

As described above, mental health services are practically non-existent in South Sudan. This is the case both for the general population as well as for victims of human rights violations who experience psychological harm. There are no collective reparations programmes for victims of conflict-related violations. Amnesty International has not identified any case in which the government has provided any individual victim of conflict-related violations with compensation for psychological harm or psychological rehabilitation.

¹⁷⁰ UN Basic Principles and Guidelines. The CRC requires state parties to fulfil the right to rehabilitation and to “promote physical and psychological recovery” of child victims of torture and armed conflict. CRC, Articles 24 and 39. The CAT requires that states parties ensure “as full rehabilitation as possible.” CAT, Article 14.

¹⁷¹ The state has a duty to “provide those who claim to be victims of a human rights or humanitarian law violation with equal and effective access to justice...irrespective of who may ultimately be the bearer of responsibility for the violation.” UN Basic Principles and Guidelines, Principle 3(c).

¹⁷² In response to Sri Lanka's report, the Committee recommended to “establish a reparation programme, including treatment of trauma and other forms of rehabilitation, and to provide adequate resources to ensure its effective funding.” UN Committee against Torture, Conclusions and Recommendations of the Committee against Torture: Sri Lanka, 2005, UN Doc CAT/C/LKA/CO/2, para. 16. In response to Chad's report, the Committee called on it to “[o]ffer full reparation, including fair and adequate compensation for the victims of such acts, and provide them with medical, psychological and social rehabilitation.” UN Committee against Torture, Concluding Observations of the Committee against Torture: Chad, 2009, UN Doc CAT/C/TCD/CO/1.

¹⁷³ UN Voluntary Fund for Victims of Torture, available at: <http://www.ohchr.org/EN/Issues/Torture/UNVFT/Pages/WhattheFunddoes.aspx>

¹⁷⁴ Committee on the Elimination of Discrimination Against Women, General Recommendation 19: Violence against Women, 1992, para. 24.

¹⁷⁵ UN General Assembly, Declaration on the Elimination of Violence against Women, 1994, UN Doc A/RES/48/104.

7. THE WAY FORWARD

END VIOLATIONS AND ABUSES OF HUMAN RIGHTS AND HUMANITARIAN LAW

The violations and abuses of international human rights and humanitarian law committed by warring parties have heightened the psychological burden of the conflict on civilian populations. Acts such as rape and other forms of sexual violence, torture or other ill-treatment, targeted killing of civilians and the looting and destruction of civilian homes—all of which can trigger psychological distress and other mental health conditions—are war crimes. The hunger, dispossession and constant insecurity faced by so many are also exacerbated by unlawful acts such as the obstruction of humanitarian access and intentional targeting of civilian livelihoods. The effective availability and provision of mental health services will have little impact on an individual or national level as long as these ruthless and inhumane acts, which continuously pile trauma on the people of South Sudan, continue.

One core component of addressing the mental health impact of this conflict and future ones, will therefore lie in changing the culture of warfare and ending the seemingly routine and flagrant violations and abuses of human rights and humanitarian law. To this end, the Transitional Government of National Unity (TGoNU) should work to end and suppress all violations and abuses of international human rights and humanitarian law committed by members of the armed forces or associated personnel and ensure that violations and abuses are not committed with impunity. Specifically, all forces should immediately cease unlawful killings; acts of sexual violence and any other attacks on civilians; looting and destruction of public and private property; violence against humanitarian personnel and assets; and other obstructions to humanitarian assistance. It is also critical that the TGoNU provide all forces with sufficient training and clear orders to ensure they are aware of what conduct is prohibited under international law. The government and the opposition should also put in place mechanisms to adequately monitor the conduct of their forces.

The signing of the August 2015 peace agreement was quickly followed by the announcement of a permanent ceasefire by Salva Kiir and Riek Machar, but has unfortunately not brought a complete end to fighting or to its accompanying violations of international humanitarian law. The Joint Monitoring and Evaluation Commission (JMEC), which oversees implementation of the peace agreement, should continuously condemn violations and abuses of human rights and humanitarian law by parties to the conflict. The Ceasefire and Transitional Security Arrangements Monitoring Mechanism (CTSAMM), the body under JMEC established to monitor and report on ceasefire violations, should ensure that its monitoring and reporting addresses the parties' respect for international humanitarian law.

A deep and pervasive sense of impunity has emboldened armed actors to commit human rights violations and abuses. To deter future violations, South Sudan should fulfil its obligation to initiate prompt, effective and impartial investigations into all allegations of crimes under international law and human rights violations or abuses by all sides to the conflict and bring those credibly suspected of criminal responsibility to justice in open, accessible civilian courts and in fair trials without recourse to the death penalty. The TGoNU should immediately suspend military and civilian officials for whom

there is credible information that they committed crimes under international law or human rights violations, until allegations concerning them can be independently and impartially investigated.

While conducting investigations and holding individuals responsible accountable is the primary responsibility of South Sudan, it has so far failed to demonstrate a willingness to discharge this obligation.¹⁷⁶ It is therefore critical that UNMISS provide regular and timely reporting on the human rights situation, as mandated by the Security Council. The AU Commission should quickly establish the Hybrid Court for South Sudan (HCSS) with a mandate to prosecute genocide, war crimes, crimes against humanity and other crimes under international law committed during the conflict, as is provided in the August 2015 peace agreement.

The UN Security Council should use the tools at its disposal to prevent and deter future violations of humanitarian law and violations and abuses of international human rights law. Specifically, it should impose a comprehensive arms embargo on the direct or indirect supply, sale or transfer, including transit and trans-shipment, of weapons, munitions, military vehicles and any other forms of military assistance, including technical and financial assistance, equipment maintenance and training, to South Sudan. The Security Council should also impose targeted sanctions, including travel bans and asset freezes, against civilian and military officials who have engaged in violations of international humanitarian law and violations and abuses of international human rights law in South Sudan.

IMPROVE THE AVAILABILITY, ACCESSIBILITY AND QUALITY OF MENTAL HEALTH SERVICES ACROSS THE COUNTRY

South Sudan's ongoing violation of the right to health through failure to provide adequate mental health services must be remedied through the improvement in availability, accessibility, and quality of services. The WHO recommends that in order to improve mental health services, resource constrained countries such as South Sudan should prioritize providing treatment through primary health care; providing care at the community level; making psychotropic drugs available; educating the public; establishing national policies, programmes and legislation; supporting research and monitoring; developing human resources; increasing funding to mental health services and; mainstreaming mental health interventions across other sectors.¹⁷⁷ South Sudan's mental health plans and policies should be directed towards these priorities.

INTEGRATE MENTAL HEALTH TREATMENT INTO PRIMARY HEALTH CARE

The integration of mental health within primary health care—already among the stated goals of the health ministry's Department of Mental Health—is critical to making mental health care more available and accessible.¹⁷⁸ Integration increases the likelihood that mental health problems will be detected; contributes to destigmatizing mental health care as mental; and saves costs by reducing the need for specialized mental health professionals.¹⁷⁹

The management and treatment of mental disorders in primary care will require adequate training of primary health care staff to treat, manage and appropriately refer patients suffering from mental health conditions. There also need to be sufficient numbers of staff with the knowledge and authority to prescribe psychotropic drugs, and mental health specialists should be available to support and monitor general health care personnel.¹⁸⁰

¹⁷⁶ Though South Sudan claims to have conducted multiple investigations into conflict-related abuses, the results of these investigations have not been published and criminal proceedings have not been initiated.

¹⁷⁷ WHO, *The World Health Report, Mental Health: New Understanding, New Hope*, 2001.

¹⁷⁸ Interview with Dr. Atong Ayuel, Director, Mental Health Department, Ministry of Health, Juba, South Sudan, 10 April 2015.

¹⁷⁹ WHO, "Integrating Mental Health Services into Primary Health Care," available at: http://www.who.int/mental_health/resources/mentalhealth_PHC_2008.pdf; WHO, *The World Health Report, Mental Health: New Understanding, New Hope*, 2001, p. 89.

¹⁸⁰ WHO, *The World Health Report, Mental Health: New Understanding, New Hope*, 2001, p. 90.

PROVIDE CARE AT THE COMMUNITY LEVEL

South Sudan should develop community-based mental health services to provide locally-based treatment and care that is easily accessible to patients and their families. Community-based facilities might include mental health outpatient facilities, short-stay inpatient care, day care centres, and programmes to support people with mental disorders living with their families. Greater collaboration with “informal” mental health care providers, including families, as well as religious leaders, faith healers, traditional healers, school teachers, police officers, and local NGOs is also needed.

As a priority, the government should develop a plan to remove people with mental disabilities from prisons and to provide them with appropriate mental health services, in general hospitals or community settings.

MAKE PSYCHOTROPIC MEDICINES AVAILABLE

The government should improve the currently limited and inconsistent availability of psychotropic medicines. According to the WHO, these drugs can ameliorate symptoms, reduce disability, shorten the course of many disorders, and prevent relapse.¹⁸¹ The government should also ensure that sufficient funds are allocated to purchase psychotropic medicines and make sure they are available in primary care settings. International donors should support the availability of these medicines.

EDUCATE THE PUBLIC

In South Sudan, awareness and understanding of mental health issues is generally low, impacting the likelihood of seeking care and also increasing stigma associated with mental health conditions. Increasing awareness about the nature of mental health conditions, their treatability, the recovery process, and the care options available can increase the use of mental health services, and reduce stigma and discrimination.¹⁸²

ESTABLISHING NATIONAL POLICIES, PROGRAMMES AND LEGISLATION

Mental health policy and legislation are important precursors to significant and sustained action. The Ministry of Health, currently in the process of revising the National Health Policy, the Health Sector Development Plan and the Basic Package of Health Services, should ensure that all of these policies address mental health needs. The Ministry of Health should also support the Department of Mental Health to develop a mental health policy and appropriate mental health legislation. Stakeholders, including persons with mental and psychosocial disabilities, carers and family members, professionals, policymakers, and other interested parties should participate in the development of a policy and legislation.¹⁸³ The policy and any legislation should comply with international and regional human rights standards. The WHO should provide technical assistance, ideally through a long-term mental health officer based within the WHO office.

The mental health policy should provide concrete and measurable steps towards ensuring that mental health services are available, accessible, acceptable, and of good quality. It should also specify necessary actions to incorporate mental health information and services at the primary health care level, including necessary training for health care staff and community workers to provide essential information, care, support and referral services. It should set priorities and outline approaches, based on identified needs and taking into account available resources. It should take into account the particular needs of children, women, the elderly, and displaced people.

Mental health legislation should guarantee respect for the dignity and human rights of people with mental disorders, particularly non-discrimination, freedom from torture and ill-treatment, and physical integrity. Legislation should prohibit the incarceration of people solely on the basis of mental disability,

¹⁸¹ WHO, The World Health Report, Mental Health: New Understanding, New Hope, 2001, p. 110.

¹⁸² WHO, The World Health Report, Mental Health: New Understanding, New Hope, 2001, p. 111.

¹⁸³ The CESCR's General Comment 14 recognizes “participation of the population in all health-related decision-making” as critical to the right to health. CESCR, General Comment 14, para. 11. WHO, The World Health Report, Mental Health: New Understanding, New Hope, 2001, p. 80.

and instead articulate clear regulations for the admission, forced commitment, and discharge of people with mental disabilities to medical facilities in line with international standards. Legislation should also establish rules on consent to treatment, and ensure the existence of mechanisms, such as a monitoring, review board or complaint mechanism to promote and protect the rights of individuals with mental health conditions.

South Sudan should demonstrate its commitment to respecting, protecting and fulfilling the right to health by ratifying or acceding to the International Covenant on Economic, Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), and the Convention on the Rights of People with Disabilities. The Government should complete ratification of the African Charter on Human and Peoples' Rights (the African Charter) by depositing the instrument of ratification with the African Union (AU).

SUPPORT RESEARCH AND MONITORING

The formulation of a mental health policy and efforts to improve services should be based on reliable information, including quantitative data on the prevalence and impact of mental health conditions. A comprehensive assessment and continuous monitoring of existing mental health resources and structures, and the extent to which they fulfil mental health needs is also necessary to inform the design of appropriate interventions. There is, however, a notable lack of such research and monitoring in South Sudan. The Ministry of Health should take steps to remedy this gap. The WHO should contribute to building research and monitoring capacity.

DEVELOP HUMAN RESOURCES

The lack of specialists and health workers with the knowledge and skills to manage mental health conditions is a significant barrier to treatment and care. The Ministry of Health should explore building partnerships with external institutions and mental health training facilities to help train existing staff. The Ministry of Health also should work with the Ministry of Higher Education to integrate mental health and psychosocial training into university curricula, particularly in departments of medicine, psychology, and social work, so that new graduates can effectively contribute to the provision of mental health services.

INCREASE ALLOCATION OF FUNDING TO MENTAL HEALTH SERVICES

The Ministry of Health should work to ensure that funds are available to increase and improve mental health services. Specifically, the Ministry should ensure that there is a clear budgetary allocation to the Department of Mental Health to support mental health programming. The Ministry should seek international cooperation and assistance to support mental health care services by making specific requests to donors for such support and by working with donors to ensure that general support to the health sector does not neglect mental health needs. International donors should provide necessary financial and technical support to increase the availability and accessibility of mental health services as part of their development and reconstruction assistance. The WHO should advocate for donor support to mental health and take greater responsibility for mobilizing necessary resources to ensure implementation of its Mental Health Action Plan.

MAINSTREAM INTERVENTIONS ACROSS ALL SECTORS

Mental health, like other aspects of health, can be affected by a range of socioeconomic factors including poverty, education level, employment status, material standard of living, and access to basic services. Responsibility for promoting mental health and preventing mental disorders therefore extends across all sectors and all government departments. The government, international donors and NGOs should mainstream mental health initiatives into all development and humanitarian interventions.

ENSURE INTEGRATION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT INTO EMERGENCY RESPONSE PROGRAMMING

South Sudan, through the Ministry of Humanitarian Affairs and Disaster Management, should make financial and programmatic contributions to emergency mental health services and should facilitate and encourage international cooperation and support for implementation of the Inter-Agency Steering Committee (IASC) guidelines.

International donors should ensure that support for mental health and psychosocial services is an appropriate component of their financial contributions to humanitarian support. With support from international donors, humanitarian organizations providing emergency assistance in settlements of internally displaced people and in conflict-affected areas of the country should work to increase the availability of mental health and psychosocial support, in accordance with the IASC guidelines. While there is a need for the expansion of all levels of service provision, there is a particular dearth of programming in the provision of specialized services, such as psychotherapy or pharmacologic intervention for people with severe mental disorders.

The government, humanitarian organizations and donors should work to ensure that emergency response programming creates a sustainable impact and is mainstreamed into broader national mental health strategies. Donors who fund mental health services during emergencies should be prepared to facilitate the transition to funding for longer-term mental health programming.

PROVIDE REPARATIONS FOR PSYCHOLOGICAL HARM

The Agreement on the Resolution of the Crisis in South Sudan (ARCSS) provides that the three transitional justice institutions it envisions—the Hybrid Court for South Sudan (HCSS), the Commission on Truth, Reconciliation and Healing (CTRH), and the Compensation and Reparations Authority (CRA)—“shall independently promote the common objective of facilitating truth, reconciliation and healing, *compensation and reparation* in South Sudan.”¹⁸⁴ The HCSS, in addition to prosecuting and punishing those responsible for crimes under international law, is mandated to “award appropriate remedies to victims, including but not limited to reparations and compensation.”¹⁸⁵ The functions of the CTRH include recommending “processes and mechanisms for the full enjoyment by victims of the right to remedy, including by suggesting measures for *reparations and compensation*.”¹⁸⁶ The CRA will administer a Compensation and Reparation Fund (CRF) to “provide material and financial support to citizens whose property was destroyed by the conflict and help them to rebuild their livelihoods.”

The ARCSS places particular emphasis on the role of the TGoNU in relation to internally displaced people and refugees. The ARCSS recognizes the right of refugees and internally displaced people “to return in safety and dignity and to be afforded physical, legal and *psychological protection*.”¹⁸⁸ It requires the TGoNU to institute programs for the “relief, protection, repatriation, resettlement, reintegration and rehabilitation of internally displaced persons (IDPs) and returnees.”¹⁸⁹ The ARCSS also requires that, in the provision of health services, special consideration be given to conflict-affected persons.¹⁹⁰

¹⁸⁴ ARCSS, Chapter V, Article 1.3 (emphasis added).

¹⁸⁵ ARCSS, Chapter V, Article 3.5.3.

¹⁸⁶ ARCSS, Chapter V, Article 2.1.5.

¹⁸⁷ ARCSS, Chapter V, Article 4.2.d.

¹⁸⁸ ARCSS, Chapter III, Article 1.1.2.

¹⁸⁹ ARCSS, Chapter III, Article 1.2.1.

¹⁹⁰ ARCSS, Chapter III, Article 1.2.2.

The emphasis in the agreement on reparations and compensation offers an important opportunity to address the impact of the conflict on mental health. As the African Union Commission of Inquiry in South Sudan (AUCISS) has recommended, reparative measures undertaken should include rehabilitation and psychosocial assistance and should be implemented immediately.¹⁹¹ South Sudan should work to ensure the speedy establishment of the HCSS, the CTRH and the CRA envisaged by the ARCSS. South Sudan, together with the AU and other supporting institutions and governments, should ensure that in fulfilling their reparations mandates, the HCSS, the CTRH and the CRA give consideration to the mental health consequences of the conflict and the resulting need for psychological rehabilitation as one element of individual or collective reparations programs and initiatives.¹⁹² International donors should provide financial and technical support for the establishment and operationalisation of the HCSS, the CTRH and the CRA. They should support South Sudan's obligation to ensure access to reparations, through technical and financial support.

South Sudan should also ensure that the national justice system allows victims of human rights and humanitarian law violations and abuses to claim compensation, including for psychological harm, from individual perpetrators in civil proceedings. South Sudan should ensure the provision of legal aid to victims who cannot afford legal assistance.

¹⁹¹ AUCISS, Final Report, para 1152.

¹⁹² The Peruvian Truth and Reconciliation Commission (TRC), for example, devoted an entire chapter of its report to the devastating psychosocial damage caused by the war and recommended that reparations programmes include a mental health component. Lisa J. Laplante and Miryam Rivera Holguin, "The Peruvian Truth Commission's Mental Health Reparations: Empowering Survivors of Political Violence to Impact Public Health Policy," Health and Human Rights, 2006.

8. CONCLUSION: THE IMPORTANCE AND URGENCY OF MENTAL HEALTH SERVICES

With high inflation and a sharp decline in national oil revenues as a result of reduced oil production and a drop in international oil prices, South Sudan is facing a severe economic crisis.¹⁹³ There is also persistent violence in some areas of the country. Despite this challenging context, for a myriad of reasons there must be increased attention to mental health both in the immediate and longer-term.

Though lack of resources is often cited as a key reason for failures to improve mental health services, there are steps South Sudan can take that require political commitment more than funds. The development of a mental health policy and legislation, for example, is not heavily resource-intensive but could go a long way towards galvanizing greater attention to mental health in South Sudan and attracting additional international support. Integrating mental health services into the primary health care system is also not heavily resource-intensive.

Doing more to address mental health needs is not only essential for individual well-being, it is also critical for South Sudanese to effectively rebuild their communities and country. Mental health problems impact physical health and contribute significantly to morbidity. They also impact people's ability to function as productive members of society. As described in this report, people with poor mental health may be unable to carry out day-to-day tasks, participate in community activities, and pursue livelihoods or education.

The societal impacts of poor mental health are also long-term. Poor mental health among parents has an inter-generational impact on child health, development and growth.¹⁹⁴ According to a psychologist working in Juba, *"If you don't deal with mental health care in the current generation this will create problems long into the future. A traumatized parent won't care for their child; the child will grow up with his own problems, and the cycle will continue. The impact isn't just about now, it's about 10-15 years down the line."*¹⁹⁵

Restoring mental health—and the ability of citizens to function productively—can therefore play a vital role in contributing to human development, sustainable economic growth and poverty reduction.¹⁹⁶ This is reflected in the fact that in September 2015, the UN included mental health as an element of the new global Sustainable Development Goal (SDG) on health.

¹⁹³ Sudan Tribune, "IMF warns of further deteriorating economy in South Sudan," 2 June 2016 available at: <http://www.sudantribune.com/spip.php?article59164>

¹⁹⁴ Delan Devakumar et al., "The intergenerational effects of war on the health of children," BMC Medicine, 2014, available at: <http://bmcmedicine.biomedcentral.com/articles/10.1186/1741-7015-12-57>

¹⁹⁵ Interview with expatriate psychologist, Juba, South Sudan, 7 April 2014.

¹⁹⁶ The World Bank, Mental Health and Conflict, "Conflict Prevention and Reconstruction," October 2003, available at: <http://siteresources.worldbank.org/DISABILITY/Resources/280658-1172610662358/MentalHealthConfBaingana.pdf>; WHO, Mental Health Gap Action Programme, p. 6.

Many South Sudanese and international observers identify poor mental health as a destabilizing force that has contributed to violent behaviour at family, community, and national levels—an observation supported by studies showing the links between poor mental health, anger, and desire for revenge.¹⁹⁷ “Societies that didn’t have the space to digest trauma are more likely to go back to violence,” said one NGO worker.¹⁹⁸ A South Sudanese peace activist described the level of trauma as a “liability to the country.”¹⁹⁹ The African Union Commission of Inquiry in South Sudan (AUCISS) emphasized in its final report that reconciliation cannot take place unless the suffering and trauma experienced by South Sudanese is addressed:

“In our view, one cannot expect materially deprived victims, those with unhealed mental scars to embrace reconciliation and forgiveness. Deep, sustainable reconciliation and peace requires more than acknowledgement of wrongs and apology. Genuine attempts must be made to address concerns specific to surviving victims, which may include loss of family and relatives, displacement, loss of property as well as physical and mental scars from violations suffered, which necessitate psycho-social support and rehabilitation.”²⁰⁰

Addressing mental health is therefore critical to achieving and maintaining peace, stability and reconciliation in South Sudan.

¹⁹⁷ See for example, Oscar I. Gonzalez and Raymond W. Novaco, “Anger Intensification with Combat-Related PTSD and Depression Comorbidity,” *Psychological Trauma: Theory, Research, Practice, and Policy*, 2016, available at: <https://www.apa.org/pubs/journals/releases/tra-0000042.pdf>; Ulrich Orth and Elias Wieland, “Anger, Hostility, and Posttraumatic Stress Disorder in Trauma-Exposed Adults: A Meta-Analysis,” *Journal of Consulting and Clinical Psychology*, 2006, available at: https://uorth.files.wordpress.com/2011/01/orth_and_wieland_2006_jccp.pdf

¹⁹⁸ Interview with NGO staff member, Juba, South Sudan, 8 April 2015.

¹⁹⁹ Presentation by South Sudanese peace activist, Juba, South Sudan, 9 April 2015.

²⁰⁰ AUCISS, Final Report, para. 894.

9. RECOMMENDATIONS

TO THE TRANSITIONAL GOVERNMENT OF NATIONAL UNITY (TGNU)

- End and suppress all violations of international human rights and humanitarian law committed by members of the armed forces or associated personnel. In particular, all forces should immediately cease unlawful killings; acts of sexual violence and any other attacks on civilians; looting and destruction of public and private property; violence against humanitarian personnel and assets; and other obstructions to humanitarian assistance;
- Provide armed forces with sufficient training and clear orders to ensure they are aware of conduct prohibited under international law and put in place mechanisms to adequately monitor the conduct of their forces;
- Initiate prompt, effective and impartial investigations into allegations of crimes under international law and human rights violations or abuses. Bring those suspected of criminal responsibility to justice in open, accessible civilian courts and in fair trials without recourse to the death penalty;
- Immediately suspend military and civilian officials for whom there is credible information that they committed crimes under international law or human rights violations, until allegations concerning them can be independently and impartially investigated;
- Ratify or accede, without reservations, to international and regional human rights treaties, particularly the International Covenant on Economic, Social and Cultural Rights (ICESCR) and its Optional Protocol, the International Covenant on Civil and Political Rights (ICCPR) and its Optional Protocols, the Convention on the Rights of People with Disabilities, and the African Charter on Human and Peoples' Rights;
- Take steps to improve the availability, accessibility and quality of mental health services available in the country. Specifically, the government should:
 - Work to integrate mental health treatment into primary health care services by providing training to primary health care staff to treat, manage and appropriately refer patients suffering from mental health conditions;
 - Develop community-based mental health services to provide locally-based treatment and care that is easily accessible to patients and their families;
 - Remove from state prisons people suffering from mental health conditions and provide them appropriate mental health services in general hospitals or community settings;
 - Improve the availability of psychotropic medicines;
 - Increase public awareness about the nature of mental health conditions, their treatability, the recovery process, and the care choices.
- Ensure revisions to the National Health Policy, the Health Sector Development Plan; and the Basic Package of Health Services address mental health needs;

- Develop a mental health policy in consultation with stakeholders, including persons with mental and psychosocial disabilities, carers and family members. The policy should:
 - Comply with international and regional human rights standards;
 - Provide concrete and measurable steps towards ensuring the availability, accessibility and quality of mental health services;
 - Specify necessary actions to incorporate mental health information and services at the primary health care level;
 - Set priorities based on identified needs and taking into account available resources;
 - Take into account the particular needs of children, women, the elderly, and displaced people.
- Pass mental health legislation in consultation with stakeholders, including persons with mental and psychosocial disabilities, carers and family members. Legislation should:
 - Comply with international and regional human rights standards. In particular, legislation should guarantee respect for the dignity and human rights of people with mental disorders, particularly non-discrimination, freedom from torture and ill-treatment, and physical integrity;
 - Provide for and regulate the provision of mental health care services;
 - Prohibit the incarceration of people solely on the basis of mental disability, and instead provide clear regulations for the admission, forced commitment, and discharge of people with mental disabilities to medical facilities in line with international standards;
 - Establish rules on consent to treatment;
 - Create mechanisms to promote and protect the rights of individuals with mental health conditions, such as a monitoring body, review board, or complaint mechanism.
- Conduct and support research and continuous monitoring of the prevalence and impact of mental health conditions and existing mental health resources and structures;
- Integrate mental health and psychosocial training into university curricula, particularly in departments of medicine, psychology and social work;
- Ensure that funds are made available to increase and improve mental health services, including by making a specific budgetary allocation to the Department of Mental Health to support mental health programming;
- Seek international cooperation and assistance to support mental health care services by making specific requests to donors for such support and by working with donors to ensure that general support to the health sector does not neglect mental health needs;
- Mainstream mental health initiatives into all development and humanitarian interventions;
- Make financial and programmatic contributions to support mental health services in emergency settings while also ensuring that emergency response programming creates a sustainable impact and is mainstreamed into broader national mental health strategies;
- Work to ensure access to reparations for victims of human rights and humanitarian law violations and abuses, including for psychological harm. Specifically the government should:
 - Support the speedy establishment of the Hybrid Court for South Sudan (HCSS), the Commission on Truth, Reconciliation and Healing (CTRH) and the Compensation and Reparations Authority (CRA) provided for in the Agreement on the Resolution of the Conflict in South Sudan (ARCSS);
 - Ensure that in fulfilling their reparations mandates, the HCSS, the CTRH and the CRA give consideration to the mental health consequences of the conflict and the resulting need for psychological rehabilitation as an element of individual or collective reparations initiatives;
 - Ensure that the national justice system allows victims of human rights and humanitarian law violations and abuses to claim compensation, including for psychological harm, from individual perpetrators in civil proceedings. Provide legal aid to victims who cannot afford legal assistance.

TO THE JOINT MONITORING AND EVALUATION COMMISSION (JMEC)

- Continuously condemn violations and abuses of human rights and humanitarian law by parties to the conflict;
- Ensure that the Ceasefire and Transitional Security Arrangements Monitoring Mechanism (CTSAMM) effectively monitors and reports on the parties' respect for humanitarian law;
- Support the speedy establishment of the Hybrid Court for South Sudan (HCSS), the Commission on Truth, Reconciliation and Healing (CTRH) and the Compensation and Reparations Authority (CRA) which are provided for in the Agreement on the Resolution of the Conflict in South Sudan (ARCSS).

TO INTERNATIONAL DONORS

- Continuously call on parties to the conflict to cease violations of international humanitarian law and violations and abuses of international human rights law;
- Provide increased financial and technical assistance to support improvement of the availability and accessibility of mental health services;
- Mainstream mental health interventions into all development support, particularly in the health sector. Ensure that support for mental health and psychosocial services form an appropriate component of financial contributions to humanitarian emergency support efforts;
- Ensure sustainability of mental health and psychosocial services established as part of the emergency humanitarian response by committing to funding for longer-term mental health reform;
- Provide technical and financial assistance for the speedy establishment of the Hybrid Court for South Sudan (HCSS), the Commission on Truth, Reconciliation and Healing (CTRH) and the Compensation and Reparations Authority (CRA) provided for in the Agreement on the Resolution of the Conflict in South Sudan (ARCSS);
- Support the government's obligation to ensure access to reparations, including for psychological harm, through technical and financial assistance;
- Continuously call on the TGoNU to adequately protect internally displaced populations, ensure their security, and help create conditions that would allow them to return or safely relocate in accordance with their wishes.

TO THE UN MISSION IN SOUTH SUDAN (UNMISS)

- Provide regular and timely reporting on the human rights situation in South Sudan, as mandated by the UN Security Council;
- In coordination with humanitarian agencies, work to increase the availability and accessibility of mental health services within Protection of Civilian (PoC) sites. Also work to improve general living conditions, including housing, food, and sanitation;
- Ensure thorough investigations take place into attacks against civilians in and around PoC sites, with a view to ensuring perpetrators are held accountable;
- Take all possible additional measures to ensure effective protection of civilians who have sought refuge within PoC sites.

TO THE AFRICAN UNION (AU)

- Continuously call on parties to the conflict to cease violations of international humanitarian law and violations and abuses of international human rights law;
- Ensure the speedy establishment by the AU Commission of the Hybrid Court for South Sudan (HCSS) in a format that complies with international law. Provide financial and technical support for the establishment and operationalisation of the Commission on Truth, Reconciliation and Healing (CTRH) and the Compensation and Reparations Authority (CRA);

- Work to ensure that in fulfilling their reparations mandates, the HCSS, the CTRH and the CRA give consideration to the mental health consequences of the conflict and the resulting need for psychological rehabilitation as an element of individual or collective reparations initiatives;
- Support the government's obligation to ensure access to reparations, including for psychological harm, through technical and financial support.

TO THE WORLD HEALTH ORGANIZATION (WHO)

- Provide financial and technical assistance to support improvement in the availability and accessibility of essential mental health services. Specifically, the WHO should:
 - Advocate for increased donor support to mental health and take greater responsibility for mobilizing necessary resources to ensure implementation of its Mental Health Action Plan;
 - Work to increase national capacity to conduct research and continuous monitoring of the prevalence and impact of mental health conditions and existing mental health resources and structures;
 - Provide technical assistance, ideally through a long-term mental health officer based in the WHO office in Juba, for the development of a mental health policy and legislation.

TO THE UN SECURITY COUNCIL

- Continuously call on parties to the conflict to cease violations of international humanitarian law and violations and abuses of international human rights law;
- Impose a comprehensive arms embargo on the direct or indirect supply, sale or transfer, including transit and trans-shipment, of weapons, munitions, military vehicles and any other forms of military assistance, including technical and financial assistance, equipment maintenance and training, to South Sudan;
- Impose targeted sanctions, including travel bans and asset freezes, against civilian and military officials who have engaged in violations of international humanitarian law and violations and abuses of international human rights law in South Sudan.

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“OUR HEARTS HAVE GONE DARK”

THE MENTAL HEALTH IMPACT OF SOUTH SUDAN’S CONFLICT

Violations and abuses of international human rights and humanitarian law committed by parties to South Sudan’s internal armed conflict that erupted in December 2013 have had significant repercussions on the mental health of South Sudanese. Internally displaced people impacted by the conflict described having nightmares, getting angry easily, feeling unable to concentrate and considering suicide—common manifestations of psychological stress associated with mental health disorders such as post-traumatic stress disorder (PTSD) and depression. They attributed these impacts to their experiences as victims of, or witnesses to, torture, arbitrary detention, sexual violence, unlawful killing, and forced displacement.

This report describes the serious mental health impact of South Sudan’s conflict in order to highlight the urgency for more attention, and resources, to improve the availability, accessibility, and quality of mental health services in the country. It is based on interviews with 161 internally displaced South Sudanese and with government and UN officials, donors, representatives of non-governmental organizations (NGOs), and international and South Sudanese mental health professionals.

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