Do humanitarian crises offer opportunities for change? A critical review of the mental health and psychosocial support post emergency in the Republic of the Congo, Intervention 2014, Volume 12, Number 1, Page 108 - 114

Do humanitarian crises offer opportunities for change? A critical review of the mental health and psychosocial support post emergency in the Republic of the Congo

Babak Moayedoddin, Christelle Nangho Makaya & Alessandra Canuto

Violent explosions rocked the city of Brazzaville (the capital of the Republic of the Congo) on 4 March 2012, officially causing more than 280 deaths and leaving approximately 15,000 people displaced. Two months after this event, despite a large number of people suffering from considerable psychological distress, few people had called for, or had received, appropriate mental health care or any external psychosocial support. A field evaluation, following this emergency, led to a critical review of the limited capacity of the mental health care system in Brazzaville to respond to the population's needs. This evaluation also allowed a review of the current state of affairs in regard to mental health and psychosocial support by health care actors in Brazzaville. The crisis has, in this way, facilitated an increasing awareness and triggered a process of deeper examination of how to improve mental health care in the Republic of the Congo.

Keywords: disaster response, mental health, psychological support, Republic of the Congo

Introduction

The Republic of the Congo, commonly known as Congo Brazzaville, is a country located in Central Africa. It is a lower middle income country that ranks 142, out of 186 countries, in the United Nations Human Development Index (UNDP, 2011). Brazzaville and Pointe Noire are the two major cities, and where 50% of the population resides. This field report focuses on Brazzaville, the capital of the Congo. The reflections in this article emerged during a two-week mission undertaken by the first author, a Swiss psychiatrist, to Brazzaville in 2012. This was in the aftermath of several explosions that had taken place at an ammunition storage site, near a residential area, causing hundreds of deaths and the displacement of thousands of people, in a country already marked by a traumatic history of civil war.

Overnight, a significant portion of the population had lost their homes, access to sources of income, drinking water and food. Many families had also lost key members of their family who had been responsible for feeding and protecting them. A segment of those affected by the explosion became disabled, surviving amputations and were unable to continue every day activities. This unexpected, brutal and violent event created fear and terror in affected neighbourhoods. The population sought help, and psychological and spiritual support, mainly from their priests and pastors. People did not ask for help from the mental health care system mostly because of the stigma attached, and because this service exists almost exclusively in hospitals that often work with insufficient facilities. Additionally, the lack of information and education on mental health was another

important obstacle to seeking help from the mental health care system.

The goal of the mission was to conduct an assessment of the response, and to train caregivers about psychosocial aid during emergencies. Several questions emerged during this mission and are discussed in this paper. For example: taking the *Inter-Agency Standing Committee Guidelines* (Inter-Agency Standing Committee (IASC), 2007) as a framework, how was mental health and psychosocial support (MHPSS) provided in the aftermath of the disaster? How is help and support organised at different levels of the mental health care system? What are the strengths and the weaknesses of the mental health care system in Brazzaville, and how do these influence the care given to the population? Finally, how can stakeholders improve mental health care in the Congo?

Health and mental health care systems in Brazzaville

Administratively, the Congolese health care system is organised into three levels: 1) at the central level, with the Ministry of Health responsible for strategic planning and coordination; 2) at the intermediate level, with the Senior Health Management Departments adjusting the national guidelines to the community level, taking into consideration local capacities and limitations; and 3) at the community level, with each district providing health care services to between 50,000 and 100,000 inhabitants in rural areas, and between 100,000 and 300,000 inhabitants in urban areas. There are six general hospitals, including one University Hospital, located in Brazzaville. There are 24 health care clinics affiliated to the general hospitals. Currently, the Congolese Ministry of Health is working on a national health care plan, which at this point does not include mental health care, but will likely be included in the future (Figure 1).

Despite the fact that a government strategy for mental health was written in 2002, it has never been applied at the national level. Specialised mental health services did not exist outside of urban Brazzaville until 2012. Currently there are three psychiatrists working in the Congo. One of the psychiatrists is attached to the psychiatric services of the University Hospital in Brazzaville, and another at the psychiatric consultation office of the Armed Forces General Hospital. The third psychiatrist provides inpatient consultation in Pointe Noire. The psychiatric service of the University Hospital of Brazzaville has the only beds that

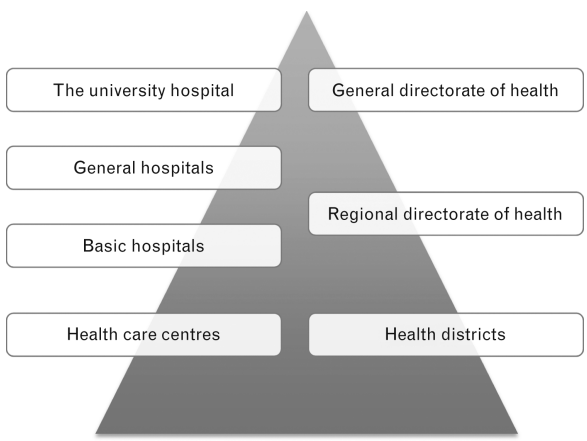

Figure 1: The health care system in the Republic of the Congo.

are dedicated to mental health care. The two other psychiatrists use general medical beds when required.

Specialised mental health care does not exist outside the aforementioned hospitals, with the exception of the Trauma Counselling Group (TCG). The TCG is a government group with the ability to create mobile teams to provide counselling outside of a hospital environment. They are also the only way that specialised mental health care can reach community level. This counselling group is heterogeneous in terms of specialities and level of training, and is composed of clinical psychologists, non-clinical psychologists, social workers and educators. It should also be noted that, in the Congo, the term *clinical psychologist* is used when the person has a master's degree, or studies at a master's degree level. It does not necessarily mean that the person has had significant clinical experience. The TCG does not have regular and/or sustained activities, and the group is not regularly updated in terms of new field knowledge and/or training. It was mobilised as a direct result of the explosions in 2012, in order to provide mobile teams of psychological support to survivors.

4 March 2012: explosions

On 4 March 2012, a former military camp containing tons of ammunition caught fire in the Mpila district, in the southeast area of urban Brazzaville, leading to several large explosions. Initially, nine emergency camps, mostly religious sites, were opened to house the 15,000 displaced survivors. These sites have been subsequently closed, being replaced by three long-term sites, housing a total of 3000 to 4000 people.

Psychosocial interventions following the explosions: strengths and weaknesses

In cases of emergency, the *IASC Guidelines* (IASC, 2007) have emphasised the necessity of integrating MHPSS into all levels of care. This includes providing services on a variety of levels, including: 1) social, psychological and cultural considerations in basic services, such as the provision of safe food, clean water and sanitation, and appropriate shelter; 2) encouraging community mobilisation and facilitation of community self-help and social support; 3) MHPSS provided by non-specialised workers who are, nonetheless, trained in basic MHPSS techniques; and 4) focused MHPSS interventions by specialists (Figure 2).

Level 1: social, psychological and cultural considerations included in basic services

In the immediate aftermath of the explosions in Brazzaville, efforts focused on ensuring the safety and basic needs of survivors, in line with the *IASC guidelines*. Emergency camps were opened, tents were set up, food and drinking water were distributed, and temporary modern sanitation was implemented. Security agents were deployed at camp entrances to ensure the safety of survivors.

However, some weaknesses were observed. For example, the population was not involved in food or water distribution, nor encouraged to promote self-help and social support. As a result, the population was, primarily, a passive recipient. However, select individuals representing the population were present during discussions with government representatives in each camp. This seemed to have little impact, however. For example, modern water closets were made available, but without prior discussion as to the population's needs, or habits. As a result, the water closets were different from those the residents had been using. This contributed to difficulties using them, which in turn led to the emergence of major hygiene issues. Also, according to the residents, the drinking water distribution was insufficient, even though it was regularly distributed.

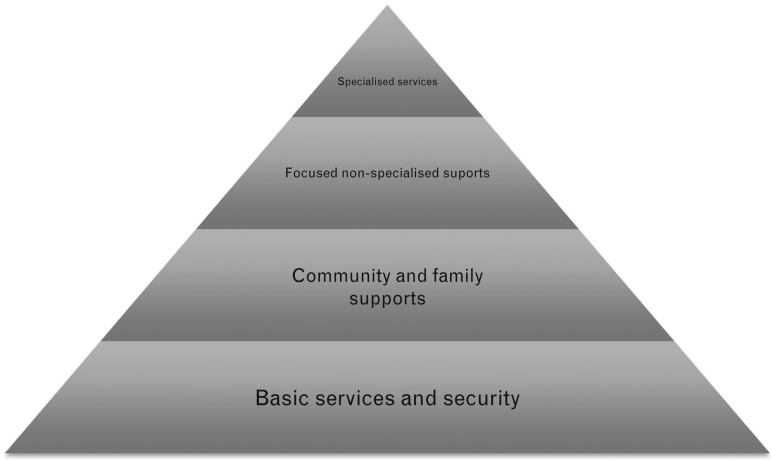

Figure 2: IASC system of multi layered MHPSS interventions.

Food distribution had been halted quickly after the camps were set-up, because authorities considered them to be independent. Once again, there was no discussion with the population about their needs. Withdrawal of the food distribution had further, major impacts on the population's well-being, in terms of lack of adequate nutrition and on health. While, within the population there were many families whose main wage earner (usually the father or eldest son) had become disabled, mainly as a result of amputation(s), or other major health issues arising from surviving the explosions. Moreover, due to lack of space, the new sites had been set-up far from their original residences and work areas. Additionally, the population had no alternative, but to go to the camps. This created significant additional expenses that some families could not afford, as well as additional challenges for those still able to work to reach workplaces, or for children to get to school.

Level 2: Community and family supports

The community and family support included an active search for survivors, re-uniting families and relatives, and organising funeral ceremonies. As mentioned, however, transportation to work or schools was not facilitated. This was a major issue, as helping people to restart their normal routines and regain a sense of control over their everyday lives is a major goal in psychosocial support. Moreover, little effort was made to provide social support to families in need, or to encourage establishing problem resolution and mutual aid groups within the community. In spite of this, people spontaneously gathered in small groups to try and help each other with security issues, support for those who had been disabled and the elderly, and to find lost relatives. Religious centres (churches, parishes, temples, etc.) organised ceremonies to collect articles of clothing and money for those that had been worst impacted. Priests and pastors provided significant spiritual support to the population. However, during the months following the explosions, religious leaders were faced with an increasing number of people complaining of nightmares, recurring mental images of the traumatic scenes they had witnessed, and feelings of tension and anxiety. According to these leaders, people were requesting prayers in order to restore the inner peace they had lost.

Level 3: Focused non-specialised supports

General practitioners and nurses provided medical care and nursing within the camps. Health care providers were facing a variety of unusual and non-specific complaints. Among these complaints, the general practitioners noted the following: irritability, insomnia, tendency towards violent behaviour, headaches, blurred vision, and diffused pain. Additionally, according to some general practitioners, there were a significantly higher proportion of patients with high blood pressure, as compared to their usual practice. They were expressing difficulties dealing with such symptoms. Health care providers were therefore treating symptoms without being able to educate their patients about their condition, or offer them psychological support. They were not trained to offer psychological first aid, nor to consider the psychological aspects of care.

Level 4: Specialised services

Specialised care was offered by the TCG, the psychiatric service of the University Hospital, and the psychiatric consultation office located in the Armed Forces General Hospital. The TCG was mobilised during the initial month after the explosions to visit the survivors, mainly in the camps and hospitals. The team, however, was forced by circumstance and a lack of staff to recruit young psychologists or psychology students, most of whom did not have the benefit of any clinical knowledge or experience. As a result, senior group members offered brief trainings on stress and trauma before sending them into the field. A few debriefing groups also took place in the month after the explosions, and some patients were offered a single debriefing session. More frequently, a brochure was given to people explaining signs and symptoms of psychological distress, which offered the opportunity to ask for help by calling a phone number. If a patient called, they would then be referred either to the TCG, or to the hospital. This MHPSS activity was significantly decreased, however, after only a few weeks due to a lack of financial support. Furthermore, most patients were visited only once, without any possibility of follow-up.

During this period, the two specialised psychiatric consultation services of Brazzaville supported in-patients hospitalised for medical or surgical reasons, and that had also expressed clinical symptoms of psychological distress. Very few out-patients asked the specialists for help during this period, as the majority of the population did not ask for mental health support due to the lack of information and education about mental health issues, the stigmatisation of mental health care, and the lack of community based, mental health care facilities.

How can this crisis help to create a new approach to mental health care in Brazzaville?

The information above highlights some of the strengths and the weaknesses in the developing mental health care system in Brazzaville. In reference to the IASC system of multi layered MHPSS interventions, important efforts were made to meet the basic needs of the population, to provide community and family support, and to provide specialised and non-specialised health care to survivors. Significant obstacles remain in terms of establishing an effective health care system that is able to provide efficient psychosocial support in the case of a major emergency. These obstacles are rooted in political, economic, cultural, organisational, and educational realities in Brazzaville. They generate multiple breaking points in the health care chain, from the place a patient seeks help to the place they receive specialised health care.

Congo-Brazzaville is a poor country planning to create a mental health policy. In the meantime, the psychiatry services provide specialised mental health care, despite

being marginalised and stigmatised, while at the same time mental health is not yet considered as a health priority, nor integrated into the health care system. Access to mental health care is further limited by lack of knowledge and training of caregivers to identify, manage and refer people suffering from mental illness. This lack of access is compounded by the lack of communication between different stakeholders, namely the community health care and specialised mental health care structures. Moreover, access to mental health care is additionally limited by lack of public education and information.

Since the explosions in 2012, there has been a growing sense within the health policy staff of Brazzaville of the need to ameliorate some of the weaknesses mentioned above. During the two weeks mission, several meetings took place with staff representing the Ministry of Health and Population, the Ministry of Social Affairs and Humanitarian Actions, the University Hospital and the Armed Forces General Hospital. During these meetings, all stakeholders emphasised unanimously the necessity of improving the mental health care system in Brazzaville, stressing the history of wars and disasters in the Congo.

Following these meetings, a collaboration project between Geneva University Hospital and health authorities in Brazzaville emerged, using tele-medicine and tele-education systems already established in Brazzaville, offering a training programme to the community, and to in-patient health care staff in Brazzaville. The goal of this project is to facilitate the detection, management, and referral to specialised care for people with mental health disorders. The World Health Organization (WHO) authorised the use of the Mental Health Gap Action Programme (mhGAP) for this training, and the regional and country offices of the WHO in the Congo expressed their support for the programme. As a result, nearly one year after the disaster, the training is about to start. It will involve the department of psychiatry, the medical informatics and tele-medicine service of the Geneva University Hospital, and the in-patient and community health care staff of Brazzaville. The authors believe that, at this stage, it is important to facilitate a gradual change in the health care system, leading to:

1. Empowerment of the general, non-specialised caregivers to detect, manage and refer people suffering from mental illness; and
2. Facilitation of the integration of mental health care at different levels of the community health system, and help to reduce the stigma associated with these services through educational campaigns aimed at the general population, community leaders, and religious figures.

These two points would restore the chain of care, starting at the place where the patient asks for help and ending at specialised mental health care structures. Such an ambitious project requires mental health professionals to work closely with policy makers in Brazzaville at the political level, and to gather, train, and link different stakeholders within the community health care system, at the operational level. This should gradually and continuously facilitate the increased awareness of the population, the promotion of mental health, prevention, early detection, support, treatment and empowerment of people with mental illness. The need to integrate mental health care into all levels of the health care system, to provide the necessary human resources, and to facilitate the access of the population to educational and social services, should be emphasised.

Deep and long lasting change requires awareness, and a movement rising from all levels of the society, leading to a new understanding of health care, including mental health at all levels. It requires the sustained engagement of all stakeholders, at different

levels, to promote education, awareness, advocacy, implementation and the expansion of such a project, and above all, its spirit.

Conclusion

This report links the weaknesses of the Congolese response to the 4 March 2012 emergency and the non-existent mental health care policy to the weakness of the mental health care system in the country and a poorly educated population. Together, these factors show the deep gaps that exist between the population and the existing mental health care structures. This report emphasises the need to create, through a community based mental health care system, a bridge between the population and specialised mental health care structures.

The authors are aware that in the coming years, mental health will be a major public health issue around the globe. Congo-Brazzaville is a country that has a history of wars and natural disasters. The explosions in March 2012 are a part of the history of the trauma of the Congolese population. Within such a context, the mental health of the population becomes an even higher public health priority. At this time, the Congolese health system is undergoing restructuring and a national health development plan is being created. The difficulties the Congolese health system has in terms of addressing the mental health needs of the population reinforce this priority. The opportunity offered by the tragic 2012 explosion emergency must be seized, using the crisis as a driving force for change.

Acknowledgements

The authors wish to acknowledge Emile Godefroy Ngakeni, Mark van Ommeren, Vivien Matingu and Antoine Geissbuhler for their helpful suggestions.

References

Inter-Agency Standing Committee (IASC) (2007). *Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings.*

United Nations Development Programme (UNDP). (2011). *Human Development Report*. New York: United Nations Development Programme.

Babak Moayedoddin is a psychiatrist in the Liaison Psychiatry and Crisis Intervention Service of Geneva University Hospital (HUG). email: Babak.Moayedoddin@hcuge.ch
Christelle Nangho Makaya is a psychologist working with a health focal point for the International Committee of the Red Cross (ICRC) in Brazzaville.
Alessandra Canuto is chief of the Liaison Psychiatry and Crisis Intervention Service of the Geneva University Hospital (HUG)