

REVIEW OF MENTAL HEALTH AND PSYCHOSOCIAL NEEDS AND RESPONSES DURING EMERGENCIES IN NIGERIA

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50TH International Course in Health Development (ICHHD).
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A thesis submitted in partial fulfilment of the requirement for the degree
of Master in Public Health

by:

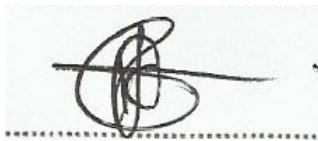
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LIST OF ABBREVIATIONS

ASD	Acute Stress Disorder
CBOs	Community-based Organisations
CHWs	Community Health Workers
FBOs	Faith-Based Organisations
FMoH	Federal Ministry of Health
GBV	Gender-Based Violence
GDP	Gross Development Product
GNI	Gross National Income
NHIS	National Health Information System
IASC	Inter-Agency Standing Committee
IDPs	Internally Displaced Persons
IFRC	International Federation of Red Cross and Red Crescent Societies
IHL	International Humanitarian Law
KNG	Kenya National Guidelines
LEMA	Local-government Emergency Management Agency
LGA	Local Government Area
LMICs	Low and middle income countries
mhGAP	Mental Health Gap Action Program
MHPS	Mental Health and Psychosocial
MHPSS	Mental Health and Psychosocial Support
MoH	Ministry of Health
MSF	Medecins Sans Frontieres
NEMA	National Emergency Management Agency
NET	Narrative Exposure Therapy
NGO	Non-Government Organisation
NMHAC	National Mental Health Action Committee
NRCS	Nigerian Red Cross Society
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PHC	Primary Health Care
PPP	Purchasing Power of Parity
PTSD	Post-Traumatic Stress Disorder
RCT	Randomized Control Trial
SEMA	State Emergency Management Agency
SGBV	Sexual and Gender-Based Violence
UI	University of Ibadan
UN	United Nations
UNDP	United Nations Development Programmes
UNICEF	United Nations Children's Fund
VU	Vrije Universiteit
WHO	World Health Organisations
WHO-AIMS	World Health Organisations- Assessment Instrument for Mental Health System
WPA	World Psychiatry Association

GLOSSARY

'Humanitarian crises', 'emergencies', 'crises', 'disasters' and **'conflicts'** are similar words that are used interchangeably in this paper as roughly synonymous expression to describe extremely stressful events or circumstances that represent a critical threat to health, safety, security and wellbeing of a group of people.

'Mental health' refers to a state of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community. It also refers to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders (WHO 2013).

'Psychosocial' refers to the inter-connection between psychological and social processes. That is, the close relationship between the individual and the collective aspects of any social entity, and the fact that each continually interacts with and influences the other. "MHPSS describe any type of local or outside support that aims to protect or promote psychosocial well-being and/ or prevent or treat mental disorder." (IASC 2007).

ABSTRACT

Background: Despite the evidence on the relationship between extremely stressful situations and poor mental health, little is being done to prevent the mental and psychosocial consequences of emergencies in Nigeria. Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC-MHPSS Guidelines 2007) is a multi-sectoral and interagency framework developed to coordinate different minimum but high priority activities that have been shown to be effective in promoting mental health and psychosocial wellbeing in emergency settings. But up till the time of this study the framework is not being implemented in Nigeria.

Objective: To help improve effective MHPSS responses during emergencies in Nigeria, through a review of MHPSS needs and responses, a review of the international MHPSS literature and the formulation of evidence-informed recommendations tailored to the specific situation in Nigeria.

Methodology: Review of literature and reports that are available through VU-library and hand-searching of internet was done. IASC-MHPSS intervention pyramid model was used to analyse the situation in Nigeria.

Results: Prevalence of PTSD in Nigeria ranged from 19%-85% among survivors of conflicts. Given the lack of coordinated systematic MHPSS response, humanitarian actors and communities themselves have made some efforts to provide MHPSS to survivors of disasters. However, when provided it is not coordinated, at scale, sustained or supervised; and its impact is not measured.

Conclusion: Implementation of the IASC-MHPSS framework will contribute to improved system of MHPSS response to promote recovery of mental health, livelihoods and social cohesion. Recommendations for multi-sectoral collaboration are made.

Keywords: mental health, psychosocial support, emergencies, PTSD, Nigeria

Word count: 13,150

INTRODUCTION

During humanitarian response, the concern of aid workers is to get people to safety and to provide shelter, basic medical care, food and safe water; but there is usually little time to attend to their minds. Being part of the humanitarian organisation workforce responding to different types of disasters in Nigeria, I have received reports and sometimes witnessed people commit suicide or acts of self-harm following these traumatic events. Some experienced serious impairment of their mental and social functioning and those with pre-existing mental health conditions could not access healthcare services for their medications and follow up. I have also heard people affected by conflicts express ideation of revenge and over time there can be intergenerational transmission of hatred and conflicts if left unaddressed.

In the last two decades, the frequency of both natural and man-made disasters in Nigeria has increased considerably (NEMA 2010). The impact of these crises on individuals and communities can be physical, psychological and social. People affected by humanitarian crises are particularly vulnerable to poor mental health and psycho-social problem, especially when there are limited supports and services for recovery (Norris et al. 2002). Therefore humanitarian responses should include mental health and psychosocial support (MHPSS) in addition to medical treatment of physical injuries (Van Ommeren, Saxena & Saraceno 2005).

The prevalence of psychiatric disorder is high in Nigeria and it is also recognized as one of the leading causes of disability globally (WHO 2009). Failure to recognize and manage survivors of emergencies that are at risk of psychiatric disorder can lead to an increase in the burden of mental problems on the already weak health system. It can also affect recovery and productivity of individuals, communities and the country.

The aim of this study is to (i) describe the potential mental health and psychosocial problems among survivors of emergencies in Nigeria, (ii) identify evidence and international guidance that exists in the global literature to inform appropriate mental health and psychosocial response following emergencies, (iii) describe MHPSS services for emergencies that are available in Nigeria (iv) identify the gaps in mental health and psychosocial response for emergencies and (v) formulate recommendations on how the evidence from global literature can be used in the Nigeria context to improve MHPSS response, hence reduce the burden of mental disorders due to emergency situations.

The first part of this thesis gives a brief description of relevant demography and socio-economic status of Nigeria and its health system. Then the problem upon which this study is based, the justification, the objectives; and the methods of data collection will be outlined. Following this the results from the literature search will be analysed under the discussion chapters using the specific objectives and analytical framework as guide. Based on the outcome of the review, recommendations are proposed.

The outcome of this research will contribute to the available knowledge on MHPSS during emergencies in Nigeria. It will identify evidence and good practice that will inform the formulation of recommendations on ways to improve policy and practices of response to mental health and psychosocial effects of humanitarian crises in Nigeria. It will also benefit relevant policy makers and stakeholders in ensuring effective MPHSS responses as well as public health professionals and volunteers working in the area of post-disaster in Nigeria. It is also hoped that this study will be able to inform clinical psychiatrists on current MHPSS framework in emergency situations considering the frequency and scale of crises in the country today.

This study is in partial fulfilment of the requirement for MPH and also in fulfilment of my personal goal of having in-depth knowledge about MHPSS in emergency settings in order to enhance my skills in advocacy and rendering effective assistance to the most vulnerable in our society.

CHAPTER 1: BACKGROUND INFORMATION ON NIGERIA

This chapter contains brief background information on socio-demography, economy, emergency situations and disaster response, and health system in Nigeria as they relate to the topic. The mental health system is analysed in details because of its relevance to the study.

1.1 Socio-demography

The Federal Republic of Nigeria is the most populous country in Africa which according to the last census in 2006 the population was estimated to be 140 million people. With an annual growth rate of 2.5% the current population is estimated to be 170 million people (OCHA 2014). The male to female ratio is 1: 0.99 (NDHS 2008). Nigeria is made of 36 states and Abuja- the federal capital territory (FCT), 774 Local Government Areas (LGAs) and over 250 ethnic groups. Ethnic diversity is one of the causes of conflict in Nigeria and different ethnic groups have different beliefs about the causes and treatment of mental illness. The country is broadly divided into six geopolitical administrative zones which are: north-central, north-east, north-west, south-east, south-south and south-west zones. There are wide geopolitical zone disparities in terms of health status, health care delivery, resources and economic status. There are more health services and resources in the southern states than in the north. States in the northern zones have the poorest key health indicators in the country and are experiencing more recurrent conflicts than the rest of the country. The official language in Nigeria is English and the three major indigenous languages are Hausa, Ibo and Yoruba.

1.2 Economy

Nigeria has rich natural resources that include crude oil and gas and solid minerals, with about 70% of the population engaged in agriculture. And with current Gross Development Product (GDP) growth rate of 6.7% (World Bank 2014) the country has experienced exponential economic growth driven by the oil industry. Between 2000 and 2012, the per capita gross national income (GNI) based on purchasing power of parity (PPP) increased by 61%. Despite the economic growth, about 68% of the population live below poverty line of less than \$1.25 per day, with increasing levels of inequality between rich and poor(UNDP 2012). Moreover, the oil industry has led to a degradation of the environment affecting the agriculture and fishing industries upon which much of the

population depends for their livelihood. This is one of the reasons for the continuous crises in the Niger-Delta region of Nigeria. Poverty is an important determinant of health including mental health and it also worsens the outcome of disaster and impacts people's ability to recover.

1.3 Emergency situations in Nigeria

In the last fifteen years there has been a considerable increase in the number of emergency situations in Nigeria (NEMA 2010). Emergency situations can be caused by natural or man-made disasters. OCHA reported that between January 2013 and January 2014, an estimated 9.5 million people were affected by natural and man-made disasters including insurgency and subsequent state of emergency in the north-eastern part of Nigeria (OCHA 2014). The crises-prone regions are shown in Figure 1, and some of these emergencies are briefly described below:

1.3.1 Man-made Disasters

Ife/Modakeke crises: which are still on-going have a long history dated back to 1835 when the first crisis occurred as a result of disputes over land ownership and payment of royalties in the southern part of the country. Between 1835 and the year 2001, eight major wars have been recorded in this region. The 2001 crisis claimed the lives of over 2,000 people, and displaced many more (Asiyanbola 2010).

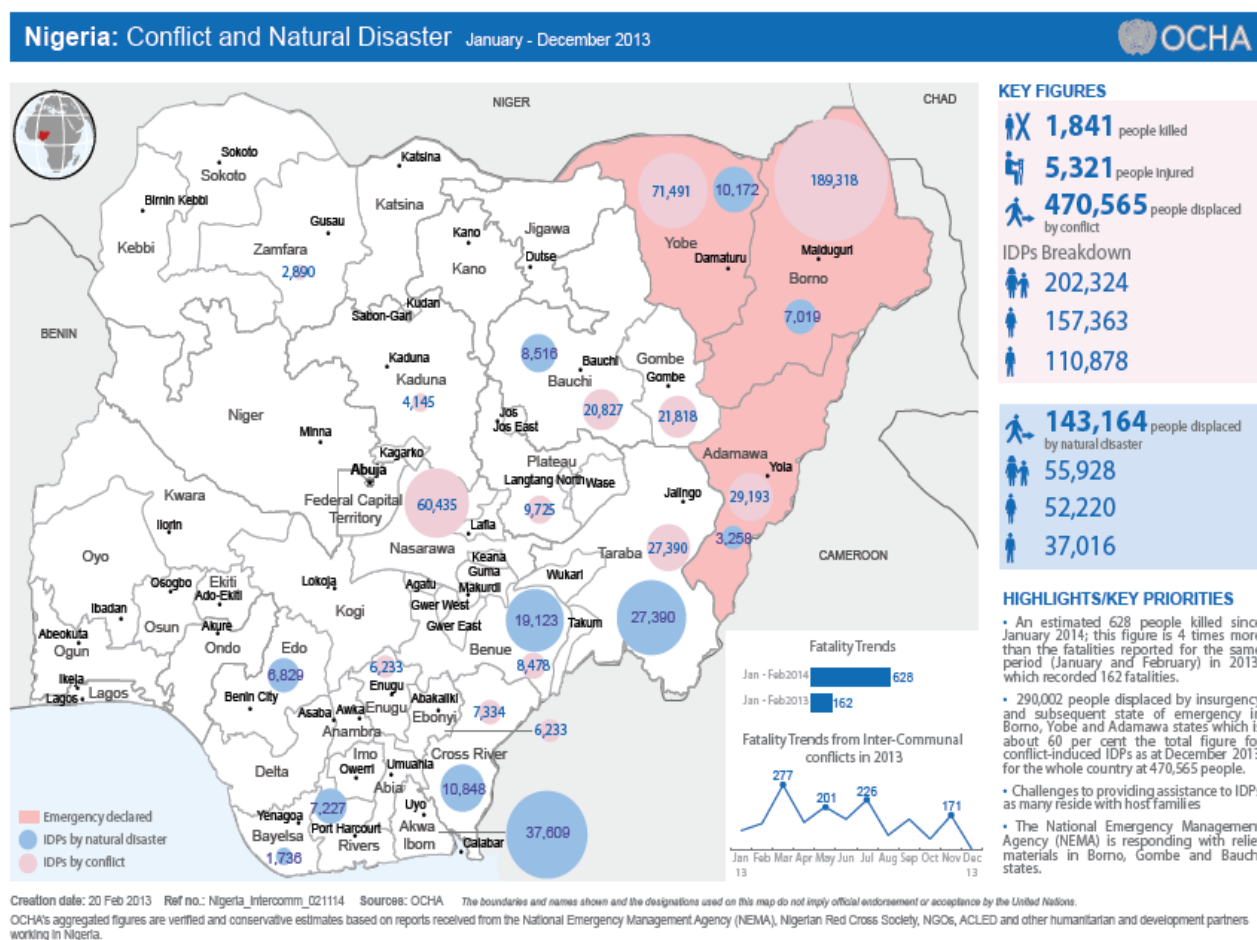
Niger –Delta oil basin crises: are recurrent and still on-going, about 2,000 people were reported killed in a year, and the death toll and incidents of kidnapping in the region continue to rise (Hunt cited in Beiser, Wiwa & Adebajo 2010).

Nation-wide terrorist attacks and insurgencies by Boko Haram: (a religious sect) that started in 2009 claims hundreds of lives on a weekly basis and is still on-going in the country such that it has attracted global attention. The violence and corresponding deaths are escalating causing marked displacement of people from the affected region. From January to December 2013 an estimated 4,679 people were reportedly killed and millions displaced (OCHA 2014). In April 2014, about 234 schoolgirls were kidnapped by this sect (Ross 2014).

Ethno-religious crises: The recurrent crises in Jos, Plateau state started in 2001. Obateru, (cited in Obilom & Thacher 2008) reported that 53,789 people (almost equal number of men, women and children) died due to the violent conflict during the period of reporting (Obilom & Thacher

2008). In 2013 also, more than 5,000 lives have been lost due to the conflict (OCHA 2013).

Figure 1: Map showing conflicts and natural disasters in Nigeria



Source: OCHA 2014

1.3.2 Natural Disasters

Flooding is the most commonly experienced natural disaster in Nigeria. The 2012 floods were the worst experienced in over 40 years in the country claiming 363 lives. A total of 7 million people in 33 out of the 36 states and the FCT were affected with 14 states severely affected. About 618,000 houses were estimated to be destroyed and 2.1 million people displaced (OCHA 2013). Properties, homes, infrastructures, farms and food stocks were washed away.

1.3.3 Disaster Response

The National Emergency Management Agency (NEMA) is responsible for coordinating emergency response in the country and is jointly operationalizing the national disaster response framework with other relevant government agencies, Nigerian Red Cross Society (NRCS), and local and international agencies like UN agencies, Save the children, MSF, Oxfam and ICRC (NEMA 2002). Their main activities in emergency response are search and rescue, shelter, distribution of relief items, water, food, security, medical care, restoring family links and rehabilitation. NRCS's community-based volunteers are most of the time the first-line responders in emergency situations in Nigeria but their activities cut across all phases of emergency. Other relevant government agencies and their responsibilities in emergency response are shown in Appendix 2.

1.4 Health System

The health system in Nigeria includes orthodox, alternative and traditional systems of health care delivery. The health care delivery is structured in line with the universal three tiers of primary, secondary and tertiary levels of healthcare and mainly provided by the public health sector; however provision by private sector also cuts across all levels of healthcare delivery. Primary level care is the community entry point into health care system and includes dispensaries, clinics and health centres. It is staffed by nurses, community health officers or community health workers (CHWs) and environmental health officers. The organizational structure for primary level care is shown in Appendix 5. It provides mainly preventive health care but also general treatment of simple ailments. At secondary level, general medical, laboratory and specialized services are provided by medical officers, specialists, and allied health workers in general hospitals. It also serves as referral centre for primary level. Tertiary healthcare is the highest level of care in the country which serves as referral centre for primary and secondary level; and also as resource centres for knowledge generation. The coverage of most key preventive and curative health service in Nigeria is very low. And this is compounded by geopolitical zone, rural-urban and socio-economic disparities in coverage. In the public sector, the different tiers of government are charged with different health care delivery functions. Federal government is responsible for tertiary care; State government is responsible for secondary care while local government is responsible for primary

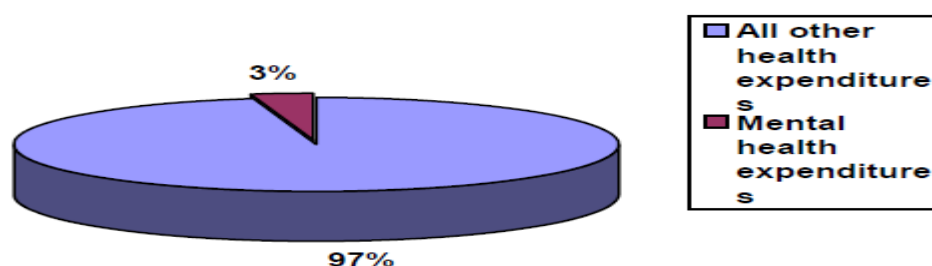
healthcare services. Total expenditure on health is only 5.3% of the gross domestic product which is below the 15% commitment during Abuja declaration in 2001(WHO 2011). The flow of government funding is directly from the national health account to the different tiers of government (although this is not clearly defined and is complex in this context).

1.5 Mental Health Services

Mental health indicators are not captured in the national health information system (NHIS); therefore it is difficult to make an informed analysis of mental health services in the country. The government's commitment to mental health services is still very low in Nigeria despite the high prevalence of psychiatric disorder which in 2006 was estimated to be 12.1% (Gureje et al. 2006). Appendix 1 outlines the prevalence of lifetime and 12 months DSM IV disorders in Nigeria. However, mental health in Nigeria started gaining attention after the WHO mental health system assessment (WHO-AIMS) in 2006 when the result showed the neglect that mental health issues have suffered in the country.

World Health Organisation- Assessment Instrument for Mental Health System, version 2.2 (WHO-AIMS 2.2) is a tool developed to assess mental health system and services in order to provide important information for relevant actions that will strengthen mental health system in the country (WHO 2005). The 2006 WHO-AIMS report for Nigeria shows that only 3.3% of government expenditure on health is earmarked for mental health (See Figure 2). And 90% of mental health expenditure goes to mental hospitals. There is very little expenditure for community-based services for adequate coverage and access by the population, particularly in rural and semi-urban areas of the country (WHO & MoH 2006).

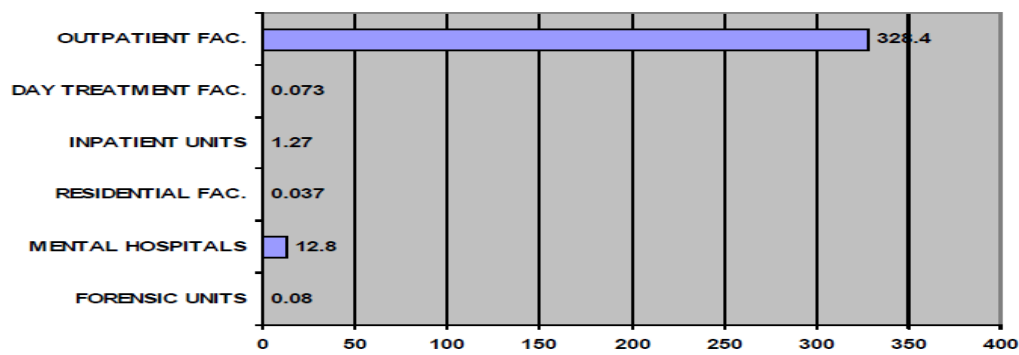
Figure 2: Health expenditure towards mental health in Nigeria



Source: WHO & MoH 2006

Mental health services provided at the community level are through health centres, NGOs and family groups. Mental health services are also provided through out-patient and inpatient psychiatry departments of general hospitals, day treatment and residential facilities (secondary level) and through psychiatric hospitals and forensic units (tertiary level). Figure 3 below, shows that out-patient psychiatric department of general hospitals and psychiatric hospitals are the main providers of mental health services in Nigeria. Most of these facilities are concentrated in the large cities which prevent easy access by people in rural areas and also affect continuity of care.

Figure 3: Patients treated in mental health facilities (rate per 100,000 populations)



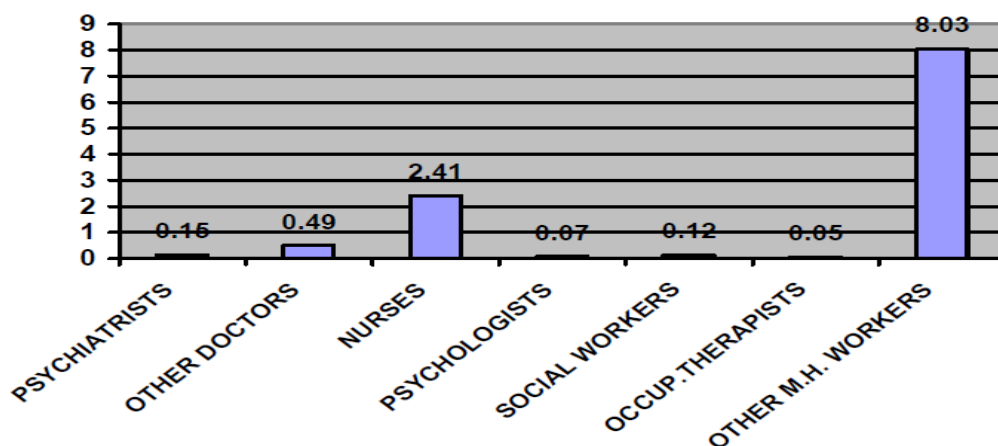
Source: WHO & MoH 2006

The condition of health facilities providing mental health services is also poor, and the number of mental health specialists is grossly inadequate. As shown in Figure 4 below, there are less than 150 psychiatrists in the country and very few psychiatric nurse, clinical psychologists, social workers, neuro-psychotherapists and occupational therapists (WHO & MoH 2006). Also, a report from University of Ibadan (UI 2012) shows that only 10% of people with mental, neurological and substance use disorder received any form of treatment in the previous 12 months of the study. And that about 50% of psychotropic drugs on sale are not genuine. It also shows that there is no formal social support system for people with mental health problems in Nigeria and there is limited coverage for mental health care on the available health insurance scheme (UI 2012).

In 2013, delivery of mental health services at primary care level was passed into the national policy for mental health services delivery in Nigeria with aim of reducing treatment gap for mental health disorder. This is being piloted in Ogun State, where about 80 nurses and CHWs

were trained based on adapted WHO mental health gap action program (mhGAP) intervention guide. They were then deployed to rural health centres to manage depression, anxiety, psychosis, substance use disorder and epilepsy; and to provide community mental health education. Framework was developed for support and supervision of the project (Umukoro 2013). However, there is no study found on the outcomes of this promising project.

Figure 4: Human resources for mental health (rate per 100,000 populations)



Source: WHO & MoH 2006

Only 33% of the Nigerian population has free access to essential psychotropic medicines and poverty among the general population make the care of people with mental illnesses a major burden for them and their families (since they cannot afford the treatment). Mental illness is highly stigmatized in all regions of the country due to the belief that misuse of hard drugs, supernatural or spiritual forces is the cause of mental illness. Hence, many people with mental illness turn to spiritual or traditional healers for help. This may in part be due to lack of awareness on the causes and treatment options that are available. Although a national human rights act exists, there are no specific monitoring activities to protect the rights of psychiatric patients. About 20% of patients in mental health facilities were restrained or secluded, and this estimate will be higher among traditional healers where the treatment of the patient is usually inhumane (WHO & MoH 2006; Hammond 2013).

Positive outcomes of the WHO-AIMS report were the reaffirmation of commitment and updating of the policy for mental health services delivery

in 2013 (22 years after the first policy) and the creation of the national mental health action committee (NMHAC) under the Federal Ministry of Health (FMoH). NMHAC was created to coordinate implementation of the mental health care policy and provide expert advice to the minister of health on matters relating to mental health (FMoH 2013).

CHAPTER 2: PROBLEM STATEMENT, JUSTIFICATION, OBJECTIVES, METHODOLOGY AND CONCEPTUAL FRAMEWORK

This chapter describes the identified problem upon which this study is based and justification for the choice of topic. The objectives of the study and methodology used for the research are also outlined.

2.1 Problem Statement

The dramatic increase in the number of man-made and natural disasters in Nigeria over the past fifteen years has had serious impacts on the population. These disasters have caused significant displacement and loss of lives and property and breached security in a large part of the affected regions (IDMC 2014; See Appendix 4).

Deaths generally constitute a very small proportion of those affected by disasters; the greater consequences are the physical, social and psychological impacts (Goldmann & Galea 2013). The sudden nature of these events can have huge impacts on the psychological state of the survivors. People who witnessed their loved ones shot at, beheaded, tortured, burnt, raped or maimed, or saw their houses and properties burnt or washed away in floods, or were exposed to horrific acts of violence will not easily recover from the negative psychological effects of these events.

Anecdotal evidence and some research have shown that posttraumatic stress disorder (PTSD) is a significant problem among survivors of conflict in Nigeria. A study by Obilom & Thatcher (2008) shows prevalence of 41% of PTSD among respondents exposed to the ethno-religious crisis in Jos (Nigeria) nine months following the crises (Obilom & Thatcher 2008). There were also unpublished reports of suicide and self-harm following these traumatic events in Nigeria.

Studies conducted in other countries have also shown a definite increase in the incidence and prevalence of other mental health problems among survivors of disasters, especially if there are no sufficient protective factors. Other common sequelae include: depressive and anxiety disorders, alcohol and substance abuse and somatization (Goldmann & Galea 2013; Steel et al. 2009; Murthy & Lakshminarayana 2006; Norris et al. 2002). Furthermore, in emergency situations, disruptions of healthcare facilities, drug supplies and social support, reduced access to religious and traditional healing, increased stigma, discrimination and inhumane treatment of people with pre-existing or disaster-induced mental health

impairment can worsen their condition (Murthy & Lakshminarayana 2006).

According to global burden of disease (2010), mental health disorder is one of the top-five leading causes of years lived with disability in Nigeria (IHME 2013). Emergency situations in Nigeria can further lead to increased need and demand for mental health services which translate into increased burden on the already weak mental health system. Poor mental health also interferes with the ability of children to learn, and prevents adults from productive functioning at work and at home. This leads to increased poverty, subsequently affecting economic development of the country (Levinson et al. 2010).

Challenges with ability of survivors to cope, recover, rebuild and return to normalcy are often overlooked. The aid given by government and other non-government agencies in humanitarian responses in Nigeria is focused on relief distributions of household items, nutritional support and physical treatment of injuries.

There is a disaster response policy in Nigeria and provision of psychosocial support for survivors is stated. However, there is currently no specific framework or detailed implementation plan in the FMOH and NEMA that is developed for MHPSS in emergencies (WHO & MoH 2006; Abdulmalik et al. 2013).

2.2 Justification

The reason for deciding to review mental health and psychosocial needs and response of people exposed to emergency situations in Nigeria is because of the considerable increase in the frequency of violent conflicts that is affecting millions of Nigerians. Despite the evidence on the relationship between extremely stressful situations and poor mental health, little is being done to prevent the MHPSS consequences on survivors in Nigeria.

Evidence shows that promotion of sense of safety, calming, sense of self- and community efficacy, connectedness and hope are essential in reducing mental health problems among disaster-affected population (Hobfoll et al. 2007). These are the kind of supports and services offered in MHPSS programmes. This means that MHPSS interventions can contribute to the reduction of psychological consequences of emergencies.

Furthermore, there are very few studies on the mental health and psychosocial impact of conflict and disasters among survivors in Nigeria that can be used for advocacy or planning. Very few fragmented reports have documented MHPSS interventions provided to survivors of emergencies in the country. Also, no study has been conducted to analyse the situation of MHPSS system in Nigeria with the aim of identifying the gaps and providing solutions to the identified problems.

The result of this study will add to the available knowledge of mental health and psychosocial needs during humanitarian crises in Nigeria. It will also identify gaps in MHPSS response and formulate recommendations on ways in which evidence and guidance can be used to improve the policy and practice of humanitarian response in the country.

2.3 Objectives

Overall Objective: To help improve effective MHPSS responses during emergencies in Nigeria, through a review of MHPSS needs and responses, a review of the international MHPSS literature and the formulation of evidence-informed recommendations tailored to the specific situation in Nigeria.

Specific Objectives:

1. To describe potential mental health and psychosocial problems among survivors of emergencies in Nigeria
2. To identify evidence and international guidance that exists in the global literature to inform appropriate MHPSS following emergencies
3. To describe MHPSS services for emergencies that are available in Nigeria
4. To identify gaps in the system of MHPSS response for emergencies in Nigeria
5. To formulate recommendations on how the evidence from global literature can be used in the Nigeria context to improve MHPSS response hence reduce the burden of mental disorders due to emergency situations

Expected result:

1. Result of this study will contribute to the available knowledge on mental health and psychosocial needs and responses during emergency situations in Nigeria

2. The study will identify evidence and good practice that may inform policy formulation and implementation of responses to crisis-induced mental health problems in Nigeria
3. The study will formulate recommendations on ways in which existing evidence and consensus-based guidance can be imbedded in policy and practice of response to mental health effects of emergencies in Nigeria

2.4 Methodology

This sub-section outlines the criteria used for selecting the literature reviewed for this study, the search strategy, limitation of research and the analytical framework used.

2.4.1 Search strategy

Both peer-reviewed and grey literature was used in this study. The data search and selection for primary studies were done in multiple stages and based on the different research questions being answered. Databases and websites were searched based on the search terms for each specific objective (and sometimes for cross cutting issues) as noted below to identify citations. Then, the title and abstract were screened for inclusion and exclusion criteria. The full-text of the remaining studies was reviewed to confirm that the studies met inclusion criteria. And lastly, the selected articles were reviewed in depth.

For specific objective 1, primary peer reviewed journals were systematically searched and selected from PubMed, Science Direct, VU data bases and the Google scholar search engine was used. The criteria for selection were topic-specific studies conducted in Nigeria among adult population in natural and man-made disaster. Articles used were searched using different combinations of the following keywords: [mental health OR mental disorder OR psychiatric problem OR psycho-social needs AND emergency OR conflict OR crises OR humanitarian crises OR disasters AND Nigeria]. Only three articles met the inclusion criteria. See table 1.

The initial findings were very few and did not include social consequences of humanitarian crises in Nigeria. This led to the broadening of the search to include global reviews inclusive of those from low and middle income countries (LMCs). Studies that were specific to children and adolescents were excluded because determinants and outcome of mental health of children may be different from those of adults. Studies on individual-targeted trauma were also excluded, e.g. robbery and common crimes.

Table 1: Literature reviewed for PTSD in Nigeria

S/N	Literature	Methods	Findings
1.	Obilom, RE & Thacher, TD 2008, Posttraumatic stress disorder (PTSD) following ethno-religious conflict in Jos, Nigeria	Community-based prevalence survey of PTSD 7-9 months after Jos crisis to assess the prevalence and risk factors of PTSD among the survivors exposed to the violent event. CIDI was used Diagnostic criteria: those that witness/ experience the traumatic event; with symptoms of re-experience, avoidance and arousal; and have all symptoms during the preceding month. Age: 12 and above	PTSD prevalence was 41% History of personal attack correlated with PTSD There was no gender effect There was significant association between high basal pulse rate and presence of PTSD symptoms.
2.	Beiser, Wiwa & Adebajo 2010, Human-initiated disaster, Social disorganisation and PTSD above Nigeria's oil basin	Cross-sectional study that compared the prevalence of PTSD and its risk factors (at least 6 months) among people in a community exposed to continuous political unrest with people in a relatively peaceful community in Niger-Delta region of Nigeria. WHO CIDI manual was used Age: 18 and above	PTSD prevalence was 60% and 14.5% among survivors in the affected and non-affected community respectively. There is no correlation between PTSD and gender. Alcohol use is also higher among the exposed group There is dose response relationship between exposure to human-initiated violence and mental health consequences
3.	Idehen et al. 2013, Posttraumatic Stress syndromes among victims of the Ife/ Modakeke Crisis.	Ex-post facto, quasi-experimental study to burden of PTSD and its risk factors among survivors of year 2000-Ife/ Modakeke crisis about a decade after the incidence. APA and ICD-10 were used Age: 13 – 44 years	Prevalence of PTSD among people with severe traumatic experience was 86%, 34% among those with mild traumatic experience and 19% among sample representing the general population of Ife and Modakeke. Age and degree of exposure to trauma correlated with PTSD symptoms There is no significant gender effects

Years covered in the data search were between 2004 and 2014 but some cross-references dated back to before 2004. For instance the empirical review by Norris et al. was published in 2002, but was included because it is a very important reference for the topic. The search yielded articles from global studies including LMICs (See Table 2 below). Also, reports from NGOs and other grey literature were hand-searched for more information on this specific objective.

For specific objective two, overview of peer-reviewed articles (systematic and literature reviews) and grey literature were used. Peer-reviewed data search were done in PubMed; Google scholar search engine was also used. Grey literature used was hand-searched from humanitarian research publications and websites. Websites of WHO and international NGOs (INGOs) like Red Cross were searched. Keywords used include different combination of "mental health", "psychosocial support", "emergency", "guidelines", "interventions" and "humanitarian response".

Information on objective three was through grey-literature search from websites of the following organisations: NEMA, FMOH, IFRC, ICRC, UN agencies, MSF and WHO.

For specific objective four, result of analysis of literature from objective three and other grey literature on best practices were used. Two case studies are briefly summarized to give the readers insight into challenges that can be faced and lessons learnt during implementation of IASC-MHPSS Guidelines in two countries that share some similarities in context to Nigeria – Kenya and Afghanistan. At the end, recommendations are drawn from analysis of evidence from the reviewed articles and my personal work experience.

It is important to note that some of these studies were not well developed and quality of the data varies considerably. Also most of the studies reviewed were cross-sectional studies, limiting the ability to draw conclusions and generalisations on their results.

Table 2: Reviews on psychosocial impacts of disasters on survivors

Literature	Methods	P	D	A	S	O	Findings
Goldmann E & Galea S, 2013. Mental Health consequences of Disaster.	Overview of research on mental health following disasters. With focus on the burden; correlates; treatment and challenges to research.	+	+	+	+	+	<p>Psycho-social consequences of disaster</p> <ul style="list-style-type: none"> • Specific psychological problems: Post-Traumatic Stress Disorder (P), Depression (D), Generalized Anxiety Disorder (A), substance use disorder (S), panic disorder, phobia, dissociative response, prolonged grief, death anxiety and suicide. • Non-specific psychological distress (O): demoralization, remorse, perceived stress, negative affect and other culturally specific syndromes • Health problems and concerns: physical illness, somatic problems, sleep disruption, alcohol and drug use, clinical worsening of pre-existing mental health, increased perceived illness burden. • Problems with living: troubled interpersonal relationship, family strains and conflicts, occupational stress, financial stress, environmental disruption • Loss of psychosocial resources: perceived loss of social support, self-efficacy, social participation and belongingness; control, optimism and goal achievement. • Problems specific to children: clinginess, dependence, temper tantrum, incontinence, aggressive behaviour, separation anxiety and hyperactivity • Problem specific to youth: minor deviance and delinquency.
Murthy R. S, Lakshminarayana R, 2006. Mental Health consequences of war: a brief review of research findings	Literature Review of impact of war (between and within countries) on mental health of the general population and specific vulnerable groups in 12 countries	+	+	+	+	+	
Norris F. H. et al, 2002. 60,000 Disaster victims speak: Part 1. An Empirical Review of the empirical literature, 1981-2001.	Empirical review of two decades of research to determine the potential range of mental health impairment following disaster; the effect of type, magnitude and duration of disaster on mental health, as well as risk and protective factors of mental health impairment following disaster.	+	+	+	+	+	
Roberts B & Browne J, 2011. A Systematic Review of factors influencing the psychological health of conflict-affected population in LMIC	A systematic review of 15 studies conducted among adult population in conflict-affected LMIC on factors influencing their mental health outcome. Countries in the studies are Colombia, Nicaragua, Peru, Ethiopia, Rwanda, Burundi, Uganda, India, Afghanistan, the Gaza strip, Lebanon, Bosnia, Herzegovina, Serbia and Kosovo						<p>Risk factors (Prevalence correlates)</p> <ul style="list-style-type: none"> • Pre-disaster: pre-disaster mental health functioning; female gender (except SUD which is higher in males); younger age; prior disaster experience; low socio-economic status; ethnic minority status; low social support; personality characteristics, existing physical illness or disability, location of the disaster, family factors (marital status, number of children) • Peri-disaster: disaster type; severity and duration of exposure to disaster; death toll and proximity to where disaster occurred • Post-disaster: (on-going) life stressors, loss of resources and reduction in social support, parental distress <p>Psychological resources and beliefs are protective factors</p> <p>Course of disaster mental health</p> <ul style="list-style-type: none"> • Majority of people cope well (Resistance). • Substantial experience psychological impairment but symptoms decline immediately (Resilience). • In some, symptoms decline more gradually (Recovery). • Smaller proportion suffers from sustained moderate or severe symptoms (Chronic dysfunction). • Some present with the symptoms long after exposure to the traumatic event (Delayed dysfunction) <p>Coping strategies: Spiritual/ cultural and religious practices e. g. praying; family support; talking, keeping busy; social support; active search for loved ones, active outreach, informed pragmatism and reconciliation.</p>

2.4.2 Limitations of research

Overall, only free peer-reviewed article published in English that are available through VU library were used in this study. This means that, articles on the topic in other languages or that have to be purchased are missing from this paper. For instance, the part II of Norris’s Review could not be accessed freely. Concerning studies conducted in Nigeria, the limited number and differing methodologies might influence generalisation of the results. It is not likely that many studies from Nigeria were excluded because of language.

2.4.3 Analytical framework

The result findings and the discussion sections will be guided by the specific objectives. The MHPSS services in Nigeria will be analysed using the IASC-MHPSS intervention pyramid model as a guide.

IASC-MHPSS Intervention Pyramid model

IASC-MHPSS Guidelines developed in 2007 was based on the emerging consensus among professional experts in the field that social support in the early phase of emergencies is essential to prevent mental health disorders and promote psychosocial wellbeing. Psychiatric and psychological interventions for specific conditions might be necessary in an emergency.

The IASC-MHPSS Guidelines are a multi-sectoral and interagency framework to coordinate different minimum but high priority activities that are aimed at promoting and implementing mental health and psychosocial (MHPS) wellbeing in emergency that will serve as a foundation for comprehensive interventions in a more stabilized situation.

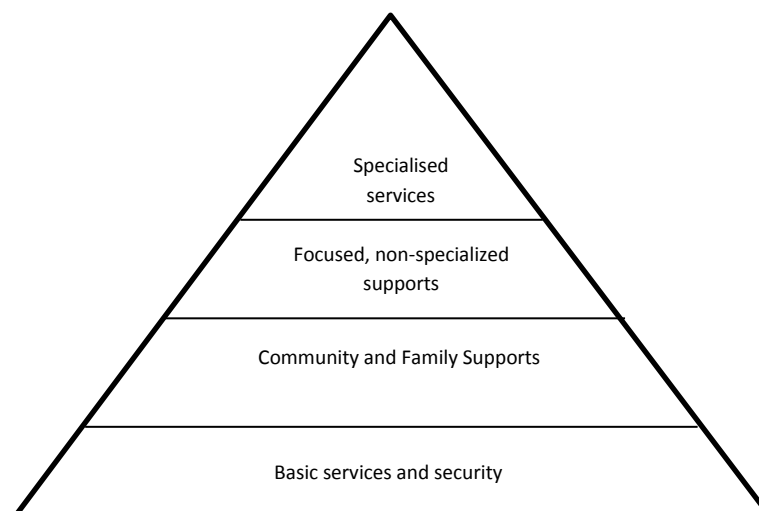


Figure 5: IASC-MHPSS Intervention Pyramid (IASC 2007)

These activities are described in a layered system known as the Intervention Pyramid for MHPSS as shown in Figure 5. It has the following interventions ranging from those targeted towards the general population to those targeted to more specific groups of people. These include: Social considerations in basic services and security, strengthening community and family supports, focused (person-to person) non-specialised supports and specialised services. These activities are complementary to each other and should be implemented concurrently. These activities will also vary depending on the local context. Important to the implementation of MHPSS are the principles of local capacity building, self-help support, strengthening and utilisation of existing local resources; and integration into an existing wider system (IASC 2007).

1. Social considerations in basic services and security:

The ways humanitarian services are provided have significant implications for mental health and psychosocial wellbeing of the affected person. Therefore these responses should integrate social and cultural considerations to their services. This level of intervention pyramid encompasses activities that protect local dignity, strengthen local social support and mobilize community networks. Examples include: advocacy for social considerations in planning and provision of basic needs; ensuring communal space and promotion of community participation in humanitarian response.

2. Strengthening community and family supports:

This level is for people who may need community and family supports in order to maintain good mental health and psychosocial well-being. These activities include: family tracing and re-unification, assisted mourning, communal healing ceremonies, activation of social networks, community traditional support and supportive parenting programs, child-friendly spaces, creative play, cultural and other non-formal recreational activities, community initiated social support and formal and non-formal education.

3. Focused (person-to person) non-specialised supports:

Still smaller number of people (e.g. survivors of gender-based violence (GBV) and ex-combatants) will require additional support in the form of individual-focused or family or group-focused interventions by trained and supervised workers. Examples include: Psychological First Aid (PFA) and other basic counselling for individuals, groups or family psychosocial

support by community workers and referral for specialized psychiatric treatment.

4. Specialized service

The apex level of the intervention pyramid is directed towards the small proportion of the affected population with mental health and psychological disorders. These can be pre-existing before the crisis and often worsened after exposure to the emergency, or caused by the emergency. They require clinical intervention/treatment for basic daily functioning. The specialized services are psychological or psychiatric support provided by mental health specialists (psychiatrist, psychologists, etc.).

Each level of this intervention pyramid reinforces the other. Implementation of services at each level is guided by core principles including: promotion of human rights and equity, ensuring community participation, reducing risk of harm, building on available local resources and capacities and integration of all activities aimed at MHPSS into existing community support and mental health systems. The guidelines should also be considered for all phases of emergency.

CHAPTER 3: STUDY FINDINGS

3.1 POTENTIAL MENTAL HEALTH AND PSYCHOSOCIAL CONSEQUENCES OF HUMANITARIAN CRISES IN NIGERIA

The purpose of this sub-chapter is to outline results from review of research literature on common types of mental disorder, psychological distress and social impacts of disasters in Nigeria and other similar contexts. These are categorized into specific psychological problems (See their definitions in Appendix 6), non-specific psychological distress, health problems and concerns, secondary stressors, loss of psychosocial support/resources, and problems specific to children and youth. Additional findings in the literature reviewed are common prevalence correlates between disasters and psychological problems; and coping strategies. These are also summarized in table 2.

3.1.1 Specific psychological distress and disorders

Posttraumatic stress disorder

PTSD is one of the outcomes that has been commonly studied among those directly or indirectly affected by conflict or disaster. In Nigeria, studies were conducted among those that experienced traumatic events to determine the prevalence of PTSD. A decade after Ife-Modakeke crises, prevalence of PTSD among people that experienced severe trauma, mild trauma and a random sample representing the general population was 86%, 34% and 19 % respectively (Idehen, Olasupo & Adebusuyi 2013). And in Jos, 7 to 9 months after the ethno-religious crises of 2001, 41% of the study population met all criteria of PTSD (Obilom & Thacher 2008). While in another study in the Niger-Delta region, prevalence of PTSD after six-months was 60% among a randomly selected affected population compared to 14.5% in the non-exposed population (Beiser, Wiwa & Adebajo 2010). In these studies, male adolescents tend to suffer PTSD more than the other age groups, but there was no significant association found between gender, age and PTSD symptoms (Idehen, Olasupo & Adebusuyi 2013; Beiser, Wiwa & Adebajo 2010; Obilom & Thacher 2008). All of these studies showed significant associations between PTSD and being a victim or witnessing personal attacks and the number of exposures to trauma experienced.

There was no literature on other common mental health consequences following disaster found in Nigeria. However, overview of other literature and systematic reviews shows the types of other mental health sequelae that can be anticipated in Nigeria. These are as follows:

Depression

Depression is the second most studied mental health impact of disaster. Overview of a literature review from twelve LMICs on impact of conflict (between and within countries) on mental health of general population shows high prevalence of depression among those exposed to conflict. In Afghanistan, the prevalence of depression among those exposed to conflict ranges from 38.5% - 67.7%. In a Cambodian internally displaced persons (IDP) camp, 55% of adults met the western diagnostic criteria for depression. About 16.3% – 41.9% of adult Lebanese aged 18-65 years met criteria for major depression. In Sri Lanka, 25% of civilians exposed to 30 years of conflict met symptom criteria for depression in a population survey (Murthy & Lakshminarayana 2006). The increased prevalence of depression among population exposed to humanitarian crises is also found in a review of 20 years research by Norris et al. (2002) and review by Goldmann & Galea (2013).

Anxiety

There are fewer studies assessing anxiety as mental health outcome of emergencies. However, all articles reviewed on this topic show high prevalence of anxiety following emergencies. For instance, 25% of the Sri Lanka general population and 51.8% - 72.2% of Afghanistan's adult population have symptoms of anxiety following decades of armed conflicts (Murthy & Lakshminarayana 2006).

Substance use disorder

Although less frequently studied after emergencies, increase in alcohol, drugs and cigarette use as coping strategy following crises has been observed. A study conducted in Sri Lanka after 30 year of continuous conflict shows a 15% prevalence of alcohol and drug misuse among the respondents (Sumasundaram & JAmunanatha 2002 cited in Murthy & Lakshminarayana 2006; Velden et al. 2009 cited in Goldmann & Galea 2013). This is similar to the result of the study conducted in Uganda among people displaced by war and persecution that found a 17% prevalence of alcohol disorder among the sample population. More than 66% of the respondents reported drinking alcohol at least once a month (Roberts et al. 2011).

Feeling of Hatred and Revenge

In a survey conducted among adult Kosovar Albanians, 89% of men and 90% of women had strong feelings of hatred; 51% of men and 43% of

women had strong feeling of revenge and 44% of men and 33% of women said they would act on this feeling (Cardozo et al. cited in Murthy & Lakshminarayana 2006). These effects of trauma may carry legal (e.g., issues of compensation and restitution) and political (e.g., wars and cycles of violence, ethnic and racial strife) implications. These feelings may be passed down as family legacy. For example, the perpetrators group which were seen as "evil doers" and enemies may not be forgiven by the first and second generation of the victims, perpetuating cycles of violence into the future.

Others

Other potential specific psychological problems that are not commonly assessed following disasters are acute stress disorder (ASD), panic disorder, phobia, dissociative response, prolonged grief, death anxiety and suicide. Also the worsening of pre-existing psychiatric disorder or organic mental disorders secondary to head injury, toxic exposure, illness, and dehydration have received less attention. It is important to note that pre-existing psychological disorder can be aggravated by stressful conditions of traumatic events or conflict situations or sudden discontinuation of psychotropic drugs.

3.1.2 Non-specific psychological distress

These include: somatization of stress (a common outcome that can be difficult to distinguish from diagnosable medical conditions), fear, demoralization, remorse, sleep disturbance, hostility, perceived stress, negative affect, family violence (wife abuse, child abuse) and other culturally specific syndromes (Norris et al. 2002; Murthy & Lakshminarayana 2006; Goldmann & Galea 2013).

3.1.3 Health problems and concern

Although not well studied, somatization of stress burdens the health system, but not well recognised as stress or treated appropriately. Injuries and illnesses following emergencies also cause suffering and deaths thereby adding to MHPS problems for those trying to recover. There may also be increased challenges to health service delivery due to destruction of health facilities, attacks on health care providers and disruption of drug supply chains due to road damage during or following disasters. The picture might be complicated by the fact that people with pre-existing mental disorder often times cannot access healthcare for psychiatric medication and follow-up (Norris et al. 2002)

3.1.4 Subsequent life events (Secondary stressors)

Financial strains or poverty

Pre-existing social problems like poverty and marginalization of some social groups may persist or worsen during the post-emergency period. Altered economic status as result of death of family breadwinners, destruction of economic resources or loss of livelihoods can exacerbate extreme poverty and family violence (Norris et al. 2002).

Food shortage and increased in food prices

Low supply of foodstuff was reported in the northern region of Nigeria due to the on-going emergency situations. For instance in August 2013, food supply was reported to drop by 40% in three conflicts-prone States in the region. Also, it was projected that 296,500 children will suffer from severe acute malnutrition across the country in 2013. This is exacerbated by an increase in food prices due to risks undertaken by traders and restricted business activities (UNICEF 2013). Food shortage coupled with reduced psychosocial stimulus during emergencies affects children growth and development (inclusive of mental development); and exacerbates overall health problems (WHO 2006).

Occupational stress and undermined opportunity to generate income:

Persistent insecurity and displacement frequently prevent people from their source of income generation. Also, local and foreign investors may not be interested in continuing or investing in conflict-prone regions, thereby reducing job opportunities and development in these regions. Unemployment can further exacerbate family violence, alcohol use and risky behaviour like insurgency and prostitution.

Disruption of local governance and formal education:

Disruption of the local governance system heightens loss of trust in authority for protection. For instance, the Boko Haram groups in Nigeria also dressed in military forces uniforms so that people could not differentiate those attacking them from those that were supposed to protect them.

Formal education systems are often frequently targeted or disrupted. For example, teachers and pupils are being killed in the northern region of the country by Boko Haram groups leading to closure of schools and disruption of learning. About 17 schools were attacked and closed in Borno State and formal education for about 20,000 students was disrupted between March 2012 and August 2013 (UNICEF 2013). The

recent kidnapping of over 200 female students further disrupts education and may promote fear among families and communities in sending their children to school leading to loss of developmental opportunities (Ross 2014).

3.1.5 Loss of psychosocial support

Perceived loss of social support

Forced displacement as a result of emergency can lead to destruction of community structures and family separation, and loss of loved ones, relatives and friends leading to destruction of social networks. These survivors usually have to struggle to feed, clothe and shelter themselves and their families with little or no social support.

Also, vulnerable groups may experience even further isolation and marginalization due to lack of freedom of choice, opportunity, voice and dignity as well as physical, social and mental hardship (Adediran 2009).

Perceived discrimination

There is also often the problem of familial and socio-cultural reintegration by survivors of rape, ex-combatants and returnees. Many of these groups confront profound feeling of loneliness, isolation and mistrust of the society. For instance following the civil war in Nigeria, rape victims and children born to rape victims in Edo State were stigmatized and hated by their community members resulting in family discord, increased number of street children, forced migration to where their identity is secured; and change of names (Adediran 2009). This social deprivation can lead to social disconnection or lack of social cohesion and mistrust within the community. It can also lead to new tension and conflict over critical resources.

Sometimes, humanitarian aid can cause social problems by undermining community structures or traditional support system during relief distribution. Relief can be diverted by armed forces or preferentially given to certain groups (ethnic, religious) exacerbating tensions, violence and marginalization (IASC 2007).

3.1.6 Problems Specific to children and youth

Symptoms like clinginess, dependence, tempers tantrums, incontinence, aggressive behaviour, separation anxiety and hyperactivity have been observed among young children exposed to traumatic events like natural and man-made disasters. Minor deviance and delinquency are common among adolescents (Norris et al. 2002).

3.1.7 Additional findings

3.1.7.1 Common Prevalence correlates (Risk Factors)

An important outcome of the studies reviewed was the association of certain risk factors with mental health impairment following emergencies. Reviews by Norris et al. (2002), Goldmann & Gilead (2013), Murthy & Lakshminarayana (2006) and Roberts & Browne (2011) showed similar results on the correlates between selected risk factors and mental health outcomes following emergencies. These are classified into pre-, peri- and post- emergency risk factors.

Pre-emergency risk factors

Gender: Evidence from these studies showed a consistent association between gender and most mental health problems. Prevalence of most mental health disorders following disaster is about two times higher among women than men (Roberts & Browne 2011). Ninety-four per cent of the studies reviewed by Norris, et al, reported higher prevalence of mental disorders in women following emergencies, except for prevalence of substance use and abuse which was found to be higher among men than women (Norris et al. 2002 & Goldmann & Galea 2013).

Age: Younger age is an important pre-disaster risk factor to poor mental health outcomes following disaster (Goldmann & Galea 2013). Children and adolescents suffer more severe outcomes than adults (Norris et al. 2002). In adult disaster-affected populations, psychological problems decrease with increasing age which may be related to prior experience, knowledge and skills of appropriate action to take in disaster (Roberts & Browne 2011).

Marital Status: Being single or without a spouse/partner positively correlates with poor mental health outcomes following emergencies (Roberts & Browne 2011; Norris et al. 2002; Goldmann & Galea 2013).

Others: Other important pre-disaster risk factors that positively correlate with poor mental health following disasters are low socio-economic status (income and assets), lower level of education, ethnic minority status, low social support, pre-existing psychological or physical illness/disability, location of the disaster in developing countries, non-urban areas and close proximity to location (Roberts & Browne 2011; Norris et al. 2002; Goldmann & Galea 2013). Furthermore, being a parent with psychopathology, or being the child of parents with psychopathology is also associated with poor mental health outcomes (Norris et al. 2002).

Peri-emergency risk factors

Exposure to trauma: Direct witnessing of horror or personal threat, high death toll; multiple or prolonged exposures to traumatic events and close proximity to where disaster occurred positively correlate with worse psychological problem (Murthy & Lakshminarayana 2006; Roberts & Browne 2011; Norris et al. 2002; Goldmann & Galea 2013).

Post-emergency risk factors

Life stressors: On-going post-emergency events like loss of job and property, family stress, poor health conditions and displacement can increase the likelihood of having post-disaster psychological problems like PTSD and depression (Norris et al. 2002; Galea et al. 2005; Maguen et al. cited in Goldmann & Galea 2013).

Loss of social support: Deaths, disability, displacement, and disruption of community and social fabric can result in loss of pre-disaster social support. Loss of social supports correlates with increase post-disaster psychological problems like PTSD, depression, prolonged grief disorder and substance use disorder (Norris et al. 2002; Maguen et al. & Velden et al. cited in Goldmann & Galea 2013).

Parental distress: Parental post-emergency psychological distress strongly correlates with their children's distress (Norris et al. 2002).

3.1.7.2 Coping Strategies

Psychological resources and beliefs: Psychological resources and beliefs are protective factors. Being hopeful and optimistic, having belief in one's ability to cope, being in control, as well as self-esteem correlate strongly with good psychological outcome following disasters (Norris et al. 2002).

Other coping mechanisms like praying, family support, talking, keeping busy, active search for loved ones, informed pragmatism and reconciliation are associated with reduced likelihood of post-disaster psychological problems (North et al. cited in Norris et al. 2002).

Posttraumatic growth

Some experts argue that for some people exposure to trauma can foster a feeling of having a second chance hence gear survivors towards a healthy living, reorganisation of a previously unstructured life and reorientation of values and goals (Tedeschi & Calhoun 2004).

3.2 EVIDENCE AND INTERNATIONAL GUIDANCE ON MHPSS FOLLOWING EMERGENCIES

This section contains research findings on the previous and on-going debates on PTSD which is the focus of this study. It outlines the controversies and consensus on post-emergency mental health that preceded the development of IASC-MHPSS Guidelines in 2007. It also contains an overview of a systematic review on the effectiveness of MHPSS interventions in LMICs.

3.2.1 Controversies and debates around PTSD

Global evidence shows that majority of people exposed to crises do well, with mild transitory psychological symptoms which are normal responses to abnormal events. There are arguments that only a small proportion of individuals develop psychiatric illness as aftermath of disaster which could be specific trauma-related psychiatric disorder or those secondary to physical injury or sickness (Davidson 2006). Galea et al. (2003) also argue that PTSD symptoms are transient.

There are also uncertainty, doubts and controversies about whether PTSD is a psychopathology that arises after extreme traumatic experience or it is a label that treats normal reaction to an abnormal situation as a medical problem (Galea cited in Hobfoll et al. 2007). Some of the discussions are whether or not it is an illness, disorder, complication, a passing phase or a predictor of development of other psychiatric disorder following exposure to a traumatic event. Furthermore, the debates include the appropriateness of the definition/classification of its diagnosis (Jones 2014).

Humanitarian and psychosocial expert Dr. Lynn Jones in a recently published essay describes how people's psychological reaction following disaster is influenced by their socio-economic situation and other broader determinants of health. She postulates that it is difficult to classify people's reaction to traumatic event based on diagnosis criteria alone considering the complexity of the relationship between the type and form of traumatic event experienced, individual and community's resilience, availability of economic resources, infrastructure, policies and socio-cultural factors that influence people's ability to cope (Jones 2014). That is, PTSD is not necessarily the appropriate or most important explanation for people's distress in emergencies. And use of pharmacotherapy might be inappropriate as it may not address the underlying issues.

Also reaction to traumatic events will depend on various individual risk and resilience factors because some people (see table below) are more

susceptible than the others. Therefore it is a complex task to appropriately and adequately identify, classify or describe people's psychological reactions to traumatic events.

Table 3: People at greater risk of psychological distress/disorder

People at greater risk of psychological distress or disorder (IASC 2007).
<ul style="list-style-type: none">• Children• Women• Elderly• Men who have lost their means of livelihoods• Victims of torture• Victims of rape• Ex-combatants• IDPs and refugees• Extremely poor• Those that lost close relatives• People with pre-existing mental problems• People at risk or already exposed to human rights violation

IASC 2007

3.2.2 Consensus on MHPSS following emergencies

Evidence shows that exposure to extremely stressful situations is linked to mental health problems, that stressful events such as emergencies can disrupt social structures, including social supports involved with the care of persons with pre-existing psychological disorder, that social interventions tend to have secondary psychological effects and psychological interventions tend to have secondary social effects on people exposed to emergencies (Hobfoll et al. 2007).

Following years of controversies and debates on post-emergency mental health issues, a consensus was reached to include mental and social aspect of health into the minimum standards of disaster response and to merge MHPSS in emergency response in 2005 (Batniji, Van Ommeren & Saraceno 2005; Van Ommeren, Saxena & Saraceno 2005).

This was based on evidence available on the effect of emergencies on mental health and how it can be addressed. For example, a review by Hobfoll and a group of professional expert from different parts of the world shows that extremely stressful events like disaster and conflict can reach a traumatic level in an individual or community as a result of some

of the factors explained above. This can lead to reduced capacity to cope or recover; loss of territory or loss of safety within one's territory, and stressful effects of the traumatic event on people's sense of meaning, justice and order. Furthermore, they suggested evidence-informed interventions that can be provided to survivors of emergencies (Hobfoll et al. 2007).

In 2006, the debate centred around what priority mental health interventions should be included in disaster response because of the complexity in classification of normative response and psychopathology following disaster (Silove & Steel 2006).

In 2007, there was an interagency agreement on guidelines to coordinate MHPSS interventions that are provided to survivors of emergency situations. As explained above the guideline consists of 25 action sheets explaining minimum MHPSS responses to provide in emergencies (IASC 2007). Development of IASC-MHPSS Guidelines was based on evidence of the importance of MHPSS in emergency situations. Examples are the results from review by Hobfoll et al. (2007) shown below:

1. Promoting a sense of safety by bringing people in emergency situation to safe place, identification of loved ones and social support reduced the prevalence of mental health disorders among IDPs and refugees.
2. Promoting connectedness, sense of belonging and hope through social support and sustained connections with loved ones, social groups and religious group are related to positive emotional outcomes and recovery from traumatic events.
3. Promoting people's sense of worth through skills development and availability of resources to overcome adversity improves their capacity to cope and recover from traumatic events.
4. Using psychopharmacological treatment to promote calming among people that are agitated and depressed as a result of exposure to traumatic events increases their daily functioning, social interaction and rational decision-making capabilities.

Hobfoll's review suggests that those affected should be provided with these resources and support to help them through the transition to normalcy.

3.2.3 Effectiveness of MHPSS interventions in emergencies

Tol et al. (2011) reviewed 160 reports from LMICs on activities that were carried out in emergencies since the development of IASC-MHPSS Guidelines in 2007 to 2010, in order to assess the beneficial effects of MHPSS interventions at each level of the intervention pyramid. Although the analysis and statistical presentations of the data are not clear, the findings are described below:

3.2.3.1. Social considerations in basic services and security:

There was no study showing positive outcomes or effectiveness of MHPSS interventions at this level for Tol's review.

3.2.3.2 Strengthening of community and family supports:

In Tol's review, Vijayakumar et al. (2008) showed that home-visits by trained volunteers reduced PTSD and depressive symptoms among bereaved adults in India. Bolton et al. (2007) in the same review argued that structured recreational activities improved children's ability to control their emotions in Pakistan; increased resilience of Ugandan children; but has no effect on functional impairments among adolescents in Uganda.

3.2.3.3 Focused (person-to person) non –specialised supports:

In Tol's review a study conducted in Bosnia and Herzegovina by Layne et al. (2008), shows that adolescents in war affected areas that received classroom-based trauma and grief therapy in combination with life skills training and psycho-education showed improvement in PTSD and depression symptoms. A RCT in Uganda showed improved PTSD symptoms and a positive orientation as results of trauma healing and reconciliation therapy among adults exposed to genocide (Staub et al. cited in Tol et al. 2011). However, some of the activities described at this level are specialized services according to IASC-MHPSS Guidelines.

3.2.3.4 Specialized service

According to Tol's review, reports from Haiti, Jordan and Nepal showed that less than 5% of their MHPSS interventions were on provision of psychotropic drugs and psychotherapy. Tol's review shows improvement in PTSD and depressive symptoms among Rwandan children that received NET (Narrative Exposure Therapy) and interpersonal psychotherapy. Catanic et al (2009) also argued that meditation-relaxation treatment and NET have similar effect in improving PTSD symptoms. However, the review showed that NET is not effective for the treatment of depression,

anxiety and other general psychological functioning among adult Sudanese refugees (Neuner et al. cited in Tol et al. 2011).

Important findings from Tol's review are the diverse results of the interventions in different context and different combinations. It also shows the research gap on the most commonly implemented interventions which are also important preventive interventions - that is, the interventions at level 1 and 2. Furthermore, no study on the effectiveness of traditional support interventions or exploration of the roles of cultural interventions (traditional and religious healers) was found despite the important roles that they play in MHPSS in emergency and non-emergency situations (Eisenbruch, Jong & van de Put 2004).

3.3 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT SERVICES FOR EMERGENCIES IN NIGERIA

In 2009, a World Psychiatry Association regional meeting was held in Abuja, Nigeria and the issue of providing MHPS services to those affected by emergencies was on the agenda. A workshop on introducing the IASC-MHPSS Guidelines in emergency response was part of the regional meeting (Gureje 2009).

As stated earlier, this framework is not being implemented in a coordinated manner in Nigeria. Currently, there is no disaster preparedness plan by the NMHAC in the country nor specific MHPSS work plan by NEMA; and the national policy makes no clear mention of MHPSS in its objectives (WHO & MoH 2006; FMoH 2013; Abdulmalik et al. 2013).

Some of the MHPSS interventions provided by different humanitarian actors in Nigeria are described below and summarized in Table 3. In general, it is important to note that these interventions are not being implemented at scale, sometimes missing completely and in few cases where implemented, they are not done systematically and there is no specific coordinating system or structure for their implementation, monitoring and impacts evaluation.

3.3.1 Social considerations in basic services and security

The main actors involved in some forms of MHPSS interventions during emergencies in Nigeria are: national emergency management agencies (NEMA), State emergency management agency (SEMA), and local government emergency management agency (LEMA); Ministry of Health (MoH), Red Cross (NRCS & ICRC), UN agencies. Other NGOs include Oxfam, MSF, Save the Children and other CBOs and FBOs. Some of the recent emergencies they have been involved in include the 2012 floods, continuous northern region ethno-religious crises, communal clashes and on-going nationwide terrorist attack and insurgency by Boko Haram and the Niger/Delta crises in the Southern region of Nigeria.

All these actors are involved in advocacy for social considerations in provision of basic services like food and nutrition, shelter, water and sanitation, basic medical health and essential household items. As an example, NRCS volunteers who are usually the first responders in emergency are also members of the affected community; hence they understand the culture and tradition of the people to whom they are rendering assistance.

Table 4: MHPSS Interventions in Nigeria

WHO?	WHAT?	WHERE?	WHEN?
1. Social consideration in basic services and security			
PHC (MoH)	Social consideration in provision of basic medical care, search and rescue, shelter, food and nutrition, community mobilisation, first aid, dead body management, essential household items, Hygiene kit, water and sanitation, promotion of IHL & other supportive services	Affected communities and IDP camps	Emergency preparedness and response
NEMA/ SEMA/ LEMA		Affected communities and IDP camps	
Red Cross		Affected communities and IDP camps	Emergency preparedness and situations
UNICEF, Save the children		Affected communities IDP camps	Emergency preparedness and response
Other Government and Non-Government Agencies		Affected communities and as directed	Emergency preparedness and situations
Community (CBOs, FBOs, Social groups, religious and traditional healers)		Affected Communities	Emergency situations
1. Strengthening community and family support			
Community	Burial and community healing ceremonies, Traditional support	Affected communities	Emergency and non-emergency situations
Red Cross	Family re-unification	Affected communities and international	Emergency situations
UNICEF, Save the children	Child friendly spaces	Some affected communities	Emergency situations
1. Focused non-specialized support			
Community	Spiritual and traditional support	Communities	Emergency and non-emergency situations
Community Health workers and Red Cross volunteers	Psychological first aid, Referral to health facility	Communities	Emergency situations
1. Specialized services			
PHC	Psychotherapy Pharmacotherapy	Primary, Secondary and Tertiary level of mental healthcare	Emergency and non-emergency situations

NRCS and NEMA volunteers also mobilize and coordinate community members to join in search and rescue, evacuation, first aid, retrieving and management of dead bodies, camp management, distribution of relief items, communication and rehabilitation processes. Also, during relief distribution, NRCS interventions aim at maintaining the socio-cultural structure of the affected community by engaging community leaders in decision making and giving relief items to the head of the family usually to men who are traditionally the breadwinners for families. Cultural values are respected for dead body management.

Red Cross is actively promoting the respect of international humanitarian law (IHL) and other laws that protect people's dignity and rights during armed conflict among police officers, military, and the government for the protection of civilians and detainees in Nigeria. ICRC was granted access by the federal government of Nigeria to visit detainees that are connected with armed conflicts and violence to monitor their health and material condition in the prison. ICRC also provides water and sanitation facilities to improve the material conditions of detainees (ICRC 2012).

3.3.2 Strengthening community and family support

Main actors involved in this level of intervention are the community members themselves, social groups within the community, traditional and religious leaders. Sometimes, NRCS and emergency management agencies and other NGOs might be involved.

Nigerians have strong faith in God and often rely on spiritual beliefs when in critical situations. For example, most Christians trust God for everything and rely on their beliefs to maintain hope for a better tomorrow. Most Muslims believe that Allah is the giver of life and resources, and that he can take these away at any time, giving a sense of meaning to losses. They also believe in the saying "You are your brother's keeper", which promotes people helping each other therefore decreasing social isolation.

Religious and community leaders (sometimes with support from SEMA and NRCS) coordinate mass burial and communal healing ceremonies. Community members and social groups provide community traditional support. For instance Religious group members, clans and peers assist in mourning and providing supportive parenting care to those that lost loved ones and orphans.

The Restoring-Family-Link department of NRCS is involved in family tracing, exchanging family messages, re-unification and seeking to clarify

fate of people who remain missing in emergency situations (ICRC 2014). UNICEF and Save the children provided child friendly spaces, recreation kits, kits for formal education and nutritional support for the children affected by floods in 2012 and those displaced by Boko Haram terrorist attack (Save the Children 2012; UNICEF 2013).

3.3.3 Focused non-specialized supports

For this level of intervention, spiritual support is the most common form of intervention for coping and recovery in Nigeria. Major actors providing some forms of individual or group-focused non-specialized interventions for people that require it (survivors of GBV, direct torture or attack and ex-combatants) in Nigerian communities are religious leaders (IFRC 2012). Sometimes, Red Cross volunteers and community health workers provide PFA and referral of people that require immediate medical attention to Health Facilities (IFRC 2012; IFRC 2014).

In 2012, NRCS trained 30 volunteers and staff from emergency-prone regions of the country on basic psychosocial support in emergencies. Although this is a good step forward, the training was one-off and not in-depth, and the quantity of staff and volunteers trained was inadequate (IFRC 2012). Also, ICRC trained 14 NRCS staff members on psychological consequences of emergencies and how they can help those affected cope better with the situation by providing counselling and stress-coping mechanism (ICRC 2012). Save the Children trained CHWs to provide psychosocial support to orphans and vulnerable children in emergency situations (Kids' club and Caregiver's forum) in the northern part of Nigeria (Save the Children 2012).

Despite these efforts much is still lacking. For example, there was no report on training of doctors, nurses, community and religious leaders, national society field volunteers and teachers on psychosocial support in emergency situations, even though these are the people that community members turn to for help during crises.

3.3.4 Specialized services

Mental health services have been described extensively in section 1.5 above. As mentioned earlier, the public health facilities, local NGOs and private hospitals are mainly involved in the provision of specialized care to those that require psychotherapy and pharmacotherapy in emergency and non-emergency situations in Nigeria. Although there are effective treatments for mental health disorders, many people turn to traditional or spiritual healers for treatment of mental distress and disorders. Only 2%

of people with neuropsychiatric problem use mental health services in the country (Wang et al. 2007).

As shown in Figure 4 above, there is about one psychiatrist to one million population and fewer psychologists, social workers and therapists to provide psychosocial support. Hence, treatments available are mainly medical without ancillary and complementary care for families and communities or interventions to address social needs (WHO & MoH 2006).

3.4 CASE STUDIES

This section highlights two different ways in which the IASC-MHPSS Guidelines was used in Kenya and Afghanistan who share some similarities in context with Nigeria; and lessons learnt from them.

3.4.1 Kenyan case study

Similar to Nigeria, Kenya is an African country with no previous experience with the use of IASC-MHPSS Guidelines before the outset of the post-election violence of 2008 which caused displacement of about 500,000 Kenyans. Also, the government and international agencies were not prepared for the magnitude of MHPSS interventions that were required to meet the need of the increasing number of people that were mentally impacted. This was coupled with the weak mental health system and lack of coordination and monitoring of the large numbers of small organisations providing MHPSS services to the IDPs.

The government of Kenya agreed for International Organisation for Migration (IOM), UNICEF and the mental health division of its MoH to form a psychosocial working group that coordinated the MHPSS programmes during the post-election violence. The working group adapted the IASC-MHPSS Guidelines to Kenya context to develop the Kenya national guidelines (KNG) and disseminated it for use by field officers (mainly Kenya Red Cross volunteers) during the crisis. This did not go well as planned because those on the field did not have easy access to the KGN, a good number found it too cumbersome to understand and use; and too much time was spent on training causing delay in its implementation (Horn & Strang 2008).

3.4.2 Afghanistan case study

Afghanistan is similar to Nigeria context in that mental health services was limited to general and federal hospitals, focused on pharmacotherapy, there was brain-drain of qualified workforce, people mostly patronise traditional healers, and decentralization of mental health care to community level was not nationwide. In order to rebuild its MHPSS responses following the fall of the Taliban; the government of Afghanistan employed NGOs as consultants to build its fragile health system. This intervention was piloted in Nangarhar, Kabul and Herat provinces and is being scaled to other regions of the country. Between 2002 and 2008, Afghanistan was able to initiate and integrate MHPSS into its basic health package and general health budget. This was achieved through initial need assessment to understand the local concept of mental illness, the priority mental health disorders and appropriate care for each

level of PHC service delivery. The different cadre of health workers were trained to provide appropriate MHPSS services. Districts were equipped with resources and capacity to provide full-time mental health services and CHWs developed and led activities to promote community resilience by involving community leaders and members in their interventions. Mental health indicators were added to NHIS.

It resulted in improved capacity of mental health service providers. Three hundred and thirty four doctors, 275 nurses/midwives and 931 CHWs received appropriate basic mental health training; covering 592 health-posts, 39 basic health centres and 17 comprehensive health centres in Nangarhar province alone. Utilisation of mental health services was increased; also community- based activities and involvement resulted in the training of more than 500 CHWs and 300 teachers on stress management and other violence-related issues (Ventevogel et al. 2012; WHO 2013).

3.4.3 Lessons learnt from implementation of IASC-MHPSS Guidelines in the case studies

In this section, a summary of lessons learnt from implementation of IASC-MHPSS Guideline in various countries will be described. These lessons learnt are important for consideration in how the guidelines can be best implemented in the Nigerian context.

1. The key lesson learnt from global review (WHO 2013) is that implementation of IASC-MHPSS Guidelines helps to highlight needs/gaps in the system and how emergency situation can be used to rebuild mental health system. An example is the Afghanistan case study, priority MHPSS issues were identified and different cadre of health workers were trained to provide appropriate MHPSS services (Ventegovel, 2012; WHO, 3013).
2. An important lesson learnt from Kenya is that creating an inter-agency MHPSS taskforce is useful to coordinate and adapt IASC-MHPSS Guideline to the country's context and local capacity; and develop strategic plans that will guide and coordinate immediate response (Horn & Strang, 2008).
3. At the same time, a longer-term and sustainable plan can be developed that includes policies and other broader determinants of mental health. As seen in Afghanistan case study, the country invested in improving accessibility to services, training of different cadres of professionals to provide MHPSS, provision of other resources and

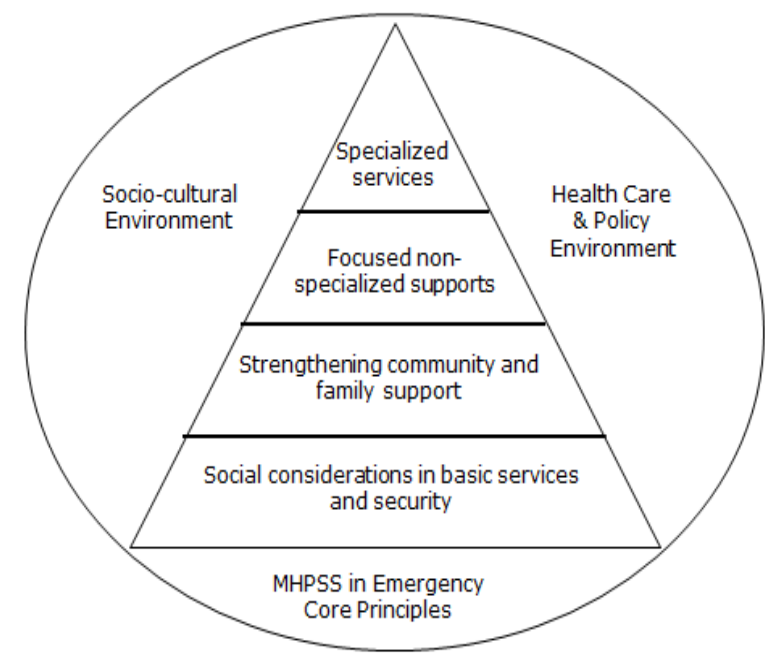
community engagement (Ventegovel 2012; WHO 3013). These concurrent efforts can help to promote a successful transition for handling over to the government in the long-term.

4. Another lesson from Kenya is that coordination of different actors and integration of MHPSS into other sectors can be very challenging. Hence, it is essential that the MHPSS taskforce be led by an expert in the field (Horn & Strang 2008).

5. Furthermore, involving front-line humanitarian workers and volunteers in planning and training has shown to be helpful to ensure cross-cultural appropriateness of interventions, encourage better understanding and possibility of sustainable implementation of the guidelines, and well-coordinated response in Kenya (Horn & Strang 2008).

6. The last lesson from various countries is that contextual factors will influence implementation and outcomes of MHPSS interventions. Therefore, the adaptation of IASC-MHPSS framework; future analysis of MHPSS system; and recommendations for MHPSS interventions in Nigeria can be linked to particular contextual factors that play major roles in MHPSS delivery in Nigeria. These are: (i) Healthcare environment (ii) Policy environment and (iii) Socio-cultural environment. (See Figure 6).

Figure 6: Recommended modified IASC-MHPSS model for Nigeria



CHAPTER 4: DISCUSSION

In this chapter, the possible influences of socio-cultural factors and daily stressors on the prevalence of PTSD among survivors of emergencies; as well as gaps identified in MHPSS response for emergencies in Nigeria are discussed.

4.1 Socio-cultural context of PTSD in Nigeria

The high prevalence of PTSD among Nigerians exposed to different degree of violent conflicts is anticipated and in line with the situation in similar African countries like Rwanda, Uganda and South Sudan with prevalence of 24.8%, 54% and 36% of the population meeting the diagnostic criteria for PTSD respectively(Pham, Weinstein & Longman 2004; Roberts et al. 2008 & 2009). It is also consistent with results from the literature from other LMICs (Murthy & Lakshminarayana 2006). The dose response relationship between exposure to human-initiated violence and PTSD found among Nigerians is also consistent with findings from other review studies (Johnson & Thompson 2008).

However, an important finding of this research is that in certain instances higher prevalence of PTSD than in similar countries were reported among Nigerians. This could be due to poor research methodology, the recurrence of violence or lack of MHPSS to participants following crises. Also, prevalence of PTSD does not correlate with gender in Nigeria contrary to what was observed in other African and non-African countries. For instance, there is association between gender and prevalence of PTSD with more women affected compared to men in all the twelve countries reviewed by Murthy & Lakshminarayana (2006). Possible explanations of this might be methodological issue or psychological resiliency Most cultures in Nigeria teach women from childhood that they have to be strong and that expressing feelings of pain or emotional suffering is weakness. Therefore, this might have helped them to recover faster; or biased their responses during interview. This shows the important role that culture plays in people's response to traumatic events which should also be anticipated while providing MHPSS interventions to Nigerians. However, resilience is an important factor in people's response to emergencies that needs to be further explored among Nigerians.

It is also important to note that PTSD may not be a transient symptom or affecting small proportion of individuals among Nigerians that are exposed to chronic crisis situations as against the arguments by Davidson (2006) and Galea et al. (2003). It is important to consider the possibility of

higher enduring rates of PTSD in the crisis-prone regions where people are continuously experiencing the traumatic events for more than a decade now with increasing intensity and gruesomeness. Also, the impact of chronic daily stressors caused or worsened by emergencies or those unrelated to the emergency situations (e.g. loss of livelihood, property and social network; and family conflict) can further prevent recovery of survivors from psychosocial impact of emergencies (Schafer et al. 2014). Therefore, psychological reactions to these traumatic events may be deeply imprinted in people's psyche. Hence PTSD and other psychological problem may not be transient but may persist causing long-term disability in this population (Hobfoll et al. 2007).

Multi-disciplinary interventions to address daily stressors like livelihoods, psychosocial support in addition to more specialized mental health services are therefore needed to reduce the psychological consequences of emergencies in Nigeria.

4.2 Gaps in implementation of MHPSS interventions in Nigeria

Although some actors provide some forms of MHPSS interventions to survivors of disasters in Nigeria, a coordinated MHPSS framework is not being implemented.

The main gap identified is the lack of coordination and oversight of MHPSS interventions; and the importance of a coordinated inter-agency taskforce has been shown from lessons learnt above. In Nigeria, emergency response is usually coordinated by NEMA with support from OCHA who are also supposed to oversee implementation of IASC-MHPSS Guidelines. But since structure for implementation of the guidelines does not exist, donor agencies usually provide assistance through NRCS or other local NGOs but sometimes they provide aid directly to the affected community or through health facilities. In these cases, lack of supervision and coordination can hamper accountability for quality and suitability or cultural appropriateness of aid that is given to the beneficiaries.

Other gaps identified are categorized into those related to: (i) Specialized mental health services; (ii) Non-specialized MHPSS services; and (iii) MHPSS-related policies.

1. Gaps in specialized mental health services

As mentioned earlier, the general mental health system in Nigeria is weak in terms of adequate human resources like psychiatrists, psychiatric nurses, psychologists, social workers, etc. - which may be due to

migration to other countries. The system also needs capacity strengthening in terms of training different cadres of mental health professionals; decentralization of mental healthcare to community level (still at pilot level); adequate supply of genuine psychotropic drugs; improving condition of mental health facilities; mental health information management system; and skills and knowledge of IASC-MHPSS Guidelines and tools (strategic plan and framework).

Also there is no formal avenue for professional interaction and referral between PHC mental health staff and other emergency care providers, especially humanitarian aid workers and community volunteers (WHO & MoH 2006).

2. Gaps in non-specialized MHPSS services

Most of the actors implementing the lower levels interventions do so through community involvement. Therefore, there is need to build local capacity of community members to provide better quality non-specialized MHPSS services. For instance, community members like community leaders, CHWs, teachers and volunteers who are usually engaged as first-responders in MHPSS interventions can be trained to provide PFA. In addition, services provided by traditional and spiritual healers are not documented or regulated.

3. Gaps in MHPSS-related policies

There is no specific MHPSS strategy, structure, and implementation and evaluation framework in Nigeria. Also, Nigerian policies for national disaster response that concerns mental health and national mental health service delivery policies that concern disaster response are poorly enforced and implemented. However, it is possible to integrate IASC-MHPSS Guidelines into the disaster response policy and plan.

Although protection of human rights and dignity of people affected by humanitarian crises are being highly advocated for by all actors, there are still significant gaps in this aspect (Hammond 2013).

CHAPTER 5: CONCLUSION AND RECOMMENDATIONS

5.1 CONCLUSION

It is possible to prevent and manage negative mental and psychosocial impact of severely traumatic events through coordinated MHPSS interventions. The effectiveness of these interventions can be significant in reducing the burden of mental illness and the burden on health system in the country. These interventions can promote coping, recovery and rehabilitation; and even minimize the feeling of hatred and revenge that might result in continuous cycle of conflict (Tol et al. 2011). The IASC-MHPSS Guidelines provide a useful framework for MHPSS intervention planning and coordination. Implementing the guidelines will help to highlight the gaps in the system and give opportunity to address them.

However, determinants of MHPS wellbeing are broad, including: national policies, social protection, living standards, working conditions, community social support, exposure to adversity; and the quality and accessibility to the health system and availability of mental health professionals to mention a few. Therefore, it is important to note that while implementation of MHPSS guideline will contribute to the overall mental health and wellbeing of those affected by emergencies in Nigeria, there are other bigger issues that need to be addressed concurrently. Those are these broader determinants of mental health and psychosocial wellbeing. For instance, there are hardly policies for social support like employment, accommodation; reintegration, poverty reduction and counselling that can help promote recovery for survivors of humanitarian crises in Nigeria. All these constraints put the country in a vulnerable position for the implementation of IASC-MHPSS Guidelines. Should Nigerian stakeholders then give up on establishing a coordinated MHPSS in emergency policy at this time? Probably not; implementation of IASC-MHPSS Guidelines can be done while efforts are being made to address the bigger issues through concerted efforts of different sectors.

Implementation of IASC-MHPSS Guidelines in Nigeria will help in coordinating timely and high quality mental health and psychosocial assistance to the increasing number of people that are being impacted by the on-going emergency situations in the country. It will also help in reducing and even preventing mental health and psychosocial consequences of emergencies among survivors. It will improve the quality of MHPSS provided and reduce burden on the health system. When people are in healthy state of mind they will be able to function well in their community and work thereby contributing to the country's

development. However, Nigeria will be faced with challenges posed by the gaps identified above in implementing standard IASC-MHPSS Guidelines that is socio-culturally appropriate and that can be provided by its local capacity. There is a need for coordination of humanitarian actors involved in MHPSS in Nigeria; and capacity building for provision of intervention at all levels in terms of tools, skills, knowledge, structures and systems.

5.2 RECOMMENDATIONS

This section provides recommendations on how to overcome potential constraints in Nigeria in the successful implementation of IASC-MHPSS Guidelines for people affected by emergencies based on lessons learnt and my personal work experience.

Most importantly, there is a need for coordination and cooperation among the government, MoH, academia, NEMA, Red Cross, media, community-based organisations, other relevant government agencies, NGOs and NGOs (See Appendix 3). The leadership and governance structure of NEMA and FMoH (NMHAC) with support from OCHA can be assigned to oversee and ensure collaboration or partnership between these stakeholders in the planning and implementation of IASC-MHPSS Guidelines in Nigeria.

The following recommendations are organized according to the tasks that various actors and stakeholders can take responsibility for in a coordinated system. Immediate, mid-term and long-term interventions are proposed for each stakeholder to consider.

5.2.1 Government/Federal Ministry of Health

A. Immediate:

- 1) Nigerian government needs to address MHPSS of people affected by the on-going crises in the country as priority health and social issues that require immediate solution.
- 2) A taskforce can be created possibly with international assistance to coordinate, plan, adapt, and implement the IASC-MHPSS Guidelines.
- 3) Important stakeholders to include are MoH (Division of mental health), NEMA, Red Cross, CBOs, FBOs, Academia, media, national and international NGOs involved in MHPSS interventions; and other relevant government agencies.
- 4) The taskforce will be responsible for MHPSS situation analysis in Nigeria, development of detailed national strategic plan and

frameworks for its implementation, and monitoring and evaluation. It can also create awareness; build local capacity in terms of skills, knowledge, tools, systems and structures; and community engagement.

B. Mid-term:

- 1) NHIS can be updated to capture mental health data (Wang et al. 2007).
- 2) Accelerating the integration of mental health into primary-level healthcare services might help to scale up the process across the country.
- 3) Rapid training of different cadres of mental health professionals on appropriate MHPSS services (specialist and non-specialist).
- 4) Training and supervision of primary-level healthcare staff to provide essential mental health services including basic pharmacological and psychosocial interventions to relieve symptoms and restore function that is being piloted in the southern part of Nigeria can be scaled-up especially in the conflict-prone regions.
- 5) Establishment of a system that promotes community-level continuity of care and home-based care or support of self-care (e.g. clear referral system, especially back-referral), SMS reminders to patients to take their drugs and working with the local community to protect those with severe mental health impairments can be included as part of the primary mental health services (Eaton & Agomoh 2008; WHO 2013; Brian & Ben-Zeev 2014).

The above recommendations (3), (4) and (5) may lead to over-diagnosis and use of psychotropic drugs; however promotion of psychosocial counselling will reduce this potential problem.

- 6) Sustainable supply of genuine drugs using mobile tracking seems to have worked well with anti-malaria in Nigeria and can be used for psychotropic drugs as well (Eaton et al. 2011; Umukoro 2013; Brian & Ben-Zeev 2014).

C. Long-term:

- 1) Development of policies for motivation and retention of professionals in the area of mental health can help to increase workforce, improve quality of services and prevent attrition due to migration.
- 2) The possibility of building relationships with traditional and spiritual healers where appropriate can be explored.

- 3) Other broader determinants of mental health also need to be addressed, e.g. ensuring source of livelihood for those affected or displaced, rebuilding their communities and infrastructure, State/formal social supports for survivors and those with psychological problems; and early conflict resolution. This will require multi-sectoral approach and detailed plan of how this will be implemented during disaster response and recovery.
- 4) Legislation to ensure appropriate implementation of related policies, IHL and other Human right laws can be developed or enforced.

5.2.2 National Emergency Management Agency

- 1) NEMA is best placed to co-lead the MHPSS taskforce with MoH because it is responsible for coordination of emergency response in Nigeria.
- 2) The disaster response plan can be updated to include detailed plan for MHPSS interventions in emergency situation - that is, who will do what when, and where? This will require resource mobilization to ensure availability of capacity and other materials required for disaster preparedness, planning and response.

5.2.3 Red Cross

A. Immediate:

- 1) ICRC and IFRC (based on their experience in implementation of IASC-MHPSS Guidelines) can support NRCS to initiate the need for the country to have specific plan for the implementation of coordinated IASC-MHPSS Guidelines. This can be done through advocacy and creating a platform for relevant stakeholders to come together.
- 2) The magnitude of MHPS needs of the affected population can be measured through Rapid (Mobile) Survey and the results can be used for advocacy. The survey can gather data on post-emergency prevalence of psychosocial problems among the general population, humanitarian workers and high risk groups (e.g. detainees, victims of sexual violence, family of missing persons and unaccompanied children).
- 3) The current MHPSS response in the northern and Niger-Delta regions can be intensified with further engagement of the community members in decision-making, implementation and evaluation of interventions.
- 4) Update training of NRCS senior staff (Trainers) on IASC-MHPSS Guidelines will help to build local capacity and ability of the national

society to scale-up these interventions at community level through step-down training for field volunteers.

- 5) Collaboration with PHC mental health staff and other CBOs in implementing MHPSS interventions can create sustainable care.
- 6) Impact evaluation of previous interventions (e.g. the plane crash response in 2012) can be used for advocacy to decision-makers.

B. Mid-term:

- 1) MHPSS can be integrated into community-based health and first aid in action (CBHFA) activities. Activities like: PFA, raising community awareness on psychological wellbeing, fight against discrimination of people with mental health problems, case identification, and referral of people with psychological problems to health facilities and livelihood projects.

Being a humanitarian organisation that is donor-dependent, NRCS will require greater government and donor commitments in terms of funds and technical support for successful implementation of these recommendations. See Appendix 7 for preliminary plan of action.

5.2.4 ACADEMIA

The research gap in post-emergency mental health in Nigeria is glaring and immediate research can focus on the following priority research questions (Tol et al. 2011):

- 1) The post-emergency prevalence of PTSD, depression, anxiety, substance-use disorder and other prioritized mental health and psychosocial problems.
- 2) The determinants of post-disaster mental health problems in Nigeria (stressors and protective factors). Qualitative studies can also explore the perspectives of the affected people.
- 3) Key factors to consider in adapting IASC-MHPSS Guidelines to meet socio-cultural context of Nigeria.
- 4) The effectiveness of MHPSS interventions, using culturally appropriate methods and indicators.
- 5) To what extent are MHPSS interventions actually meeting the perceived needs of the affected population?
- 6) The roles of traditional and religious healers in MHPSS; local coping mechanisms and effectiveness of traditional support interventions.

Possible constraints will be research funding and insecurity especially in the conflict-prone regions. However, global interest in mental health has created a number of grants for research in this area and partnerships

between local academics and international disaster research institutions can be helpful.

5.2.5 MEDIA

- 1) Media can be involved in raising community awareness on mental health issues and discourage discrimination of people with psychological impairments (Eaton & Agomoh 2008).
- 2) Media can also bring to limelight the sufferings and psychological impairments of the survivors of disasters, the on-going terrorist attacks and other conflicts in the country. This may help to gain interest, willingness and financial commitments of national and international decision makers to improve MHPSS in emergency response.

Possible constraints may be political opposition to broadcasting the traumatic experiences of the survivors. However, local and international media can present their findings in ways that engage political actors and other decision makers.

5.2.6 OTHER INTERNATIONAL NGOS

International NGOs in addition to Red Cross can provide technical assistance and resources for successful implementation of IASC-MHPSS Guidelines, and its transition into a sustainable mental health system following the disaster recovery phase.

5.3 DISSEMINATION AND USE OF RESULTS

This thesis will be available on KIT and Red Cross websites for public use. A dissemination workshop will be organized with support from Red Cross and KIT to disseminate the findings of this thesis and recommendations to the following stakeholders: Red Cross, Director of NEMA, Director of NMHAC (MoH), OCHA, other NGOs and important stakeholders in Appendix 3. The aim will be to stimulate stakeholders to jointly develop an action-plan for the implementation of the recommendations, and make continuous advocacy to decision makers to formulate related policies and laws for successful implementation of IASC-MHPSS Guidelines in Nigeria.

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APPENDICES

APPENDIX 1: Prevalence of lifetime and 12 month DSM IV disorder

Disorder ¹	Lifetime % (s.e.)	12-month % (s.e.)
Anxiety disorders		
Panic disorder	0.2 (0.1)	0.1 (0.0)
Generalised anxiety disorder	0.1 (0.0)	0.0 (0.0)
Specific phobia	5.4 (0.7)	3.5 (0.5)
Social phobia	0.3 (0.3)	0.3 (0.3)
Agoraphobia without panic	0.4 (0.3)	0.2 (0.1)
Post-traumatic stress disorder ²	0.0 (0.0)	0.0 (0.0)
Obsessive–compulsive disorder	0.1 (0.1)	0.1 (0.1)
Any anxiety disorder ³	5.7 (0.7)	4.1 (0.6)
Mood disorders		
Major depressive disorder	3.3 (0.3)	1.0 (0.1)
Minor depressive disorder	0.8 (0.2)	0.2 (0.1)
Dysthymia	0.2 (0.1)	0.1 (0.0)
Bipolar disorder (I, II)	0.0 (0.0)	0.0 (0.0)
Any mood disorder	4.1 (0.4)	1.3 (0.2)
Substance use disorders		
Alcohol abuse	2.8 (0.5)	0.5 (0.2)
Alcohol dependence	0.2 (0.1)	0.1 (0.0)
Drug abuse ²	1.0 (0.3)	0.2 (0.1)
Drug dependence ³	0.0 (0.0)	0.0 (0.0)
Any substance use disorder ²	3.9 (0.5)	0.8 (0.2)
Any disorder		
Any	12.1 (1.0)	5.8 (0.7)

1. Diagnosed with the World Mental Health Survey Initiative version of the Composite International Diagnostic Interview.

2. Part 2 sample.

3. Part 2 sample. No adjustment is made for the fact that one or more disorders in the category were not assessed for all part 2 respondents.

Source: Gureje 2006

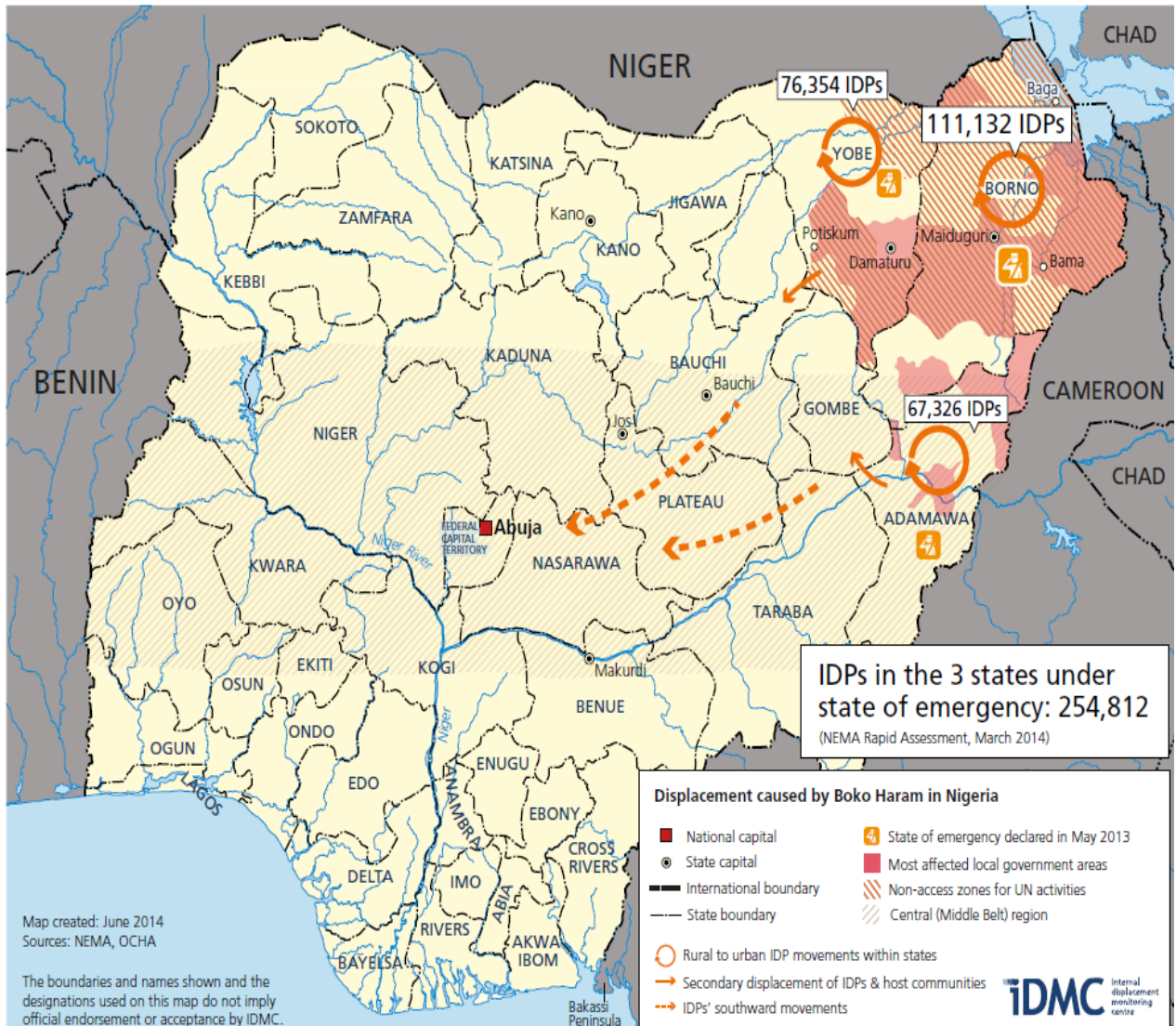
APPENDIX 2: Assignment of disaster-related responsibilities (NEMA, 2002)

ORGANIZATION	PRIMARY RESPONSIBILITIES	SECONDARY RESPONSIBILITIES
NEMA	6,7,8,11	9,10
Ministry of Transport	1	4,5,7,10,13
Nigerian Immigration Service		1,13
Nigerian Army	1,9,13	2,3,4,6,7,8,11
Nigerian Air Force	1,9,13	2,3,4,7,8
Nigerian Navy	1,9,13	2,3,4,7,8
Nigerian Police	1,9,13	3,4,6,7,8
Nigerian Ports Authority		1
NSDC (Civil Defence)		5,6,7,9,13
Nigerian Maritime Authority	1	
Federal Road Safety Corps	9	1,4,8,13
Nigerian Railway Corporation	10	1
Ministry of Works and Housing	3	1,4,6
Ministry of Health	6,8,11	1,3,4,,5,9,10,13
Federal Ministry of Environment	10	1,3,5,8
Ministry of Agriculture	11	1,3,5,6,7,8,10
Ministry of Communication	2	
Federal Radio Corporation of Nigeria		2
Nigerian Telecommunication (NITEL)		2,3
Nigerian Television Authority (NTA)		2
Ministry of Aviation		2
Federal Fire Service	4,9	3
Nigerian Red Cross Society	6	3,4,5,8,10,11,13
NEPA	12	3
NAMA	4	9
Ministry of Water Resources	11	3,4,6,10,11,12
Ministry of Information	5	
Ministry of Education		5
Ministry of Labour and Productivity		7
NAFDAC		8,11
FAAN		9
NNPC, Oil Companies	10,12	1,4,8,9,12
DPR	10	
Ministry of Power and Steel	12	
Construction Companies		1,3,4,9
NGOs		8,11
Nigeria Customs Service		13
Support Service Areas: 1. Transportation. 2. Communication. 3. Public Works and Engineering. 4. Fire Fighting. 5. Information and Planning. 6. Mass Care. 7. Resource Support. 8. Health and Medical Services. 9. Search and Rescue. 10. Hazardous Materials. 11. Food and Water. 12. Energy. 13. Military Support		

APPENDIX 3: Potential Stakeholders for MHPSS-IAWG in Nigeria

Government Bodies	National NGOs	International NGOs	Independent/Private Actors
NEMA	NRCS	OCHA	Practitioner (Psychiatrists, Psychologists)
MoH, NMHAC	Catholic Relief Service	ICRC, IFRC	Community Leaders (Traditional, Religious)
Academia (University Teaching Hospitals)	Federation of Muslim Women Assoc. of Nigeria	All UN organisations at national and local levels	Representatives of Community Social Support Groups
NAFDAC	Cartars	Save the Children	Media
Min. of Education, Min. of Information, Min. of Women Affairs, Min. of Agriculture	Civil Society Coalition for Poverty Eradication	MSF	Other Community-Based Organisations
Police and Military Personnel, other relevant government agencies	Other NGOs	Oxfam & others	Academia
			Research institutions and donors

APPENDIX 4: Map showing displacement caused by Boko Haram in Nigeria



Source: IDMC 2014

APPENDIX 5: Organizational structure of Nigerian Primary level care



Source: Abdulmalik et al. 2013

APPENDIX 6: Definition of Terms

1. **Acute stress disorder (ASD):** is characterized by acute stress reactions that may occur in the initial month after a person is exposed to a traumatic event. The disorder includes dissociative, re-experiencing, avoidance, and arousal symptoms. Some patients who experience ASD go on to experience posttraumatic stress disorder (PTSD), which is diagnosed only after four weeks following exposure to trauma.
2. **Generalized anxiety disorder (GAD):** is characterized by excessive and persistent worrying that is hard to control, causes significant distress or impairment, and occurs on more days than not for at least six months. Other features include psychological symptoms of anxiety, such as apprehensiveness and irritability, and physical (or somatic) symptoms of anxiety, such as increased fatigue and muscular tension.
3. **Major depressive disorder (MDD):** is characterized by a history of five or more of the following symptoms nearly every day for at least two consecutive weeks; at least one symptom must be either depressed mood or loss of interest or pleasure: (i) Depressed mood (ii) Loss of interest or pleasure in most or all activities, (iii) Insomnia or hypersomnia, (iv) Significant weight loss or weight gain (e. g, 5% within a month) or decrease or increase in appetite, (v) Psychomotor retardation or agitation that is observable by others, (vi) Fatigue or low energy, (vii) Decreased ability to concentrate, think, or make decisions, (viii) Thoughts of worthlessness or excessive or inappropriate guilt, (ix) Recurrent thoughts of death or suicidal ideation, or a suicide attempt. In addition, the symptoms cause significant distress or psychosocial impairment, and are not the direct result of a substance or general medical condition. Bereavement does not exclude the diagnosis of a major depressive episode.
4. **Posttraumatic stress disorder (PTSD):** PTSD is characterized by intrusive thoughts, nightmares and flashbacks of past traumatic events, avoidance of reminders of trauma, hyper vigilance, and sleep disturbance, all of which lead to considerable social, occupational, and interpersonal dysfunction. The diagnosis of PTSD can be challenging because of the heterogeneity of the presentation and resistance on the part of the patient to discuss past trauma.
5. **Substance use disorder (SUD):** Unhealthy substance use encompasses the spectrum from sporadic consumption of alcohol or drugs with no adverse consequences of that consumption; through consumption of drug or alcohol use that risks physical and psychological consequences.

APPENDIX 7: Preliminary work plan for creation of MHPSS-IAWG/Taskforce

Activities	Timeline										Responsible	
	2014			2015				2016				
	Q4			Q1	Q2	Q3	Q4	Q1	Q2	Q3		Q4
	Oct	Nov	Dec									
MHPSS-IAWG PLAN OF ACTION												
Dissemination of research findings and recommendations												Red Cross
Advocacy meetings with decision makers and other stake holders for creation of MHPSS inter-agency working group (MHPSS-IAWG)												Red Cross & other stake holders
Inauguration of MHPSS-IAWG												Key stakeholders
Orientation of stakeholders on IASC-MHPSS Guidelines												Expert in the field
Joint development of plan of action for recommendations by stakeholders												MHPSS-IAWG
Implementation of plan of action												MHPSS-IAWG
Follow-up on implementation of plan of action												
coordination meeting, advocacy, supervision, M&E, review meetings												MHPSS-IAW

	NRCS INTERNAL PLAN OF ACTION											
Development of a detailed plan of action for MHPSS	█						█				█	
Refresher training for Red Cross PSS trainers	█	█				█				█		
Development/Adaption of field guides, check list and other tools to local context	█	█										
Training of field volunteers	█	█				█				█		
Scale-up interventions in collaboration with other actors	█	█	█	█	█	█	█	█	█	█	█	
RAMP survey for MHPS consequences among high groups	█	█	█	█								
Integrate MHPSS into CBHFA				█	█	█	█	█	█	█	█	
Supervision, monitoring & evaluation	█	█	█	█	█	█	█	█	█	█	█	
Continuous advocacy, participation & coordination with MHPSS-IAWG	█	█	█	█	█	█	█	█	█	█	█	