

### I. Introduction

While there have been volumes upon volumes written about the physical consequences of war, most visions of "holistic" peacebuilding overlook the often invisible mental costs wrought in war. People affected by conflict may witness traumatic events, be separated from their families, become victims or perpetrators of fighting, and be exposed to sexual violence. These experiences raise the risk of developing mental disorders such as PTSD, anxiety, and depression. A systematic review by the World Health Organization (WHO) estimated that more than one-in-five residents of conflict-affected countries have a mental disorder (Charlson et al 2019).

Nigeria's State Ministry of Health has worked closely with the International Organization for Migration (IOM), WHO, and local NGOs since 2015 to expand mental health and psychosocial support (MHPSS) in Northeast (NE) Nigeria, which has been affected by conflict with Boko Haram (Mohammed and Magdalena 2018). This study examines the barriers and facilitators to the provision of these MHPSS services and its integration with peacebuilding.

This study bridges an important gap in the literature of mental health (MH) and peacebuilding which are rarely combined despite the importance of their nexus. Tankink and Bubenzer (2017) find that MH stresses make a return to conflict more likely as they fray the social fabric within communities and weaken opportunities for reconciliation and economic recovery. However, Bubenzer (2020) noted that "few studies were found that explored how the fields of MHPSS and peacebuilding might be brought together in theory and practice." In the case of NE Nigeria, no peer-reviewed literature could be identified that examined the fusion of MHPSS and peacebuilding responses.

The questions this study seeks to answer are of great personal meaning. My grandmother and her siblings grew up as Jews fleeing the Nazi occupation of Belgium. As young children, they witnessed nearly all of their extended family being taken to concentration camps where they were later killed. My grandmother still lives with the weight of the trauma from these experiences. I, personally, have experienced MH issues that I was lucky enough to receive treatment for, seeing first-hand the benefits that interventions can provide.

### II. Methods

- This study utilized qualitative in-depth interviews with a range of stakeholders (n = 13) including MH specialists (n = 7), primary health care providers (n = 2), non-specialists trained in MHPSS (n = 1), and peacebuilders (n = 3). Most respondents (n = 9, 69%) lived and/or worked in NE Nigeria.
- An in-depth interview guide was prepared. After the guide was piloted, new questions were added based on inductive salient themes that were discovered in stakeholder narratives.
- To analyze the data, framework analysis (FA) was employed (Gale et al. 2013). The stages of FA were (1) transcription (2) interview familiarization (3) coding with NVivo V. 12 software (4) developing an analytical framework (5) applying the analytical framework (6) charting the data into the framework matrix and (7) interpretation of the data.

Characteristic	N	%
<b>Gender</b>		
Male	9	69.23
Female	4	30.77
<b>Age (in years)</b>		
30-35	3	23.08
35-40	4	30.77
40-45	4	30.77
50-55	1	7.69
55-60	1	7.69
<b>Years of experience</b>		
Less than 5	2	15.38
5-20	10	76.92
More than 20	1	7.69
<b>Occupation</b>		
Mental health specialist *	7	53.85
Primary health care provider	2	15.38
Non-specialist trained in MHPSS	1	7.69
Peacebuilder	3	23.08
<b>Organization</b>		
United Nations Agency	6	46.15
International Peacebuilding Organization	2	15.38
International MHPSS NGO	4	30.77
Local MHPSS NGO	1	7.69

Figure 1: Respondent Profile

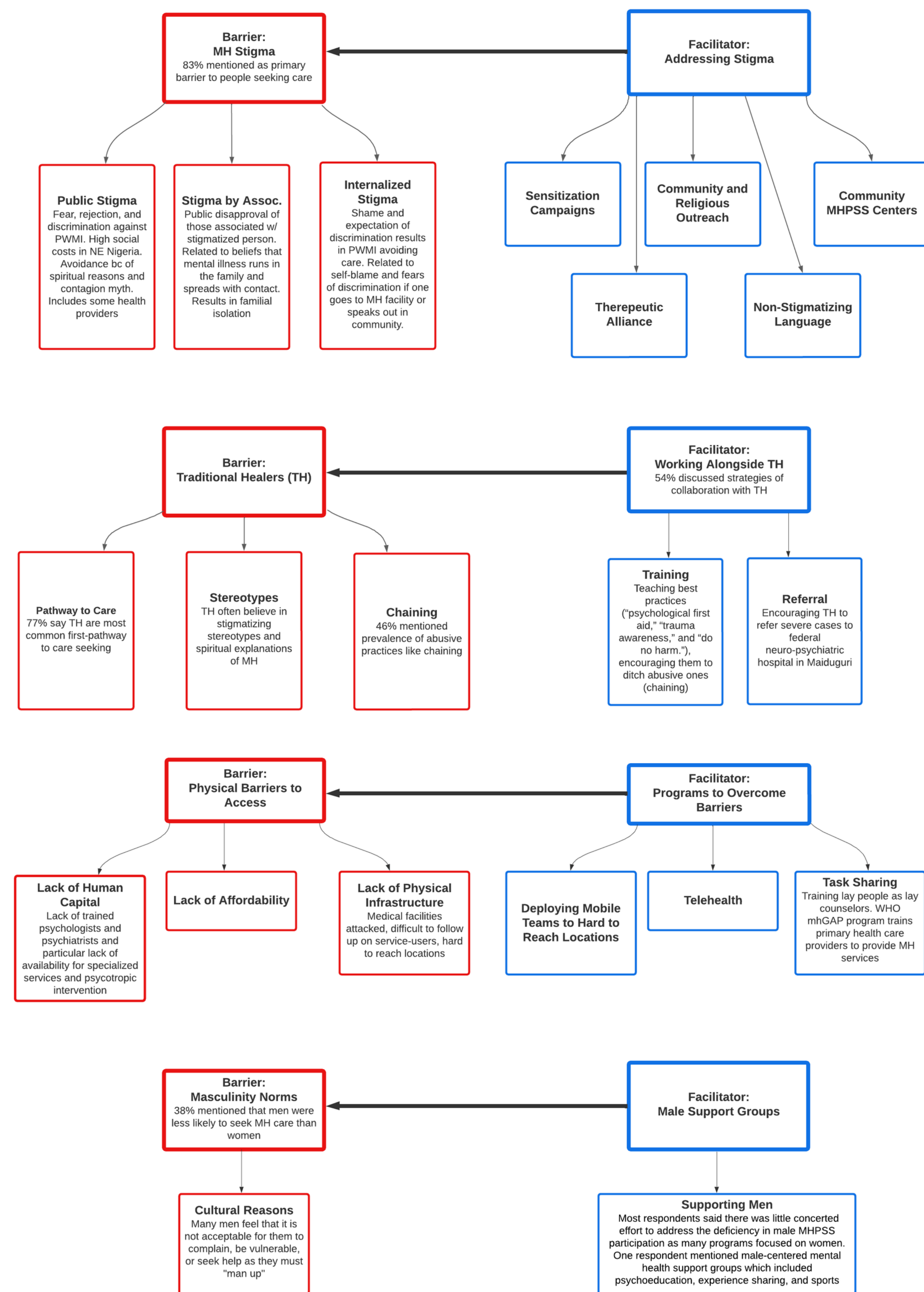
\*MH specialists includes respondents with a master's degree in psychology, psychiatry, or psychiatric nursing

### III. Causal Factors of Mental Illness

<b>Disorders</b>	PTSD, anxiety, and depression most commonly mentioned
<b>Symptomatology</b>	Lack of sleep most common, often associated with flashbacks
<b>Violence from Boko Haram</b>	Every respondent involved in the field of MHPSS named as primary contributor. Killing, raping, and abduction of community members.
<b>Economic Hardship</b>	38% mentioned as cause. "Dependency syndrome" among breadwinners ashamed to need international help.
<b>Spiritual &amp; Supernatural</b>	Most common explanation by community members. Community members saw as a "spiritual problem," "attack from the spirit world" or "by some sort of demons," or "witchcraft," all of which had negative stigmatizing connotations.

"I met a mother had experienced many traumatic events, including losing seven of her children from childhood illnesses. And two years before, she was grieving the loss of her husband. So the only sense of hope that she had left with her only child — that daughter. And when the daughter was abducted in 2014, the woman felt a loss of the sense of what she was living for. Who is she living for? She concluded that the best thing for her to do was to take her life."  
42-year-old primary health care provider (NG-05)

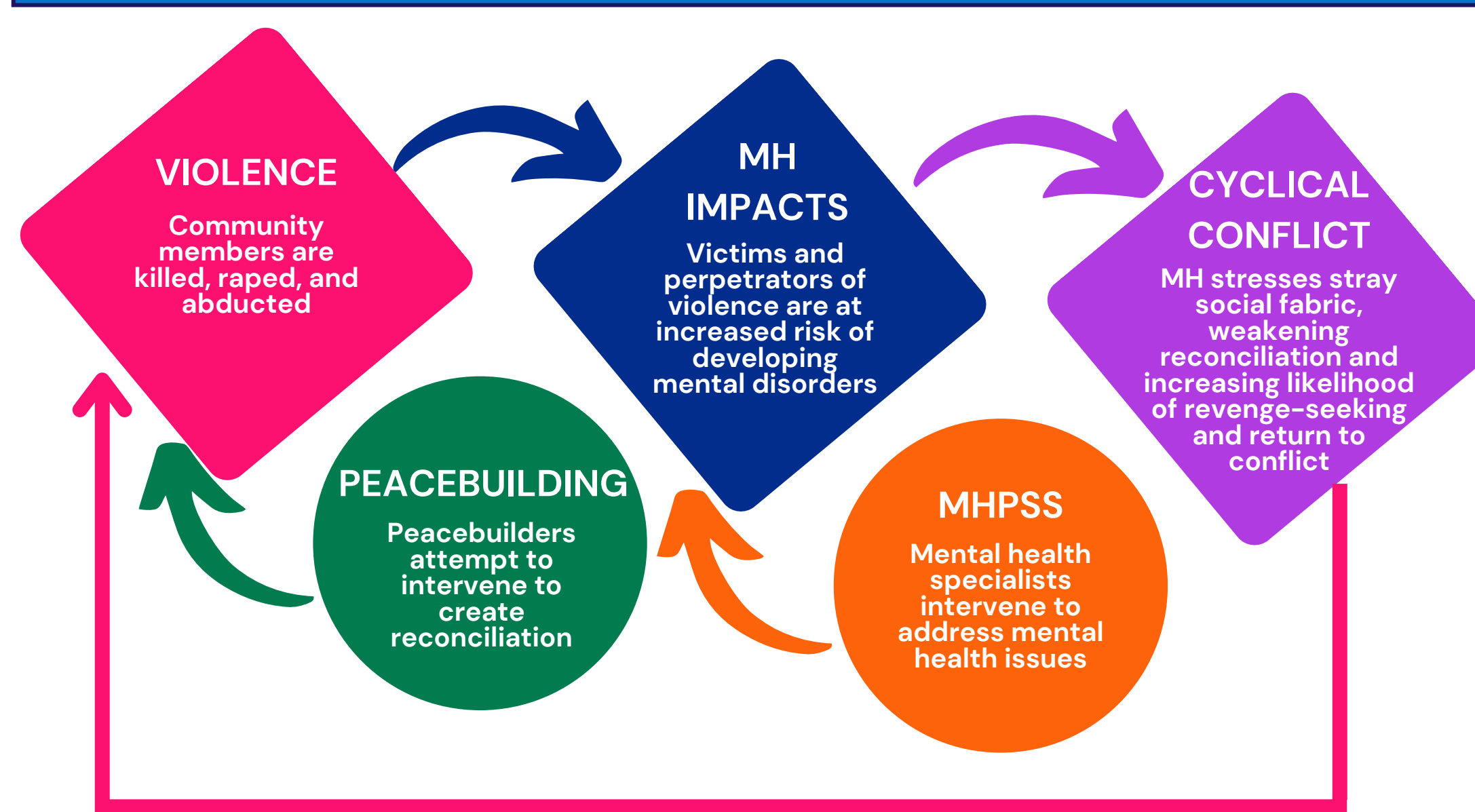
### IV. Barriers and Facilitators (Figure 2)



### V. Narrative of Overcoming Stigma

"There was a woman I worked with who was released after being abducted by Boko Haram for four years. She was having a lot of flashbacks. A little sound would just make her go unstable. We encouraged her to come with us to the neuropsychiatric hospital but she told us 'If I go there, I'm going to be tagged a mad person. And then, even if I'm not going to be tagged as a mad person, I've tried, our cultural people have tried, the traditional rulers have tried, the spiritual leaders have tried but treatment doesn't work. And they say that means that this is a spiritual attack.' But we tried to explain to her to say 'Okay, instead of you thinking about using the incense, all the traditional processes that you did and you feel have failed, you don't have to accept that. You can try the mental services in our hospital, and you're not going to be labeled. If you want me to come to your home, pick you up in the car, they will take you to the neuropsychiatric hospital without anyone knowing.' And it took us almost a month before she would be able to accept and before her father was able to accept that yes, she could go. Because he's also feeling that if his daughter should go there, he is going to be tagged a father of a mad person. And we had to convince the family and they later accepted. And once we went to the hospital, it wasn't even a serious issue. They had a psychiatric session and she was given some medication. It was just a serious migraine she was having and some mild mental health issues. And she was treated and within a few times she was okay." - 32-year-old non-specialist trained in MHPSS (NG-03)

### VI. Biopsychosocial Model of Mutually Reinforcing Cycles of Violence and MH Challenges



- Most respondents (n = 9, 69%) mentioned the importance of integrating the fields of MHPSS and peacebuilding. These respondents mentioned that the conflict deteriorated social cohesion, requiring psychosocial work to rebuild.
- Several respondents mentioned that, when MH issues—particularly trauma—are left unresolved, they can result in a desire for "revenge" that feeds into more conflict. The resulting conflict feeds this cycle by adding to MH issues (see Figure 3).

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### VII. MHPSS & PB Integration

- Ten respondents (77%) argued that reintegration processes in NE Nigeria—whereby ex-combatants rejoin their community—were adding to MH challenges. These include:
  - The community finds difficulty accepting the return of those who harmed them and can be re-traumatized by reintegration.
  - Ex-combatants themselves face trauma and MH challenges from battlefield experience and ostracization in the community upon re-entry.
- Several respondents (n = 7, 54%) described MHPSS programming provided directly to ex-combatants to help them process trauma and move forward as productive members of society, in turn aiding the construction of peace. This programming includes MH services, trauma counseling, and economic reintegration work.
- A few respondents discussed integrating MHPSS and peacebuilding by making "MHPSS the umbrella under which other concerns, such as protection, counter-trafficking, and GBV are part of as one unit."
- Two respondents mentioned the importance of "co-creation" whereby MHPSS and peacebuilding practitioners meet together to understand their respective fields and areas where they could be integrated.
- Several respondents (n = 6, 46%) described programs of community sensitization, forgiveness, acceptance, and trauma counseling meant to help communities process and accept reintegration processes.

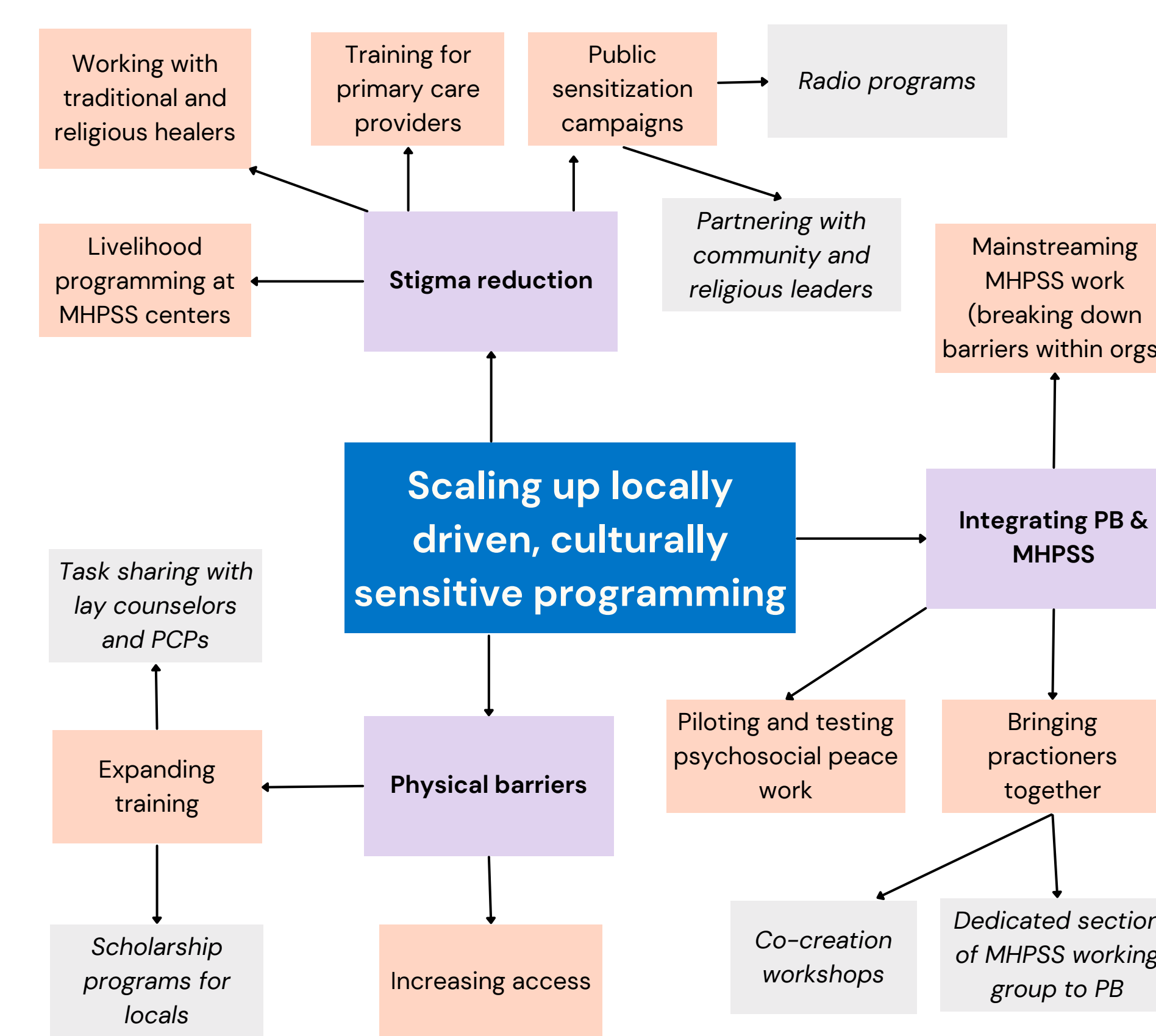
One 36-year-old MH specialist (NG-13) shared their experience working with eight ex-combatants doing both PB and MHPSS work. They gave these ex-combatants MH services, taught them to forgive themselves and understand the pain they caused their community, and equipped them with startup capital to become economic contributors. They shared one example of an ex-combatant: "He is loved by the people in the community where he is, even though they do not know what he has done. He helped a lot of people which he feels is a means of paying restitution for what he has done in the past"

### VIII. Barriers to Integration

- Barriers persist in integrating these fields. Four respondents (31%) discussed the lack of knowledge among PB and MHPSS practitioners about their respective fields, as well as the donors that fund their projects, as being a primary barrier to the fields working together.
- Three respondents (23%) noted that peacebuilders often hold a misconception that MHPSS is focused on trauma, rather than the range of issues that MHPSS practitioners respond to.
- This lack of awareness is only compounded by the stigma around MH, which one respondent noted made donors and practitioners in the peacebuilding community less interested in MHPSS programming, in addition to context-specific barriers to integration.

"We are one of the few organizations that started psychosocial peacebuilding in Northeast Nigeria. But even here, mental health is a standalone program here. And peacebuilding is also a stand alone program. I'm an active member of the MHPSS sector working group. For the past three years, I've been very active in attending monthly coordination meetings. But then you hardly hear about the issue of peacebuilding from these experts working in the field of MHPSS. So the target for them is let's do psychosocial support. So honestly, mainstreaming mental health into peacebuilding is not something that has happened a lot." - 40-year-old mental health specialist (NG-11)

### IX. Recommendations



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