RESILAC*

*REDRESSEMENT ÉCONOMIQUE ET SOCIAL INCLUSIF DU LAC TCHAD

ACTION CONTRE LA FAIM

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Groupe URD
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REGIONAL REPORT

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THE TREATMENT OF PSYCHOLOGICAL DISORDERS IN THE LAKE CHAD BASIN

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GROUPE URD

RELIEF. REHABILITATION. DEVELOPMENT

Founded in 1993, Groupe URD is an independent think tank that specialises in analysing practices and developing policies for the humanitarian sector. Our multi-disciplinary expertise, based on continual field visits to crisis and post-crisis contexts, provides us with insight into the functioning of the sector as a whole. We believe in sharing knowledge and collective learning, and we help aid actors to improve the quality of their programmes.

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Our thanks go first of all to the women and men who agreed to take part in this study who shared their experiences on a subject as sensitive as psychological suffering in a crisis context. This report has no other ambition than to transcribe as faithfully as possible their words and analysis.
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DISCLAIMER

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SUMMARY

In the majority of violent conflicts in the world, 90% of the victims are civilians. Terror is used as a means of social control: it is the fundamental component of modern political violence and is orchestrated to penetrate the social universe of a population and the psyche of individuals.
Destroying all forms of social cohesion, peace, individual resistance and well-being is a strategy in most of today's conflicts, including those in the Lake Chad Basin. Violent incursions into villages, looting, and physical and moral abuse are the morbid props of a political theatre designed to literally 'stun' an entire society. The victims are thus confronted with the deliberate destruction of their social, economic, family and religious environment.

Not only do attacks by non-state armed groups (NSAGs) make little or no distinction between civilians and soldiers in their targeted actions, but the former 'ethical obligation' to spare women and children is giving way to a strategy of systematically attacking them. Sexual violence against women, the recruitment of youth and hostage-taking are real methods of warfare that characterise the violence of Boko Haram and other non-state armed groups in the region.

It is in this context that thousands of families have fled their villages and their land to migrate to areas deemed more secure. However, although this very relative security allows them to stay alive, it obviously does not provide decent living conditions. There are many inter-connected causes of trauma: from the displacement of populations to the fragmentation of family and village entities; from uncertain access to resources to the reinvention of a 'makeshift' economy; from the anguish of displacement to resettlement in an unfamiliar and socially unstructured environment. When the crisis drags on, once the possibility of a better life fades and the hope of being able to return home becomes more uncertain, social vulnerabilities set in and fuel psychological trauma. This sequence of traumatic events also leads to the transformation of social relations and mutual aid dynamics, which is only made worse by the prolonged interaction between host and displaced populations. Suspicion towards the 'cultural other' begins to grow. They begin to be seen either as a real danger (collusion with the GANE) or as a risk (sharing resources).

Similarly, social sanctions against people in psychological distress, whose disorders are visible in the public arena, are becoming more prevalent. Collective representations linked to mental health - formerly limited to the distinction between "being crazy" and "being normal" - no longer hold, or at least they include other dimensions of mental illness and other explanations.

When psychiatry detects an increase in manifestations of mental disorders, psychosis, depression, anxiety or traumatic neurosis, traditional medicine sees individuals who are increasingly under the influence of occult forces, whether they are the instigators or the victims of attacks.

However, whatever the aetiology (study of the causes of illnesses) and the treatment used, the social function of therapists (traditional practitioners, psychologists, ATS, etc.) is increasingly promoted due to the place given to speech and the relief of suffering. Taking into account personal histories and traumatic experiences is, moreover, one of the common points of the 'traditional' and 'conventional' approaches to the treatment of psychological disorders.

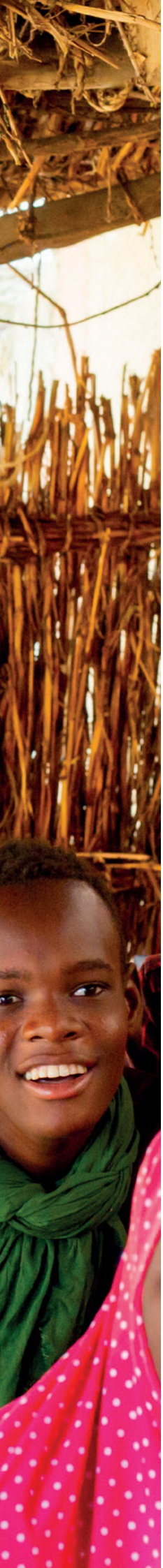
The different ways of accessing care and managing mental disorders coexist, without really competing, as biomedical care is scarce. While people initially tend to go to traditional or faith-based healers, they may decide to use psychiatric and psychosocial services "by default"

depending on the availability of state services and international organisations or when traditional treatment has failed.

In this context, it is difficult to speak of people's resilience or of a stabilised and sustainable social situation. Rather, it is a context of day-to-day survival strategies and therapeutic pluralism. The different types of care are motivated by the same objective of recovery. As such, each person mobilises the social, economic or symbolic capital available to them in order to cope with the suffering and the uncertainty that the crisis will soon end.

1

INTRODUCTION



Interview with a displaced village chief (Niger[1])

Before, we were breeders, fishermen, farmers ; these are activities linked to water. Now we are far from our environment.

Sometimes our young people take the risk to go fishing. Sometimes they are chased away by the jihadists, sometimes it is the military who confiscate their catch. We are caught between these two forces. This crisis started in Nigeria. It came to Niger little by little, but nobody knows what they want. They kill, they loot, they rape under the guise of religion.

In our community, some young people have gone to join Boko Haram, but not many. On the other hand, many young people from the banks of the Komadougou join them, as well as among the Boudouma from Chad, towards Bol, and in Nigeria as well. In general, they are the ones who come to do damage here. Nobody knows what they want, they don't make any demands.

As far as security is concerned, we ourselves have not been directly targeted, but in neighbouring villages there have been victims, and even in N'guigmi which is a large centre. Young girls have been abducted and traders have been kidnapped for ransom.

Since we have been here, we have been living on the distributions we receive from time to time. But these distributions are really insufficient. And the little we get is shared with all those who have not received anything. This is the main difficulty. My people are hungry, especially the children. We didn't bring anything, we left everything behind when we left the Lit du Lac where we used to live. Our cattle were confiscated by the Boko Haram jihadists, as were our clothes and belongings. We could not take anything. We just had to save our lives.

Since we've been here, we've had people who have psychological difficulties. In my community, we say that "the poor man is half 'mad'. There is one person who has completely deteriorated, who doesn't make sense when he speaks. Our main source of treatment is the marabouts. In these cases, we pray. If the person does not recover, we can turn to the health services.

To get out of this situation, I personally do not know what to do. It is difficult. There is no solidarity. None of our attempts to organise ourselves in order to resist has been successful. Because as soon as the jihadists learn about these attempts, they carry out reprisals against the population, who are often not protected by the government forces . They have their informants within the communities.

1. The names of the villages and informants have been kept confidential for security reasons.

Interview with a traditional healer in Baga Sola (Chad)

Before, we used to deal with children and women's illnesses, especially those related to maternity or conception problems. Now we receive a lot of cases of mental disorders.

The mentally ill who arrive here are mostly those who are possessed by the devil and also those who have been attacked by armed groups. They show several signs that cannot be immediately distinguished. Many come in an emaciated state because they no longer eat, they often speak to themselves, or are mute, and others vomit, shout or call out the names of people or places.

Many are from Baga Sola and are possessed by evil spirits. Then there are the internally displaced people who come from the islands in the interior of Lake Chad and others from places like Bol or Tchoukoutelia. We receive young girls, women from polygamous households, men and also children.

Recently, most of the patients who come from the lake are traumatised by violence. Their relatives report violence or loss of property that have made them mentally disturbed.

The patients in most cases start their treatment with the traditional healers. We make the diagnosis based on the circumstances of the onset of the illness and also from invocations and recitations of Koranic verses. We sometimes use a little fumigation and local herbal drinks. A lot of the treatment I give to patients is based on religion. We recite Koranic verses and to make up a medicated drink. In any case, when you are ill, prayer brings a lot of relief.

For religious people like imams or Goni, they cannot clearly tell you what mental illness you are suffering from. They can only make Koranic invocations to relieve the patient. For example, to make him sleep, or to make him less violent. Here, there is a mixture of Koranic verses, fetishes and our experience in curing these types of diseases. There is powder to put on embers to fumigate the patient, rare plant species from Sudan, Yemen or Egypt that were once used by the Prophet Mohamed to relieve these diseases, local plants boiled as a drink (...). We also need to know the patient's past. It is thanks to the family that we can cross-check information about their past and the symptoms they are experiencing. The family then looks after the patient. These patients are often violent, so we need people to look after them. The family also helps to look for rare medicinal plants and helps to administer the treatment to the patient.

Here, if the illness is related to witchcraft or an evil spirit, I try to treat the cases. But if the illness is related to trauma caused by Boko Haram attacks, most often I ask them to go to Baga Sola Hospital where they treat cases of mental illness.

The life story of a female victim of the attacks, Nigeria

My name is N. I am 32 years old. I was married with 4 children, 3 girls and 1 boy. I only went to the Koranic school, not to the white people's school, so I don't know how to read or write.

At the time, we lived in Madagali with my whole family. We made our living from agriculture and animal husbandry, growing rice, white beans, maize and millet called "Mbairi". We had sheep and a few goats.

I am a housewife. I only accompanied my husband to his various activities, but otherwise I had no personal activities myself.

I have forgotten the day Boko Haram attacked us, but I was in the field that day with my husband. Our children had gone to school.

I still remember the first word they said to us: "So it's you who comes to our territory to provide information to the police? When my husband wanted to reply, they suddenly shot him, and he fell down dead. I was crying. They told me not to cry or they would shoot me too. They took me away from the field and raped me until I lost consciousness. They left me there. I spent two days there in the bush. When I regained a little strength, I went back to the village where I was shocked to find nothing left. The village had been emptied. All the houses were destroyed. There was nothing at all, no animals, no people. All that was left of the village was the trees.

I wasn't able to scream. I didn't have any strength. I just cried. I wanted to know where my children had gone. And I continue to ask myself the same question; because for my husband, they killed him in front of me, but my children, I still don't know. I believe that we have been cursed.

There was an NGO that was able to give me treatment. As I can't read, I don't know what was written. It was this NGO that took care of me in its health centre. Afterwards, I went to see a Modibo (spiritual leader) so that he could say prayers to protect my children.

In fact, I have lost my appetite for life on earth, because I don't like anything anymore.

These testimonies are undoubtedly disturbing, but we felt it was important to introduce this report with a piece of 'reality', based on biographical accounts that show the complexity of human experience in the current context of the Lake Chad Basin crisis. Several key points from these interviews are worth analysing.

The village chief first mentions the hold exerted on the population by the forces that are present: the 'jihadists' on one side and the army on the other. He then expresses the collective incomprehension of the 'religious' motives invoked by the NSAGs, the rallying of certain young people to these groups, the consequences of the displacement of populations on food security, the psychological impact of the attacks and finally the risks of failure of adaptive strategies.

The traditional practitioner refers to the nature of psychological suffering and to the types of healing implemented according to the nature of the ailments. He explains how the long trajectory of care for the patient and their family is understood,

the "relief" provided by traditional and faith-based care practices and the benefit of therapeutic pluralism. Finally, he explains that his ability to treat certain types of suffering is limited and that he needs to collaborate with hospital practitioners.

Finally, N.'s account is one of the many testimonies describing the violence of the attacks, of the shock and emptiness felt by the victims, and of the difficulty of psychological and social recovery, in a context of uncertainty and lasting conflict.

What emerges, above all, is the way that psychological suffering is analysed and the way that individuals interpret suffering. It is this approach, based on testimonies and life stories, that has guided and nourished the work of the researchers involved in this study.

Indeed, understanding "mental health" in a crisis context is not related to a notion (trauma), nor to its scientific interpretation (the meaning of the disorders observed), but to the acceptance of mental illness by society and the place it reserves for the person who is mentally ill. Whether the condition is interpreted as a "psychotic disorder" by biomedicine or as a "possession" by traditional medicine, what matters above all are the individual and collective resources mobilised to cope with it, and the effectiveness of the support as perceived by the person suffering and by those around him/her.

Knowledge of these local resources, i.e. the family and community support mechanisms that are involved in caring for people with psychological problems, is essential in designing and implementing mental health interventions. It is one of the factors that contributes to the sustainability of activities and the resilience of populations. This is what the study has highlighted and attempted to explain.

1.1. CONTEXT AND ISSUES[2]

The Lake Chad region covers parts of the four states established by the colonial borders between Cameroon, Niger, Nigeria and Chad. This region represents an area stretching 1,000 km from north to south and 500 km from east to west, with a surface area similar to that of France, where approximately 29 million people lived in 2017 with an average density of nearly 55 inhabitants/km²[3].

This area is currently considered to be one of the most vulnerable in Africa and the world. In addition to the generic challenges of the Sahel, it is currently facing an unprecedented political and humanitarian crisis. Since 2009, the gradual expansion of the jihadist group Boko Haram from its birthplace in Nigerian Borno, as well as the brutality of the military repression, has caused thousands of victims and led to hundreds of thousands of displaced persons and refugees[4].

As of 28 July 2021, Cameroon, Chad, Nigeria and Niger had a total of 5,267,685 crisis-affected individuals, including internally-displaced persons (IDPs), refugees and returnees (former IDPs and returnees from abroad). Of these, 75 per cent (or 3,947,631 people) were in Nigeria, 11 per cent in Cameroon (579,818 people), 9 per cent in Chad (474,091 people) and 5 per cent in Niger (266,145 people) (IOM, 2021).

2. For a more detailed analysis of the security and humanitarian contexts in the four countries covered by the study, see the country reports in the annexes.

3. Magrin G. (éd.), Pérouse de Montclos Marc-Antoine (éd.), Seignobos Christian (ill.), Gluski Pauline (cartogr.), Crise et développement : la région du lac Tchad à l'épreuve de Boko Haram, *Paris : AFD, 2018.*

4. Géraud Magrin and Christine Raimond, " La région du lac Tchad face à la crise Boko Haram : interdépendances et vulnérabilités d'une charnière sahélienne ", Bulletin de l'association de géographes français, *2018.*

The emergence of Boko Haram in the Sahel is not due to a single cause. Although the climate was initially put forward as an explanation, this does not hold up in the face of rather favourable rainfall since the 2000s. Poverty is certainly a valid argument, but it is not specific to the Lake Chad basin, where the poverty rate is average for the Sahel. The ethnic factor, which would tend to consider Boko Haram as a resistance movement of the Kanouri group in the face of Hausa expansionism, is not necessarily more convincing as an explanation[5]. According to Magrin and Raimond, Boko Haram's expansion can be explained by many interrelated factors. Land conflicts, the loss of state legitimacy, lack of public services, endemic corruption and the disproportionate repression orchestrated by the Nigerian authorities thus appear to have provided fertile ground for the Salafist group's progression.

The direct consequences of the Boko Haram crisis are considerable. The violence of the conflicts and the repression by the army, as well as the measures taken in connection with the state of emergency, have led to the displacement of vast numbers. Approximately 2.4 million people have taken refuge around cities or in rural areas that are not equipped to accommodate large populations and are totally dependent on food aid (Magrin and Raimond, 2018).

The security crisis has profoundly altered a regional system built over time, and has disrupted several types of relations at different levels: territorial complementarities at the regional level, power relations at the local level and family tensions at the household level (Magrin and Raimond, 2018).

1.2. THE RESILAC PROJECT

The RESILAC project "Redressement Économique et Social Inclusif du Lac Tchad" (Inclusive Economic and Social Recovery around Lake Chad) aims to contribute to the economic recovery and to the strengthening of the resilience and social cohesion of the territories of the Lake Chad Basin that have been most affected by the security crisis and climate change. Co-funded by the European Union (Emergency Trust Fund for Africa) and the French Development Agency for a period of 4 years (2018-2021), RESILAC is implemented by an international consortium (Action Contre la Faim - lead partner, CARE and Groupe URD) in partnership with the CCFD - Terre Solidaire network, Search For Common Ground and local organisations in the four countries.

The regions targeted by the project - (i) the Far North in Cameroon, (ii) Diffa region in Niger, (iii) the Lake region in Chad, and (iv) Borno State in Nigeria, - are faced with deep social problems since the Boko Haram attacks. They are located around the main focus of the crisis, in concentric areas in the four countries bordering Lake Chad.

The specific objectives, or "pillars", of the project are as follows:

- **PILLAR 1:** Reinforcing human capital, social cohesion and the collective and sustainable management of natural resources in the targeted territories.
- **PILLAR 2:** Promoting economic recovery in the targeted territories and increasing the resilience of the most vulnerable people, notably young people and women, through access to employment and intensive agro-sylvo-pastoral systems that are adapted to climate change;
- **PILLAR 3:** Promoting and consolidating actors

5. Seignobos C., Chronique d'un siège, Boko Haram dans ses sanctuaires des monts Mandara et du lac Tchad. Afrique contemporaine, *2017.*

of the targeted territories by encouraging dialogue and participation, and by reinforcing their capacities based on the competences and roles of the different stakeholders;

➔ **PILLAR 4:** Producing knowledge to contribute to the quality of the project activities, and to inform the decisions made by local actors.

One of the expected results of Pillar 1 is to improve the psychological state and socio-professional integration of the people affected by the Lake Chad crisis. The related activities are: individual and group psychological support for people identified as vulnerable[6] / psychological first aid training for community workers / accompanying and strengthening the psychosocial skills of young people in their professional projects.

1.3. STUDY OBJECTIVES AND RESEARCH QUESTIONS

Objective of the study:

Analyse individual strategies and collective dynamics that condition the mental health and socio-economic integration of young people in the Lake Chad Basin .

Specific objectives:

i) Draw up an inventory of mental health systems in the four countries targeted by the RESILAC project

After a review of the existing literature, the study will focus on identifying exogenous mechanisms for managing mental disorders in the Lake Chad Basin. The aim is to understand how external interventions integrate mental health into their programmes, in what contexts, which actors are mobilised, the tools used, the strategies implemented and the main issues at stake in these interventions.

Research questions:

- What external interventions provide psychological assistance to victims of conflict (NGOs, faith-based organisations etc.)?
- Are the activities of these organisations integrated into the primary health care system of the target countries? In what way?
- Are there national mental health strategies? What progress has been made and what challenges exist?
- Is traditional medicine recognised by the Ministry of Health?
- At the community level: the role and legitimacy of psychosocial workers: how do international organisations identify the psychosocial workers (PSWs) they recruit? What is their profile and their relationship with the local authorities?
- What are people's perceptions (benefits and limitations) of external interventions that provide psychosocial care?
- What population groups are primarily targeted by these interventions (victims, ex-combatants, prison populations, etc.)?

ii) Identify the nature of emerging mental disorders and the profile of people with symptoms of psychological distress

This line of research aims to draw up a global inventory of psychological problems linked to

6. En lien avec le mandat du réseau Action Contre la Faim-International (ACFin), les personnes identifiées comme vulnérables montrant des signes de troubles psychiatriques ne seront pas prises en charge par le projet mais référées aux structures compétentes (hôpitaux psychiatriques de référence dans la zone/pays).

conflict and its effects on the social and economic integration of young people. The aim is to understand the social consequences (domestic violence, not attending school, loss of jobs and income, etc.) and emerging psychological co-morbidities (maladaptive stress reaction, post-traumatic stress disorder, depression, addiction, etc.) linked to increased mental disorders in the sub-region.

Research questions:

- According to health and mental health professionals, what are the predominant signs of conflict-related psychological problems? What is the nature of these disorders? What are the major causes identified?
- Which population subgroups are most affected by psychological problems and conflict-related trauma?
- How do these signs manifest themselves in family and community environments? What are the social consequences of these disorders (on education, and on economic and domestic activities)?
- According to the health professionals and psychologists spoken to, what are the emerging pathologies (maladaptive stress reaction, post-traumatic stress disorder, depression, addiction, etc.)?

iii) Understand the endogenous mechanisms for dealing with mental disorders and trauma

The aim is to identify institutional mental health services and to highlight the community dynamics involved in providing individual support to people with mental disorders. This objective includes identifying 'carers' active at the domestic and community level, specifying the different profiles, types of support as well as the different types of care available locally, that are not related to any external intervention. From a cross-cutting point of view, the study aims to understand the place that society gives to people suffering from trauma (exclusion or integration) and the room for manoeuvre that these people have in the community.

Questions de recherche :

- What is the "therapeutic pathway" of people with psychological problems? What types of actors do people with problems turn to initially? And thereafter?
- What is the role of the family in supporting people in distress? Who has the power to make the decision to seek external help?
- What are the individual coping strategies of people with problems? What are the sources of comfort that are used individually by women and young people (including drug use if available)?
- What mutual aid exists within communities and refugee camps?
- What is the place of religion in the individual management of psychological disorders? What do religious texts say about psychological disorders and mental illness?
- How do religious leaders identify and treat psychological disorders? What advice do imams and/or marabouts give to people with problems?
- How do traditional therapists/healers diagnose and treat psychological disorders? What pharmacopoeia is used? Do specific rituals exist?
- Are there traditional therapists who claim to be specialists in psychological problems and mental illness?
- What other actors are involved (health professionals, matrons, Dr. Choukou, etc.)?

iv) Describe collective perceptions of trauma in general, and of people with post-traumatic symptoms in particular

Through an in-depth discursive analysis, the study aims to understand popular representations related to trauma and how "the norm" and "deviance" in mental health are perceived. The aim is to find out:

- how community actors refer to trauma and those who are affected by it
- what causes they associate with this psychological state
- what they see as the visible manifestations of trauma

- what social, family and economic determinants influence the occurrence of post-traumatic symptoms?

Research questions:

- What is the difference between being "crazy" and being "psychologically distressed" in collective perceptions?
- When does psychological distress become a mental illness and warrant treatment? (in collective perceptions and according to customary and religious leaders)
- What are the different categories of 'illness' or distress listed? (establish a typology of mental illnesses)
- What is the terminology used in the local language to describe the main mental health conditions?
- Is there an equivalent of 'trauma' in local cultures and languages (i.e. psychological distress following an event that generates uncontrolled emotion)?
- Apart from the current crisis and related violence, to what other type of cause are these different pathologies linked (ancestral spirits, maraboutage, witchcraft, genies, etc.)?

1.4. METHODOLOGY

1.4.1. METHODOLOGICAL FRAMEWORK

The following methodological considerations were taken into account in the implementation of the study:

Multidisciplinary regional study: This study is based on a multi-country (Niger, Nigeria, Cameroon, Chad) and multidisciplinary approach. Four national consultants whose professional profiles were chosen to be complementary (psychology, psychiatry, political science, anthropology) were mobilised throughout the research. Their work led to the drafting of four "country" reports, presented in the appendix. The study was also based on cross-border and regional analyses in the Lake Chad Basin, which is the geographical and social reference area for this study.

Qualitative approach: The analysis of the endogenous and exogenous mental health care mechanisms is based on a qualitative approach and favours semi- and non-directive interviews, as well as observation, as investigation tools. Interview guides and observation guides were prepared and adapted to the different contexts of the study. The methodological advantage of the qualitative socio-anthropological approach is that it relies on the testimonies of the interlocutors and allows them to proceed by free association so that unexpected aspects emerge. Emphasis was placed on the analysis of 'private' discourses, which refer to real practices and the meaning that people give to their practices, as opposed to 'public' and normative discourses, which refer to 'official' practices.

➔ 130 semi-structured interviews were conducted during the fieldwork. Of these, 42 interviews were fully recorded, translated and transcribed

Biographical approach: Life stories allow the meaning that actors give to their actions to emerge, by calling on their reflexive capacities. The consultants were asked to collect stories from the personal experience of the victims of armed groups in order to allow for a detailed analysis of their experience and their care trajectories. Some life stories are presented in specific boxes.

➔ 10 life stories were recorded, translated and transcribed.

Operational research: The study falls within the scope of operational research and aims to produce new knowledge that will be useful for achieving the project's results. It will produce

practical knowledge for the organisations involved in the RESILAC project, with a view to sustainably improving the operations.

➔ The operational recommendations resulting from the research will be the subject of a remote workshop involving the members of the research team. Once the recommendations have been made, Groupe URD will work with an organisation specialising in the prevention of post-traumatic stress disorder, using dissemination tools such as comics.

1.4.2. THE IMPLEMENTATION PHASE

The methodology is based on the following six phases:

1. **A scoping meeting** was held with each expert to clarify the methodology and expected deliverables and to discuss the topic and the research questions. These meetings helped to define the scope of the study, the profile and the number of key informants as well as the methodological tools to be standardised.
2. **Literature review** including project documents (initial assessments, protocols, activity reports, etc.), scientific studies, cartographic data, the legal framework specific to each country, international conventions and WHO reports on access to health, etc. Each consultant was responsible for compiling a bibliography for each country and for writing a bibliographic report intended to define the scope of the study and to identify the specific themes that needed to be completed by the field surveys.
3. **Kick-off workshop** during which the timetable of the study and the composition of the research teams were specified; the methodology and drafting plans were validated in order to ensure that there was coherence between the tools and approaches suggested by the national experts.
4. Following the kick-off workshop, the study coordinator produced some data collection tools which were then re-appropriated and re-contextualised by the national experts.
5. **Fieldwork:** the national experts and their teams carried out 15 days of fieldwork, each in their respective countries.
6. **Data processing and report writing:** The transcripts and notes of the semi-structured interviews were analysed using the MAXqda qualitative data analysis software, which allowed the field data to be triangulated effectively. The national reports were written by the national experts and the regional report was written by the study coordinator.
7. **Feedback:** A remote feedback workshop will be organised and will bring together Groupe URD experts, national experts, and the RESILAC team's 'mental health' and 'knowledge production' focal points.

1.4.3. CONSTRAINTS AND METHODOLOGICAL GUIDELINES

- **Operational research rather than an evaluation:** While this study aims to be operational and to provide new knowledge on strategies for dealing with mental illness, it is in no way an evaluation of the mental health activities of the RESILAC project. Indeed, an evaluative approach - which compares the expectations that are related to a project with the results recorded at a specific moment - is contrary to a knowledge production approach in many respects. RESILAC staff were approached in the same way as any other mental health actors involved in the area, but the project was not the entry point for the study.

- **Heterogeneity of contexts and experts:** The profiles of the experts and the composition of the research teams were heterogeneous. Despite a certain standardisation of the methodological tools, the four "country" reports were equally heterogeneous, which

made the synthesis work relatively difficult. Moreover, the socio-political, economic and health situation is very different in the four countries targeted by the study. This diversity was interesting rather than restrictive for the analysis, but did not allow any generalisations to be made about the social mechanisms involved in caring for people in psychological distress. The report therefore presents a typology of the forms of care and the actors involved, avoiding as far as possible hasty comparisons and simplifications.

- **Numerous delays** (partly related to the health context): Restrictions made carrying out the interviews more complicated and prevented access to some local organisations and key informants. The political and security crisis that affected Chad from February to April 2021 also led to delays in carrying out the fieldwork.

- **The nature of the topic:** In many contexts, mental health problems are difficult to address because of the high level of social stigma involved. Moreover, in contexts where people's basic needs are nutrition and housing, soliciting interviews on the subject of mental health sometimes seemed of secondary importance to the people interviewed.

- **Remote coordination:** The methodological challenges of 'remote' research are multifaceted. The current crises, whether health or security-related, have paradoxically had beneficial effects on the 'localisation' of operational research. Here we understand "localisation" to mean the involvement of more national researchers in research teams.

- What seemed obvious in theory - but was not always followed in practice - became indispensable. While the study was coordinated remotely, the field surveys, the analysis of the data collected at local and national level, and the drafting of the country reports were carried out exclusively by the regional experts, who undeniably have contextual expertise. This type of set-up will be documented and reproduced in Groupe URD's future research work, not as a "replacement solution" for sensitive and difficult to access areas, but whenever operational research requiring a detailed analysis of local dynamics is required.

1.4.4 THE RESEARCH TEAM

	Niger	Nigeria	Chad	Cameroon
Leader	➔ YAMIEN Ibrahim	➔ NDZANA Ignace Bertrand	➔ MBARKOUTOU Mahamat	➔ MOHAMADOU Galy
Composition of the team	➔ Team of 3 clinical psychologists + 1 leader	➔ Team of 3 anthropologists + 1 leader	➔ Mixed team (socio / psycho) of 2 people + 1 leader	➔ Mixed team (socio / psycho) of 2 people + 1 leader

1.4.5. POPULATIONS AND TARGET AREAS

The priority beneficiaries of activities aimed at improving mental health and psychosocial well-being are young people (19- 34 years) and women, as well as victims of acts of violence suffering from post-traumatic stress, whose professional integration is conditioned by their psychological state. Among them, the different populations - host, displaced, and returnees - were included in the study.

The study targeted the project's operational zones, including the Diffa region of Niger, the Lake Chad region of Chad, Borno State in the North East region of Nigeria and the Far North region of Cameroon.

La description des localités se présente comme suit :

A. Cameroun

Localities	Villages	Features
Dargala	Dargala	Capital of the eponymous district; small cosmopolitan town (Fulani, Guiziga, Moundang). Agricultural and livestock area, prey to elephant attacks, population young, but vulnerable due to unemployment.
Koza	Koza	Capital of the eponymous district, located in the Mandara Mountains. Cosmopolitan town (Mafa, Mandara, Kanuri). Limited exposure to the exactions of armed groups, but concentration of displaced persons and returnees.
	Mazi	Village in a mountainous area, hosting people displaced by the security crisis, large population of vulnerable and psychologically distressed young people.
Mindif	Mindif	Located about 25 km from Maroua, cosmopolitan (Peul, Moundang, Guiziga, Kanuri...) and exposed to the risks of locust or granivorous bird invasions. Young population but high level of unemployment.
	Mendéo	Village located on the roadside on the Maroua-Kaélé axis via Mindif. Farmers and herders live together. Presence of a traditional healer with an established reputation.
Mora	Mora	Capital of the Mayo-Sava department, a cosmopolitan town (Mandara, Mafa, Arab, Peul, Podoko, Moutal, etc.) and heavily militarised. The town has suffered several attacks, a large population of displaced persons, a district hospital with a psychological care unit. A large number of people in a state of psychological distress.
	Mémé	Village in the Mora district, with a strong presence of IDP and returnee camps. Traditional authority working with the population, strong community of traditional healers, many people with mental disorders.

B. Chad

Localities	Villages	Features
Bol	Bol	Capital of the Lake Province; a cosmopolitan town; the historic stronghold of the Budumas and the main town of the Bol canton; Bol Regional Hospital with a psychiatric unit; headquarters of several mental health organisations
	Yakoua site	Village located near Bol, on the edge of a polder sharing resources with other villages; close to other IDP sites, many people in a state of psychological distress, RESILAC intervention site
	Ngarangou	Chief town of the Ngarangou canton, a village where historically Kanembou and Buduma have lived together; a canton where several polders host IDPs and returnees with several cases of people suffering from psychological distress
	Sya	Village located on the edge of a polder where Kanembous live; presence of returnees from deserted islands and formerly settled families
Mindif	Nguéléa	Main town of a formerly Kanembou canton; has hosted several IDPs and returnees; several cases of mental illness recorded among IDPs and host populations
	Tchingam	Village located not far from Baga Sola on the edge of a large polder where host populations, displaced persons and returnees from the lake islands cohabit; high prevalence of mental illness; significant use of local and cross-border traditional healers
Mora	Baga Sola	Seat of the prefecture that administers the lake, seat of the canton of Nguéléa 2 created following a split with the canton of Nguéléa 1, strong presence of displaced populations from the lake islands; strong presence of psychosocial support organisations; recognised local know-how in the traditional treatment of mental illness
	Talia	Village relevant du canton de Nguéléa 2; site de cohabitation difficile entre déplacés Budumas venus des îles du lac et populations hôtes Kanembou; village partageant avec d'autres les ressources des polders disputés, plusieurs personnes affectées par des troubles mentaux

C. Niger

Localities	Features
Diffa	The commune of Diffa is home to 72,492 inhabitants and includes 38 villages that have abandoned their original sites to move to reception sites north of national road N°1. The commune is home to the only official refugee camp, several organisations specialising in mental health have their headquarters there, and many humanitarian NGOs have set up in the capital of the Diffa region.
Chétimari	The commune of Chétimari is home to 101,247 inhabitants, the majority of whom are Yourandi. The commune hosts refugees in Gagamari and IDPs in Malanboucardi.
Maine Soroa	A cosmopolitan population (Folani, Haoussa, Kanouri, Manga, Toubous, Arabs and Tuareg) estimated at 108,557 inhabitants. The commune includes 5 villages that have abandoned their original sites. It is home to a population of refugees and internally displaced persons. 3 out of 12 health centres are closed (Tam, Boudoum and Malamboulamari).
N'Guigmi	The commune of N'G uigimi has 94,246 inhabitants; of its 6 health centres, 3 are closed (Bilabrine, Arikoukouri and N'Galewa); 30 villages have abandoned their original sites. The displaced population are on the Kinglé site.

D. Nigeria

Localities	Features
Maiduguri	Maiduguri, a city of 810,764 inhabitants, is the capital of Borno State in the north-east of Nigeria. Maiduguri is home to 71 camps and 119,395 IDPs. It has a central regional hospital and also hosts a medical university and specialised mental health facilities. UNHCR, WHO, UNCHR and WFP are the main non-governmental agencies on site.
Jere	Jere township, located in the far north-east of Nigeria in Borno State, has a population of 247,860. The municipality hosts numerous refugee camps supported by UNHCR and WHO in which more than two million IDPs live. Access to basic services in the township remains difficult due to water shortages, lack of access to land and lack of basic services (hospitals, markets and shops). NSAGs have destroyed most basic services. WHO and UNHCR have opened health facilities, particularly in the commune, to care for the mentally ill.

2

TRAUMA AND PSYCHOLOGICAL RESILIENCE IN A TIME OF CRISIS

2.1. SOCIAL VIOLENCE AND POLITICAL VIOLENCE: INTERCONNECTED FORMS OF INSECURITY

Social, political and territorial conflicts in the Lake Chad Basin have been the subject of extensive multidisciplinary research for many years, some of which has recently been compiled in the book resulting from the 17th Mega Chad Conference *"Conflits et violences dans le bassin du lac Tchad"* (Chauvin, Langlois, Seignobos, Baroin, 2020).

After defining the three main factors of insecurity as conflict (confrontation between actors pursuing incompatible goals), violence (the opposition between an aggressor and a victim within a relationship of subjugation) and risk (the probability of an event causing damage), the authors analyse insecurities according to three social levels.

At the microsocial level, everyday or 'ordinary' violence is materialised by chronic crises (malnutrition, undernourishment, etc.) or recurrent crises (famine, epidemics, pandemics, etc.). These are distinct from political, economic or ideological violence, but are nonetheless linked to them. For while their manifestations are expressed primarily at the household and village level, and are in fact part of intergenerational gender or social class divisions, ordinary violence evolves within a broader set of environmental and socio-political determinants. This violence – also defined as structural or systemic (Bouju, 2008) – mainly affects social categories whose status is globally perceived as dominated: women and young people. We will come back to this.

Meso-social insecurities concern broader categories than the family or the village. They are related to territorial issues and the control of land and water resources and can also reinforce ethnic and/or religious conflicts. Macrosocial insecurities, on the other hand, concern larger-scale violence that is related to broader political systems and their dysfunction. These can be civil wars with a regional dimension or locally targeted conflicts perpetrated by state and non-state armed groups.

Two central points emerge from this theoretical perspective of types of insecurity. On the one hand, we have to remember that the very notions of violence, insecurity or danger are very subjective and are based on diverse and evolving categories of thought and representations. On the other hand, 'insecurities' cannot be considered independently of each other: rather, it is how they are interconnected that should be analysed. 'Ordinary' violence is influenced, over time, by macro-social insecurities which may themselves arise from inter-ethnic conflicts or situations of land insecurity. Different types of insecurity can also coexist in the same social space: food, land, environmental, health, etc. This can be seen in the current situation, which combines a global pandemic, drought, poverty, corruption and a security crisis.

Finally, the interconnection of different forms of violence, at the household, village or regional level, allows us to understand the social and political factors that lead to invisible and unexpressed suffering, i.e. psychological disorders and trauma.

2.2. PSYCHOLOGICAL TRAUMA IN CRISIS CONTEXTS

2.2.1. TRAUMA: A PROCESS OF PSYCHIC DESTRUCTION

Sigmund Freud constructed a general theory of neurosis in which trauma is considered to be a violent shock (physical or not) with psychic intrusion, followed by internal disruption. This event brings a surge of psychic agitation that the individual has difficulty assimilating and which causes lasting disorders. Psychic trauma is therefore caused by events (real or fantasized) prior to the manifestation of the disorder and with a very strong emotional charge, which motivates the repression[7].

Trauma therefore implies a process of destruction of the pre-existing psychic balance. In this sense, the reference to an intrusion is explicit, since it presupposes an event that enters the psyche by force and remains there, like a foreign body, causing confusion and loss of reference points for the person who experiences it[8].

According to Louis Crocq, trauma is defined according to:

- An alteration of the personality insofar as "a traumatic event disrupts the defences of a personality that is subjected to it[9] " ;
- A different temporality since the traumatised person lives in a frozen time where the future is 'blocked';
- L'introduction d'un non-sens dans la vie du sujet.

Trauma is therefore related to the idea of a deep wound following a sudden event, which did not allow the subject to defend him- or herself. But the potentially lasting nature of the trauma is also due to the lack of response on the part of the subject (blocking of the psyche) and those around them (incomprehension of the disorders, feeling of rejection).

2.2.2. DIFFERENT PSYCHOLOGICAL DISORDERS IN CRISIS CONTEXTS

First published in 1952 and inspired by Freud, the Diagnostic and Statistical Manual of Mental Disorders (DSM[10]) has evolved into an increasingly categorical approach to mental illness and the fifth edition developed by the American Psychiatric Association (APA) is now used as a reference in research and clinical practice for many countries around the world.

The confidence that scientists place in it is due to its fully standardised nature, with operational definitions adopted for each clinical category[11].

According to the DSM, there are a great many psycho-traumatic disorders, which vary in terms of their onset over time. A distinction is made between post-immediate and post-traumatic disorders.

Post-immediate disorders

Post-immediate disorders can take different forms:

➔ **Acute stress disorder (ASD)** occurs within the first few weeks after the event. People

7. *Tyszler,* Freud et le traumatisme, *Journal français de psychiatrie, 2010.*

8. *Milleliri Jeanne, Liscia Thierry,* La prise en compte du traumatisme psychologique des populations, *Éditions universitaires européennes, 2009.*

9. *Crocq Louis,* Les traumatismes psychiques de guerre, *Paris, Odile Jacob, 1999.*

10. *See the MSD manual: www.msdmanuals.com*

11. *Demazeux Steeves,* L'échec du DSM-5, ou la victoire du principe de conservatisme, *L'information psychiatrique, 2013.*

who experience acute stress may have experienced the event directly or indirectly. Direct exposure may, for example, mean that the person has suffered serious injury, violence, or a threat to life. Indirect exposure may mean that the person has witnessed events that involve other people. The person mentally relives the traumatic event, avoids reminders of it, and experiences increased anxiety. The disorder may be accompanied by dissociative symptoms (feelings of disassociation from their memories, their perceptions, their thoughts, their emotions or their body) and sufferers may, for example, feel emotionally numb or disconnected from themselves[12]. Acute stress leads to distress and reduces the ability to carry out certain obligations.

- **Adjustment disorders** occur between 3 and 6 months after the traumatic event and are characterised by reactive disorders in the form of anxiety and depressive symptoms and behavioural disorders (Liscia, 2009).
- **Acute and transient psychotic disorders** take the form of hallucinations, delusions and symptoms of confusion.

Post-traumatic disorders

According to the DSM criteria, *Post-Traumatic Stress Disorder* (PTSD) is defined by the following reactions or symptoms:

- **The confrontation with the traumatic event:** the subject experienced or witnessed events in which his/her physical integrity or that of others was threatened; also when the subject's reaction to the event was one of intense fear, helplessness or horror.
- **Intrusion symptoms**, i.e. when the traumatic event is constantly relived (repetitive and intrusive memories causing distress; repetitive dreams, sudden actions "as if" the traumatic event will happen again; distress when exposed to cues evoking an aspect of the traumatic event).
- **Avoidance symptoms** which involve an effort to avoid thoughts, feelings or conversations associated with the trauma, but also places and people that trigger memories of the trauma. These symptoms can also be expressed as an inability to recall an important aspect of the trauma and a marked reduction in interest in previously important activities as well as a sense of detachment from others and restriction of affect.
- **Neurovegetative symptoms** such as difficulty falling asleep, angry outbursts, difficulty concentrating, hypervigilance and exaggerated startle reactions.

2.2.3. LIMITATIONS OF INTERNATIONAL CLASSIFICATIONS AND THE DIAGNOSIS OF POST-TRAUMATIC STRESS DISORDER

Although PTSD diagnosis is useful in that it allows the distress to be named and post-traumatic reactions to be normalised in reference to a detailed list of psychological disorders, many psychologists have developed a critical analysis of this type of diagnosis. Like any standardised assessment tool based on a universal view of a phenomenon (in this case, trauma), PTSD diagnosis does not allow for an in-depth interpretation of different forms of distress and the weight of contextual determinants in the development of pathologies. As it is totally centred on the individual, it is conceived more as

12. According to the DSM, Acute Stress Disorder occurs in 70% of people who experience a traumatic event within one month of exposure. Of these, 30% return to a "normal" state within a month of the event, while 63% develop PTSD afterwards. (Bubois, V., In: Liscia and Milleliri, 2009)

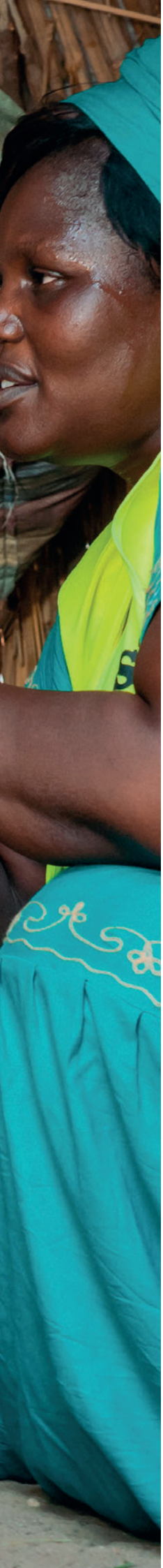
a nomenclature of illnesses allowing them to be classified so that homogeneous and comparable epidemiological data can be collected to guide public health policies. Thus, according to Christian Lachal: "If we focus solely on PTSD, we miss a wide variety of disorders and reactions that are related to war, the context or displacement, but which cannot be assimilated to post-traumatic disorders in the strictest sense" [13].

In the Sahelian context, where the etiology (study of the causes of illness) and nosography (classification of illnesses) used in traditional medicine differ from those used in biomedicine, this classification system may not be effective. Particularly as "naming" an illness is not the same as curing it. And attributing a cause and a name "here" may be broken down into several causes and several names "over there". Moreover, even if the caregiver does manage to attribute the disorder in question to a category of PTSD diagnosis, it is very unlikely that the associated therapy (according to the DSM) will be available, at least not in the long term, and that the prescribed medication (again according to the DSM) will be available in the country in question. In other words, it may be ineffective to fit pathological signs into pre-established categories when these categories do not evoke anything in the country of reference. We will come back to this.

13. Lachal, C., quoted by Liscia, T., Mettre en place une mission de soins psychologiques. Pourquoi ? quand ? comment ? *In Thierry Baubet, Soigner malgré tout. Vol 1 : trauma, culture et soins, Grenoble, La pensée sauvage, 2003.*

3

NATIONAL AND INTERNATIONAL MENTAL HEALTH PROVISION



3.1. THE PLACE OF MENTAL HEALTH WITHIN GLOBAL HEALTH

According to the WHO, mental health is an integral part of health and well-being. The UN agency defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[14] However, nowhere in the world is mental health given the same importance as physical health, either in national policies and budgets or in medical education and practice. Mental health is globally considered as the poor relation of health and it appears only briefly as a sub-chapter of national strategies for non-communicable diseases, which are themselves secondary in national health policies.

Although the countries targeted by the study have, more or less explicitly, included the management of mental disorders in their national health strategies, the under-funding of this sector by international donors and the small share given by national budgets are obvious. The share of the health budget allocated to mental health in the four countries is so small that it is impossible to quantify. In Chad, in 2019, the total budget allocated to public health did not exceed 7% of the general state budget;[15] in Cameroon, it has never exceeded 7% and will be 3.7% in 2022[16]. In Niger, it was only 5.74% in 2019[17] and 4% in Nigeria in 2020[18]. We are therefore a long way from the 15% to which the African Union member states committed themselves in the Abuja Declaration in April 2001.

Globally, spending on mental health is less than 10% of spending on physical health worldwide (OHCHR, 2017). Between 1995 and 2015, of the $36 billion allocated to health, only $110 million was spent on mental health (Charlson *et al.*, 2017).

Moreover, of those who have suffered from a mental illness in their lifetime, 80% reside in developing countries (Mnookin, 2016; Petit 2019). While a limited number of medicines are sufficient to treat the majority of these conditions, about a quarter of countries lack the three most commonly prescribed medicines for schizophrenia, depression and epilepsy at the primary health care level (Patel et al., 2007; Petit, 2019). Between 75 and 85 per cent of people with severe mental disorders in these countries receive no care at all, and these people are frequently denied their rights (Kastler, 2011). According to WHO, there are on average 6.6 psychiatrists per 100 000 population in high-income countries, compared to less than 0.5 in lower-middle-income countries (WHO, 2015).

Furthermore, the lack of data on the prevalence and incidence of mental illness - due to the

14. Global Action Plan for Mental Health 2013 - 2020, WHO 2013.

15. The 2019 draft General State Budget (BGE), which includes External Investment, is set at CFAF 979,974,912,000. The MSP's draft budget, which includes the Investment proposed in the draft State budget, is FCFA 67,135,351,000, or 6.85% of the BGE. (cf. Extraordinary Council of Ministers, Monday 9 December 2019, www.tachad.com).

16. In Cameroon, the Stratégie sectorielle de santé 2016–2027 notes that the proportion of the national budget allocated to the Ministry of Health between 2012 and 2015 fluctuated between 5% and 5.5%. Since 2015, this performance has not improved. The best rate is that of 2016, which stood at 5.57%. The lowest level is that of 2022 (3.70%), preceded by that of 2018 (3.86%). Thus, Cameroon has never reached the 15% target since the adoption of the Abuja Declaration, with the best performance being the 7.07% recorded in 2009 (https://www.africanconstituency.org).

17. CSU Niger National Strategy, June 2021.

18. The countries of the African Union should recommit themselves to the Abuja (www.one.org).

scarcity of psychiatric care but also to the difficulty of defining it precisely and developing an adequate measure - constitutes an obstacle to international funding, which is essentially based on epidemiological data. There are several reasons for this lack of statistical information in Africa. Firstly, mental health is rarely included in primary care, or only temporarily via international interventions. Patients are referred to specialised centres, each of which develops its own database, which complicates the compilation and standardisation work needed to produce coherent statistical series (Petit, 2019). On the other hand, the computer data entry work is carried out by health workers for whom it represents a significant additional workload. Finally, the indicators are defined according to strategies decided at the international level, particularly in connection with the MDGs or the Global Fund, and not in relation to locally defined priorities.

Several epidemiological studies have re-evaluated upwards the weight of mental illnesses in global morbidity (Funk, Benradia and Roelandt, 2014). In 2013, globally, this represented 32.4% of years lived with disability and 13% of years of life lost, which placed them just below cardiovascular diseases in the Global Burden of Disease Study. In addition, a WHO review of 129 studies in 39 countries found that one in five (22%) people who have experienced war or another form of conflict within the previous ten years will develop depression, anxiety, post-traumatic stress disorder, bipolar disorder or schizophrenia (WHO, 2019).

According to the WHO, the estimated prevalence of mental disorders among conflict-affected populations - regardless of timing (point prevalence) - is 13% for mild forms of depression, anxiety and post-traumatic stress disorder, and 4% for moderate forms. The estimated point prevalence for severe disorders (schizophrenia, bipolar disorder and severe forms of depression, anxiety and post-traumatic stress disorder) is 5%. Finally, it is estimated that one in 11 people (9%) living in a place that has been exposed to conflict in the last ten years will have a moderate or severe mental disorder (WHO, 2019).

National statistics on the prevalence of different forms of mental illness are not available for the four countries targeted by the study. However, we do know that the continued displacement of populations and, by extension, the breakdown of protection and conflict resolution mechanisms have increased cases of psychological distress, such as anxiety and depression. According to a psychologist working in the Bol area in Chad: *"In terms of percentage, I would say that 25% of the mental disorders I encountered were depression and anxiety, followed by medically unexplainable or somatic disorders (somatoform disorders) which are at 18%, cognitive disorders came in at around 10% to 15%, and severe mental disorders (psychoses and bipolar disorders) probably 5% to 10%. The rest are moderate disorders that can be dealt with by means of group activities, i.e. work groups, psychoeducation, psychological support groups and so on*[19]*. "*

3.2. PUBLIC MENTAL HEALTH SYSTEMS

While it is increasingly emerging as a public health issue at the international level, mental health is still not a priority in many countries. This is particularly true in Africa, where less than a quarter of countries have a mental health programme (WHO, 2015).
In the countries covered by the study, mental health structures and policies are as follows:

19. Interview with Serfebe Daba Charleau, Psychologist, COOPI, Bol, 20 February 2021.

Niger

Municipalities targeted by the study	Population	No. of displaced	Health structures
Diffa	72,492	51,314 (including 33,421 in Sayam camp)	18 (including 4 relocated: Assaga, Gangam, Zarwaram and Dewa)
Chétimari	101,247	56,035 (including 9,711 refugees in Gagamari and 4,248 IDPs in Malanboucardi)	4 health facilities (Zarwaram, Mala-Boucardi, N'Guel Kolo, Issari, Sayam-forage and Sayam-centre)
Maïné-Soroa	108,557	15,415	12 of which 3 are closed (Tam, Boudoum and Malamboulamari)
Nguigmi	35,962		6 of which 3 closed (Bilabrine, Arikoukouri and N'galewa)

Sources : Direction régionale de l'État civil (DREC), Service de planification et d'informations sanitaires (SPIS) et Direction régionale de la santé publique (DRSP) de Diffa, UNHCR, 2021, Direction régionale de la santé, service de planification et d'information sanitaire.

The Diffa region has a psychiatric care unit located in the regional hospital (CHR) and a regional mental health coordination unit which is a branch of the National Mental Health Programme created in 1993. Since 2015, the results of an action research study on the integration of mental health care into general care, carried out by the National Mental Health Programme, have helped to make some progress in this area of health in Niger. This was reflected in the development of the National Mental Health Plan 2017-2021, which emphasises the priority given to the integration of mental health care into primary health care. However, the existence of these strategic documents does not mask the difficulty of the community health system to really integrate mental health into its systems.

Cameroun

Municipalities targeted by the study	Population	No. of displaced	Health structures
Dargala	39,009	1001 - 5000	Maroua Regional Hospital (3 district centres)
Koza	110,000	20,142	Mokolo Regional Hospital (20 FoSa)
Mindif	50,466	1001 - 5000	Maroua Regional Hospital (19 FoSa)
Mora	244,330	54,029	Maroua Regional Hospital (19 FoSa)

Sources: Updated Cameroon Village Directory. Third General Census of the Population and Housing of Cameroon, Central Bureau of Census and Population Studies, 2005.
DMT, Cameroon I Far North Region I Travel Report I Round 21 I 2020
BUCREP, La population du Cameroun en 2010, 3e RGPH, Yaoundé
WHO, Assessment of the availability and functionality of health services in the Far North, 2017

Cameroon has had a national mental health programme since 2016, which is struggling to function optimally throughout the country. For the time being, the programme does not have a focal point for the Far North, even though the region is experiencing a worrying increase in mental pathologies linked in particular to the numerous security, political and economic crises. The new sectoral strategy for 2016-2027 highlights the low availability of specialised mental health care services and recommends strengthening initial and ongoing training in mental health professions. To overcome the lack of human resources, a specialisation course in mental health has been created at the University of Yaoundé I.

Chad

Municipalities targeted by the study	*Population*	*No. of displaced*	*Health structures*
Bol	***164,878***	66,697	Bol regional hospital (14 health centres) Health coverage of Bol and Ngarangou cantons.
Baga Sola	***79,295***	116,000	Baga Sola District Hospital (15 health centres) Coverage of Ngueléa 1 & 2 townships

Sources: DMT, Chad I Lake Province Region I Displacement Monitoring Matrix I Round 15 I May-June 2021
LMD, Lake Chad Basin I Displacement Monitoring Matrix I Dashboard n°33 I June 2021
DSR, Health Cluster, Lake Contingency Plan Emergency, 2017
Second General Population and Housing Census in Chad 2009
USAID, REACH, Multi-sectoral assessment in the Lake Chad region - November 2017

Chad has no mental health legislation, let alone a national strategy. According to the National Health Development Plan 2016-2021, of the six health districts in Lake Province, four do not have district hospitals. Of the 105 functional responsibility zones in the province, 93 have a health centre, a percentage of 87%. The province does not yet have a regional hospital[20]. Similarly, front-line infrastructure such as health centres are poorly represented. Mental health problems are only timidly taken into account in the 2016-2030 National Health Policy, one of whose sections - on the "development of prevention and promotion actions to improve environmental health" - insists on the implementation of integrated intersectoral programmes to act on the social and economic determinants, among others, of mental health. On the basis of this strategic document, the Multisectoral Plan to Reduce and Control Non-Communicable Diseases 2017-2021 was developed. However, the state is having difficulty implementing the strategies in a context where there is a structural shortage of health facilities.

20. Ministry of Public Health, National Health Development Plan 2017-2021 (PNDS3)*, 2016.*

Nigeria

Municipalities targeted by the study	*Population*	*No. of displaced*	*Number of health centres*
Jere	***247,860***	150,601	General Hospital and University of Maiduguri Teaching Hospital (7 health facilities) + WHO mobile teams
Maiduguri	***810,764***	+ 150,601	General Hospital and University of Maiduguri Teaching Hospital (21 health facilities) + WHO mobile teams

Sources: LMD, Lake Chad Basin I Displacement Monitoring Matrix I Dashboard n°33 I June 2021
DMT I Nigeria North East Zone I Displacement Report Round 38 I October 2021
UNCHR, Nigeria, All Population snapshot, November 2021.
City population, LGaS, Nigeria population: Administrative Division, 2011
WHO, One third of health facilities in north-eastern Nigeria destroyed, 2016
NHIS Providers, Integrated Health Care.

In Nigeria, mental health care is governed by the 1958 Insanity Act, a legacy of colonial rule that effectively legitimises violations of the rights of people with mental illnesses. For example, the law allows magistrates to arrest mentally ill people and determine how they should be detained[21]. This law is due to be revised since 2003. A 2017 WHO-commissioned study estimated that one in five people would face a mental health problem in their lifetime requiring long-term treatment. Only 20% of Nigerians with serious mental illnesses have received treatment in the last 12 months. Mental health care is faced with many challenges. These include low political commitment, insufficient budget allocation (only 3.3% of the federal health budget is spent on mental health) and the difficulty of including mental health in primary health care.

According to a Nigerian psychiatrist, the country does not have up-to-date data on the number of people requiring treatment, but with fewer than 300 psychiatrists in a country of about 200 million people, families are turning to traditional healing centres and faith-based institutions, both Christian and Muslim.

3.3. RECOGNITION OF TRADITIONAL MEDICINE IN HEALTH POLICIES

The WHO defines traditional medicine as "the total combination of knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating physical, mental or social diseases and which may rely exclusively on past experience and observation handed down from generation to generation, verbally or in writing" (WHO, 2000). Already in 1978 with the Alma-Ata Declaration, and again in 2008 with the Ouagadougou Declaration, the WHO and the United Nations emphasised the importance of traditional medicine and traditional practitioners in primary health care[22].

However, while the WHO supports the provision of mental health care in a "culturally appropriate"[23]

21. Ifeanyi M. Nsofor Director, Policy and Advocacy at Nigeria Health Watch, www.weforum.org

22. WHO, Promoting the role of traditional medicine in health systems: strategy for the African region, *AFR/RC50/9, 2000*

23. World Health Organization, Mental Health Action Plan 2013-2020, *Genève, WHO, 2013.*

and the dissemination of traditional medicine, its actual recognition in health policies remains theoretical and embryonic. According to WHO data, 80% of rural populations in Africa rely on traditional medicine[24]. Recently, as part of the fight against COVID-19, the WHO established a regional expert committee for Africa on traditional medicine. This committee has, among other things, the task of approving protocols for clinical trials, as well as drafting a charter and terms of reference for the establishment of a data and safety monitoring board for herbal medicine clinical trials.

In the four countries targeted by the study, ministerial departments responsible for the promotion of traditional medicine do exist. However, these institutions lack funding, particularly from the international community, which, while recognising the value of the pharmacopoeia, is struggling to give it the means to gain legitimacy.

In Cameroon, the framework law that enshrines the national health policy attempts to promote "collaboration between the public, private and traditional sectors to ensure the production of quality care and medicines". The government's interest was reflected in the creation of a department in charge of traditional medicine. With the recent innovations in the search for an anti-COVID 19 treatment, the authorities seemed to give a little more importance to the treatments offered by traditional medicine[25]. However, in practice, traditional medicine is still slow to be recognised and integrated into public policy agendas.

In Niger, since 2001, traditional medicine has been officially recognised by the Ministry of Health under the supervision of the *Direction des pharmacies et de la médecine traditionnelle (DPh/MT).* Traditional practitioners are organised into an association: the Association of Traditional Practitioners of Niger (ATPN). The National Integrated Strategic Plan for the Prevention and Control of Chronic Non-Communicable Diseases (PNLMNT) provides, among other things, for the integration of the "positive aspects" of traditional medicine into the health care system, without however defining these "positive aspects" or explaining any "negative aspects".

In Chad too, the inclusion of traditional medicine is limited to good intentions. The national public health policy 2017-2030 (under its specific objective 19) envisages the promotion of traditional pharmacopoeia and medicine essentially through supervision, regulation, research and funding[26]. Other initiatives have been taken by the Ministry of Health, including the adoption in 2018 of a national policy on traditional medicine, the drafting of regulatory texts on traditional medicine (pending adoption), adherence to WHO resolution AFR/RC 50/9[27] and the creation of a directorate for traditional pharmacopoeia and medicine.

In Nigeria, the recognition of traditional medicine is also limited in health policies. A national policy for traditional medicine has been in place since 2007, but the second National Strategic Health Plan 2018 - 2022 notes that investment in research and development for traditional medicine is extremely low and that coordination between conventional medicine and the "alternative medical system" is non-existent.[28] A congress was held in Lagos in December 2019 with the aim of discussing the role of traditional medicine in regional medical provision.

24. Bannerman, Buton, Wen-chieh, 1983, Traditional medicine and health care coverage, OMS.

25. Several traditional therapists had proposed alternative treatments for COVID-19 and were supported by the government. Since July 2021, the National Commission on Medicines of the Ministry of Public Health has approved four improved traditional medicines for a period of three years: Adsak-Covid/Exillir-Covid by Monseigneur Samuel Kleda; Corocur powder by Dr Yabgnigni; Soudicov Plus by Imam Modibo and Palubek's by Mrs Christine Bekono.

26. Ministry of Public Health, National Public Health Policy 2017-2030.

27. WHO resolution AFR/RC 50/9 calls for the integration of traditional medicine into health systems.

28. Federal government of Nigeria, Second national strategic health development plan 2018-2022.

4

COMMUNITY ACTION AND ENDOGENOUS MECHANISMS FOR DEALING WITH MENTAL DISORDERS AND TRAUMA

4.1. THE IMPORTANCE OF TAKING LOCAL PRACTICES INTO ACCOUNT: UNDERSTANDING RATHER THAN MEASURING

After decades of international scientific advocacy, the epidemiological measurement of psychiatric morbidity has led to the inclusion of mental health in the Sustainable Development Goals (SDGs) and global health. The SDGs call on countries, by 2030, to reduce premature mortality from non-communicable diseases by one-third through prevention and treatment as well as to "promote mental health and well-being" (target 3.4, indicator 3.4.2). The SDGs also call on nations to " strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol" (target 3.5, indicators 3.5.1, 3.5.2). And finally, they call for universal health coverage (target 3.8, indicators 3.8.1, 3.8.2), which includes mental health.

However, while the inclusion of mental health in the SDGs is a step forward, this brings a number of challenges. On the one hand, mental illnesses are very poorly covered by mortality data because they are long-term chronic diseases. On the other hand, data on morbidity are difficult to obtain other than through surveys conducted using standardised diagnostic instruments, which is an almost impossible undertaking in the Sahelian countries.

At the international level, however, the calculation of the prevalence and incidence of a pathology is subject to increasingly complex statistical processing as tools are perfected and surveys are generalised and standardised. However, the generalisation and standardisation of tools runs the risk of producing knowledge that is itself general and standardised, and of leaving out the markers of diversity and singularity specific to the practices and representations surrounding the disease in question. Knowing how many people are affected by a symptom (e.g. PTSD) does not make it possible to understand why they are affected, nor does it make it possible to understand the individual coping mechanisms and the collective dynamics of inclusion or exclusion of these people: issues that are inherently impossible to measure and therefore not susceptible to classification and categorisation.

It may be easier to look for a "local" equivalent of a standard than to question the standard, but using scales to measure and/or diagnose psychological suffering is problematic as it is based on a relatively individualised conception of psychological distress, and overlooks the social dimension of mental illness. Also, when international reports on mental health point out the gap between the national realities of sub-Saharan Africa and the objectives of the international agenda, it is important to analyse these realities in depth, but also to question the standards. In the field of mental health, the standards are based on indicators which are not necessarily relevant in the countries of the Sahel. Knowing that there are 50 beds per 100 000 patients requiring psychiatric hospitalisation does not provide any information about the treatment that is provided or how mental disorders are managed in these countries. Worse still, it implies that there is no treatment or management and therefore no "psychosocial support" in the targeted communities.

By highlighting *the "gap"* between the supply of care and the needs of the population in terms

of mental health, priority is *de facto* given to the accessibility of medication and health structures, i.e. to the biomedical response. However, the predominance of the biomedical model - which relies in particular on neurobiological aspects and processes to explain mental disorders - is increasingly challenged[29].

In Chad, Cameroon and in Niger as well as Nigeria, the designation of emotional disturbances does not always correspond to current biomedical categories and classifications and is expressed rather through symbolic and spiritual forms (spells, possession). Yet it would be unthinkable to attempt to quantify these types of conditions. To say that 5% of people affected by war develop post-traumatic stress disorder seems a credible and reliable indication. However, claiming that 30% of the pathological signs are due to possession and 20% to spells seems totally unreasonable. Yet this is probably how a traditional practitioner would describe the current situation if asked to express himself in terms of proportions. Everything depends on the 'rationality' or 'irrationality' commonly attributed to psychological pathologies.

Attempting to establish links between the two forms of nosology seems inefficient as it would always come down to placing sufferers in categories of illness. There are neither "Western pathologies" nor "African pathologies", only different ways of naming, understanding and treating them. It is therefore important for carers and humanitarian actors to avoid pathologising mental illness using universal classifications. Instead they should try to understand the systems of meaning (signifier) and naming (signified) associated with mental health, without a priori or value judgements.

There is another bias to be avoided: when the focus is on a *"gap"*, the analysis is carried out through the prism of a "lack" and "deficiencies", and by extension "what should change". It is true that the aid sector is driven by the demand for improvement and change (of institutions, actors, services, procedures, etc.) and it is even its central purpose, but by placing too much emphasis on "what should be", there is a risk of forgetting to analyse "what actually is".

In fact, it is not possible to improve the way people in psychological distress are cared for without analysing endogenous strategies for providing treatment, care pathways and community-based self-help approaches. This chapter will therefore focus on the analysis of these two themes: care pathways and community care.

4.2. CARE PATHWAYS

For an affected person, as well as for their family and friends, the experience of mental distress consists of living with the mental disorder on a daily basis, sometimes for a long time. The time spent by patients in psychological or psychiatric institutions is only a small part of their care trajectory. Most of their time is spent daily within families and more broadly within social groups that are either community-based (villages, refugee camps, etc.) or faith-based. Moreover, serious mental disorders generally evolve towards long-term social challenges due in part to the stigmatisation and exclusion of mentally ill people.

Overall, the care pathway includes three stages: recognising the distress, searching for the cause and providing treatment. Different types of care are involved in therapeutic trajectories: domestic care, "traditional" care and medical care. We will see that far from being linear, different stages and types of care can be intertwined and approached in a complementary manner; the objective of curing the patient justifying all the healthcare measures taken.

29. Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, OHCHR, 2017.

> *Firstly, there is the fact that many people are unaware of the existence of mental illness in our environment. So they start by using the usual treatments made from bark, leaves and powder from dried and crushed plants. Then, when this does not help, patients are taken to traditional healers: marabouts, Gonis or animist traditional practitioners who use exorcism rituals. Usually, here, it is the traditional healers who treat mental distress. We are pioneers in terms of modern mental health care in this locality.*
>
> **Psychosocial worker, Koza, Cameroon**

4.3. RECOGNITION OF DISTRESS AND DOMESTIC CARE

The first step in a care trajectory is the recognition by family members of the person's distress. The interviews reveal that neither the sufferers nor their relatives initially suspect a psychological cause for the physical symptoms. As the symptoms appear to be benign, or at least relatively common (headaches, fatigue, muscular pain, difficulties in carrying out daily activities, etc.), common illnesses or mystical causes are initially suspected. When the symptoms persist, the psychological distress manifests itself in the form of isolation, loss of appetite, uncontrolled anxiety attacks, night-time fears, etc. The pathological signs worsen and the patient becomes dependent on his or her family.

The following testimony illustrates the beginning of the care trajectory in the home and the essential role of the carer in recognising the person's distress and seeking treatment:

> *At first, as he was no longer talking to us and eating as usual, I tried to talk to him. He still didn't answer me. Then he started to spend time on his own and that worried me a lot. I spoke to his uncle about it, but he trivialised my son's illness. I prepared a decoction made with the boiled roots of certain plants as I thought he was suffering from witchcraft. Nothing changed. His paternal aunts and some neighbours brought all sorts of medicines (powder, incense, perfumes, extracts from Koranic verses...). When he started making strange and sometimes violent gestures, speaking in monologues and screaming at night, I took him to a traditional healer after a month of care at home.*
>
> **Mother of a patient, Kourgui, near Mora, Cameroon**

The care provided by the carer, who is female in the vast majority of cases (mother, aunt, sister...), is multi-faceted. First of all, this consists of helping with hygiene, regular meals, the preparation of herbal concoctions, prayers, etc. But domestic care goes far beyond the strictly therapeutic framework to encompass a broader social dimension of care.

If the person who is ill does not engage in socially stigmatising behaviour - which concerns 'public' manifestations of the disease – neighbours will generally be tolerant towards the person and their family. Close neighbours will show solidarity through courtesy visits, prayer sessions, and gifts of food, sacrificial animals or incense.

> *First of all, there are the village members, depending on the religion. Muslims visit each other and make prayers to ask God to relieve the suffering of the sick. Sometimes they come with financial support or advice about medicines or a suitable healer. Elsewhere, particularly in the IDP camps, solidarity is not based on people's home village. There is a form of solidarity that goes beyond ethnic, religious or geographical divides. Everyone in the IDP communities shows solidarity by offering sacrificial animals, food, or prayers, and by paying regular courtesy visits.*
>
> **Psychosocial worker, Baga Sola, Chad**

On the other hand, when the visible expression of pathologies becomes difficult to conceal (night-time screaming, vagrancy, paranoid delusions, violence, etc.), the sick person and their family can be socially sanctioned.
In Bol, Chad, the mother of a patient spoke of the actions she takes every day to hide the behaviour caused by her son's pathology, which she considers "humiliating". This involves, for example, "adopting an attitude of resignation that calls for compassion from visitors" or preparing the reception area for visitors so that they are as far away from the sick person as possible[30].

> *We see the problems that happen when a family member is mentally ill: tensions between the family members, the abandonment of children and women, disputes over property, increased precariousness, divorce, and stigmatisation of the family by the community.*
>
> **Former Mayor of Bol, Chad**

Indeed, over time, as the illness takes hold, people with mental health problems are increasingly marginalised within their families and society. They are sometimes subjected to various forms of violence (restraint, detention, denial of their rights, etc.), especially if the symptoms are seen as being socially transgressive.

The interviews underlined the "division of labour" within households caused by the presence of a psychologically distressed person. Women take care of hygiene, food and administering medication. Men make decisions about the choice of treatments.
For the family, as for the individual, the illness is not a temporary stage or a brief, painful moment to be spent waiting for a cure. When signs of psychological distress set in, family members know that they will have to devote their time and resources to caring for the person.

> *The other displaced people here get by working in the surrounding fields and they get paid. Many young displaced people have a small motorbike-based or commercial activity in the town of Bol. But me and my husband can't do anything. I spend the day looking after him while his father looks for medicine from the healers. As we lost everything when we fled, it is more difficult to live with a mentally ill person here.*
>
> **Karé Oumoul, mother of a mentally ill son, Bol, 25 February 2021**

30. Interview with the mother of a patient, Bol, 25 February 2021.

However, in a context marked by a security crisis and population displacement, the family structure is changing. The figure of the head of the family - traditionally the holder of decision-making power - is evolving. When the father dies, disappears or is mentally ill himself, when family resources depend more on social than financial capital, and therefore on mutual aid, the place of women and carers becomes crucial.

> *Each family has its own way of dealing with an ill person. But traditionally, the mentally ill are always looked after within their families. With a mentally ill person to take care of, it is really difficult for these families to cope. The children no longer go to school. When they are ill, they don't have the means to pay for hospital treatment. Here in the chief's courtyard, I have already had to assemble the customary court to judge divorce applications because one of the spouses is permanently affected by mental disorders. Families break up and they can be stigmatised within the community because of mental illness.*
>
> **Interview with the chief of Bol canton, Chad**

4.4. TRADITIONAL MENTAL HEALTH THERAPIES

4.4.1. POPULAR PERCEPTION OF ILLNESS AND HEALING

In biomedical sciences, since Hippocrates, there are only diseases of the individual: one cannot conceive of disease in any other way than through the image of an individual condition[31]. Quand un médecin diagnostique une maladie chez un individu, il la nomme et l'attribue à une cause, mais jamais à la volonté d'un être invisible situé en dehors de son patient. C'est pourtant ce type d'investigation dont il est question dans les thérapies traditionnelles, qu'elles soient empreintes de croyances coutumières, religieuses ou ésotériques, ou les trois à la fois.

When a doctor diagnoses an illness in an individual, he names it and attributes it to a cause, but never to the will of an invisible being outside the patient. However, this is the kind of investigation that is involved in traditional therapies, whether they are imbued with customary, religious or esoteric beliefs, or all three.

In traditional therapies, social and cultural dimensions take precedence over the biological. Indeed, while modern medicine has become secularised by focusing on the biological, traditional medicine has kept a sacred and spiritual character as illness is perceived to be the consequence of external forces. And it is precisely these forces that traditional therapies combat by highlighting not the biological character but rather the mythical and religious aspects of the illness. (Collignon, 1983)

Healers focus on the root cause of the problem and ask which human or supernatural entity is causing the pathology. The diagnosis or treatment follows from the identification of the cause. A paranoid psychosis, as it is called by biomedicine, can be an evil possession, a demonic spell or the consequence of a transgression of social or religious norms. The name of the pathology may vary, as may the

31. Zempleni A, Livre 5. Les rites de possession chez les Wolofs et les Lebou du Sénégal, Anthropologies et sociétés, www.youtube.com/watch?v=AUXfW1QvyzY

manifestations of the disorder. What remains constant, whatever the term, the meaning or the cause identified, is the distress and the need to be helped.

4.4.2. PRIORITY USE OF TRADITIONAL CARE

> *In the communities here, it is the traditional healers who are most in demand. Almost all our patients consult and get treatment from traditional healers. This is due to the cultural proximity between our perception of mental illness and the treatment methods which are compatible with our customs and values.*
>
> **The chief of Bol canton, Chad**

In the four countries targeted by the study, the situation is generally the same: patients and their families almost always turn to traditional practitioners as a first resort to treat cases of mental illness. Why? Although the analysis of mental health policies regularly highlights the very low availability of specialised structures as an explanatory factor, we shall see that it is not the only determinant, quite the contrary. The idea that people turn to traditional therapists for lack of 'more appropriate' care is generally false.

In fact, the various testimonies tend to show the opposite: because of the stigma attached to using psychiatric institutions, they are generally feared, in particular because they make 'madness' visible and institutionalized. The explanation lies more in the representations that Sahelian populations have of illnesses in general and mental illness in particular. These are socially acceptable explanations, since they link mental illness to causes involving ancestral spirits, maraboutage, witchcraft and Islamic genies.

4.4.3. ... AND TRADITIONAL THERAPISTS

The term 'traditional therapist' is polysemous. We use it, for practical reasons, to highlight the distinction with biomedical practitioners, but it covers a variety of profiles for which it is often difficult to give a strict definition. In the Sahel, most of them are 'marabouts', 'healers' and 'fetishists', but there are also diviners, hunter-herbalists and fortune-tellers. They all aim to treat psychological disorders using their own rituals.

With regard to marabouts, establishing a strict definition is complex. According to Didier Fassin, " no term designating a category of men of knowledge is surrounded by the same degree of confusion as the word marabout".

A distinction can be made between 'true marabouts', learned, wise and pious men, whose lives are devoted to prayer and teaching; marabouts who have some knowledge of Arabic and who teach and heal in return for money; and finally, the very numerous marabouts who have no particular religious knowledge, but who trade in healing, amulets, advice and predictions (Fassin, 1992) 'Healers', on the other hand, have practices that relate to both traditional knowledge (even animistic knowledge) and Islamic knowledge. The diagnostic and therapeutic methods that are used may vary depending on the healers and on the patients.

4.5. THERAPISTS WITH A VARIETY OF PROFILES

4.5.1. MARABOUTS

Marabouts interpret the actions of the person who is sick as the instrumentalisation of the subject's body by a spirit that has taken possession of it. The therapeutic protocol is organised in the following way:

➔ **le diagnostic** is based on a series of tests that the healer performs either by reading certain Koranic verses or by subjecting the person to incense smoke. Their reaction helps to some extent to determine the cause of the disease. If the subject becomes violently agitated and speaks vehemently to an invisible interlocutor, the hypothesis of demonic possession is more plausible. If the subject remains unresponsive and inert, then the healer moves on to the observation phase to support the hypothesis of a conflict-related trauma. Observation consists of scrutinising the patient's behaviour at night and during the day in order to identify attitudes that are considered 'deviant', such as night-time shouting, excessive anxiety, incessant monologues, references to certain people who have been victims of violence, lack of appetite, insomnia, etc. When this behaviour is dominant, it is interpreted as a sign of trauma caused by the security crisis. In this case, some healers - the most conscientious and perhaps also the least greedy ones - refer their patients to psychiatric medicine when it is available.

Patients suspected of being possessed by evil spirits are treated according to a protocol agreed with the family. This collaboration allows the family to retain some flexibility regarding the place of treatment, the rhythm of taking traditional medicines or the more active involvement of a family member in the treatment process, for example through the reading of Koranic verses.

> *The treatment starts with a diagnosis to distinguish between a mental illness related to possession or a disorder related to the Boko Haram crisis. To make the diagnosis, I read some verses from the Holy Koran at the bedside. The patient sometimes immediately starts moving and talking, and becomes agitated or violent. They often go into a trance-like state. They may also drool. These signs are related to possession by an evil spirit. The patient may also remain inactive for a week with no visible symptoms. If so, it is likely to be a disorder linked to the exactions of Boko Haram. If this is the case, I then interview the patient's family members to build up a profile by identifying events from his past that affect his mind. In general, based on this type of diagnosis, 9 out of 10 patients are possessed by evil spirits. Most of the treatment process I use is based on the Holy Koran. These are verses that the prophet Mohammed used in his time. I use the same verses to diagnose and to treat. But I also use decoctions, powders from certain plant essences also used at the time of the prophet. But these plant essences are rare here. I order them from my colleagues in Nigeria who are able to get them from Saudi Arabia, Sudan, Yemen, etc. So, the treatment of the mentally ill in my country is based on a combination of Koranic verses and the use of plant essences in liquid form, incense, perfume.*
>
> **Malla Boukar Maina, Marabout, traditional healer**[32]

32. Interview with Malla Boukar Maina, Marabout, traditional healer, displaced from Kérawa (border village with Nigeria) and settled in Mora since 2014, Mora, 12 December 2020.

➔ **The therapeutic phase** may last several months or years depending on 'the capacity of the evil spirit possessing the patient's body to cause harm'[33]. The persistence of the distress is generally attributed to poor communication with the evil spirit whose desires have not been satisfied. From then on, sacrifices are multiplied in the hope that they will be able to satisfy the spirit and thus free the possessed body of the person who is ill.

For patients who are diagnosed with trauma, healers have two options. Either they refer the patient to other traditional healers whom they deem suitable to treat pathologies of this kind. This is a routine option, with a series of healers being referred to, to avoid being in a position of failure[34]. Or they refer patients to health facilities.

In Cameroon, the semantic nomenclature used to name traditional therapists varies. However, whether they are marabouts, healers, traditional practitioners, Goni, or Modibo, their practices remain more or less the same and are based on a mixture of religious knowledge, fetishism and phytotherapy. Regardless of the country under study, the figure of the marabout is subject to some suspicion. On the one hand, they are the first recourse for people in pain and, most of the time, they are recognised for their therapeutic skills. On the other hand, since they offer paid care, competition is fierce and accusations of "charlatanism" are as frequent as the "charlatans" themselves. It is therefore difficult to find one's way around, and this is why the advice of traditional chiefs and members of the community to which they belong is essential.

When asked about the existence of marabouts specialising in the treatment of mental illness, an imam from Jere said, " *People say that there are traditional therapists who claim to be specialists in mental distress and illness, but we honestly don't know them, let alone what they do". Another imam from the same locality stated that, "Any spiritual man in Jere who claims to be a doctor of everything, heals everything, is a fraud* ". Thus, it is neither specialisation nor the universal character of the practitioners' competence that is valued, but rather the individual reputation of the practitioners. In Chad, the reputation of certain traditional healers extends beyond national borders. Thus, the chief of the canton of Bol attested to the existence of traditional healers of regional renown consulted by the populations of the four countries bordering the lake. For example, in Mémé, in Cameroon, the healer, Mal Amadou, has a national and cross-border reputation[35].

In Chad and Cameroon, the title of Goni is conferred by the Kanuri to those with the highest level of learning of Islamic religious knowledge. Synonymous with the Arabic word *'Hafiz'*, it is attributed to those who have memorised the Koran and recite it fluently. The Goni are highly regarded among the Kanuri. They symbolise the place accorded to Islamic knowledge in the hierarchy of values[36] and are generally consulted for the treatment of certain illnesses, particularly mental illness. As with marabouts and healers, Goni therapeutic practices combine the use of Koranic verses[37] and decoctions of medicinal plants[38].

33. Interview with Abdoulaye Mahamat, Marabout-healer, Baga Sola, 27 February 2021.

34. In Nigeria, where traditional healing follows much the same trajectory, some informants who were victims of NSAG attacks referred to a therapeutic practice specifically designed to heal the trauma. This involves taking a hot bath in which the healer dissolves powdered bark every morning for three weeks

35. The healer Mal Amadou is extremely well known. Patients come from Yaoundé, Douala, conflict zones and also from neighbouring countries such as Nigeria or Chad. The healer's residence consists of a large courtyard divided into reception, observation and internment sections. The flexibility of the rules is one of the reasons for the attractiveness of this traditional healer who uses all sorts of fetishes and medicinal plants as well as Koranic verses. There are no fixed prices, nor is there an a priori fixed time for the internment. Chain-link cages are reserved for the most violent patients.

36. Saibou Issa, Mbarkoutou Mahamat, Bana Barka & Abdoul-Aziz Yaouba (éds.), 2019, Boko Haram, les mots d'une crise, *Paris, L'Harmattan.*

37. Les versets coraniques les plus utilisés dans le traitement des maladies mentales sont " ngourchi souraoute Bagara ", verset 4 ou " Innassanaou souraoute Nasi "

38. According to Malloum Oumar Goni Mbodou from the village of Sya in the canton of Ngarangou in Chad, the plant species used are the following, designated in the Kanembou language:
- *Kidibaclagana: is a creeping root plant with simple, thin leaves and blue flowers;*
- *Mourr: is a small shrub of one metre in height, with medium-sized leaves and deep roots;*
- *Blangah: This is also a shrub of about one metre in height that grows on the mainland and on the islands of the lake.*

4.5.2 ANIMIST DIVINERS

Among the animist populations of Chad, Cameroon and Niger, therapeutic practices are based on ancestral customary beliefs. The diagnosis is established through observation of the patient and knowledge of his or her past, which enables the diviner to define the nature of the problem. The treatment involves specific rites, the dominant forms of which consist of the immolation of animals, the fumigation of the patient, invocations of ancestral spirits or exorcism sessions[39] on sites dedicated to initiation rites.

In Cameroon, animist communities live on the slopes of the Mandara Mountains in Koza and Oudjilat. Treatments in these communities can involve animal sacrifices, the pouring of wine over the patient[40] or dance and trance rites. Some populations from the Mafa, Podoko and Mada ethnic groups still use animist rituals to treat people in psychological distress. In Oudjila, in the Mandara Mountains, various places are used for deliverance rituals.

In Niger, in some animist communities, there is still a strong belief in spirits, as they were represented in pre-Islamic societies. These genies of the water, the forest, the mountain, etc., can be beneficial or evil, depending on the alliance that was originally established between them and humans. Every living organism, whether located inside or outside the village, can be the home of a spirit. Many prohibitions surround these places. Breaking these prohibitions can lead to the wrath of the spirits who then take revenge by entering the offender's body in the form of a physical or mental illness.
Here too, dispossession rites are practised. According to the people we interviewed, the healer drinks a concoction of hallucinogenic roots and performs dispossession dances (calabash and violin are played so that the spirits manifest themselves). Once in a trance, the healer invokes the good spirits to help drive out the evil spirit.

A psychosocial worker told us the following story: *"The parents of a patient refused treatment because they said he was possessed by the guardian spirits at the entrance to their family home. According to the patriarch of the family, the patient must have surprised the spirits in their resting place or inadvertently destroyed some object belonging to them or caused an injury among them. As the guardian spirits cannot break the pact between them and humans, they take revenge by disturbing the spirit of one of the family members".*

4.6. THE SYMBOLIC EFFECTIVENESS OF TRADITIONAL TREATMENTS

Some analyses establish a link between magico-religious treatments and what Western medicine somewhat pejoratively calls (wrongly in our opinion) the 'placebo effect'. We prefer to speak here of the 'symbolic effect' of the treatment. Establishing such a link is a way of trying to explain what is 'inexplicable' in terms of biomedical systems of meaning and frames of reference, but it is nevertheless interesting to explore this analogy further. The word "placebo" is Latin for "I will please" and appears in Psalm 114: *"For he hath delivered my soul from death: my eyes from tears, my feet from falling […], I will please the Lord in the land of the living"*. The term here evokes a

39. Spectacular sessions for treating patients said to be 'possessed' by evil spirits. It should be noted that exorcism sessions are not the exclusive preserve of animist practitioners. All monotheistic religions have practised and still practise exorcism. Through words (Koranic or biblical verses), fumigation or libation (a ritual consisting of presenting a drink as an offering to a god or to ancestral spirits), the exorcist (marabout, priest, pastor or diviner) frees the patients from the diabolic spirits that inhabit them.

40. Treatment with traditional wine which is drunk and spat out by the traditional practitioner and then smeared on the body of the patient.

healing, for which the author of the psalm gives thanks to God. This is the medieval conception, expressed in Ambroise Paré's famous formula: *"I bandaged him, God healed him"* (Claudie Bert, 2004). From the religious domain, the word placebo then moved to the secular domain, "to placebo" meaning ' "to flatter". And it was only at the end of the 18th century that the word entered the medical field - in the United States. Hooper's Medical Dictionary of 1811 defined the term as "any medicine adapted more to please than benefit the patient". But is "pleasing" the patient and/or the family, or relieving, accompanying and giving them hope, not already a way of promoting healing?

The analysis of representations of therapeutic effectiveness shows that the attention paid to the person who is unwell is an integral part of the treatment: it is even a determining factor in its success. According to Alice Mercan, "evidence-based medicine" shows that the principal "medicine" is above all the therapist. Thus, what heals is not only the medicine, but the whole therapeutic context[41], i.e. the patient, the carers, the companions, the place, the religion, the rituals, etc. In this way, the symbolic power of treatment goes beyond the doctor/patient/medicine triptych. It encompasses other determinants, other causes, including mystical and occult causes.

At a time when the entire international community is strongly promoting the concept of "global health", which calls into question the distinction between physical health, psychological health and environmental health, it seems surprising that magico-religious explanations of disease are relegated to the status of irrational beliefs. After all, it is not the search for a universal truth that is at stake, but rather the knowledge of what each society considers to be real and effective. Indeed, the healing power of the symbolic - whether this is divine or mystical in essence - has long proven its effectiveness in a wide variety of social contexts.

4.7. MENTAL HEALTH, PROPHETIC MEDICINE AND MONOTHEISTIC RELIGIONS

4.7.1. MADNESS: ORIGINS AND THEORIES

As early as antiquity, Hippocrates (5th century BC) did away with supernatural explanations and gave a medical framework to psychological disorders (Ali Amad, P. Thomas, 2011). In the 2nd century AD, Galien gave a new status to mental illnesses by describing them as "somatic". They were said to result from an imbalance of the humours, hence the aphorism "the soul follows the body". Galien also refined the theory of humours,[42] which was taken up by Arab medicine, which in turn developed and adapted it. The religious influence also allowed Arab-Muslim physicians to develop a psychosomatic approach to mental illness. They were guided by religious principles used and recommended by the prophet, such as *"instilling hope in the patient"*, or *"spiritual consolation improves healing"*. For these doctors, the intertwining of physical and psychological phenomena became a basic principle.

41. Mercan Aline, Le placebo dans tous ses états, Bulletin Amades Anthropologie Médicale Appliquée au Développement et à la Santé, 2007.

42. According to the Hippocratic corpus, the theory of humours is one of the bases of ancient medecine. According to this theory, the body is made up of four elements: air, fire, water and earth - with four qualities: hot or cold, dry or wet. These elements, which are mutually antagonistic (water and earth extinguish fire, fire evaporates water), must co-exist in balance for a person to be healthy. Any minor imbalance leads to "mood swings" and any major imbalance threatens the health of the subject.

Ishaq Ibn Omrane, author of the *Treatise on Melancholy,* which contemporary researchers say is astonishingly modern[43], explained, as early as the 9th century AD, that in melancholic patients, sad ideas are exaggerated and erroneous and have somatic repercussions: an alteration in the general state of health, insomnia, emaciation, sadness and a weakening of the organs. The triggers are then listed. They may be suffering of the soul, fear, shyness, loss of love or the disappearance of a loved one. The therapy advocated by *the treatise* consists essentially of reassuring the patient by means of techniques as varied as music, walking, hygienic-dietary rules, physiotherapy or even "chemotherapy". At no point does the treatise mention supernatural causes (possession, witchcraft), which were prevalent at that time in Europe, where mental disorders were often equated with demonic possession and sin, and often led to the Inquisition and burning at the stake (Amar S, 2011).

It is interesting to dwell on this historical observation. Indeed, Western perceptions often tend to attribute to Africa in general, and to 'Muslim culture' in particular, an unwavering attachment to so-called traditional practices. Indeed, we tend to attribute these practices to the survival of ancestral customs that have been preserved over the centuries, since time immemorial. This idea is based more on stereotypes and preconceptions than on detailed diachronic analyses.

In reality, medical practices - whether biomedicine or traditional medicine - are changing and constantly subject to external influences. The relationship between demonic forces and psychic disorders, which is very present in current representations of 'Islamic medicine', is not a historical fact. At the end of the 8th century the Caliph (the successor to the Prophet) asked for a hospital to be built in the capital of the Muslim world, Baghdad. Here again, the aim was to comply with the religious precepts of conserving and preserving the health of individuals, as summarised by the prophetic words: *"Take care of yourselves, for every disease has its own remedy, except old age".* This model then spread throughout the Empire (Ali Amad, P. Thomas, 2011). After the Mongol invasion of Baghdad in the 13th century, many socio-economic changes took place, leading to a loss of social cohesion, the destruction of many institutions and the reduction of financial support for those that remained. The organisation of care changed, and the mentally ill were transferred to centres that resembled detention centres, leading to significant isolation and less social support. The idea began to emerge of mental illness as a form of divine punishment, with patients responsible for their condition (Ali Amad, P. Thomas, 2011).

4.7.2. PROPHETIC MEDICINE

Traditional Muslim medicine has its origins in several sources, including the medicine of the Prophet (Tibb en-Nabi), which is based on verses of the Koran and prophetic traditions (*hadith*) relating to health, hygiene, remedies and acts of purification such as almsgiving, prayer and divine invocation. The *hadith* or prophetic traditions form a corpus of accounts relating to the life of the Prophet Muhammad and constitute, with the Koran, the basis of Islam (Sunna)[44]. Prophetic medicine is consistent with the Muslim understanding of the dual nature of human beings, who are both material and spiritual. According to the Koran, human beings are made of clay, but what gives them life is the divine breath[45]. Indeed, when the human body and/or mind is affected, healing can only be spiritual.

In Nigeria, for example, the healers, who are known as *malam*, primarily use incantations and rituals to cure the mentally ill patient. The most common ritual is as follows: the *malam* writes certain Koranic verses in *hijazi* (ancient Arabic calligraphy style) on

43. Ammar S., Médecins et médecine de l'Islam. *Paris : éditions Tougui ; 1984, In : Ali Amad, P. Thomas, 2011.*

44. Moisseron and Haddad, Actualité de la médecine traditionnelle musulmane, Islam et révolutions médicales, 2013, Karthala.

45. Koran, Sura 15, verses 28-29

a slate called an *Alluha*. After reciting some Koranic verses in Arabic[46], he pours water on the slate and rubs the writings with his left hand. The water thus collected is called *dawa*. The patient is then made to drink the liquid before each of the five daily prayers.

It would be inaccurate to attribute the power of healing to the slate or the scriptures, for it is not in the objects that this power resides. The objects do not have any healing power in themselves, and serve primarily as a vehicle for the divine breath. The water poured over the slate is an example of this idea. It is not the water itself that is supposed to heal, but it is the medium of the breath transmitted by the blessings attached to the recitation of the Koran (Moisseron and Haddad, 2013). Any 'Koranised' object for healing, such as water, is supposed to carry the blessing of the Koran conveyed through the practitioner's mouth. Sunni Islam recognises the protective and therapeutic role of the recited Koran and the Prophet's medicine in opposing unseen evil entities.

Practitioners of prophetic medicine state that emotional states such as anger, grief, fear and psychological shocks are gateways for evil *jinn*[47]. *Roqya* is a practice intended to chase away the jinn and is part of an exorcistic therapeutic approach (Laplantine, 1986[48]. This practice is growing in Europe and Africa, particularly in Niger. According to some informants, the arrival of the *râqi - Roqya* specialists - in a locality is always highly publicised. They like to present their ritual as the last possible resort after other traditional or prophetic practices have failed.

What seems essential to understand in the relationship between mental health and religion is the perception of the cause of the suffering: however they manifest themselves, the disorders stem from a transgression of social or religious norms. By "social norms" we mean, for example, the prohibition of incest, or the misappropriation of inheritance, etc. Religious norms, which are just as numerous as social norms, are mainly related to the respect of worship and the recognition of God as the creator of all things. Illnesses, including mental illness, are seen as the consequence of man's fault. However, the fault does not necessarily belong to the possessed or the sick person, because in a more altruistic dimension, they may be paying for the sins of their peers.

> *Dementia is explained by the fact that the patient was influenced in his youth by Satan and neglected religious practices. So when he becomes old, he develops dementia.*
>
> **Interview with an imam, Niger**

This causal explanation of mental illness is not unique to Islam. There is a direct link between 'the madman' and the possessed, which has been accepted since the time of the Gospels. In these biblical texts, 'abnormal behaviour' is considered to be the result of the demon's hold on the patient and is usually explained by a fault and/or a sin committed by the person who is ill. According to Raymond Massé, the sacred is far from having left the field free to the profane in terms of dealing with suffering

46. According to the marabouts we met in Nigeria, six Koranic verses are regularly invoked for healing
A. Ayat Ash-Shifa, Tawba, 9:14 - "Prophet Muhammad was once healing people by spiritual methods when he was asked whether or not to seek the remedies from medicine. He replied, "Yes, you must seek the remedy from medicine, for whatever disease God has created in this world, he has also created its remedy."
B. Younus, 10:57 - "O people, an exhortation has come to you from your Lord, a healing of what is in the breasts, a guidance and a mercy for the believers.
C. Nahl, 16:69 - "Out of their bellies comes a liquor of many colours, in which there is healing for people.
D. AL-Isra, 17:82 - "We send down from the Koran that which is a healing and a mercy to believers.
E. Ash-shu'ara, 26 :80 - "And when I am sick, He heals me".
F. Al-Fussilat, 41:44 - "Say: For those who believe, He is a guide and a healing". Each Koranic verse prescribed has a unique healing property that differs from that of other verses

47. Cherak, F.-Z., La roqya, une forme d'automédication chez les possédés et les ensorcelés (Algeria, Egypt, France)?", 2019, Anthropologie & Santé (http://journals.openedition.org/anthropologiesante/5101).

48. Ibid.

and illness. All religions are concerned with tackling illness among their followers, either to propose explanations in terms of divine origin or sanctions for failure to comply with the rules laid down, or to base therapies on the mobilisation of divine or other supernatural forces[49]. And all the monotheistic religions deal with the theme of madness.
Rites of dispossession and exorcism still exist in many Christian communities in the Sahel, where priests and pastors engage in prayers of invocation and deliverance to relieve mental suffering. In Koza, Cameroon, worshippers at the temple of the 7th Day Adventist Church regularly hold exorcism sessions. Here too, mental illnesses are perceived as a satanic hold that needs to be released from possessed subjects.

4.7.3 THERAPEUTIC PLURALISM AND SYNCRETISM

According to Byron Good, our certainty that medical science can claim to be true does not sit well with our desire to respect the knowledge of other societies, or other social groups[50]. Still today, and particularly in the aid sector, international actors do not 'know what to do' with popular representations and hidden causes associated with symptoms of psychological distress. Without fully acknowledging it, we understand the health sector in two almost exclusive categories: on the one hand, "apparently irrational" practices and behaviours understood as "beliefs"; on the other hand, "scientific" practices and behaviours based on "knowledge".

This way of thinking about health, and particularly mental health, has two biases. On the one hand, representing the culture of the other in the form of 'beliefs' gives authority to the observer's position and knowledge (Good, 1998). On the other hand, by contrasting the realm of belief with the realm of knowledge, there is a risk of missing a much richer social reality which is characterised by the intertwining of modes of belief and knowledge in the mental health care sector. Rather than this simplistic dichotomy between 'traditional medicine' and 'biomedicine', there is, in fact, a wide variety of different 'medical models'; in other words, therapeutic pluralism and medical syncretism.

Moreover, the very notion of "traditional medicine" - which implies a certain homogeneity of traditional practices on the one hand, and a direct opposition to biomedicine on the other - is relatively unhelpful. In fact, there are many different forms of traditional medicine, just as there are many different care pathways. The many different forms of popular medicine vary both in terms of their practices and their representations.

The search for effective treatment leads to strategies on the part of patients and their families that render a typology based solely on the dichotomy between "modern" and "traditional" therapies inoperative[51]. In fact, it is rather the unconditional search for solutions aimed at relieving the suffering person that is prioritised, whatever these solutions may be, whatever the causes invoked, the symptoms stated and the treatments proposed.

In this respect, the interviews reveal that while before the crisis the determinants of therapeutic choices followed a certain logic (cost, accessibility, quality of reception, knowledge of carers, availability of medication, reliability, etc.), now care choices are more 'by default'. It is true that domestic care always precedes other types of care and also constitutes the therapeutic "base" throughout the care process. It is true that traditional medicine is largely preferred to biomedicine as a first line of treatment. But in a context of social and family disruption linked to the crisis, all opportunities for healing are mobilised. In Cameroon, for example, Muslim traditional healers (marabouts, Goni and Modibé) have patients of Christian faith. At Lawan Wadou[52] (a traditional healer in Mendéo near the town of Mindif), patients of all religious persuasions also come to seek treatment.

49. Benoît et Massé, " Un ministère chrétien de la voyance à Douala ", in Médecines du monde. Anthropologie comparée de la maladie, Karthala, *2002 p. 353-373.*

50. Good Byron, Comment faire de l'anthropologie médicale, Col. Les empêcheurs de penser en rond, 1998.

51. Bourdier In : Jean Benoist, s. dir., Soigner au pluriel. Essais sur le pluralisme médical. Paris, Karthala, 1996.

52. Interview with Lawan Wadou, traditional healer, Mendéo (Mindif), 22 December 2020.

5

THE PLACE OF "CONVENTIONAL" MEDICINE IN THE TREATMENT OF PSYCHOLOGICAL DISTRESS

5.1. USE OF PSYCHIATRIC SERVICES 'BY DEFAULT'

As we have seen, the use of biomedicine is not considered a priority when the disorders are perceived to be spiritual or supernatural. The view that conventional medicine cannot treat or cure mental disorders is sometimes reinforced when health centres make diagnostic errors. Indeed, many health care providers feel helpless when a person with visible behavioural problems comes to consult them. Most thealth facilities do not have a psychiatric or psychological service, and health professionals sometimes try to treat patients for an illness whose symptoms may be similar to those of trauma (e.g. malaria, typhoid fever, acute migraines) without detecting the trauma. These 'failures' often reinforce patients' and traditional healers' belief that biomedicine cannot cure their condition.

> *I get a lot of patients who have come straight from hospitals where the treatment didn't work. Often, hospitals treat other illnesses whereas the patients are suffering from disorders. You know - hospitals don't treat witchcraft, or spells that are cast on someone.*
>
> **Mal Amadou Chehou, Marabout and traditional healer**[53]

The main reasons for using specialised services are emergency referrals, the failure of all other traditional attempts at recovery and the accessibility of care (community health programmes). Generally speaking, the decision to go to psychiatric services is only taken as a last resort because the stigma associated with madness is so strong and permanent. In contrast, going to a healer is a socially recognised and accepted practice. It does not imply that the person is mad, and it is part of normal care practices, unlike that of psychiatry. Moreover, during a traditional therapeutic approach, families remain in contact with the person who is ill and accompany the care trajectory.

> *Families are the first level of care for the mentally ill. Parents prefer traditional healers to hospitals because they see the treatment that is given.*
>
> **Interview with psychosocial worker, Bol, Chad**

However, even though psychiatric hospitals are seen in this way, when the patient's behaviour becomes dangerous for themselves or their entourage and the rest of the community, the family often resolves to refer them to a psychiatric hospital. They are often keen to receive drugs, but these are often lacking in health facilities. In fact, the therapeutic model best suited to the financial, geographical and social conditions of the families remains that of community care.

53. Interview with Mal Amadou Chehou, Marabout and traditional healer, Mémé, 11 December 2020.

A priori, the first reflex of families is to seek the services of a traditional healer. By word of mouth, a traditional healer is identified, to whom the patient is taken. If the illness persists, the patient is then taken to a hospital, in this case the one in Mora. At the hospital, we need the family to draw up a pathological profile of the patient to find out whether the illness is linked to the painful experience of attacks and bombings by armed groups. Then we move on to treatment, which can be psychological or chemotherapeutic. In general, the people of this area prefer to be treated within their community. This is why, thanks to our partners, we carry out visits in the communities. I have been working in Mora for more than a year and I have consulted four times more in the community than in the hospital.

Mental health nurse Mora, Cameroon

5.2. TRADITIONAL AND CONVENTIONAL MEDICINE: DIFFICULT COLLABORATION

As mentioned earlier, some traditional practitioners refer their patients to psychiatric facilities when they conclude that their treatment has failed or that the condition is not of a spiritual or mystical nature. This is the only situation when collaboration of some kind takes place.

We are a long way from a type of "therapeutic alliance", which would have the advantage of responding to the concerns of the relatives, without calling into question the meaning and interpretation that they give to the illness. Asked about collaboration with traditional practitioners, an ACF psychosocial worker replied:

No, we do not work with them. However, many mentally ill people are referred by traditional healers to Bol or Baga Sola hospitals or to our teams for psychological care. It is true that a more structured collaboration between these two types of medicine would be beneficial to the mentally ill. .

Travailleur psychosocial ACF Baga Sola

There are, nevertheless, several common points between the psychological approach and the traditional approach to treating mental disorders. It is probably by identifying these common points that collaboration between the two approaches could take place, collaboration that would help populations to adhere to mental health programmes.

After a trauma, the severity of which is felt differently by each individual, two opposing attitudes may emerge: exclusion or withdrawal, which increases the psychological impact of the incident, preventing it from being evacuated because the memory crystallises in the brain; or the possibility of talking about it, of sublimating it by acting it out. Putting one's thoughts into words

by reactivating elements of one's history is central to psychoanalytic practice. This practice also exists in traditional medicine, as most healing rituals, whether magical or religious, begin by allowing the patient and/or family to express themselves.

In Niger, a practice reported by a traditional practitioner consists, for example, of asking the patient to speak into an empty bottle and to spit into it as soon as a painful point comes up. The practitioner then seals the bottle to symbolise the disappearance of the revealed event from the subject's memory. This is then followed by incantations and other ritual processes whose symbolic function is to reduce suffering (or weaken the spirit, or the source of the spell). In Cameroon, another therapeutic practice consists of asking the patient to talk about their distress to a stone. The stone thus captures the words and frees the subject from his or her pain. These examples help to differentiate between what is symbolic in traditional medicine and what is therapeutic. One may not believe in the strength of the stone or in the capacity of the bottle to enclose the painful experience, but this does not change the effectiveness of allowing a person to express themselves.

It is precisely at this level that there are similarities between the psychosocial approach and the traditional approach. It is very likely that by analysing the whole range of traditional practices in depth, further analogies could be made between the two approaches. In all cases, the time spent with the ill person, the attention given to them and the willingness to stop their suffering can all have a decisive impact on the way pathologies develop.

6

THE STIGMATIZATION OF TRAUMA AND ITS SOCIAL CONSEQUENCES

6.1. THE DISTINCTION BETWEEN BEING "CRAZY" AND BEING "PSYCHOLOGICALLY ILL" IN COLLECTIVE PERCEPTIONS

It is interesting to analyse the distinction between curable and incurable conditions from the perspective of traditional medicine. Possession is caused by an external force transmitted by a genie or the spirit of a human or non-human being, living or dead. There is no difference between psychological and somatic illness, since it is the manifestation of evil, not the evil itself; healers can cure both by identifying and removing the 'culprit' from the sick mind or body.

But when we look at trauma, the analysis of the aetiology differs. It too is linked to an external cause (e.g. attacks by armed groups, loss of a loved one, etc.), but it is a constituent cause of the surrounding social disorder and not the effect of individualised persecution. In this case, there is no external spirit troubling the person, it is the personal experience of suffering, a raw suffering that is difficult to alleviate by traditional treatments.

> *In our country, we distinguish between two types of mental illness: those who are possessed by spirits and those who have psychological disorders linked to the exactions of Boko Haram. So when a patient arrives, the situation is confusing. There are no specific signs for each type of mental illness. In general, the main signs are silence, a haggard look, spontaneous reactions, sudden attempts to flee, bizarre screams. Some are so violent that they have to be tied to tree trunks. We need to diagnose whether it is a mental illness linked to evil spirits or to disorders caused by the Boko Haram crisis.*
>
> **Interview with traditional practitioner, Jere, Nigeria**

In the region of Diffa, where the majority of the population belongs to the Kanuri ethnic group, the notion of trauma is linked to the notion of injury. In the Kanouri language, the terms gersewe (sudden and violent occurrence of an event), kutu (lasting mental pain), blezu (disturbance of an individual) or leru (physical or mental injury) are the terms used to describe this notion of quasi-irreparable injury (since it is difficult to treat by traditional medicine). Thus, to explain that someone is traumatised, one can say: "kutu blezo" or "kutu leruzo". Trauma thus has its equivalent, the meaning of which is linked to the intervention of a violent and unexpected event causing a permanent impact on the individual.

By looking at local definitions and ways of naming madness, the aim is to go beyond a strictly medical and institutional reading which would seek, beyond the patient's discourse, a universal semiology and nosography. A 'bottom-up' reading of madness thus makes it possible to analyse interpretations of mental disorder in mystical, magical or religious terms. More broadly, this approach makes it possible to question how society and culture determine the expression of mental illness in various ways.

In Cameroon, the research team worked on the semantics attached to the distinction between 'madness' (i.e. an condition caused by a supranatural entity, an evil spell) and psychological suffering.

The table below illustrates this distinction:

Locations/ sites	*Ethnicities/ Languages spoken*	*Designated conditions/suffering*	*Designation in local language*
Mora, Mémé	***Mandara***	Psychological distress (lost their mind)	*Outché*
		Crazy (possessed by chetan, the devil)	*Chetané*
	Kanuri	Crazy	*Zoli*
		Psychological distress (memory loss)	*Angale kol zna*
Koza	***Mafa***	Mental disorder	*Rvda*
		Crazy	*Halawi*
Mindif, Dargala	***Moundang***	Crazy	*Titime*
		Mental disorder (headache)	*Tequinre*

In Nigeria, too, the psychological distress following NSAG attacks is not directly regarded as a curse. Some imams serving in Jere and Maiduguri believe that NSAG fighters are inhabited by evil spirits and that these can 'possess' victims when the attacks take place. It is as a result of these evil possessions that the victims become mentally unbalanced, even to the point of 'madness'. An imam from Maiduguri explained that the current war is not only political, but also mystical: in order to combat the evil spirits, the various denominations involved conduct numerous prayers, sacrifices, fasts and other dispossession rites.

Beyond the divide between 'disease of the mind' (psychological distress) and 'disease of the spirits' (evil possession), the distinction between 'mad' and 'ill' is more related to the acceptance or, conversely, the social exclusion that manifestations of the disorder induce. In the collective imagination, someone who is mad is perceived to be on the margins of society, having lost their ability to appreciate social norms. The image of someone wandering the roadside in rags and talking to themselves is highly representative of popular perceptions of "mad" people[54]. Some people see in this an almost irremediable status caused by diabolical mysticism, while psychological disorders are assimilated to individual and internalized distress, which is caused more by the psychological and physical faculties of the person, hence expressions such as being "out of your mind".

For the Buduma and Kenembou, the status of

THE FOLLOWING CASE ILLUSTRATES THE ABOVE POINT:

Mr. B. was attacked by the NSAGs who left him for dead in his village after raping and killing his wife and daughter. He says he prays incessantly for the conversion of terrorists who, believing they are acting in the name of Allah, commit inhuman acts that only "men who are no longer men", i.e. possessed by demons, can commit. According to him, receiving treatment from marabouts allows the victims to be purified; as the terrorists are "impure", they also make the victims impure during the attacks.

54. See Diagne and Lovell, Vivre avec la folie dans le Sénégal périurbain mondialisé, 2020, Karthala.

'madman' is attributed to the person who is at odds with his physical world and who has established a direct link with the invisible world. He sees what is imperceptible and hears what remains inaudible by others. The passage into this abstract world exposes the subject to possession by demonic spirits, hence his isolation and, later, his exclusion. Here too, according to Mahamat Abdoulaye, a marabout and traditional healer in Baga Sola, the explanation lies in a transgression of social and divine rules, which exposes the subject to sanctions up to and including madness[55].

On the other hand, the interviews reveal that because of the different ways that "madness" and "psychological distress" are perceived, there is no causal link between the two aetiologies. Madness is not seen as an extension of mental disorders, and mental disorders do not generate what is referred to as "madness" in collective perceptions. Hence the theoretical distinction between the two types of pathology, that some traditional therapists recognise by entrusting them to biomedicine, and that others try to ignore by repeating the same rituals indefinitely.

6.2. PEOPLE WITH DRUG- AND ALCOHOL-RELATED PSYCHIATRIC CO-MORBIDITIES

Apart from the victims of psychological trauma, other people, who are seen as socially "deviant", are also considered "incurable" from the point of view of traditional medicine and on the margins of society. This is the case for drug users and alcohol addicts.

In the four countries covered by the study, the use of psychotropic substances is increasing. The main substances used are cannabis, cocaine, heroin, tramadol and hallucinogenic plants such as "sobi-lobi", known as "zakami" in eastern Niger. Of these, the drug whose consumption has increased the most is undoubtedly tramadol. Its molecule has powerful analgesic properties similar to morphine, which can cause hallucinations and euphoria. The effects sought are mainly an increase in strength and physical endurance, as well as resistance to stress, which contributes in particular to altering the relationship to fear and pain. Sometimes bought in pharmacies, but more often obtained outside official channels (and sometimes counterfeited or fake), the pills that have been seized in West Africa are unusually strong. Instead of the 50 milligrams that are usually found in pharmacies, the packaging - with its images evoking strength, vitality and vigour - mentions 100, 200 or 250 milligrams of the active substance[56].

Seizure figures show an increase in tramadol use in recent years. In July 2020, in a transnational trafficking case, senior security and intelligence officials were convicted in Chad for trafficking tramadol[57]. In Nigeria and in Cameroon, drug trafficking and amphetamine laboratories are concentrated in the port cities of the Atlantic coast and historically have their sources in merchant or military circles. In Nigeria, Ibo migrants from the South in Borno run the counterfeit drug industry, including tramadol[58]. In Nigeria, the molecules of this product are found in natural form in a Borno

55. Interview with Mahamat Abdoulaye, Marabout and traditional healer in Bago-Sola, 27 February 2021.

56. Tisseron Antonin, Tramadol, médicament et drogue du pauvre en Afrique de l'Ouest et au Sahel L'Afrique en questions, *n° 39, 2017.*

57. Remadji, H., Illicit drug trafficking in Chad contributes to regional insecurity, *ISS report, 2020.*

58. Magrin G and Pérouse de Montclous M-A, Crise et développement : La région du Lac Tchad à l'épreuve de Boko Haram, *AFD, 2018.*

shrub, "the African peach tree (Sarcocephalus latifolius)[59] ", which favours local production.

According to some sources and authors, this painkiller is widely consumed by Boko Haram members. In 2017, the United Nations Office on Drugs and Crime also warned about the extent of trafficking in the Sahel and its use by NSAGs[60]. However, the non-medical use of tramadol does not seem to be limited to NSAGs, which is spreading to many categories of the population in the Sahel. Observed among fishermen and truck drivers[61], it is also widely used by young people of all social classes.

> *Each category develops their own strategy to adapt. When it's a young person, they take doping tablets that are sold along the streets at the market. For the members of the vigilance committees, it's the same thing. They take doping tablets sold on the street from Nigeria. They think they can overcome their suffering by making themselves stronger thanks to the products they consume. In the same way, some people consume traditional wine to overcome their anxieties.*
>
> **Interview with the former mayor of Bol, Chad**

Repeated use of tramadol leads to addiction, which is often part of a pattern of multiple psychotropic drug use, itself combined with alcohol abuse. This type of poly-drug use can lead to states of agitation and hallucination, which cause tensions within communities. Socially reprehensible behaviour thus contributes to the stigmatisation and social exclusion of drug users. In a context of multiple social vulnerabilities, few people are willing to consider psychotropic drug abuse as a pathology in which the user is, if not the victim, at least the hostage. Therefore, in addition to the figure of the "madman", there is also the no less stigmatising figure of the "drug addict", who is not supervised or provided with therapeutic treatment.

> *We see a lot of young people who are addicted to drugs like tramadol. Sometimes at the market here in Baga Sola, young people collapse in public because of their drunkenness. Others consume liquors in sachets which have a high alcohol content.*
>
> ***Focus group* of young people in Baga Sola, Chad**

Indeed, although the psychiatric co-morbidities associated with drug use [62] have been widely documented for several years, it seems that neither traditional therapists nor psychologists have really seen the need to consider this phenomenon as a whole. In fact, recourse to the use of psychoactive products can be interpreted as an attempt at self-medication on the part of person who is ill. The quest is not so much for a cure as for a temporary escape from an intolerable psychological state. Drug users and alcoholics are punished twice, due both to their psychological dependence on the product, and their global exclusion.

59. Ibid.

60. www.issafrica.org

61. Seignobos, C, Chronique d'un siège : Boko Haram dans ses sanctuaires des monts Mandara et du lac Tchad, De Boeck Supérieur, 2017

62. Concomitance between psychiatric disorders and drug use.

6.3. THE STIGMATISATION OF MENTALLY ILL DISPLACED PERSONS

The social sanctioning of mentally ill people is linked to collective representations of mental illness. As we have seen, mental illness does not strike randomly, but most often occurs in response to a social or religious transgression. The victims of NSAGs are not immune to this stigmatisation: whether they are released after abduction, particularly women who were forced into marriage and those who had children from these unions, or the relatives of repentant Boko Haram members or survivors from attacked communities, the recognition of their victim status is also accompanied by suspicion. This suspicion has to do with the non-consensual nature of the marriages and sexual relationships, and about why they were spared during an attack.

According to Seignobos, "the widespread distrust of alleged Boko Haram supporters is a factor of vulnerability, especially as double agents are regularly found[63]." In collective perceptions, children born from a relationship with NSAG members are also cursed because they inherit their father's 'bad blood'.

In addition, the long-term settlement of displaced populations within resident communities generates, over time, feelings of rejection and stigmatisation of the new arrivals. It is said that they are disrespectful of local norms, that they are not worthy of the aid they receive, that they have bad morals, that they bring crime and trafficking, etc.

There are many testimonies attesting to the negative social consequences of the new settlements, which tend to increase as the number of displaced people increases. Though initially there is solidarity and mutual aid, this subsequently diminishes until there is resistance on both sides.

> *We can't do much. See for yourselves! We sometimes go to the public dispensaries to get medicines, but we are not treated well. We are displaced people who are far from the health centres, we are not treated well. Sometimes, even with children, we can go a whole day without getting any medicine. Sometimes we are served, sometimes we have to buy. This happens most of the time.*
>
> ***Focus group* of displaced women, N'guigmi, Niger**

In Chad, the dozens of polders surrounding Bol, Nguéléa 1, Ngarangou and Baga Sola are regularly affected by conflicts between host and displaced or returnee populations. In Bol, Baga Sola and IDP sites, many mothers who have been widowed by the abduction or death of their husbands are considered to be additional burdens by the host communities. When they suffer from psychological disorders, which are interpreted as a punishment, they are regularly excluded and labelled as 'jinxed'[64]. As such, informants reported that in some cases, the mental illness of married women leads to tension between families.

When young wives are unwell, and therefore perceived as victims of possession by evil spirits, and can no longer fulfil their role as wives, the repayment of the dowry is sometimes demanded by the husband's family. When the dowry is expensive (several heads of oxen or camels), the husband's family may take the dispute to

63. This is the case of the head of a three-hundred-man vigilance committee in the border town of Fotokol, the main crossing point between Cameroon and Nigeria, who was caught and arrested in January 2017. In such a context, everyone denounces everything and believes that they recognised such and such a person here or there... All these denunciations make the police and the army doubtful, so they intervene weakly and are, in return, accused of passivity' (Seignobos, 2017).

64. Interview with Kadidja Tchari, mother of a mentally ill person, Bol, 25 February 2021

the traditional authorities or, if necessary, to the courts[65]. The stigma attached to mental illness can therefore have serious consequences and impact on family cohesion as well as on economic capital.

In general, displaced families who have a mentally ill person within a smaller family structure (e.g. single-parent families consisting of a mother and her children, elderly parents with children or grandchildren) find that the household economy is severely undermined by the cost of the illness, especially if the ill person is part of the productive workforce.

> *Many of our young people no longer live in this camp. They have gone to live in Bol to carry out activities such as shoemaking, motorbike deliveries, selling fuel, catering... Here in the village, some young people fish in the neighbouring polders, despite some difficulties in cohabiting with the populations of the neighbouring villages.*
>
> **Interview with an IDP, Bol, Chad**

6.4. THE SOCIAL AND ECONOMIC CONSEQUENCES OF MENTAL ILLNESS

EXTRACT FROM NOTES FROM AN INTERVIEW WITH A YOUNG NIGERIAN:

One young person told us that he feels as if he is trapped in a bottle. To the question "Why do you feel this way?", he gives us three answers. Firstly, he says that he only knows how to fish and to do market gardening. Unfortunately, he cannot risk going to the river or lake for fear of being caught and forcibly recruited by the NSAGs. Secondly, if he ventures there and manages to avoid being seen by the NSAGs, but is caught by the defence and security forces, he will be considered an accomplice of the NSAGs. And lastly, where he lives, nothing that is done for young people can help them get out of this situation. According to him, training 20 tailors in the same site or 20 carpenters in a community where no one has an income does not make sense. So he simply feels as if he is trapped in a bottle with no way out.

The crisis has totally disrupted and weakened the lake's economy. The areas most affected by the conflicts have seen their agricultural, pastoral and fishing activities destroyed. In the secure areas, the influx of displaced persons has created tension over the sharing of resources between host families and new residents. Due to the frequency and violence of attacks by NSAGs, people have fled the islands of the lake, where most of the fish and agricultural products used to come from.

In Chad, the lake economy has moved northwards, particularly in the sub-prefecture of Liwa on the border with Niger, westwards to Baga on the border with Nigeria and southwards to Darak on the border with Cameroon. In the localities of Bol and Baga Sola, the populations have had to reinvent an emergency economy based essentially on services and daily survival.

65. Interview with Oumar Goni Mbodou, traditional imam-healer, Sya, 25 February 2021

> *Today, many of our activities have changed. Before, we used to cultivate our fields, we used to fish, everyone was autonomous. Here, there is no farming or fishing. To survive, we women are sometimes obliged to cut wood to transform it into charcoal, which we carry on our heads and sell in the nearby town of N'guigmi. During the dry season, we buy rakes and hoes to collect straw, which our children sell in N'guigmi. Can we make a living from this activity? If we were to be helped, we would like the aid to be brought directly to us. We should not go through intermediaries. Everything that goes through intermediaries is lost. It's hard to live on these resources. It's not a life.*
>
> ***Focus group* with displaced women, N'guigmi, Niger**

The interviewees mentioned a number of new informal activities, including catering, transport, petty trade and selling products at the market. Young people are also moving into manual and commercial activities such as bricklaying, shoemaking, men's hairdressing, selling adulterated fuel, transporting black market goods, mobile phones, etc. Around the markets, other activities are being organised such as motorbike deliveries, public transport parking, small-scale laundry and manual labour. Some young people have learned new trades such as hosiery, sewing and shoemaking[66]. In Nigeria, adaptive economic strategies include selling wood, setting up tontines and weaving straw (Seko) for fencing. The latter activity has increased since the onset of the crisis.

This transformation of the local economy is accompanied by a change in power relations within households. In some families, young people - who have become the main earners – have become the head of their households. In other cases, they have been the ones most affected by the lack of economic opportunities and the resulting social consequences. Marriages are becoming less frequent and the possibility of establishing a family increasingly uncertain.

> *Today we see young girls and boys over 15 or 20 years old who have nothing. It is good that at this age you have something in your life. Usually, in our tradition, it is not like that. Today, we see young people over 20-25 years old who are unable to take on anything. This makes us sad. They can't even get married. Whereas in our Boudouma community, people get married at a very young age. They are obliged to come and ask their mothers for their everyday needs.*
>
> ***Focus group with displaced women, N'guigmi, Niger***

66. Focus group *with young people from Baga Sola, 28 February 2021*

7

MENTAL HEALTH PROJECTS BY INTERNATIONAL AND LOCAL HUMANITARIAN ORGANISATIONS

In the four countries targeted by the study, international partners have invested heavily in psychosocial support, the fight against gender-based violence and emergency assistance to displaced populations:

- United Nations organisations, particularly UNHCR, UNICEF, WHO, UNFPA, UNWomen and IOM, fund and implement psychosocial care programmes, in particular through support for the deployment of mobile multidisciplinary teams to provide community psychosocial support in hard-to-reach areas. They are also involved in the rehabilitation of health structures and listening centres, and awareness-raising and prevention activities against GBV, including care for women victims of GBV and sexual violence. And lastly, they provide protection and assistance to displaced populations, as well as maternal and child healthcare.

- There are also a large number of international non-governmental organisations involved in the field of mental health. Among the main organisations are: ACF, MSF, Plan International, ICRC, InterSOS, IRC, CRS, CLIRA, COOPI, USAID, Médecins du Monde, Solidarités International, ALIMA and Première Urgence Internationale. The services offered by these organisations are also oriented towards emergency aid for displaced populations, psychosocial care, medical assistance, support for isolated children, mental health promotion, etc.

- In terms of national and local organisations, we can cite, for example: i) in Chad, : Association des femmes juristes du Tchad (AFJT); ii) in Cameroon, the Cameroon Red Cross, Association de Lutte contre les violences faites aux femmes (ALVF), Association Locale Pour un Développement Participatif et Autogéré (ALDEPA), Association des enseignants-maîtres coraniques, Association pour le dialogue interreligieux (ACADIR) and Rayons de soleil; III) in Nigeria, the Association of Teachers of Arabic and Islamic Studies and ACADIR.

7.1. SUMMARY TABLES OF AID ACTORS

A. Chad

ORGANISATIONS	PROJECTS	AREAS OF INTERVENTION	ACTIVITIES
		United Nations agencies	
IOM, UNFPA, UNWomen, UNICEF, WHO, UNDAF	• Psychosocial care • Awareness raising and assistance to women victims of sexual violence	Bol, Baga Sola	• Support for the deployment of mobile multidisciplinary psychosocial teams to provide psychosocial support • Rehabilitation of several listening centres • Awareness and prevention activities against GBV • Care for women victims of GBV
		International organisations	
MSF, ACF, INTERSOS, COOPI-USAID, IRC	• Primary and mental health care • Prevention of mental illness and resocialisation of unaccompanied children • Promotion of mental health and psychosocial well-being	Bol, Baga Sola, Dar es Salam, several IDP sites, Kousseri Maria, Kousseri-Gourtoula, Koudoukolé, Kaya, Fouli and Mamdi departments	• Mental health care in mobile clinics and refugee camps. • Training of medical staff, supply of medicines • Raising awareness of mental health • Strengthening of psychological care facilities • Psychosocial care and psychosocial support through discussion
		National and local organisations	
Association des femmes juristes du Tchad (AFJT)	• Protection and promotion of the rights of women and children. • Psychosocial and legal information and counselling for victims of GBV	Several localities in the Lake District	• Training of women from the islands and the shores of Lake Chad on Gender-Based Violence: GBV • Organisation of listening and counselling sessions to help displaced people and their host communities overcome their trauma.

B. Cameroon

ORGANISATIONS	PROJECTS	AREAS OF INTERVENTION	ACTIVITIES
		United Nations agencies	
UNFPA, UNHCR, UNWomen, UNDAF, WHO, UNICEF	• Providing counselling on reproductive health and GBV, - Protection and assistance to refugees and displaced persons, assistance to women victims of violence, economic empowerment of women	Mora, Mokolo, Kolofata, Kousseri, Logone et Chari, Mayo-Sava and Mayo-Tsanaga	• Establishment of a specialised human resource mechanism for counselling in the target locations • Psychosocial care for refugees and women victims of GBV • Psychological first aid training
		International organisations	
ACF, MSF, INTERSOS, IRC, PLAN, CICR, CRS, CLIRA	• Psychosocial support, emergency aid, medical assistance – Legal support • Socio-economic integration of young people • Psychosocial support for children	Localities of Mayo-Sava, Mayo-Tsanaga, Logone, Chari, Maroua, Mora, Gancé, Kourgui, Mokolo, Moskota, Kousseri	• Mobile clinics providing mental health care • Psychological first aid training for nursing staff • Distribution of emergency kits to vulnerable people • Mental health consultations
		National and local organisations	
Cameroon Red Cross, AVLF, ALDEPA, Association of Teachers of Arabic and Islamic Studies, Association for Interreligious Dialogue (ACADIR), Rayons de soleil	• Psychotherapy sessions for rescue workers with disorders • Inter-community cohabitation on a religious basis, spiritual de-radicalisation • Psychosocial support • Raising awareness against GBV	Several localities in Mayo-Sava, Mayo-Tsanaga, Logone et Chari affected by the security crisis, including Maroua, Kousseri and Mokolo	• Psychological follow-up • Psychotherapeutic care • Drug treatment • Legal support for women victims of GBV • Spiritual accompaniment • Collective prayer sessions • Socio-cultural activities

C. Nigeria

ORGANISATIONS	PROJECTS	AREAS OF INTERVENTION	ACTIVITIES
		United Nations agencies	
UNHCR, WHO, WFP, UNICEF, UNFPA	• Resettlement of refugees and displaced persons • Psychosocial care	Chad River Basin, Maiduguri and Jere, Jigawa, Borno State, Ngala, Adamawa State	• Medical and psychosocial care • Construction of resting places and purchase of tents for displaced populations, nutrition, water, sanitation, hygiene • Medical equipment and support for vaccination campaigns
		International organisations	
Première Urgence Internationale, Médecins du Monde, ACF, Plan International, Solidarités International, ALIMA	• Improving access to primary and mental health care • Income-generating activities • Technical support to the Ministry of Health	Chad River Basin, Maiduguri and Jere, Damboa, Jigawa, Kano, Yobe, Borno State, Dikwa, Monguno	• Implementation of a prevention and awareness-raising programme on gender-based violence • Psychosocial support in mental health and health education. • Programmes to combat malnutrition • Rehabilitation of school and health infrastructures
		National and local organisations	
Associations of Koranic teachers, Association for Interreligious Dialogue	• Faith-based inter-community cohabitation, spiritual de-radicalisation	Chad River Basin, Maiduguri and Jere, Borno State, Damboa, Monguno	• Spiritual accompaniment • Prayer sessions • Socio-cultural activities

D. Niger

ORGANIZATIONS	PROJECTS	AREAS OF INTERVENTION	ACTIVITIES
		United Nations organisations nies	
WHO, UNICEF UNHCR, UNWomen, UNDAF	• Psychosocial care • Improving sanitary equipment and facilities	Chétimari N'guigmi, Maïné-Soroa	• Establishment of a specialised human resources facility for counselling in the target localities. • Donation of important medicines and health equipment to protect the population's health. • Accompaniment and reinforcement of young people's psychosocial skills in their professional projects
		International organisations	
COOPI, ACF, MSF Spain, Plan International, ICRC	• Psychological support for people identified as vulnerable • Mental health activities and psychosocial support at community level	Chétimari, N'guigmi, Maïné-Soroa	• Training of health care staff • Psychological First Aid Training • Multi-faceted support to improve the psychosocial well-being of the region's populations. • Integration of communities into the general health system
		National and local organisations	
Customary and religious authorities, village chiefs, traditional healers, Caritas Niger, DIMOL, Agir Plus NGO	• Faith-based inter-community cohabitation, spiritual de-radicalisation • Psychosocial support	Chétimari, N'guigmi, Maïné-Soroa	• Spiritual accompaniment • Prayer sessions • Socio-cultural activities • Referring individuals with psychological disorders to qualified health care personnel

7.2. ANALYSIS OF MENTAL HEALTH PROJECTS IMPLEMENTED BY INTERNATIONAL ACTORS

7.2.1. COMMUNITY-BASED CARE AND THE PLACE OF PSYCHOSOCIAL WORKERS

Most of the mental health activities implemented by international actors fall within the WHO's focus on "community-based services". The term "community-based care" should be understood here as opposed to centralised care in health facilities. Indeed, as we have seen, the stigma of hospitalisation in psychiatry (institutionalisation of mental illness), but also the excesses of certain traditional care centres[67] (coercion and internment of the patient), make the community model more appropriate and more functional.

At the community level, i.e. in villages, the psychosocial workers who interface directly with the population, as far as possible, come from within the community, which represents an undeniable added value in terms of following up those who are ill. Their legitimacy is not questioned and their experience in psychological support is solid. Moreover, it can be considered that the vast majority of them are "professional psychosocial workers" whose skills are "reactivated" with each new programme that is funded.

On the other hand, the mandate of psychosocial workers, and the psychosocial approach that they use, are not always well understood, especially in the most isolated areas. Though they are easily solicited as social workers to support families in their daily difficulties, they are less so as 'psychologists', which in itself is not alarming since the objective is above all to meet people's needs. For example, when families observe that traditional treatments have failed, they ask psychosocial workers to refer them to provincial hospitals and to support them financially for the purchase of medication and transport costs. According to the interviews, it is not often that families request psychological care from the psychosocial workers themselves. The challenge for psychosocial workers is therefore to reach out to the mentally ill and their families to "convince" them of the merits of their approach.

However, people's adherence to psychosocial activities depends largely on how much they know about them and how visible they are. Some informants reported that the projects lacked visibility. Some even saw this as a strategy to "favour" certain population groups over others.

> *Some NGO training is done in secret. Sometimes it is after the training that we learn that some people have been trained, there is no transparency".*
>
> *"They don't help everyone. That is, they don't help everyone in need, indiscriminately. In order to do that, you need to identify people properly and you need a place that everyone knows so that everyone can get treatment without problems.*
>
> **Women's *focus group*, Niger**

67. Numerous reports highlight the degrading and inhumane treatment to which some mentally ill people are subjected in state psychiatric centres as well as in "rehabilitation centres" run by Islamic or Christian organisations. Human Rights Watch and other human rights organisations have for several years alerted the authorities to regulate this sector. However, in the context of this study, the consultants were not given the opportunity to observe these types of centres. We therefore do not have enough information to analyse this phenomenon, but it would be interesting to include these structures in future diagnoses and studies on mental health in the Lake Chad basin.

These accusations of favouritism and lack of transparency, whether legitimate or not, need to be addressed by projects. While such criticisms are inevitable to varying degrees, "rumours" and accusations need to be identified to be better deconstructed or challenged.

7.2.2. COLLABORATION WITH PUBLIC SERVICES AND COMMUNITY ACTORS

In Niger, the psychosocial activities of international organisations are generally well perceived and the competence of psychosocial workers and psychologists recognised. While training activities for public officials are also welcomed, the lack of collaboration with state services was pointed out. The systems for monitoring and supervising community workers seem to lack harmonisation. On the one hand, state services assess the skills and competences of the agents based on tests before and after the training; on the other hand, international organisations insist above all on the proper mastery of the treatment protocols by the psychosocial workers. According to one health manager, "projects have their own protocols and guidelines that are difficult for actors outside the project to understand. This can compromise the objective of sustainability and replication of good practices by state agents".

On the other hand, some mental health actors (psychosocial workers, psychologists, health service workers) regret that some psychosocial activities are not oriented towards greater empowerment of the mentally ill and their relatives. The underlying idea would be to avoid care based solely on the individual, without taking into account the people around him or her and the nosological framework that is dominant in collective perceptions. In terms of programmes, it would be a matter of establishing a therapeutic alliance between the different actors who interact around the mentally ill person. Without an effort to include the family and other therapists in the care process, there is a risk that, once the project has been completed, the carers - who are the main actors in direct assistance to the person - will not be able to replicate the strategies of support and self-esteem that psychological care encourages. If the objective is to strengthen the resilience of populations in the face of the current crisis, it seems important that caring for the person who is ill should include the whole person, i.e. first and foremost the family, but also the other actors involved in psychological support, i.e. the healers, imams, marabouts, etc.

7.2.3. STRENGTHS AND LIMITATIONS OF THE PROBLEM MANAGEMENT + (PM+) PROTOCOL AND PSYCHOMETRIC SCALES

The predominant treatment strategies in the WHO protocol (PM+) refer to the concept of resilience, which consists of not engaging in victimology but rather looking for what is strong in each individual. This approach, which combines listening and self-esteem, is generally well perceived by the interviewees.

Psychological care spread over five sessions, as recommended by the PM+, has an undeniable therapeutic value for people who need to put what they are feeling into words. It should be remembered, however, that this is not the case for all victims, particularly in group therapy where the recounting of traumatic experiences in front of a group of strangers may seem disturbing and intrusive. In this case, given the weight of the stigma attached to some victims, the discomfort can easily outweigh the benefit of expression.

The Problem Management + (PM+) protocol was a source of concern for the mental health

professionals met during the study. The manual - developed by WHO and revised in 2018 - describes a low-intensity psychosocial intervention for adults affected by distress in communities exposed to adversity. The protocol is based on five weekly sessions, each lasting 90 minutes[68].

While the principle of using the PM+ protocol in the Sahelian context is not really questioned, its application is problematic. It is too generic, it is not contextualised, it does not take into account the different forms of trauma and it has been developed without the participation of mental health professionals in the region. It is therefore not always very effective in practice. Moreover, although there are areas where the therapeutic practices of the MP+ and those of traditional practitioners converge (essentially the practice of encouraging the ill person to express themselves), traditional practitioners are unaware of the content of the MP+ and its usefulness. Bridges could be found between the two approaches, which would have the advantage of popularising the tool and encouraging its replication by therapists.

Another challenge for PM+ is its acceptance by the population. The interviews reveal that young people often have difficulty understanding what counselling programmes are "trying to achieve" with this tool. It is true that positive stories about PM+ have been documented and promoted by many organisations. However, it would be reductive to adhere to it too strictly. In reality, no such standardised tool stands up to the diversity of practices, expectations and perceptions regarding psychological support. This is particularly true in the countries, provinces and populations of the Lake Chad Basin where there is a wide variety of social, ethnic and faith-based groups.

The same issues apply to psychometric scales that are used to detect anxiety and depressive disorders. There are several of these: the Connor-Davidson Resilience Scale (CD-RISC), the Hospital Anxiety and Depression Scale (HADS), the Impact of Event Scale (IES-r), and the World Health Organisation-Five Well-Being Index (WHO-5), to name only the most widely used. If we take the example of the WHO-5, we can see how many interpretation biases there can be. This is the questionnaire used:

" Please indicate for each of the five statements which is closest to how you have been feeling over the last two weeks.
Notice that higher numbers mean better well-being.
Example: If you have felt cheerful and in good spirits more than half of the time during the last two weeks, put a tick in the box with the number 3.
The questionnaire consists of 5 statements: Over the last two weeks i) I have felt cheerful and in good spirits, ii) I have felt calm and relaxed, iii) I have felt active and vigorous, iv) I woke up feeling fresh and rested, v) My daily life has been filled with things that interest me.
There are six possible answers (Likert scale[69]): "All the time / Most of the time / More than half of the time / Less than half of the time / Some of the time / At no time".
The score is calculated by adding up the responses. A high score means better well-being.

It goes without saying that this type of questionnaire, if administered 'as is' to populations affected by the Sahelian crisis, is likely to lead to more misunderstandings than it will reveal. Indeed, even if the interviewer manages to translate literally terms such as "fresh and rested" or "active and vigorous", the respondent still has to be able to evaluate this state according to six possibilities and "during the last two weeks". There are numerous cognitive and methodological biases which mean that the results should be

68. https://apps.who.int/iris/bitstream/handle/10665/275831/WHO-MSD

69. A Likert scale is a psychometric tool for measuring attitudes among individuals. It is named after the American psychologist Rensis Likert who developed it and consists of one or more statements (statements or items) for which the respondent expresses his or her degree of agreement or disagreement (Wikipedia)

treated with some caution and should not be over-interpreted.

Although psychometric scales are not intended to understand the subjective nature of mental illness, but rather are designed as a *screening tool*, the increasing demand from donors and the WHO to produce measurable results often forces projects to use scales as tools for analysing and evaluating well-being, with the risk of reducing the multiple effects of psychological care work with victims to a single result (whether positive or negative). Indeed, what can be said about results such as "90% of care recipients experienced an improvement in their state of well-being" or "20% of care recipients experienced an improvement in their state of well-being"? Do they not implicitly lead to a binary interpretation (effective/not effective) of the quality of psychological care?

In reality, whether the 'objective' of improving well-being is achieved or not, it says nothing about the social and psychological determinants that influence well-being or lack of well-being and nothing about how to act on these determinants, an analysis which is nevertheless a central concern of those involved in psychological care. Therefore, to conclude that a project 'works' or 'does not work' by means of a single result amounts to removing from sight, or even discrediting, the resilience strategies of carers, support workers and the patients themselves which are extremely rich in experience and learning.

It should also be recalled that the use of subjective measures to produce quantifiable assessments of well-being was first initiated not by psychologists, but by economists[70]. Since the late 1990s, the growing interest in measuring subjective well-being has indeed contributed to the birth of a new branch of economics: the 'economics of happiness'[71] characterised by measures of quality of life and social progress. The explanatory value of well-being indicators therefore needs to be qualified.

Indeed, the use of scales as an assessment tool that is supposed to illustrate different emotional states and that is used with populations that have experienced such suffering that the very notion of well-being appears to be relative should be viewed with caution. Beyond their status as "contractual data", these indicators cannot be interpreted as markers of subjective reality, i.e. of people's well-being. It is therefore important to distinguish between "impact" research, which is systematically associated with quantifiable expectations and evidence-based *information* but which is also driven by the need to be accountable to donors, and the empirical study of social groups combining the analysis of practices, representations and manifestations of mental disorders. Like all human sciences, psychology needs a qualitative analysis framework which provides a more accurate account than a percentage does of the significance and scope of psychological care in a crisis context.

7.2.4. FROM POSITIVE PSYCHOLOGY TO IDEALISTIC DISCOURSES

Current mental health interventions are increasingly based on positive psychology[72] with a focus on quality of life and well-being, what makes people resilient, happy, optimistic, rather than 'the sources of pathology. Positive psychology aims to "study fulfilled, resilient and mentally healthy people"[73].
While this approach is commendable, some psychologists interviewed during the study expressed reservations about the systematisation

70. Ibid.

71. Zeindan, Jinan, Les différentes mesures du bien-être subjectif, *Revue française d'économie, 2012.*

72. According to Abraham Maslow, "psychology has been much more effective on the negative than on the positive aspects of the human being. It has revealed to us his vulnerabilities, his weaknesses, his pathologies... but little of his potential, his aspirations, his resources. It has therefore restricted itself to only half its jurisdiction. www.lapsychologiepositive.fr

73. Ibid.

of "ultra-positive", "overly reassuring" or even idealistic discourses in care programmes.

According to them, encouraging hope and confidence should not be tantamount to attempts to embellish reality and mask its uncertainties, particularly in the context of a long-lasting crisis such as the one in the Lake Chad Basin. They specify that resilience is built over a long period of time and involves becoming aware of a new situation, made up of daily difficulties which become established, often on a long-term basis, and in response to which one needs to rebuild oneself.

> *We need to make people aware of reality and not give them false hopes. We have to learn to live in the new situation and not believe that the crisis will pass. This is how people will become resilient. Above all, we need to speak the truth. We mustn't engage in demagoguery by claiming that we have come to help them and that it will pass. People are stuck, time has stopped, and they can only get going again by becoming aware of reality.*
>
> **Psychologist, Diffa, Niger**


COMITÉ
DE SECOURISTES
EN SANTÉ MENTALE

CONCLUSION : CAN WE TALK ABOUT RESILIENCE?

Although it is the most frequently cited diagnosis in post-crisis contexts[74], trauma cannot be considered a fatality that affects all the people who go through a crisis. Whether the causes of the disorders are social, historical, psychological or physical (and more likely intertwined), the occurrence of a potentially traumatic event does not necessarily lead to the development of trauma. Protective factors' are at work and play a role in the ability of individuals to cope and rebuild. What is commonly called "psychological resilience[75] has a number of determinants. These can be internal to the subject (depending on his or her cognitive and emotional resources), or external (depending on the social capital and the support that the mentally ill person can mobilise in his or her environment).

For Cyrulnik, resilience[76] can be defined quite simply: "it is a biological, psycho-affective, social and cultural process that allows for new development after a psychological trauma" (Cyrulnik, 2012). He adds: "to study the conditions of this developmental recovery, researchers from different disciplines need to be involved". Therefore, there should be no disciplinary compartmentalisation between psychologists, sociologists, political scientists or humanitarians. It is true that resilience can be understood as a polysemous 'all-purpose' notion that each sector tries to define in its own way and uses whenever 'post-shock' situations lend themselves to analysis. There have already been many more or less constructive criticisms of the concept of resilience and its 'over-use' in the aid sector, and there is no need to return to these here. Neither is it relevant to fuel the debate about the link between 'resilience and growth', about genuine resilience, sustainable resilience, local resilience, good resilience or bad resilience[77].

Resilience is not so much a condition to be looked for in a given population, for which expected outcomes are stated and impact indicators are measured. It is not so much an "operational objective" as the set of social and individual behaviours that occur when a society or an individual finds itself in a situation of distress and has to deal with it by mobilising their own strategies and resources.

F. Finally, whether resilience is a myth or an ideology, whether it 'works' or 'doesn't work', it is above all a reaction (psychological and/or social; individual and/or collective) to an

74. One of the most virulent criticisms of the DSM comes from Allen Frances who coordinated the DSM-IV. His criticism concerns the risks of overdiagnosis and therefore overmedicalisation, as well as the risks of including common psychological reactions, for example following a bereavement, in the DSM (pathologisation of bereavement and common disorders). The prestigious National Institute of Mental Health (NIMH), the largest funder of mental health research worldwide, has also disassociated itself from the DSM-5. See www.lemonde.fr/sciences/article/2013/05/13/dsm-5-le-manuel-qui-rend-fou.

75. Guedeney Antoine, " Les déterminants précoces de la résilience ", In: Boris Cyrulnik, Ces enfants qui tiennent le coup, Hommes et perspectives, 1999.

76. The word 'resilience', which comes from the Latin re-salire (re- jump, bounce back), is regularly used in the physical sciences where it refers to the ability of a material to withstand shocks and return to a proper shape. As is often the case in psychology, this physical phenomenon has been used as a metaphor to explain the idea that a human being can withstand trauma, hold on and start again. Cyrulnik, B. and Jorland, G., Résilience, connaissances de base, Odile Jacob, 2012.

77. In reference to Olivier de Sardan regarding "development", Anthropologie et développement. Essai en socio-anthropologie du changement social, *Karthala, 1995.*

external event, which deserves to be observed and analysed, like any other object of study[78].

C'est cette approche exploratoire que nous avons souhaité privilégier dans la présente étude. Il s'agissait avant tout de comprendre les logiques sociales qui entrent en jeu lorsqu'un individu est affecté par des troubles psychologiques et d'identifier les trajectoires thérapeutiques et les marges de manœuvre dont disposent les populations affectées pour " faire face ".

It is this exploratory approach that we wanted to focus on in this study. The main aim was to understand the social mechanisms that come into play when an individual is affected by psychological disorders and to identify the therapeutic trajectories and the room for manoeuvre available to affected people to 'cope'.
Understanding these mechanisms and integrating them into strategies is one of the conditions for mental health interventions to succeed. It means that projects are adapted to local care mechanisms and that they fit into the care trajectories of the people affected and their families. Without taking these mechanisms into account, 'beneficiary' populations may feel that it is up to them to adapt to the way humanitarian actors provide care, rather than the other way round. Adapting programmes to individuals is essential to ensure that there is ownership and sustainability of care activities within communities.
Finally, it should be remembered that, according to Guedeney, the people who 'cope' are not the ones who have been hurt the least, but those who have received the best support (Guedeney, 1999). In this respect, and beyond external interventions, the investment of the family and members of the community (village chief, healers, imam, etc.) has a decisive influence on the subject's mental health and acceptance by society. It is therefore by promoting these two aspects of ownership of psychosocial activities (by community actors) and inclusion in the activities (by all community actors) that aid projects can make a significant contribution to building the resilience of the populations of the Lake Chad Basin.

RECOMMENDATIONS

GENERAL RECOMMENDATIONS FOR NATIONAL AND INTERNATIONAL SMPS PROGRAMMES

1. **ESTABLISH OR STRENGTHEN A MENTAL HEALTH** within the Ministry of Health in each country to design, resource and implement a national mental health treatment framework, as well as prevention and promotion policies in this area.

2. **ENSURE THAT NATIONAL MENTAL HEALTH PLANS ARE DEVELOPED TAKING INTO ACCOUNT THE CONTEXTUAL SPECIFICITIES** of each country and ensure that a mental health legislative framework exists, is implemented and respects international human rights standards

3. **STRENGTHEN AND EXPAND COMMUNITY MENTAL HEALTH SERVICES THROUGH THEIR INTEGRATION INTO PRIMARY HEALTH CARE,** including those in peripheral cities and rural areas. Train primary health care workers to provide integrated care in community health facilities and to expand the provision of home-based care.

4. **STRENGTHEN THE TRAINING OF PSYCHIATRISTS, PSYCHOLOGISTS, SPECIALIST NURSES AND PSYCHOSOCIAL WORKERS** in order to have qualified human

78. Ibid.

resources in the various health facilities, particularly in crisis-affected areas where the security situation permits. Ensure that specialist mental health professionals are assigned to priority locations and that once in place, they are not reassigned elsewhere.

5. **ENSURE THAT THERE IS A RELIABLE SUPPLY OF ESSENTIAL PSYCHOTROPIC DRUGS** in hospitals and primary health care centres to avoid shortages of inputs in health facilities in insecure areas. Train health workers in stock management.

6. **FACILITATE ACCESS TO PSYCHIATRIC CARE** when needed and include psychiatric care in national health cost recovery systems and in service packages for the most needy.

7. **DEVELOP SPECIALISED SERVICES FOR THE RECOGNITION AND MANAGEMENT OF ALCOHOL AND SUBSTANCE USE DISORDERS.** The model of Alcoholics Anonymous has long proven its effectiveness and could easily be replicated in affected communities.

8. **DESIGN INFORMATION, EDUCATION AND COMMUNICATION MATERIALS ON MENTAL HEALTH** and promote their dissemination in health and other public facilities. In this respect, comics are a very effective tool for raising awareness.

9. **MAKE CARE AVAILABLE TO THE GROUPS WHO ARE OFTEN EXCLUDED FROM SMPS PROGRAMMES, NAMELY CHILDREN, ADOLESCENTS AND THE ELDERLY.** Adapt activities to different profiles.

10. **INCLUDE LISTENING AND TALKING SPACES FOR PSYCHOSOCIAL WORKERS IN SMPS PROGRAMMES.** Create partnership agreements between NGOs to ensure that the activities implemented by psychosocial workers are sustainable (when one programme ends and another begins, for example).

11. **DEVELOP OPERATIONAL RESEARCH IN MENTAL HEALTH** in order to design integrated and contextualised treatment approaches (PM+ or other) that ensure that local practices and perceptions of mental health treatment are taken into account.

12. **DESIGN OR STRENGTHEN NATIONAL POLICIES ON THE INTEGRATION OF TRADITIONAL MEDICINE INTO GLOBAL HEALTH** and establish multidisciplinary research institutes on traditional medicine and on the use and regulation of herbal medicines. Develop collaboration between traditional therapists and conventional medical practitioners in primary and community health care.

SPECIFIC RECOMMENDATIONS FOR NON-GOVERNMENTAL ORGANISATIONS

Develop contextualised treatment protocols and assessment tools

- In each country, create a working group bringing together psychiatrists, psychologists, psychosocial workers, traditional therapists, representatives of local and customary authorities, relatives of mentally ill people and mentally ill people themselves in order to adapt the WHO protocols (PM+ type) to existing mental health practices and social mechanisms. This contextualisation is essential to guarantee the participation of affected people and communities and the appropriation of the tools by local mental health actors.

- Do the same for the development of psychometric scales, taking into account the diversity of symptoms and diseases, and adapting the tools to the local etiology (cause of the disorders) and nosology (classification of the disorders).

- Translate all tools used into several local languages. Regularly review and adapt protocols and tools.

Ensure that the population participates in selecting the activities designed for them

This recommendation could be summed up in the well-known formula "Nothing about us without us", which promotes the genuine participation of those affected in the programmes implemented on their behalf. In concrete terms, this would mean:

- Carrying out initial qualitative diagnoses systematically upstream of the design of psychosocial care activities. Ideally, these diagnoses should be multidisciplinary (psychologists, socio-anthropologists, etc.).

- Identifying local organisations and community associations (women's groups, youth associations, religious leaders, etc.) involved in the treatment of mental disorders. Selecting and mobilising the most active ones in a working group of "contextual experts" . Delegating the second part of the initial diagnosis to the working group, then prioritising and implementing the recommendations from this diagnosis which is "by the community and for the community". Giving the working group the means to monitor the progress of the recommendations throughout the project. Sharing lessons.

Create therapeutic alliance mechanisms between families, psychologists and traditional therapists

- By taking the example of other countries (Togo and Benin, for example), systematise collaboration with traditional therapists in the care trajectories of mentally ill people. Action research carried out between 2015 and 2017 in Niger on the integration of traditional medicine in psychosocial care had established a referral and follow-up procedure between traditional practitioners and specialised mental health structures. This experience could be evaluated and possibly replicated.

- Map traditional therapists and assess their therapeutic practices before deciding whether or not to collaborate with them. Train them in psychological protocols in order to identify the common practices that exist between conventional and traditional medicine. Adapt the protocols according to these similarities.

- Promote the participation of carers in psychosocial care protocols.

- Promote the creation of associations of families and carers, provide training on psychosocial support and ensure the financial sustainability of associations.

Ensure the provision of priority services and goods to complement psychosocial support activities

- Ensure that people receiving psychosocial care receive complementary food and medical assistance to enable them to participate fully in activities. In this respect, many of the informants considered psychosocial care to be of secondary importance compared to meeting their basic needs.

- Create a referral network of non-governmental organisations and state structures involved in mental health to ensure effective referrals to other services. Follow up the referrals.

Increase collaboration with state structures

- Facilitate dialogue between Ministry of Health structures and international organisations in order to promote a transition and the sustainability of psychosocial services.

- Harmonise monitoring and evaluation procedures between the public sector and international organisations.
- Develop qualitative evaluation tools as opposed to quantitative monitoring and impact indicators (understanding "how" care is provided, rather than measuring "how many" people have benefited).
- Establish relationships with centralised state services in contexts where the decentralisation of state services is relatively inefficient and where decisions taken at central level are often disconnected from local realities.

Improve awareness

- Organise awareness-raising and outreach activities on the symptoms of post-traumatic stress disorder and psychosocial care. The aim is not to promote conventional medicine as opposed to traditional medicine, nor to devalue the latter, but to show that a variety of illnesses can be relieved by equally varied and complementary approaches.

- Awareness can be raised through social networks and on provincial radio stations. For example, the Mentally Aware Nigeria Initiative uses social media to raise awareness of mental health issues among the general public.

- Explore partnerships with audiovisual production agencies (e.g. the visual anthropology laboratory of the University of Maroua) to produce awareness-raising videos and/or a documentary on mental illness and how to alleviate it.

- Also explore possible collaborations with touring theatre groups and provincial radio stations to raise awareness of the causes, consequences and treatment of mental disorders.

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RESILAC*

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