RESILAC*

*LAKE CHAD INCLUSIVE ECONOMIC AND SOCIAL RECOVERY

LESSON-SHARING REPORT

ON THE IMPLEMENTATION OF PSYCHOSOCIAL SUPPORT ACTIVITIES

MARCH 2022

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

ACTION CONTRE LA FAIM

care

Groupe URD
Urgence . Réhabilitation . Développement

SUMMARY

LESSON-SHARING REPORT ON THE IMPLEMENTATION OF PSYCHOSOCIAL SUPPORT ACTIVITIES

ACRONYMS AND ABBREVIATIONS

ACF	Action Against Hunger
GBV	Gender-Based Violence
IASC	Inter Agency Standing Committee
IGA	Income Generating Activity
MHPSS	Mental Health and Psychosocial Support
PFA	Psychological First Aid
PM	Pillar Manager
PM+	Problem Management Plus
NSAG	Non-state armed groups
PTSD	Post-traumatic stress disorder
SFCG	Search for Common Ground
WHO	World Health Organization

INTRODUCTION

BACKGROUND

The Lake Chad region includes parts of the four countries around the lake (i.e., Niger, Nigeria, Cameroon, and Chad) and extends 1,000 km from north to south, and 500 km from east to west. In 2015, it was estimated that the active watershed of Lake Chad was home to nearly 50 million people. Considered essential to the food security of 13 million people and two metropolises - N'Djaména, the capital of Chad, and Maiduguri, the capital of Borno State in Nigeria - this area has been under threat for several decades. Indeed, the Lake Chad Basin (LCB) region is faced with major challenges, whether environmental (vulnerability of ecosystems to climate change and pressure on natural resources), socio-economic (rapid population growth, religious tensions, poverty, etc.) or political (corruption, repeated political crises, geopolitical issues).

Since 2009, the region has also been subject to an unprecedented security crisis due to the activities of various Non-State Armed Groups (NSAGs). Their attacks, exactions and territorial expansion since 2013-2014 have had a profound impact on the regional system (stopping trade flows) and its population (murders, kidnappings, massive popu-lation displacements, etc.). The NSAGs' strategy of terror and the response by the national defense and security forces, combined with the chronic challenges of the region, have both reinforced pre-existing conflicts (agro-pastoral conflicts induced by the scarcity of natural resources, inter- and intra-community conflicts, etc.) and created new forms of conflict (conflicts between displaced and host populations, between different religious and ethnic groups, the creation of citizen self-defence militias leading to an increase in violence, etc.). In 2017, this region was considered one of the most vulnerable in Africa and subject to one of the worst contemporary humanitarian crises[1].

PRESENTATION OF RESILAC PROJET

It is in this multidimensional crisis context that the RESILAC project «Inclusive Economic and Social Recovery of Lake Chad» was launched in 2018. Co-funded by the European Union (Emergency Trust Fund for Africa) and the French Development Agency for a duration of 4 years (2018-2021), and an extension of one yeay (2022).

RESILAC is implemented by an international consortium: Action contre la Faim (ACF) - lead partner, CARE and Groupe Urgence Réhabilitation Développement (URD), also in partnership with the CCFD - Terre Solidaire network, Search For Common Ground (SFCG) and local organizations in the four countries (Niger, Nigeria, Cameroon and Chad). This project aims to contribute to economic recovery and increased resilience and social cohesion in the territories of the Lake Chad Basin (LCB) most affected by the

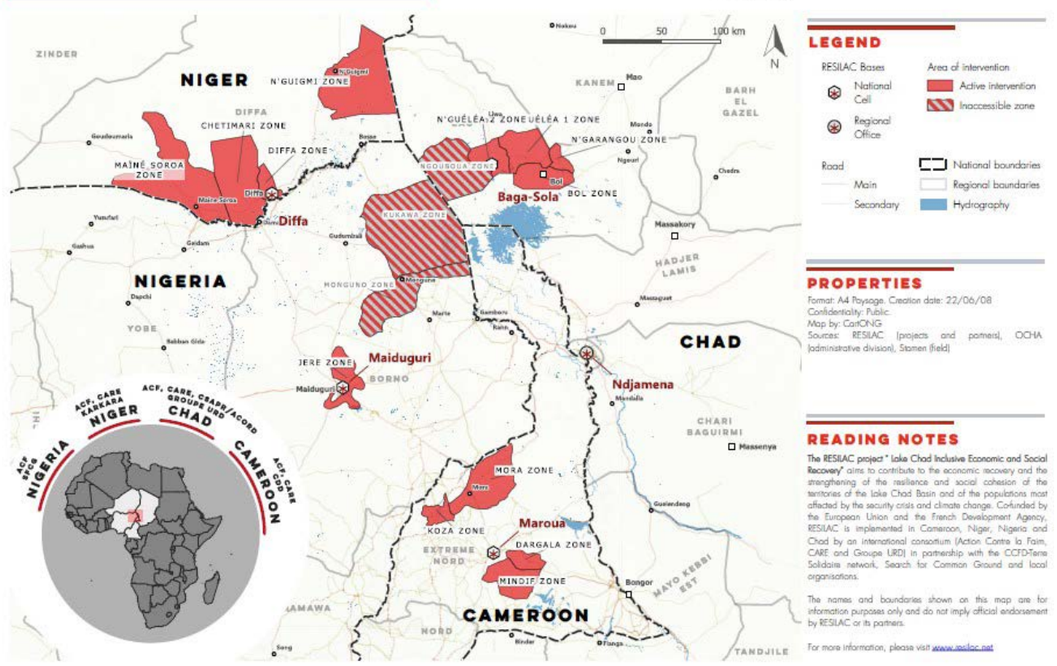
1 - Groupe URD, « Approche territoriale en contexte de crise : levier pour le renforcemente de la résilience », March 2022.

security crisis and climate change. The RESILAC project is structured around four operational areas (pillars):

- **Pillar 1:** Strengthening human capital and social cohesion, by improving the social cohesion of the population, particularly through support for territorial development and psychosocial support for victims of armed groups.
- **Pillar 2:** Economic recovery and population resilience, creating jobs on community infrastructure rehabili-tation sites and supporting agricultural micro-entrepreneurship and apprenticeships.
- **Pillar 3:** Institutional strengthening: improving the governance of municipalities for better management of territories and natural resources.
- **Pillar 4:** Knowledge production to contribute to the quality of project activities, and to inform the decisions made by local actors.

OPERATIONAL AREAS

RESILAC: INTERVENTION ZONES AND PARTNERS



METHODOLOGY OF THE STUDY

This report is part of the RESILAC lesson-sharing process after more than 3 years of implementation; it focuses on the project's psychosocial activities (pillar 1.2) and has 3 objectives:

1. Sharing the project **results** within the team, but also with donors, aid actors, authorities, local actors, etc.
2. Formalizing **lessons learned** (challenges, good practices, innovative practices, etc.) in order to share them with internal and external stakeholders.
3. Sharing these **lessons** with donors and authorities in order to help decision-making and to bring about changes in practices at a more systemic level.

The methodology of the report is based on:

- A **literature review** (project proposals, Pillar 1.2 lesson-sharing reports, success stories, experience reports, mental health research).
- About 15 **interviews** with the project team members in the 4 countries.
- 4 **focus groups** in Niger and Chad.

This lesson-sharing exercise aims to allow RESILAC actors, partners and beneficiaries to identify the important aspects of the project. It is therefore not an evaluation, and does not aim to establish a value judgement on the achievement of results. Rather, it aims to formalise the lessons learned on certain aspects of the project, beyond the results, based on their experience.

Limitations

- the limited availability of participants to provide information for the lesson-sharing process during the final phase of the project;
- the inability to travel to the operational areas.

LESSON-SHARING REPORT ON THE IMPLEMENTATION OF PSYCHOSOCIAL SUPPORT ACTIVITIES

1. CONTEXT AND ISSUES

1.1 MENTAL HEALTH DISORDERS

The economic, political, security, and climatic crisis in the Lake Chad Basin is causing serious psychological trauma among the po-pulation. This is most often linked to the increase in insecurity due to the presence of Non-State Armed Groups (NSAG), and the extreme violence of their attacks (kidnappings, killings, rape, etc.). The related symptoms can vary in severity depending on the individual: post-traumatic stress disorder (PTSD), anxiety disorders (social anxiety, generalized anxiety), mood disorders (depression, bipolarity) and some cases of psychotic disorders (schizophrenia)[2].

Large-scale displacement due to the security crisis has also weakened people's psychological state. At the beginning of 2022, there were 2.8 million IDPs and 265,000 refugees in the Lake Chad Basin region[3]. These people have had to leave their land and their loved ones, and sometimes they have been stigmatised within the host communities. In addition to possible ethnic and cultural disputes, there are also tensions over access to limited natural resources in an area that is already extremely poor and is under pressure from the massive influx of displaced people.

In addition, the region has **practical and economic** problems that have been exacerbated by the crisis. The Lake Chad Basin is affected by endemic poverty, political instability, lack of access to basic services, and climatic variability that impacts agricultural and pastoral activities in the region. Insecurity has also hampered economic activities around the lake. The NSAGs limit access to the area, prevent trade, and can sometimes directly attack the fields, livestock, or stores of local people. Government measures to combat insecurity, including border controls around the lake, can also affect trade in the area. In such a context, people have limited access to economic opportunities and basic services, and cannot meet their priority needs, which can lead to stress, fatigue, and poor mental health. In fact, the results of the midline survey reflect a fairly low level of well-being in the intervention zones, where 66% of respondents say they are in a state of subjective psychological distress[4].

2 - Groupe URD, "Regional study: The management of psychological suffering in the Lake Chad basin", September 2021.
3 - OCHA, Humanitarian Snapshot – Lake Chad Basin, January 2022.
4 - RESILAC, Midline, Août 2021, available here.

1.2 MENTAL HEALTH CARE PROVISION

Despite the growing need in the region, cultural and political barriers limit the provision of mental health care, which is mostly provided by humanitarian actors. At the cultural level, psychological disorders are still perceived in mystical terms, often associated with a divine curse that punishes the behaviour of the patient or his/her entourage. People therefore prefer to resort to traditional medicine which involves a network of familiar actors (imams, marabouts, healers) and remedies that are in keeping with local customs (Koranic verses, use of local plants etc.). These remedies are less stigmatized than those used by modern medicine, especially when the latter requires a visit to the hospital, which is often too costly, or to psychiatric wards, which are still widely associated with «madness». They also seem to be more effective because they are often accompanied by medication or rituals, whereas psychotherapy involves only talking and requires a longer and more continuous commitment from the patient. For families, this option is not always feasible. They want concrete and quick results because the patient is often an additional economic burden and can become a source of stigma and exclusion in the community. In addition, many of them live outside urban centres, where most psychosocial care is concentrated, and may not be familiar with modern medical practices.

Politically, mental health is still not a priority in the Lake Chad Basin region, which means that there is a lack of personnel and infrastructure in the 4 countries. In Cameroon, despite a national mental health policy, the network of professionals and MHPSS activities remain centralized and do not sufficiently cover the Far North of the country. The situation is even more critical in Chad where, although there is a national mental health program based at the hospital in N'Djamena, the resources allocated to it are very limited and its actions are limited to the capital. In Nigeria, the Borno State Ministry of Health developed a strategic plan in 2019 to promote the coordination and implementation of mental health activities. The country has one psychiatric hospital, and there are only 250 psychiatrists at the national level for a population of 200 million. In Niger, the situation is improving. A national mental health program covers several regions of the country, including Diffa, and the University of Niamey has a psychology program which helps to mobilise human resources in this field.

Much of the mental health care is therefore provided by humanitarian actors, particularly in the Lake Chad Province where insecurity limits the state's presence. However, this is not always a priority, especially in an environment where needs related to food, housing and physical health remain very urgent. A lot of awareness raising is therefore necessary, to destigmatize mental problems and to explain MHPSS activities and their relevance.

LESSON-SHARING REPORT ON THE IMPLEMENTATION OF PSYCHOSOCIAL SUPPORT ACTIVITIES

Examples of international structures involved in mental health in the region[5]

ACTORS	ACTIVITIES
	UNITED NATIONS AGENCIES
UNFPA	Training to improve psychosocial care services for women victims of gender-based violence (GBV)
HCR	Psychosocial care for refugees
UN Women	Identification and psychosocial care of female victims of GBV and sexual violence
IOM	Deployment of mobile psychosocial teams and rehabilitation of several listening centers
	INTERNATIONAL ORGANISATIONS
ACF	PM+ training, PSP training, psychosocial group support, mobile clinic
COOPI Unicef	Training of medical personnel, supply of medicines, psychosocial care, awareness-raising activities for the population
MSF	Establishment of psychosocial and psychiatric care units, training in mental health and medical care of mental patients, mobile clinics
Intersos	PSP training, emergency management of GBV and sexual violence cases, play activities for children
IRC	Psychosocial support for people with special needs, refugees and victims of GBV
Plan International	Conducting mental health consultations, psychosocial support for victims of sexual violence and abuse
ICRC	Psychological support and emergency intervention in cases of GBV, listening and referral activities
CRS	Psychological support and emergency intervention in cases of GBV, listening and referral activities
CLIRA	Psychosocial support activities for vulnerable people
COOPI USAID	Raising awareness of the population on mental health issues, collaboration and reinforcement of health care facilities, psychosocial accompaniment and psychosocial support
	LOCAL ASSOCIATIONS
Associations	Youth and women's associations that can visit patients and raise awareness about GBV
APPM	Association of Professional Psychologists of Niger (APPM): awareness activities and referral of patients
AMSM	Mental Health Association (AMSM): awareness activities and referral of patients in Cameroon
AFJT	Association of Women Lawyers of Chad: listening sessions and training

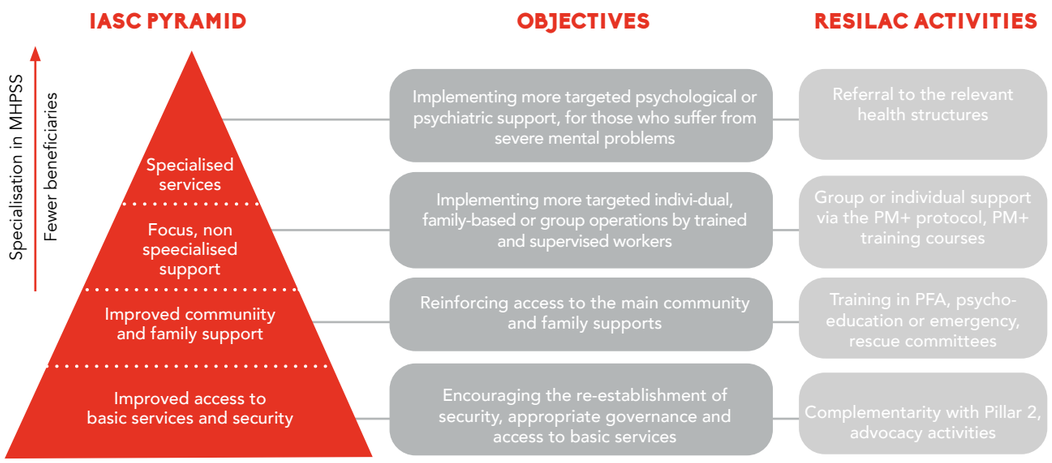
5 - This table is not exhaustive but presents a sample of mental health actors present in the zone, mentioned in interviews or in the literature review, particularly in the Chad and Cameroon mental health studies.

2. RESILAC RESPONSE

2.1 PRESENTATION OF THE PILLAR 1.2

In order to adapt to the emergency context of the Lake Chad Basin, the RESILAC project adopts a multi-dimensional approach to mental health and psychosocial support (MHPSS). As suggested in the IASC pyramid model[6], the activities cover different aspects of psychological distress, and respond to it on several levels, from strengthening access to basic services to targeted psychiatric support.

Inter-Agency Standing Committee (IASC) Pyramid and RESILAC activities



- **The support groups** are composed of about ten people who meet for six weekly sessions. They are facilitated by a pair of psychosocial workers trained by the project and supported by the Pillar Manager.

- **Individual care** is provided through the problem management protocol (PM+), based on a cognitive behavioral strategy for solving problems, which can be both psychological or practical (income, food, housing etc.). The protocol targets only beneficiaries of psychosocial support, and consists of 5 weekly sessions facilitated by psychosocial workers, with support from the Pillar Manager.

- **Psychoeducation sessions** take place before therapeutic groups are formed. They are a means of identifying people in distress and raising awareness about mental health and the support provided by RESILAC. They are facilitated by psychosocial workers, with support from the Pillar Manager, and are organized with the help of the local authorities.

- **PM+ training**[7] consists of 6 theoretical sessions and 7 supervision sessions. It is facilitated by the Pillar Manager, with support from psychosocial workers, and is mainly aimed at community-based health workers to promote psychosocial care in primary health care structures. It is part of the project's exit strategy towards empowerment and local skills transfer.

- **Psychological First Aid** (PFA) training is a three-day programme for community leaders. It raises awareness about mental health and identifying people in distress following an emergency situation, and teaches rapid response techniques.

- **First aid committees** bring together people trained in PFA via a series of 6 weekly workshops. Their role is to listen to and orient beneficiaries in the event of a crisis and are part of RESILAC's exit strategy.

- **Advocacy activities** aim to raise awareness of mental health issues among the authorities and the community. They also aim to promote the project's results among local and national health authorities in order to ensure that the project has a long-term impact.

The implementing partners for Pillar 1.2 are ACF in Niger, Chad and Cameroon, and SFCG and the Neem Foundation in Nigeria.

6 - In 2007, the Inter Agency Standing Committee (IASC) developed guidelines on mental health and psychosocial support (MHPSS) in emergencies. These guidelines help to plan, establish, and coordinate a set of multi-sectoral responses to protect, support, and enhance MHPSS for people in emergency settings. The IASC pyramid models these guidelines as a 4-level response illustrated in the diagram.

7 - The PM+ Health Protocol (WHO), is a psychosocial intervention protocol based primarily on the cognitive behavioral problem solving strategy, aimed at improving the well-being and functioning of adults exposed to adverse environments.

2.2 RESULTS OF THE PILLAR 1.2*

At the regional level

7,007 individuals
who received group support

1,749 individuals
accompanied with the PM+ protocol

1,507 individuals
trained in the PM+ protocol and PFA

8,588 individuals
made aware of mental health issues through psycho-education sessions

At the country level

Activities	Nigeria	Niger	Cameroon	Chad
GROUP SUPPORT	2335	2360	857	1455
PFA AND PM+ TRAINING	419	443	355	290
PM+ SUPPORT	634	671	210	234
PSYCHO-EDUCATION	0[8]	4431	1451	2706

** Results between March 2019 and December 2021.*

8 - No psycho-education sessions were conducted in Nigeria.

LESSON-SHARING REPORT ON THE IMPLEMENTATION OF PSYCHOSOCIAL SUPPORT ACTIVITIES

3. RESULTS

3.1 IMPROVING SUBJECTIVE WELL-BEING

The majority of beneficiaries say that their subjective well-being[9] has improved thanks to the psychosocial support activities. The group therapy sessions follow the ACF care protocol and create a space for exchange and listening within the community. As of September 30, 2021, 7,007 beneficiaries had participated in this activity in the four countries. Composed of about ten people, the groups meet to talk about life before the crisis, its impact on daily life, and the most difficult moments they have been through. They allow beneficiaries to express emotions that they have kept inside, to share these with other people who can understand them, and to relax thanks to different facilitation techni-ques, such as dancing, singing, and breathing exercises.

Support group, Chad © RESILAC

"It was our only weekly meeting place where we could share our experiences and have tea. The fact that the session is coming to an end deprives us of a space to relax, we are worried, but we will continue to meet together as we did in this group."

Beneficiary, support group, Chad

9 - The well-being of the beneficiaries was measured using the WHO-5 international scale developed by the World Health Organization (WHO) before and after the treatment in order to observe the improvement - or not - of the beneficiaries' psychological state (see section 4.6 Follow-up).

In Nigeria, some say it has helped stabilize their households because they have been able to address their marital problems and find better ways to communicate with their partners. However, for long-term family well-being, some regret that psychosocial support is not offered to children and the elderly, who are equally, if not more, vulnerable in times of crisis.

Mental health activities also address the direct causes of psychological distress, notably through the PM+ protocol, which is used to provide beneficiaries with individual care. They learn calming techniques, such as breathing exercises or stretching, which they can then pass on to those around them. For a longer-term impact, the beneficiaries also draw up a concrete action plan to address both psychological issues (depression, anxiety, PTSD, and acute stress) and practical issues such as employment, housing, or family conflicts.

CAMEROON: RESULTS OF THE PM+ APPROACH

Fatou, a young mother of two, suffered from intense anxiety. Through the PM+ protocol, she identified her problems, which she felt were related to her husband's separation, her insufficient income and her inability to join the military. She then developed an action plan with the help of the psychosocial workers to find out about public service entry exams, identify resource people, take up sport again, start a business, and foster dialogue with her ex-husband. She is now preparing the entry exams for the army, has saved money thanks to the RESILAC project's labour-intensive public works activities, and has strengthened relations with her children's father's family.

PM+ Experience Report, RESILAC, May 2020

3.2 STRENGTHENING SOCIAL COHESION

Increased well-being allows beneficiaries to regain their self-confidence and reconnect with community members. Listening, sharing, calming techniques, and action plans help them to overcome their difficulties and regain control of their lives. Some share this knowledge with people around them who cannot participate in the activities, and feel that they have become role models in their community.

They also feel **less stigmatized** thanks to the psycho-education sessions that help to change perceptions of psychological problems and those who are ill. All this helps to make them more confident and ready to get involved again in the socio-cultural activities of the village.

The regular meetings and sharing of personal experiences has also **strengthened relations** between the different members of therapy groups, whose composition is very hetero-geneous. While most groups do not mix men and women, out of respect for

traditional customs, they do bring together people of different ages, ethnicities and social status. This implementation strategy has had an impact on the stabilization of communities in Nigeria, for example by helping to reintegrate people who have «survived» Boko Haram. In Chad, they have increased dialogue between young and old on topics such as marriage, work and migration. In Niger, in the village of N'gagala, they have strengthened cohesion between the host community and the displaced. In all four countries, many groups continue to see each other, even after the RESILAC activities have ended.

NIGERIA: SUPPORT GROUPS' RESULTS

« I was taken by force to Sambisa by Boko Haram. I was married, my first husband was killed (...) After my release, I was happy to be back in town. Unfortunately, I was stigmatized, I was called different names in my community (...) After staying at home for weeks, life was boring, I thought about going back to the bush. After my mother introduced me to this session, I started to feel more confident. I chose not to go back to the bush, and the stigma decreased in the community. »

Beneficiary, support group, Nigeria

3.3 CONTRIBUTION TO THE LOCAL ECONOMY

Due to increased self-confidence and confidence in others, beneficiaries have become more involved in the local economy, through individual or group initiatives. Some believe that psychosocial support has strengthened their confidence in themselves and in the future, and thus their desire to get involved in economic activities in the area.

In some cases, this has been possible thanks to Pillar 2 activities, including labour-based works, which have allowed them to save and invest in **income-generating activities (IGAs)**.

Beneficiaries have also created strong ties within support groups, some of which have become **tontines**. These structures have enabled their members to cover a certain number of expenses (medical visits, weddings, funerals) on an ad hoc basis and, more rarely, to invest in IGAs (market gardening, small businesses). Some have not lasted due to lack of funds. If members rely solely on the tontine and no other source of income, then they cannot contribute to the shared sum and ensure that the system is sustainable. Other benefi-ciaries, about 100 in Cameroon alone, have also formed village savings and credit associations (VSCAs), and are drawing on the advice and methods used by Pillar 2 in the project.

3.4 CAPACITY BUILDING

The project has reinforced the capacity of psychosocial workers, community-based health officers and community leaders with a view to increasing decentralized mental health services in the region. As of September 30, 2021, 1,507 people in the 4 countries have had training in PFA and PM+. As a result, they have better understanding of mental disorders and the related symptoms, and are able to refer patients to the appropriate health structures. The community-based health officers trained in PM+ are able to manage their patients more effectively by using stress management, calming, listening and empathy techniques. Local authorities appreciate the PM+ training course, which is considered innovative, adapted to beneficiaries' problems and accessible to local health actors.

> *In their consultations, sometimes ASBCs can only stay 2-5 minutes per patient. Now they take the time to do a good interview to find out what the patient is suffering from. If it's within their area of expertise, they take it on, and if it's not possible, for cases of psychosis or epilepsy, they refer it to the health center.»*
>
> **Pillar Manager 1.2, Niger**

Through their work with psychosocial support groups, the newly recruited **psychosocial workers** have developed skills in listening, identifying mental disorders, and managing data. Talking to patients and gathering information about their condition needs to be done in keeping with certain notions: neutrality, impartiality, confidentiality, informed consent, etc. As a result, psychosocial workers are better able to facilitate therapeutic groups and PFA training sessions, skills that they can then use in other projects in the region. Generally, they are respected within the population and provide strong psychological support.

LESSON-SHARING REPORT ON THE IMPLEMENTATION OF PSYCHOSOCIAL SUPPORT ACTIVITIES

4. LESSONS LEARNED

4.1 TARGETING

Cultural, security, and opera-tional constraints have sometimes hindered appropriate targeting of beneficiaries and project intervention areas. For support groups, beneficiaries are identified during psycho-education sessions. These are organized with the help of the local authorities and bring together community leaders and the population with the objective of introducing RESILAC activities, targeting potential beneficiaries, and raising awareness about mental disorders and their symptoms. As they are often held outside, the organisers have difficulty controlling the number of participants in these meetings, which sometimes reaches 50 people, rather than the 30 initially planned. The profiles involved can therefore be varied and are not always those targeted by the project. For example, they may not fit into the 18-35 age group, or may not be in a state of psychological distress. This can create frustration within the community and confusion about the RESILAC team's selection criteria.

> *RESILAC believes that old people do not have psychological problems and cannot participate in economic development.*
>
> **Beneficiary, support group, Chad**

Security constraints have sometimes hindered appropriate targeting of **intervention areas**. While the project is being run in the centre of the area affected by the crisis in Chad, Niger and Nigeria, its activities are limited in certain localities in the Far North region of Cameroon. The Logone et Chari department, for example, located near the lake, has extremely significant mental health needs and is not covered by the project.

4.2 CAPACITY BUILDING

Capacity building is most effective and sustainable when training courses are culturally appropriate, accompanied by hands-on instruction and ongoing follow-up, and integrated into the local health strategy. Some community-based health officers felt that certain PM+ training tools were not culturally appropriate, particularly the psycho-metric scales used to assess the patient's psychological status through a series of questions.

These were sometimes too long, difficult to translate into the local language, and dealt with topics that were too sensitive for the patient (sex, hygiene, etc.). In addition, the PM+ training course was conducted primarily in French, while some community-based health officers only speak the local language, which meant that psychosocial workers had to be present to assist the Pillar Manager in translating certain modules.

Practical training was also provided to the community-based health officers. The 6 days of theoretical training in the PM+ protocol were complemented by supervision sessions, during which the community-based health officers discussed practical cases encountered in the field, and difficulties in implementing the protocol.

Finally, the project also included a **weekly follow-up session** with the staff in charge of psychosocial support in the field. Some were dealing with complicated psychological profiles and difficult sessions, while others were running very heterogeneous support groups, which required significant listening and diplomacy skills to ensure that there was cohesion among the participants and that all were able to express themselves despite differences in age, ethnicity or social status. These follow-up sessions help to monitor the mental health of the psychosocial workers who, in these areas of intervention, may have experienced similar traumas to those of their patients.

MHPSS training session, Cameroon © RESILAC

> *One of the psychosocial workers told us that during the 3rd session, he was blocked and he could not continue to lead the session; the other psychosocial worker had to finish the session. Sometimes he has nightmares about what the beneficiaries tell him.*
>
> **Pilar manager 1.2, Chad**

Finally, to facilitate the organization of the PM+ training and ensure that it has a sustainable impact, it is important to include its implementation in the **local health strategy**. Each intervention began with a meeting with the local authorities so that they would support the organization of the training and commit to the sustainable implementation of the PM+ protocol. This meeting also served to clarify the strategy adopted. The objective of the PM+ training is to integrate psychosocial care into primary health care, which will be accessible in any type of health center, regardless of the existence of specific mental health units. The aim of the project is therefore not to ensure that the PM+ protocol is established sustainably through the construction of new units, as may sometimes be suggested by local authorities.

In addition, the lack of available human resources in the psychosocial field sometimes slows down the implemen-tation of activities, as in Nigeria for example. The PM+ protocol is an innovative practice in the communes where the project is being implemented. It requires in-depth training for RESILAC staff, ideally in person, which is not always possible given the security situation.

4.3 COOPERATION WITH EXTERNAL ACTORS

Good cooperation with local authorities, traditional actors and international organizations can stren-gthen beneficiaries' adherence to the project, the treatment that is provided and its sustainable impact. In all four countries, the **local health authorities** helped to establish the support groups. They facilitated the organization of psycho-education sessions, the partici-pation of community leaders, and helped to raise awareness among local popula-tions who were unfamiliar with psycho-social support. They also helped to organise the PM+ protocol training courses by contacting health centers, helping to select the participants, providing training sites, etc. In Niger, they particularly appreciated the innovative aspect of the protocol, implemented for the first time in the Diffa region. In Cameroon, the health districts benefiting from PM+ training signed an agreement with the Far-North Regional Delegation of Public Health for the implementation of the protocol in the area.

There was less cooperation with **traditional medical actors** (imams, marabouts and healers). They sometimes participated in psycho-education ses-sions and PFA training sessions, but were not asked to help implement activities or to give advice. However, the MHPSS team agrees that they play a major role in patient care, and feels that it might be possible to improve cooperation. Involving these actors, who are familiar with the patients and their customs, would help beneficiaries to embrace psychosocial support more fully (see section 2.2). It would also improve the treatment provided, combining modern and traditional practices, and thereby meet patients' needs more effectively. In certain communities, such as Chetimari in Niger, increased awareness of epilepsy symptoms among traditional actors has resulted in a large number of patients being referred to health centres.

> *On another project, I worked in the commune of Chetimari, in the region with the most cases of epilepsy. Some people went to Nigeria in the hope of being cured by marabouts, but the disease continued. We then worked with health centers, the patients were provided with a medical treatment and remained stable for several months with continuous care. We did a lot of awareness-raising within the community and among traditional actors about the symptoms of epilepsy, and now people can send patients directly to the center.*

Pillar manager 1.2, Niger

The RESILAC project began working on this approach in Niger, in the village of Dosso. In late 2021, the MHPSS team conducted a study of traditional medicine, and trained 180 healers in mental illness and its symptoms. Similarly, in Nigeria, in early 2022, the team organized a roundtable discussion with 20 different practitioners of traditional medicine, some of whom are due to receive training on mental illnesses that they can then transmit within their communities. At the same time, some traditional practices can also facilitate the work of modern medicine in terms of helping the patient to express themselves and reassuring them. In Niger, for example, one practice consists of asking the patient to speak into an empty bottle and to spit into it as soon as a painful issue comes up. The practitioner then seals the bottle to symbolize the removal of the event from the subject's memory. This is then followed by incantations and other ritual procedures whose symbolic function is to reduce the suffering[10].

A lack of cooperation with **international actors** can limit the relevant targeting of intervention zones and the sustainable impact of the project. In Niger, for example, the project is being implemented in the departments of Diffa, Bosso and Nguigmi, where most humanitarian actors are already concentrated, and not in Goudamaria, where NGO action remains very limited. In Cameroon, RESILAC is active in the Far North region, but is not very present in the Logone et Chari area. More cooperation with external actors would also strengthen RESILAC's psychosocial support and its sustainable impact. It would allow more discussion of challenges and good practices, and of the advocacy messages to be communicated to the authorities. This has already begun in Cameroon, where the MHPSS team organized a mental health forum on December 15, 2021, bringing together key actors in the field in the region. The participants presented their findings and created a booklet of 10 mental health advocacy messages to promote at the national level.

10 - For more details, see the report «The management of psychological suffering in the Lake Chad Basin», Groupe URD, 2021.

Mental Health Forum, Camerooon © RESILAC

4.4 TREATMENT

The treatment of beneficiaries by means of the PM+ protocol and group therapy needs to be adaptable to the cultural, economic and security context of the different operational areas. In Chad and Niger, for example, in order to respect local customs and to allow women to express themselves freely, the support groups were not mixed. Conversely, in Cameroon, although they were reluctant at first, the participants appreciated the mixed nature of the groups and perceived this as a factor of social cohesion.

> *Being in this group and listening to other women has made me aware of the unconscious pain I was putting my wife through as well and I will change.*

Beneficiary, support group, Cameroon

Psychosocial support must also take into account the economic and security context in order to be adapted to the needs of beneficiaries. Many therefore stressed the importance of inter-Pillar coordination which ensures that activities aimed at alleviating mental suffering and identifying its causes (pillar 1.2) are complementary with those aimed at strengthening livelihoods and limiting the impact of precariousness on people's psychological state (pillar 2). The majority of beneficiaries also appreciated the PM+ protocol, which follows this approach and addresses both psychological and practical problems. However, in some of the more stable intervention areas, such as Cameroon, adherence is less strong. The beneficiaries selected based on psychological criteria were affected by vulnerability factors such as GBV or family conflicts rather than the symptoms of PTSD. Although the PM+ protocol is also aimed at these profiles, some young people felt that the psychosocial support was too long and not very effective in meeting their priority needs, which are mainly economic.

.

4.5 INTER-PILLAR COORDINATION

Inter-pillar coordination has helped to strengthen beneficiaries' adherence to psychosocial support and to provide assistance that is adapted to their needs. However, it brings a number of challenges at the operational level in terms of targeting and the implementation of activities. Given RESILAC's multi-dimensional approach, mental health is not limited to psychosocial support, but also relies on other socio-economic factors that can influence the psychological state of the beneficiary. However, challenges in relation to targeting and the implementation of activities have sometimes hindered inter-pillar coordination, especially with Pillar 2. More often than not, MHPSS activities began after economic recovery activities. This hindered the proper targeting of beneficiaries and **intervention areas** for Pillar 1.2, and the smooth implementation of its activities. In Cameroon, some villages were chosen for their proximity to the labor-intensive worksites, and not according to the criteria initially planned by the MHPSS team in keeping with RESILAC's global approach (presence of refugees or displaced persons, inter or intra-community conflicts, etc.).

Awareness raising on labour-intensive worksites, Cameroon, © RESILAC

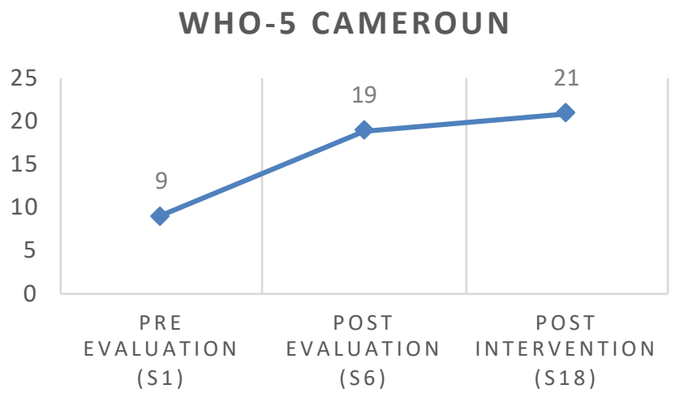
Targeting **beneficiaries** was also a challenge in all four countries. When Pillar 2 activities started well before Pillar 1.2 activities, the beneficiaries of psychosocial support were unable to take part in labor-intensive activities, as they had already been completed. When Pillar 2 and Pillar 1.2 activities were implemented simultaneously, the number of beneficiaries who took part in labor-intensive activities greatly exceeded the number planned by the MHPSS team, who were unable to provide psychosocial support to all those who wanted it. In Chad, for example, during the first operational cycle, only 30% of the youth involved in labour-intensive activities received psychosocial support. In Niger, on the other hand, as of December 31, 2021, out of the 900 youth involved in labour-intensive activities, 671 had benefited from PM+, which shows that there has been an improvement in inter-pillar coordination during the project.

Concerning the **implementation of activities**, close collaboration between the Pillar 1.2 and Pillar 2 teams is necessary. By sharing the timetables of labour-intensive activities and psychosocial support sessions, they can ensure that beneficiaries are available and justify any absences if these are necessary. This was difficult when the teams were not part of the same organizations, such as in Niger where MHPSS activities were implemented by ACF and some Pillar 2 activities were implemented by CARE.

4.6 MONITORING THE EFFECTS OF MHPSS

Post-intervention evaluations provide a partial account of the effects of psychosocial support. These are carried out three months after the end of the activities and consist of meeting the former beneficiaries to assess their state of well-being using different tools. Psychometric scales are used before and after the intervention to measure how the beneficiary's psychological state has evolved. More qualitative information is also collected via individual interviews and focus groups. These evaluations were initiated by Pillar 1.2 and staff are still working on the methodology. Nevertheless, they do provide an overview of the project results: increased social cohesion as a result of the MHPSS activities, increased well-being of individuals, and sustainable gains in the area of PFA care.

Results of the WHO-5 psychometric scale, Cameroon, 2021



The graph above shows the results of an evaluation conducted among 211 beneficiaries in the commune of Mindif and Dargala, Cameroon, in 2019, using the WHO-5 well being index developed by the World Health Organization (WHO). It measures a person's subjective state of well-being; that is, each person's perception of his or her own state of well-being through **five statements**:

1. I have felt cheerful and in good spirits
2. I have felt calm and relaxed
3. I felt active and vigorous
4. I woke up feeling fresh and rested
5. My daily life has been filled with things that interest me

Each statement has **5 possible answers** and the points are added together to obtain a final overall score between 0 and 25.

- All of the time (5)
- Most of the time (4)
- More than half the time (3)
- Less than half the time (2)
- Some of the time (1)
- At no time (0)

The graph shows how the WHO-5 scores evolve between the beginning of the intervention (Week 1), the end (Week 6), and three months later (Week 18).

However, these assessments raise methodological and operational questions that limit their implementation in the field. Measuring the state of well-being of an individual in a quantitative way is a complex operation, and RESILAC teams are aware of the limits imposed by psychometric scales. These do not take into account external factors (social, economic, etc.) that can also influence the individual's state,

LESSON-SHARING REPORT ON THE IMPLEMENTATION OF PSYCHOSOCIAL SUPPORT ACTIVITIES

and despite the efforts of RESILAC staff to adapt the tool to the cultural context, it is not always easy for beneficiaries to use (too many questions, difficult to translate into the local language, etc.). To measure the impact of interventions in greater depth, the teams adopt a more qualitative evaluation approach through interviews and focus groups.

However, thinking about appropriate and effective evaluation tools and carrying out a complete evaluation requires time and expertise that the teams in the field do not always have. First, it is necessary to identify former participants, which can be difficult at certain times of the year (rainy season, field work period, etc.) and given the number of beneficiaries, which can sometimes exceed 200 per six-week cycle. Discussions then have to be facilitated using different tools: psychometric scales to collect quantitative data, but also questions to facilitate focus groups and interviews that will allow for a more in-depth exchange. These tools need to be translated, designed and adapted to the different local contexts, all of this before the evaluation. And yet, all of this qualitative work involved in conducting post-intervention evaluations is not contractual despite sometimes requiring additional time and human resources. As a result, post-intervention data can be uneven from one country to another, and vary according to the time, resources, and skills of the teams in the field.

5. RECOMMENDATIONS

IMPLEMENTATION

1) Raise awareness of mental health and psychosocial support prior to the implementation of activities:

- Raise awareness of mental health issues within **communities**, normalize psychological disorders and destigmatize patients.
- Introduce RESILAC's **MHPSS activities**, the impact they have on economic recovery, and the project's activities in this area.
- Explain the **criteria** for selecting project beneficiaries during sensitizations to avoid potential tensions within the community.
- Provide an **alternative** for beneficiaries who do not meet these criteria, and strengthen the synergy with social cohesion activities that also contribute to enhancing well-being.

2) Adapt treatment and training to the cultural context:

- **Translate therapeutic tools** into the local language, including questionnaires used to assess patients' psychological status.
- Use culturally appropriate **facilitation techniques and tools** to avoid clashes with local customs (e.g., related to gender or religion).
- Creating a **working group** made up of psychiatrists, psychologists, psychosocial workers, traditional therapists, local authority representatives, and mental health patients and their relatives, could help to adapt the WHO protocols (e.g. PM+, scales) to the local context[11].

3) Strengthen cooperation with traditional actors, particularly those involved in medicine (marabouts, imams, healers). This should help to strengthen beneficiaries' adherence to MHPSS activities, the mental health care that is provided, and their resilience by providing sustainable psychosocial support based on endogenous care mechanisms rather than the external organisations involved in the project:

11 - For more details, see the report «The treatment of psychological distress in the Lake Chad Basin» Groupe URD, 2022.

LESSON-SHARING REPORT ON THE IMPLEMENTATION OF PSYCHOSOCIAL SUPPORT ACTIVITIES

- **Map traditional therapists**, identify common practices between conventional and traditional medicine, and adapt treatment protocols based on these similarities.
- Provide **training to traditional actors** on mental disorders and their symptoms, so that they can, if necessary, refer patients to modern medicine, and raise awareness of mental illness among the population (see the impact of this training in Niger where the project is beginning to adopt this approach).
- **Formalise collaboration with traditional therapists** as part of patients' care pathways, as is the case in other countries (Togo and Benin, for example). An action research study conducted in 2015 - 2017 in Niger on the integration of traditional medicine in psychosocial care established a referral and follow-up procedure between traditional therapists and specialized mental health structures. This experience could be evaluated and possibly replicated[12].

4) Ensure that the population participates in activities that are designed for them:

- **Systematically carry out initial assessments** upstream of the design of psychosocial care activities. Ideally, these diagnoses should be multidisciplinary (psychologists, social anthropologists, etc.).
- **Identify local organisations and community associations** (women's groups, youth associations, religious leaders, etc.) involved in mental health care in order to assess opportunities for collaboration and ensure sustainable funding for their activities[13].

5) Increase monitoring of the impact of psychosocial support:

- Increase monitoring of the **expected effects** of psychosocial support and plan the time and human resources that will be needed before the project begins. Clarify the contractual terms in this regard with the donor.
- Increase monitoring of **unintended** effects, especially regarding therapeutic groups. Some continued to meet after the end of the activities but asked for support from the project to create or find a meeting place

12 - For more details, see the report «The treatment of psychological distress in the Lake Chad Basin» Groupe URD, 2022.

13 - Ibid.

ADVOCACY

1) Insist to donors and local authorities on the importance of psychosocial support within RESILAC's integrated approach in terms of meeting the multiple needs of beneficiaries in a sustainable manner:

- Emphasize the importance of psychosocial support, including in **emergency areas**, to build individual and community **resilience** in a sustainable manner.
- Underline the importance of **multi-sector approaches** and the impact of psychosocial support on economic recovery. The beneficiaries are more confident, supportive, and optimistic, and thus more involved in the creation of Village Savings and Loan Associations and their micro-projects.

2) Point out to the authorities the importance of building community-based health officers' capacity in order to ensure that activities are sustainable:

- Continue advocacy activities with local authorities and key health actors (invitations to the mental health forum, bilateral meetings) in order to promote the training courses, their **results** and the importance of making them sustainable.

3) Emphasize to donors and other development actors the importance of better cooperation with traditional actors:

- Emphasize the importance of integrating traditional medical actors into the design and implementation of MHPSS activities to:
  - > strengthen beneficiaries' **commitment** to the activities;
  - > reinforce the **mental health care** available, and to show that different problems can be relieved using equally varied and complementary approaches;
  - > strengthen their **resilience** through psychosocial support that does not rely solely on RESILAC actors but on endogenous care mechanisms.

LESSON-SHARING REPORT ON THE IMPLEMENTATION OF PSYCHOSOCIAL SUPPORT ACTIVITIES

4) Emphasize to international actors the importance of better collaboration:

- Emphasize the importance of communicating **operational areas** in order to avoid the concentration of humanitarian aid in certain regions.
- Emphasize the importance of sharing good practices and challenges in implementing MHPSS activities through the organisation of forums. The forums organized by RESILAC in Cameroon and Niger were very much appreciated by the different actors present (NGOs, local and national authorities, associations, etc.). They provided an opportunity to exchange and learn, but also to agree on the **advocacy messages** to communicate at the national level.

RESILAC*

*LAKE CHAD INCLUSIVE ECONOMIC AND SOCIAL RECOVERY

For more information on the RESILAC project,
please contact Hélène Ronceray,
Regional Coordinator
coordoreg@resilac-actioncontrelafaim.org

For more information on the project's MHPSS activities RESILAC,
please contact Pamela Londono,
refpilier1-2@resilac-actioncontrelafaim.org

www.resilac.net

Co-funded by the European Union
and the French Development Agency

Members of the RESILAC Regional Consortium

This publication was produced with the financial support of the European Union and the French Development Agency. Its content is the sole responsability of Groupe URD and does not necessarily reflect the views of the European Union or the French Development Agency (AFD).