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global disability inclusion

Climate change, mental health and wellbeing

Examples of practical inclusive practices

Climate Change, mental health and wellbeing

Participation of people from the global south, including people with disabilities, is essential to the ongoing process of bringing about carbon reduction, building resilience, and climate justice – all of which will reduce the negative impacts on mental health and wellbeing of climate change.

Climate change, the 'defining issue'[1] of our century, disproportionally impacts the world's poorest and most vulnerable people - 20% of whom are persons with disabilities.[2] As well as causing at least 150,000 deaths per year, with over 96 percent of these taking place in low income countries[3,4], the impacts of climate change for persons with disabilities and their communities include:

- **Increasing humanitarian emergencies, both fast and slow onset;**
- **Declining food, energy and water security;**
- **Declining access to shelter, infrastructure and basic services;**
- **Increasing displacement, or being left behind in degraded environments;**
- **Reductions in human security due to competition and conflict over increasingly limited resources**
- **Substantial contribution to the record levels of forced migration currently experienced around the world**

Each of these crises have the potential to negatively impact the mental health and wellbeing of the communities surviving them. Broadly, the link between mental health and wellbeing, and climate change is in relation to the trauma associated with losing one's home, possessions and loved ones due to adverse and extreme weather events, or forced migration due to gradual environmental change, or the social effects of population pressures due to climate change (for example conflict over water resources, or migration from areas that can no longer support farming).

It is clear from the ever-increasing severity of the impacts highlighted, that climate change, and wider ecological degradation, is both a threat to persons with disabilities and their families and communities, and has potential for increasing negative health outcomes for all. These impacts will be felt most severely in the countries and communities where CBM Global has a focus of work. While climate change is largely driven by the lifestyles and resource use of the wealthiest countries, it is having its effect disproportionately in low income countries – notably low-lying islands and environments that are particularly affected by weather events like El Niño, tropical storms and cyclones, as well as changes to fragile environments that are prone to climate-related effects, like desertification.

Cover image: Flooding in Kenya caused by unusual amounts of rain

Why this document now?

We are at an important juncture in how we respond to climate change and its impact – increasing climate injustice has created an imperative to reverse negative consequences that the climate crisis has impacted the most. In this document, we outline some of the work that CBM Global federation has undertaken in five of its programme countries to support populations affected by the impacts of climate change – focused on communities living in low income and resource settings. This paper highlights what we have learnt about inclusive approaches to climate change mitigation and resilience-building. CBM Global is a long-standing member of the Inter Agency Standing Committee Reference Group on MHPSS, and is currently co-chairing the subgroup on Disability and Inclusion (with UNICEF). As part of the IASC Reference Group, we were founder members of a Disaster Risk Reduction (DRR) and MHPSS group, which has led the development of a new Technical Note (below, launched in 2021).

Five lessons on resilience and mental health

Building resilience, and engaging with communities for provision of basic needs, reinforcement of local mitigation measures, and strengthening mental health systems can all contribute to lessening the distress associated with climate change.

The impact of the climate emergency has become ever more evident, and is effecting large populations in many parts of the world, including some of our programme countries. In reviewing our programmes, five countries, **Nigeria, Zimbabwe, Burkina Faso, Bangladesh and Sierra Leone**, were chosen to demonstrate how by building resilience, and engaging with communities for provision of basic needs, reinforcement of local mitigation measures, and strengthening mental health systems, so that the distress associated with climate change can be reduced. Fundamentally though, this is an adaptative approach, protecting communities facing the brunt of climate change and it will only be through addressing the driving factors of climate change – carbon release driven by our lifestyles – that we can move towards a world where all are protected from its negative planetary impacts.

Five Common Lessons

- Any intervention needs to **address the core basic needs that have been disrupted** (e.g. nutrition, shelter, livelihoods, education and health infrastructure). Reducing sources of stress as far as possible quickly is a priority
- **MHPSS components are essential to a comprehensive response.** This includes building resilience, support for distress, initial provision of basic psychological support, as well as access to more specialist services. This is well described in the IASC Guidelines on MHPSS in Emergency Settings
- **Working to prepare systems in advance is essential, and a good investment**, as support mechanisms (like trained nurses) are far harder to develop after an emergency occurs
- **Participation of people affected is the only way to ensure an appropriate and effective response.** This is particularly true of marginalized groups, whose views may not be well represented unless specifically sought
- **Participation of people from the global south, including people with disabilities and their representative organisations, is essential** to the ongoing process of bringing about carbon reduction, reduction of risks, and responding to climate injustice

Madagascar drought and famine, stated by the UN as caused by climate change, 2021
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Nigeria

The context - Forced migration and insurgency

Climate change is causing huge changes in sub-Saharan Africa, which affect the political and economic environment. The Sahara Desert is fast expanding and encroaching into the arable lands while Lake Chad is shrinking. This is of particular importance in the countries that make up the Chad Basin – Nigeria, Cameroon, Chad Republic and Niger Republic. These are also the countries mostly affected by the Boko Haram insurgency, which is itself in part provoked by a long-term reduction in economic opportunities for young people, which is made worse by the effect of climate change on the main means of income.

Indigenous people of this region are mainly migrant herders, farmers and fishermen. As the Sahara Desert spreads and the Lake Chad basins shrinks, the herders and fishermen have started to migrate toward southern Nigeria in greater numbers. Herders have always travelled south on foot, feeding their cattle and sheep as they go, but through well marked and agreed spaces and in limited numbers. As populations grow, and there is more need to move south, the cattle trample and feed on the farm crops, destroying them as they move south. This is also made worse by greater population density reducing the free space for cattle to move. The destruction of livelihoods is resisted by the farmers, leading to outbreaks of conflict and loss of animals. The herders have mounted reprisal attacks on the farmers, killing families in the process and destroying their farms. The farmers flee their homes to huge Internally Displaced Persons (IDP) camps in Nigeria, and in turn have responded with violence against herdsmen.

These issues of violence, conflict and forced migration had led to distress and mental health problems, including precipitation of conditions including acute stress, grief, depression, Post-traumatic Stress Disorder (PTSD), harmful use of alcohol and drugs, suicide, and more. Some people receiving treatment for existing mental health conditions like psychoses may flee their homes, risking relapse without their medications. Destruction of health care delivery services

The programme

CBM Nigeria works with two partners in both the Northeast and North Central Nigeria to deliver Community Mental Health (CMH) and Mental Health and Psychosocial Support (MHPSS) services in transitional aid programmes. The aim of the project, funded by BMZ, is to help the persons returning to their homes to settle quickly by rebuilding the destroyed infrastructure in the communities.

Our main focus is the proper integration of mental health care into primary and secondary care services, which are being redeveloped after many years of insurgency. In addition, we work at community level to build understanding of mental health, to reduce stigma, and to facilitate participation of people with psychosocial disabilities in community life.

Main mental health activities in the two projects include:

1. Rebuilding and re-equipping of destroyed health centres
2. Training, retraining and support of health care workers to be able to integrate mental health care into the services in the health centres
3. Training and support of the community structures such as family members, Village Health Workers, Junior Community Health Extension Workers (JCHEWs) and Community volunteers to support persons with mental health problems in the community.
4. Provision of essential medicines and establishment of Drug Revolving Funds.
5. Provision of water, sanitation and hygiene soft and hard wares in the community
6. Support of livelihood ventures in the communities
7. Ensuring inclusion of persons with disability in the community e.g being members of the Water Committee and training them to maintain the water pumps.
8. Raising awareness on the availability of mental health services in the community

Madagascar, 2021 ©SAF/FJKM

Zimbabwe

The context: MHPSS Emergency Response to people affected by Cyclone Idai

Zimbabwe was hit by Cyclone Idai between the 15th and 17th March 2019. The tropical storm caused riverine and flash flooding in the Eastern and Southern parts of Zimbabwe resulting in loss of life, injury, destruction of livelihoods, houses, roads, bridges and other public infrastructure. An estimated 270,000 people have been affected by Cyclone Idai, and the government reported a total of 344 people dead, hundreds more missing and thousands displaced. The cyclone had a devastating impact on the infrastructure and well-being of survivors. These effects were linked to the psychological, emotional and social wellbeing of the survivors who would then need psychological services to improve their mental health and well-being. Although it has been more than a year since the cyclone, communities are still slowly recovering from the impact of the cyclone.

The programme

In 2019, CBM Global Zimbabwe, REPSSI and the Ministry of Health and Child Care (MoHCC) established a project with the goal of building the capacity of nurses and key community stakeholders on Mental Health and Psycho-Social Support in order to support the well-being of individuals and communities affected by Cyclone Idai (and COVID-19). The project ensured that the provision of MHPSS support needs are prioritised and accessible to the affected population including persons with disabilities.

The project sought to address issues of stigma and discrimination in relation to both mental health and disability inclusion; increase awareness of mental health challenges, and increase capacity for delivery of mental health services. Phase I of the MHPSS Emergency Response to Cyclone Idai project reached 50 Primary Health Care Workers (PHCW) with training on mhGAP-Humanitarian Intervention Guide and trained 253 community para-professionals, professionals, community influencers and leaders in MHPSS. This led to meaningful conversations within communities on mental health issues, however, the scale of the project only scratched the surface of the needs within the communities especially in relation to the scale of the trauma faced by communities due to the cyclone.

In February 2020, Phase 2 of the project began in Chipinge and Chimanimani district, targeting PHCW and communities with the necessary capacity building to improve MHPSS in their community. The project continues to use the IASC intervention pyramid model; focusing on improving service delivery of mental health through capacitating Primary Health Care with mhGAP trained PHC workers and improving access to services through community

awareness and training in MHPSS. Communities are also engaged to ensure strengthening of community and family support.

As people with disabilities, we have always been sidelined and considered as a minority group in most communities which impacts our mental health. We are depressed by such treatment from our families and colleagues thus need inclusion and equal participation. The MHPSS project interventions in 2020 enabled us to be conversant with the referral pathways and we now know where to seek help when distressed, participate in community activities such as the clean-up campaigns, given the opportunity to partake leadership roles in School Development Committees and some children with disabilities were also selected to be prefects as well as given the platform to conduct community dialogues to mainstream disability in programmes. This enhanced the children's mental wellbeing because they got involved in community activities which also made them realise that they are not "objects" that solely should depend on other people and also that they are equally important and useful just as other people without disabilities.

Watson Muyotcha
Treasurer, Disability Committee, Chimanimani District, Ngangu, Zimbabwe

Excess rain caused the Tana River in Kenya to flood
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Burkina Faso

The context: Food security and the mental health of vulnerable populations

The fragile security situation in northern Mali has forced thousands of people to move to neighbouring countries, including Burkina Faso. This massive flow of people, often accompanied by cattle, has the consequence of pressure on the local natural resources through overgrazing, the excessive cutting of wood, and pressure on water resources.

In Burkina Faso, since 2015, the continued deterioration of the security situation has forced more than a million people to flee their homes. In terms of health, 294 health facilities remain closed or operate at a minimum, depriving more than 1.2 million people of access to adequate health care. 2,512 schools are closed, depriving more than 350,000 children of education.

Due to the insecurity linked to attacks by armed groups, people in several localities have abandoned agricultural land and their homes to move to urban centres. The Haut-Bassins region has almost 20,000 internally displaced persons (IDPs), 53% of whom are women with children. The massive arrival of these IDPs has put great pressure on natural resources (water, pasture, agricultural land) resulting in conflicts between farmers and herders. This degradation of livelihoods contributes to the decline in agricultural production, which plunges vulnerable households into food and nutrition insecurity. This misuse of natural resources has increased the impact of climate change already existing in the municipalities, but has been more profound on poor households and people with disabilities.

All in all, attacks by armed groups, the flight of populations leaving fields and granaries, combined with climate change and the harmful effects of COVID-19 constitute major factors of stress that contribute to poor mental health. Many field accounts show that the loss of goods and means of production, fear and anxiety due to violence and insecurity increased their vulnerability, and limited ability to take care of families, trigger or worsen the psychological impact on those affected. An increase in social problems (mistrust between neighbours, social breakdown, increase in violence based on gender and disability), has also been reported.

The loss of food production increases the cases of malnutrition, and stunted growth, especially among children under 5 years old. This demonstrates the link between malnutrition and the onset of mental health problems: climate change related insecurity, violence, and flight with loss of means of production drives undernourishment, stress and psychological impacts. Faced with this situation, strong actions are needed to restore the mental health and food security of the affected populations.

The programme

The integrated production diversification and nutritional improvement program in the Haut-Bassins region (PADI), in partnership with Action Conte la Faim, contributes to food and nutritional security in the project area, particularly that of vulnerable households and people with disabilities. It sensitizes all stakeholders to sustainable management of natural resources in the context of the effects of climate change. The aim is to promote good practices in adaptation to climate change.

1. Improve the knowledge and practices of municipalities in terms of climate risks and integrated management of natural resources
    - Preparing communities for possible risks and identifying the measures necessary to increase resilience to climate risks. Promotion of adaptation measures to climate change
    - Sensitization of traditional chiefs and community leaders to environmental awareness and adaptation to climate change
2. Sustainably improve the production of cereals and vegetables
    - Support for better cereal production and access to seeds for vulnerable households (improved rice, maize, sorghum, vegetable seeds and fertilizers)
    - Support for other income-generating activities of vulnerable households
3. Strengthen mental health and psychosocial support
    - Sensitization of local populations and traditional, religious and political leaders of displaced populations on stress factors, risks related to drug addiction and Gender Based Violence (GBV)
    - Promotion of the establishment of self-help and talk groups in mental health
    - Training of health and community workers on the management of conditions linked to stress aimed at ensuring comprehensive care in non-specialized health centres using mhGAP
    - Training of health workers and traditional healers on the rights of people living with a psychosocial and intellectual disability according to the principles of QualityRights

Bangladesh

The Context: Disability-Inclusive Disaster Risk Reduction

Bangladesh is one of the most disaster-prone countries in the world and the Gaibandha District, north of the country, is one of its most disaster-prone areas[5]. Bangladesh's geography makes it prone to frequent natural disasters including floods, cyclones, and earthquakes. These phenomena are likely to become more frequent, triggering widespread loss of lives, damage to assets and to livelihoods. Each year floods can submerge between thirty to seventy percent of the country's land.

The programme

Based on an in-depth study of good practices in a longstanding comprehensive Disaster Risk Reduction (DRR) Programme implemented by CBM and two local partners (the Centre for Disability in Development (CDD) and Gaya Unnayan Kendra (GUK)), CBM published The Gaibandha Model for Disability-Inclusive Disaster Risk Reduction.

The Gaibandha Model suggests five interlinked interventions, all of which are needed to build resilient and inclusive communities:

1. Strengthen people with disabilities and their representative groups
2. Advocate with the local government for inclusive disaster risk management (DRM)
3. Build accessible DRM infrastructure and capacity for inclusive DRM at community level
4. Strengthen household-level disaster risk awareness and preparedness, in collaboration with schools
5. Promote and support sustainable, resilient livelihoods

All interventions were implemented across the following levels:

- The **household level** - persons with disabilities were identified and supported individually with rehabilitation measures and livelihood support.
- The **community level** - self-help groups of persons with disabilities and community-based Ward Disaster Management Committees (WDMC) were established. The committees then collaborated with the municipal-level Union Disaster Risk Management Committees
- The **municipal level** - formal DPOs, the Apex Bodies, were established, consisting of representatives from self-help groups. These advocate for inclusion with the Union government.

This comprehensive, tertiary approach not only supports the livelihoods of persons with disabilities in the direct sense, but also contributes to positive mental wellbeing in the long-term.

Sierra Leone

The Context: System strengthening and preparedness

In a recent publication of case studies for MHPSS and DRR[6], CBM partner Mental Health Coalition – Sierra Leone, shared their experience in strengthening health and social systems in Sierra Leone, and argue that investment in basic health and social systems is essential, and represents very good value, in ensuring availability of support when emergencies happen. This 'building better before' argument is particularly true in countries prone to climate-related emergencies.

The past three decades in Sierra Leone have seen a series of major emergencies which have resulted in substantial challenges to long-term development, and the country remains one of the poorest in the world. Sierra Leone was overrun by a brutal civil war between 1991-2002, and subsequently the Ebola Virus Disease epidemic of 2014-2015, which again frustrated efforts at economic recovery, despite substantial natural resources and positive economic reforms. In 2017, mudslides killed over 1,100 people living in poorly built housing on the hills around Freetown, displacing many more.

In 2010, services in Sierra Leone consisted of a single psychiatric hospital in Freetown[7] located near the coast and hundreds of km away from many communities.

Woman checking the maize / corn plants.
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The programme

Prior to the outbreak, CBM, the Sierra Leone Ministry of Health and Sanitation, and other partners established a strong coalition (Mental Health Coalition – Sierra Leone) through the "Enabling Access to Mental Health in Sierra Leone" initiative[8]. The programme worked to strengthen governance and greater prioritization of mental health in the country; developing a mental health policy, liaising with a Steering Committee at the Ministry of Health and Sanitation, and building a network of experienced and effective advocates. This coalition was crucial to successfully promoting investment in a sustainable mental health system, and between 2010 and 2014, 21 psychiatric nurses were trained, mental health skills were provided to over 400 other clinicians, and Mental Health Units (MHUs) were integrated into primary care services in 16 districts across the country.

The fact that these clinicians, and the Primary Care Mental Health Units, were already in place when the Ebola outbreak, and the mudslides, occurred meant that they could be utilized to support wider efforts to meet the MHPSS needs across the country. They proved to be an essential complement to the field-based psychosocial support activities delivered widely by the many actors who arrived to respond these crises. The majority of these activities involved training front line workers in Psychological First Aid, an adapted version of which was developed[9]. The consequence of this increased sensitization of front-line health, social, education and other staff, was that they identified many people with needs they could not manage. The people identified were therefore able to benefit from local access to the next level of health care. Without this, the full range of recommended interventions in a balanced approach to MHPSS, as recommended in the Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings[10] would not have been available. In addition to the fact that this would not meet the needs of people beyond the first level of support (eg informal support by families, and PFA), there are ethical questions about provision of this basic support where there is no referral option, as it places a burden on people offering PFA, and raises expectations of the population.

The psychiatric nurses played an essential role, not only seeing the many patients referred by people providing PFA, but also supporting Ebola Treatment Centres and survivors' clinics, services for children orphaned by the epidemic, and supporting health and other staff who themselves experience high levels of distress. These services were an essential element of the provision of care, which was only possible because they were set up in advance, demonstrating the importance of investment in strengthening (decentralized) mental health services, if an efficient and effective response is to be possible.

In addition, CBM worked with local organizations of people with disabilities during the crisis to ensure that key public health messages were made available in accessible formats, that barriers to accessing response services were addressed, and that people with disabilities participated in planning and coordination, so that their needs and priorities were heard.

"If MHPSS support was absent during the period of intervention, I wonder what the state of mental health would have been for the people of Sierra Leone today".

Jennifer Sarah Duncan
Psychiatric Nurse, Freetown, Sierra Leone

Further reading

- CBM Global Climate Report by Mary Keogh, CBM Advocacy Director. October 2020
- OHCHR study on climate and disability draws from CBM Global paper and also highlights the CBM project the Gaibandha model for disability-inclusive disaster risk reduction. May 2020
- Human Rights Council panel discussion on the rights of persons with disabilities in the context of climate change. Opening remarks of HRC. June 2020
- IASC Technical Note: Linking Disaster Risk Reduction and Mental Health and Psychosocial Support. Inter-Agency Standing Committee, 2021

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The drought in Madagascar in 2021 is considered by the UN to be entirely due to climate change, with no war or other political cause usually associated with famine