PASAS

PLATEFORME D'ANALYSE, DE SUIVI ET D'APPRENTISSAGE AU SAHEL

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Taking mental health into account in Sahel/West Africa crisis contexts

SUMMARY

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I. INTRODUCTION

According to the World Health Organization (WHO), one out of eight people worldwide suffer from mental disorders and the numbers are higher in conflict zones. Mental disorders are linked to social, economic and violent problems and have a negative impact on the development of countries, particularly those with limited resource. In addition, people with mental disorders often face stigma and discrimination.

In this context, a study on mental health was conducted in Mali, Mauritania and Chad to better understand the issues related to this thematic. The study used a three-step methodology: definition of concepts, mapping of actors and field surveys. The study encountered logistical and contextual challenges, including the diplomatic context, and time constraints. Despite these challenges, the study explored local perceptions of mental health, stakeholders and public policies. It provides an overview of the actions carried out and suggests ways for development actors to work

II. MENTAL HEALTH AND PSYCHOTRAUMATISM IN SUB-SAHARIAN AND WEST AFRICA

1. Psychiatry in French West Africa

Psychiatry in French West Africa was long neglected under the colonial regime. The colonial focus was initially on tropical diseases and soldiers state of mind, leaving aside the mental disorders of the natives. The colonial doctors spoke of "indigenous madness", often linked to racial theses, and psychiatric care was limited to repressive practices such as confinement in hospitals or military camps. The lack of proper care structures in Africa persisted until the creation in 1956 of the first psychiatric department at the Fann Hospital in Senegal, where Henri Collomb, a French military doctor, developed a transcultural psychiatry adapted to the local context. However, these initiatives have been developed in parallel with health policy priorities focused on infectious diseases, which has contributed to the marginalization of mental health in post-colonial public policies.

2. Definitions

According to the WHO, mental health is not simply the absence of mental illness, but a state of well-being that enables an individual to reach his or her potential, cope with difficulties and contribute to society. It depends on the combination of biological capital, personal experiences and social context, taking into account cultural influences. Good mental health is not limited to the absence of disorders and includes optimal well-being from an institutional point of view; the WHO definition takes precedence in the context of the three countries of the study.

Psychosocial refers to the interaction between individual and social factors, including emotions, thoughts, and behaviours in a relational setting. In times of crisis, this approach helps individuals overcome their trauma by reorganizing their relationships and survival strategies.

3. The determinants of mental health

The social determinants of mental health for the population, particularly in sub-Saharan Africa, include factors such as poverty, gender, education, stigma and family circle. Poverty, especially extreme poverty, increases mental disorders, creating a vicious cycle of material deprivation and stress, leading to disorders such as depression and anxiety. Gender also plays an important role, with women being more affected by domestic violence and social norms that influence the expression of mental disorders. Social stigma associated with mental disorders, often reinforced by cultural and religious beliefs, amplifies the suffering of patients. Finally, family dynamics, from pregnancy and early childhood, play a key role in the development of mental health, influencing the future emotional and social capacities of individuals.

For refugees, conflict generates a triple trauma: the experience of war and various forms of persecutions in the country of origin, the difficulties during migration, and the adaptation in the host country. Refugees often face precarious living conditions and the need to relive their trauma when telling their stories to authorities. Mental disorders, including anxiety, depression and post-traumatic stress disorder (PTSD) are common among migrants with higher prevalence than in the general population. Although PTSD is useful for identifying certain suffering, it is not always adapted to the cultural and psychological realities of refugees, as these contexts of displacement and violence generate intense suffering that is often uncommunicable, marked by a loss of security, hope and dignity.

4. Stakeholders and methods of support

The WHO pyramid of care shows that as people move to specialized care, costs increase and demand decreases, while at the bottom of the pyramid, community care, which is less expensive, responds to a greater demand. However, community mental health, especially in sub-Saharan Africa, faces challenges such as lack of infrastructure and public policies; this leads to support the integration of mental health into primary care and the community approach, which is important in rural areas and includes the contribution of traditional healers.

In this context, United Nations (UN) actors such as the WHO, the UN Refugee agency (UNHCR) and the International Organization for Migration (IOM), as well as humanitarian actors, play a crucial role, providing psychosocial support to displaced trauma victims. The psychosocial programs are increasingly using therapeutic approaches such as eye movement desensitization and reprocessing (EMDR) or mindfulness cognitive therapy.

III. MALI

1. History of psychiatry in Mali

Mental health in Mali has undergone a slow evolution, marked by military management of mental disorders before turning to more humane practices. The Point G hospital, founded under the colonial administration and initially used to isolate people with mental disorders, has benefited from the creation of a psychiatric service after the country's independence. In the 1980s, a more humanizing approach emerged with the introduction of practices such as "therapeutic koteba", a form of traditional theatre designed to integrate patients into their sociocultural environment. However, despite these advances, psychiatry remains poorly distributed across the country, particularly outside the capital, and is often supplemented by traditherapy, which enjoys popular legitimacy, although it is not officially recognized.

2. Prevalence of mental disorders

As regards the prevalence of mental disorders, data is limited and often focused on Bamako, notably the Point G hospital. Studies reveal that the most common disorders are psychotic and depressive disorders, as well as schizophrenia. Social determinants such as poverty, social pressures, marital problems, family loss and psychosocial stress are major factors of psychological vulnerability, often associated with these disorders and leading to despair and even suicide. The use of psychoactive substances, particularly cannabis, is on the rise, especially among young people.

Mali is also characterized by the widespread practice of female genital mutilation (FGM), which affects a significant proportion of women and girls. A study shows that 50% of girls under the age of 5 are excised, and almost 80% of 6-14 year-olds. Despite this, there is little research on the direct link between FGM and mental health in Mali. Yet this practice, strongly rooted in tradition, has dramatic consequences for the mental health of victims, leading to the development of anxiety, depression and post-traumatic stress disorder (even if the low prevalence of PTSD in conflict zones is due to their unsuitability in this context and to a lack of skills on the part healthcare professionals to detect).

Specific populations, such as IDPs and detainees, present worrying rates of mental disorders. IDPs suffer mainly from PTSD, while detainees, particularly men, have a high prevalence of depression, panic disorders and suicidal risks. Female detainees also show psychotic and thymic disorders, often exacerbated by difficult living conditions.

3. Public policy and mental health strategy

The mental health system in Mali is marked by the absence of a national strategic plan and specific legislation. However, mental health is integrated into the socio-sanitary development program, which prioritizes prevention, care and inclusion of mental health in health programs. The objectives are to strengthen mental health care at various levels, including community health centres and referral health centres. However, these initiatives are still limited.

4. Stakeholders

There are major disparities in the distribution, capacity and human resources of mental health facilities in Mali. Local public players, including hospitals and community health centres, face difficulties linked to the stigmatization of mental health, inadequate training of professionals with only 16 psychiatrists and 3 psychologists for a population of 19 million, and a lack of suitable hospital beds. Care mainly focuses on schizophrenia, psychoses, epilepsy and anxiety disorders, with limited therapeutic provision. Finally, access to psychotropic drugs remains limited, particularly in rural areas.

International organizations, such as IOM and the International Committee of the Red Cross (ICRC), intervene to offer psychosocial and psychiatric support services to vulnerable populations, including migrants, internally displaced persons and victims of violence. However, insufficient staff and logistical difficulties limit their action.

National humanitarian actors focus on specific groups, such as people living with HIV, victims of gender-based violence (GBV) and key populations (i.e. groups heavily affected by the epidemiological impact of a disease, also with less access to services and belonging to criminalized or marginalized populations). These organizations provide community mental health services, counselling and psychosocial support, while also facing training and human resources challenges.

5. Field study

Field study was conducted using semi-structured interviews and focus groups. For the population of adults with mental disorders, 7 focus-groups with 51 adult participants, distributed among 21 women and 30 men, were carried out in person at the hospital centre of Point G in Bamako and remotely in the reference centres for mental health of Koutiala, Bourem and Mopti. For specific populations, 8 focus-groups with 92 adult beneficiaries, divided into 46 women and 46 men, were conducted in person at Faladiè for the displaced populations, at the central detention house for detainees, and with civil society organizations (CSOs) for LGBTQIA+ people and street children.

For the general population with mental disorders, the analysis highlighted a variety of pathologies, mainly depression, acute psychotic disorders, post-traumatic stress disorder and epilepsy. These disorders are often exacerbated by socio-cultural and environmental factors. Participants also reported a combination of modern psychiatric care and traditional therapies. Thus, the first consultation is often made with traditional practitioners because of the affordability of their services, where hospital care is perceived to be more expensive, or because of their physical accessibility, related to the remoteness of modern mental health centres.

For specific populations, people seeking mental health care often lack family and community support, which complicates their daily lives. Rejection and stigma mechanisms are common, especially for women, who are often excluded from social and family circles. Most participants expressed a need for community and family support, highlighting the importance of a moral support network to deal with their difficulties.

6. Conclusion

Mental health in Mali continues to face major challenges. Thus, the lack of a national mental health strategy, the uneven distribution of psychiatric services, the lack of adequate structures, the shortage of qualified professionals, the lack of ranges of psychotropic, the lack of reliable data, the lack of funding, the growing use of psychoactive substances and the social impacts of traditional cultural practices, such as FGM, are thus major obstacles to improving mental health in the country. In this context, the combination of traditional and modern care could be a more appropriate response to patient needs, taking into account cultural beliefs and local resources.

Accordingly, the proposed recommendations focus on improving access to care, developing mental health referral centres in rural areas, training specialized caregivers, promoting awareness and education to reduce stigma associated with mental disorders, supporting the integration of traditional and modern care to provide more comprehensive care, improving treatment conditions with better hospital infrastructures and socio-occupational reintegration programmes, reducing the costs of care to facilitate access to treatment, and strengthening informal support networks for vulnerable populations often abandoned or stigmatized by society.

IV. MAURITANIA

1. History of psychiatry in Mauritania

Before independence in 1960, Mauritania had no formal psychiatric service. The mentally ill were often confined or relegated to traditional care. Modern psychiatry made its appearance in 1975, thanks to Dr. Alhoussein Dia, trained in Dakar, who set up psychiatric consultations at Nouakchott National Hospital. Influenced by transcultural psychiatry, he introduced the use of tents to house patients, in line with local culture. In 1978, a psychiatric pavilion was created, marking a milestone in the evolution of psychiatric care in the country.

In the 1990s, Mauritania saw the creation of the Neuro-psychiatric centre in Nouakchott, and the decentralization of psychiatric services. However, despite progress, challenges remain, notably the lack of infrastructure and qualified human resources, with only 10 psychiatrists for a population of three million.

Since 2010, a collaborative project with CSOs has been underway to improve access to psychiatric care in Nouakchott ; however, many obstacles remain, including mistrust of modern psychiatry and the persistence of traditional healing practices. Psychiatric care often competes with marabouts, particularly in the treatment of mental disorders linked to beliefs in possession or witchcraft.

2. Prevalence of mental disorders

Mauritania has no recent data on the prevalence of mental disorders. However, a study carried out in 2005 showed that 35% of the population of Nouakchott suffers from mental disorders. Anxiety and depressive disorders are the most common, particularly among women and older people. Lack of access to treatment and the social stigma attached to psychiatry exacerbate the situation.

Sexual and domestic violence, particularly against women, are major factors in psychological suffering. Practices such as forced force-feeding, domestic violence and female genital mutilation contribute to these disorders.

Refugee populations in Mauritania, particularly in the Hodh Ech Chargui region, are also exposed to mental disorders, although few studies are available. The UNHCR estimates that Mauritania is home to around 240,000 refugees, the majority of whom are in precarious situations. CSOs have initiated psychological support projects, but this situation remains largely ignored.

3. Public policy and mental health strategy

Mauritania has drawn up a National Mental Health Program, but it remains insufficiently detailed and implemented. At the same time, the National Health Development Plan 2021-2030 includes mental health among its priorities, the main objectives being to reduce rates of suicide and alcohol consumption, and to strengthen the protection of women against GBV. Efforts are also planned to decentralize psychiatric services and improve the management of mental disorders at health centre level.

Despite these initiatives, economic obstacles and a low proportion of the budget allocated to mental health mean that resources remain insufficient. In addition, the lack of national mental health data remains a major obstacle to the effective management of psychiatric disorders.

4. Stakeholders

In terms of public facilities, the country has no specialized hospital, and public mental health services are concentrated mainly in Nouakchott, with regional branches that have ceased to operate due to a lack of resources and qualified staff. In addition, stigmatization and unequal access to psychiatric care between different social classes aggravate the situation.

Mental health professionals, limited to around 10 psychiatrists and 16 technicians, lack continuous training and are concentrated in the capital, creating a strong disparity in access to care across the regions. The main disorders diagnosed include depression, schizophrenia and substance use disorders.

As far as international players are concerned, the UNHCR plays a significant role in integrating psychosocial actions with refugees, notably through therapies and art-therapy activities. At the same time, humanitarian organizations provide psychosocial support to vulnerable populations, including GBV victims and refugees. For example, Médecins du Monde Spain, which has been present since 1990, shifted its focus in 2017 to supporting victims of sexual violence by opening special care units, which offer free medical care and psychosocial support. Terre des Hommes-Lausanne (TdH-L), meanwhile, supports the Ministry of Justice and offers psychosocial services via local partnerships. Other organizations, such as Action against hunger, ALIMA and the French Red Cross, also provide indirect mental health support, focusing on issues such as malnutrition and refugee health. However, the difficulty of integrating qualified local mental health specialists, persistent stigmatization and the lack of qualified personnel remain major obstacles to the effectiveness of mental health interventions. What's more, with the exception of organizations such as MdM-Spain and TdH-L, these actions are often ad hoc and lack a structured, long-term approach to anchor the benefits.

5. Field study

The field study was constrained by deadlines incompatible with the administrative procedures required to obtain travel permits. Thus, the survey focused on Nouakchott, where 20 semi-structured interviews were conducted with people suffering from mental disorders, equally divided between men and women. The causes of the disorders varied, ranging from trauma related to significant life events (such as war or the loss of a spouse) to cultural interpretations, including supernatural explanations such as witchcraft. Drug treatment, although central, suffers from interruptions due to side effects or economic insecurity. At the same time, lack of social and professional integration and stigmatization contribute to the isolation of patients, creating a dynamic of self-exclusion or forced withdrawal on the part of those around them.

With regard to refugees, a study carried out by TdH-L highlights mental health challenges in Hodh Ech Chargui. The data collected shows high levels of anxiety and depression among women and men, with significant needs in terms of income, hygiene, healthcare and daily living materials. Refugee children are particularly affected psychosocially, with signs of sadness and negative thoughts more pronounced than among host children. A large majority of respondents associate mental disorders with spiritual causes, and 92% recognize a link with trauma and daily difficulties. These results underline the need to strengthen access to mental health care, to support the Al-Afiya project, and to organize psycho-education to combat stereotypes and stigmatization.

6. Conclusion

Although progress has been made in the field of mental health in Mauritania, many challenges remain. The growing recognition of modern psychiatry, increased public awareness, and efforts to improve access to care are important advances. However, the lack of human and material resources, the absence of clear legislation on traditional medicine and the influence of traditional cultural practices continue to hinder the development of adequate psychiatric care.

On this basis, the main recommendations concern the creation of specialized structures, the training of professionals, better ethical care for patients, and raising awareness of mental health issues, particularly with regard to stigmatization and GBV reduction. The integration of social work into care is also suggested to improve overall support for patients and their families.

V.CHAD

1. History of psychiatry in Chad

Mental health in Chad is marked by the recent development of psychiatric assistance, introduced by the State in 1996, with the opening of care units in various hospitals such as the N'Djamena Hospital and the Notre Dame des Apôtres Hospital. However, the management of mental disorders is still largely dominated by traditional and magico-religious practices.

2. Prevalence of mental disorders

Data on the prevalence of mental disorders are scarce, with partial figures on schizophrenia, depression and psychosis; moreover, these statistics seem to underestimate the reality of the problem.

Refugee and internally displaced populations in Chad suffer from mental disorders such as anxiety and post-traumatic stress. The situation is exacerbated by GBV, with alarming rates of physical and sexual violence, as well as female genital mutilation.

3. Public policy and mental health strategy

Chad set up a national mental health program in 1998, but has not yet developed a formal mental health policy or legislative framework to regulate the management of mental disorders. As a result, international organizations and CSOs play a crucial role in supporting mental health in a crisis context, particularly in areas affected by violence.

4. Stakeholders

In Chad, mental health care provision is very limited, both in the capital N'Djamena and in rural areas. The structures available are hospital units, often run by nurses due to the lack of psychiatrists. Common pathologies treated include depression, anxiety, delusions and substance use disorders. Qualified personnel are in short supply, and mental health training is non-existent in the country, forcing professionals to train abroad.

The Diocesan Centre for Research and Action in Alcoholism (CEDIRAA), although part of the faith-based humanitarian model, plays a key role in mental health, particularly in the treatment of addictions, but faces major challenges, such as lack of political support and insufficient human resources.

As far as international players are concerned, IOM and UNHCR are active in Chad, with missions focused on the psychosocial care of refugees. The IOM supports mental health initiatives in

refugee camps, although qualified human resources are limited and follow-up missions difficult. The UNHCR, for its part, funds mental health programs for refugees, but its operational capacity remains limited by the availability of resources and insufficient coordination.

Humanitarian organizations also contribute to mental health in Chad, focusing on refugees and vulnerable populations. They provide psychosocial care in collaboration with UNHCR and UNICEF, and focus on GBV and trauma-related issues. However, they face difficulties due to the under-funding of their activities.

5. Field study

The field study had to contend with a number of difficulties in carrying out the focus groups, including the low availability of managers due to the end-of-year holidays, as well as cultural and linguistic obstacles. In all, 9 focus groups were carried out: (i) 3 focus groups, made up of 36 people (11 women and 25 men), for the general population suffering from mental disorders, and (ii) 6 focus groups for specific populations, made up of 68 participants (37 women and 31 men), focusing on addictions, street children, GBV victims, and Sudanese refugees in the east of the country.

The results show a variety of mental disorders, such as anxiety, depression and schizophrenia, often linked to social factors such as unemployment, family pressure and economic hardship. Students also talk about the stress of studying and succeeding at school. The high cost of mental health care, which can exceed minimum wage, often falls on families. Notwithstanding, some participants report progress after psychiatric treatment, mainly through medication and psychotherapy.

Respondents expressed a need for group therapy and psychological support, highlighting a lack of suitable facilities. In addition, social stigmatization and cultural barriers restrict access to support services. With regard to specific populations, the N'Djamena groups highlighted multiple causes of mental disorders, such as family violence and poverty, and mentioned mixed forms of care between modern care and recourse to traditional practices. Sudanese refugees, meanwhile, reported similar symptoms, with triggers linked to their traumatic experience and precarious living conditions.

6. Conclusion

Mental health in Chad is still developing, with limited and recent infrastructures, such as the opening of the psychiatric unit at the N'Djamena hospital in 1996. Outside the capital, only a few hospitals offer psychiatric services, but these are insufficient to meet the needs. The country therefore continues to face major challenges linked to the absence of a mental health policy and an appropriate legislative framework. Data on the prevalence of mental disorders are scarce, and mental health is often overlooked in health priorities. In addition, the lack of specialized training and qualified professionals, as well as the excessive use of medication, hamper effective patient care. Traditional practitioners, who are involved in the management of mental disorders, work in a way that is disconnected from modern medicine.

As a result, the proposed recommendations concern the development of a national mental health policy, the training of health professionals in the management of mental disorders, the organization of awareness-raising campaigns and the creation of a referral structure for serious cases. Specific actions for refugee and displaced populations, such as improving living conditions in camps, are also suggested.

VI. CROSS-CUTTING RECOMMENDATIONS

The recommendations set out below are cross-cutting for all 3 countries, and aim to address the gaps and challenges identified in the field of mental health, through an inclusive, decentralized approach tailored to local realities, while fostering collaboration between different care structures and integrating innovative approaches.

One of the first recommendations is to support the implementation of national mental health strategies. Colonial history has contributed to the marginalization of psychiatry, and this marginalization persists in current health policies. It is therefore essential to promote studies that document the economic and social impacts of mental disorders, in order to integrate this issue into national priorities and strengthen infrastructures. Universal health coverage policies that include mental health are also needed, as families often bear the cost of care alone. It is therefore recommended to set up formal solidarity initiatives to alleviate this burden.

The stigmatization of mental disorders, linked to cultural representations, prevents equitable access to care. To reduce this stigmatization, dialogue with authorities and influential figures, such as neighbourhood chiefs and imams, is essential to raise awareness and promote a more inclusive approach to mental health. Action is also needed on the social determinants of mental health, such as poverty and gender dynamics, to widen access to care and reduce stigmatization.

Although complementary to modern psychiatry, traditional medicine is often used as a first resort, and collaboration between traditional practitioners and mental health professionals remains insufficient. The integration of traditional medicine in the management of mental disorders must therefore be encouraged in parallel with the training of mental health specialists in the public sector.

Furthermore, it is necessary to respect local realities in the application of international standards in psychiatry, and to promote an intersectional approach that takes into account the socio-economic and cultural specificities of communities.

Finally, the integration of mental health into development projects, particularly in response to psychosocial needs in crises, and the use of EMDR to treat trauma, particularly in situations of war and crisis, must be encouraged.

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Le Fonds Minka, mis en œuvre par le groupe AFD, est la réponse opérationnelle de la France à l'enjeu de lutte contre la fragilisation des États et des sociétés. Lancé en 2017, Minka finance des projets dans des zones affectées par un conflit violent, avec un objectif : la consolidation de la paix. Il appuie ainsi quatre bassins de crise via quatre initiatives : l'Initiative Minka Sahel, l'Initiative Minka Lac Tchad, l'Initiative Minka RCA et l'Initiative Minka Moyen-Orient.

La Plateforme d'Analyse, de Suivi et d'Apprentissage au Sahel (PASAS) est financée par le Fonds Paix et Résilience Minka. Elle vise à éclairer les choix stratégiques et opérationnels des acteurs de développement locaux et internationaux, en lien avec les situations de crises et de fragilités au Sahel et dans le bassin du Lac Tchad. La PASAS se met en œuvre à travers d'un accord-cadre avec le groupement IRD-ICE après appel d'offres international dont le rôle est double : (i) produire des connaissances en réponse à nos enjeux opérationnels de consolidation de la paix au Sahel et (ii) valoriser ces connaissances à travers deux outils principaux : une plateforme numérique, accessible à l'externe, qui accueillera toutes les productions et des conférences d'échange autour des résultats des études. La plateforme soutient ainsi la production et le partage de connaissances, en rassemblant des analyses robustes sur les contextes sahéliens et du pourtour du Lac Tchad.

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