Peace of mind

Exploring mental health in relation to peacebuilding and conflict in CAR

August 2022

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Executive summary
As part of the *Disarmament of the Heart* project, Conciliation Resources conducted research in Kaga-Bandoro and Sibut to inform a culturally and gender-sensitive MHPSS and Peacebuilding intervention. Using qualitative methods, 264 adult participants shared their understanding of how the conflict shaped local experiences of distress and helped to elicit the specific social-psychological determinants of the well-being of their communities. MHPSS policy, resources, and allopathic services are a highly neglected area in CAR. The access to healing resources is dominated by the non-allopathic system (i.e. traditional and religious healers), which is highly sought after by the local population and perceived as effective to address their psychological experience of distress, particularly when resulting from the conflict.

Well-being, particularly after the crisis, was defined by the access to (and ability to provide to their loved ones) basic needs. Emotions, such as unhappiness, were experienced within one's body (head and heart) and through the dominance of the good or evil spirits within oneself. Conflicts and structural violence of their daily lives caused participants significant stress framed as "moral pain". This was particularly overwhelming for young people who often had to become the bearers of their families. Derived from a set of local idioms, five overarching categories of distress dominated: unhappiness, stress, trauma-related, life-disruptions, and being tormented or madness. Diving into the cultural category *gbogbolinda* [Sangô] (madness) captured the array of experiences of suffering for communities that they attributed to specific theories of causation: Forced changes in life, Drug and alcohol addiction, Ancestral supernatural alliances, Magic, and Troubles of the heart. Furthermore, a central dimension of the collective mind that was particularly affected by the conflict was the order between the human world and the spiritual worlds, which shaped the communities' perception of the violence that was perpetrated. The underworlds consisted of: *mamy wata* (sirens) made of evil spirits, together with the world of the clan ancestors' spirits, who lived as totemic animals.

The key social-psychological determinants of well-being related to accessing interventions that responded to the theories of causation attributed to their ill-health, as well as to undergoing the socially prescribed rituals at key points of individuals' life-cycles. In practice, communities engage with five categories of actors who offer specific responses to their sorrows: healers engaging the underworld, elders and traditional chiefs, faith leaders, health professionals, and justice professionals.

The rituals core to the making of the social fabric related to: supporting individuals through life-stages (e.g. mourning, initiation), and preventing or addressing sorrows (e.g. cleansing, clairvoyance, honouring the ancestors). Clashing with the culture of emotional disclosure underpinning counselling centres, the socialisation process promotes gendered values around social duty and physical bravery, as well as shameful emotional display that must be repressed since it ultimately constitutes a threat to the survival of the group.

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Part I: Introduction of the research

Section 1. Background

1.1 Research context

1.1.1 Objectives

The overall objective of the research is to generate knowledge that can support the project team in developing a culturally and gender-sensitive MHPSS [Mental Health and Psychosocial Support] and Peacebuilding intervention in Kaga-Bandoro and Sibut[2].[3] The project is based on the premise that individuals need to find peace in themselves, including mental and psychological well-being, in order to be able to create wider peaceful change in their communities. In order to achieve this, the research pursues three specific objectives:

1) To understand community conceptions and experiences of mental health, including the way these are shaped by the conflict.
2) To elicit and gain better understanding of existing community mechanisms and resources, which support individual and collective well-being.
3) To develop specific and actionable recommendations on how the project intervention strategy and MHPSS and peacebuilding activities should integrate these community conceptions and resources to promote individual and collective well-being.

1.1.2 Socio-political-economic characteristics of the field sites

Overall socio-cultural composition

- The two research sites are made of multiple ethnic groups: Banda, Mandja, Gbaya, Rounga, Fulani (Majority are M'Bororo), Langbachis, and Gbaya. There are also ethnic groups that are considered "foreign" including Borno, Kanambou and Arab groups from Chad and Sudan.[4]
- Sangô is the primary language and together with French, the official language in CAR. Each ethnic group also has its set of dialects and follows a clanic structure grounded in totemic beliefs and an associated foundational ancestral legend. For instance, the Tongba and Bondoukou clans from the Longbachis ethnicity have the hippopotamus, and have since their ancestors made an alliance pact with them after they were saved when they capsized during a fishing trip and had called them to rescue them. The interconnection between ethnicity, language, clan, and totemic belief is crucial to the social-psychological configuration of the communities (See Annex A).
- The religions practiced are: Christianity (Catholics and Protestants – Evangelicals, Apostolic, Baptist, Pentecostal), Animism, and Islam. Kaga-Bandoro is home to Christian and Muslim communities, while Sibut is predominantly Christian, with some Muslim individuals slowly starting to return after years of displacement from the town.

[2] Maps of the two regions can be found in Annex I.

[3] The research is part of a project jointly implemented by Conciliation Resources, DanChuchAid, Fondation Vegas and Vision Enfant République Centrafrique that is funded by the United Nations Peacebuilding Fund [UN PBF] for a period of 18 months (February 2022 to August 2023). The project works with young people from the informal economy in Kaga Bandoro and Sibut to increase their readiness for reconciliation. To do so, it seeks to address their mental health and psychosocial support needs, while also helping them to become agents for peaceful change in their communities.

[4] However, the local population mostly do not distinguish between Fulani and Arab groups from Chad and Sudan; these groups of people are therefore commonly referred to as M'bororo.

Economic structure

- In urban areas, the main economic activities for young people are organised around taxi-moto transportation, credit transfer, truck charging, ambulant vendors, and commerce (i.e. the sale of basic necessity items, imported products, and agricultural and meat products). However, people in the urban centre are also engaged in more typically rural activities such as farming, fishing, and hunting.
- In rural communes, the activities revolve around agriculture (i.e. crop farming, herding), fishing, hunting, and the sale of goods resulting from these activities. Cattle are largely owned by M'bororo herders. All of these activities require the freedom of movement.
- The exchange of goods is regularly organised between farmers and herders in regular markets (e.g. in Kabo). Usually, the chiefs from herders such as the M'bororos meet with the village chiefs and agree on a market day. Herders buy agricultural items and food in exchange, and farmers buy animals and animal products (i.e. cows, sheep, goats).

Political context

- CAR has faced recurrent socio-political crises for the past three decades, playing host to a changing array of armed groups and repeated waves of violence, abuses, and displacement in a context of pervasive insecurity, endemic poverty, and significantly restricted livelihood opportunities.
- The latest crisis erupted in 2012 when a coalition of armed groups, the Séléka, overthrew President Bozizé who had been in office since 2003. During its rule, the Séléka committed grave abuses against civilians, especially targeting non-Muslim communities. In response, anti-balaka militias, often associated with Christian communities[5], mobilised to defend their communities and in turn committed serious abuses against Muslims. The rise of the anti-balaka led to a cycle of inter-community reprisal killings. Both Kaga-Bandoro and Sibut were heavily affected by these conflict dynamics, as outlined further below.
- Similar to other parts of CAR, there are conflicts between Fulani transhumant herders and communities.[6]

<u>Kaga-Bandoro</u>

- Prior to 2021, Kaga-Bandoro was occupied by the ex-Séléka armed group Mouvement patriotique pour la Centrafrique (MPC) that assumed state functions, collected taxes, and engaged in large human rights abuses. Since the arrival of the Central African army (FACA) and bilateral forces, the security situation has significantly improved, leading to an increased freedom of movement. Some IDPs are returning to their places of origin (in rural areas), while others are still trapped in the urban centre of Kaga-Bandoro. The surrounding rural areas remain more volatile than the centre, as armed groups remain active.
- Following the arrival of FACA and the bilateral forces, religious divisions have been less visible and the coexistence between Christians and Muslims has significantly improved. Christians are concentrated in the west side of the river and in southern parts

[5] While the anti-balaka groups are often associated with Christian communities, they are rooted in traditional and spiritual animist practices. The anti-balaka can best be described as a syncretic group that merged quasi-military organisation, community self-defence and spiritual belief.

[6] In Sibut, the community-led association AGRIPOLE, which is working on managing issues arising between herders and farmers, has contributed to the reduction of herder-farmer conflicts.

of Kaga-Bandoro, whereas Muslim communities are concentrated east of the river and in the northeast of the town.

Sibut

- Sibut was heavily affected by the 2013-15 crisis, when Séléka forces took control of the town. The anti-balaka militias mobilised in response to this violence with the ambition to defend communities from attack. As a result, the Muslim population was almost entirely displaced from the town and its surrounding areas, feeling safer to relocate to areas where the Muslim community was larger (like Kaga-Bandoro). Today, members of the displaced Muslim community are slowly starting to return to Sibut. However, those who have already returned face discrimination from the rest of the population[7]. The memory of the Séléka attacks is still fresh in people's memory and many of the current inhabitants perceive Muslim IDPs as complicit with them.
- While the division between Muslim returnees and Christian inhabitants of Sibut is framed around religious and ethnic identity, the deeper conflict causes and drivers are linked to socio-economic interests. Following the displacement of the Muslim community during the 2013-2015 crisis, their property and businesses were occupied by some the inhabitants who stayed behind in Sibut. The progressive return of Muslim communities is now causing tensions between individuals occupying properties in Sibut and their original and legitimate owners returning to the town.[8]

1.2 MHPSS landscape: policy, resources, and services

National Level[9]

The prevalence of mental health difficulties among the population of CAR is high, particularly following waves of violent conflict since the 1990s. However, MHPSS remains an under-resourced sector of health service provision in the country. There have nevertheless been some positive developments, including the development of the national mental health policy in 2011 and its revision in 2016 and 2019, the development of the government's strategic plan on mental health for 2019-2022 and the validation of a national protocol for psychotherapeutic management of post-traumatic disorders in 2022. Supply of essential psychotropic medication has been improving through donations but the supply chain remains largely interrupted. The international support (via the World Health Organisation) has recently focused on the training of core professionals through MhGAP[10], and INGOs are complementing these efforts. Despite the positive developments, significant challenges in this area remain, as services and capacity is more focused on the capital than the rest of the country. Using the IASC-MHPSS (2007)

[7] While the recent reconstruction of the central Mosque in Sibut is a positive sign for Muslim communities, underlying tensions remain. Local peace initiatives play an important role in managing disputes, but the focus lies on immediate response rather than long-term transformation of conflict drivers and causes.

[8] Land is an important tradable commodity, crucial for grazing and for cultivation in and around urban areas. There is a contradiction between legal requirements (i.e. certificate of ownership) and cultural rules governing land ownership. While some people may think they own the land through customary arrangements, legally they may not own that piece of land because they do not have the appropriate legal documentation.

[9] The findings presented in this section are derived from publications (International Medical Corps [2014]; Mental Health Innovation Network [2017] and updated in the field during the research interviews in May 2022; and data gathered through the MHPSS working group.

[10] MhGAP is a WHO supported initiative that provides training on the first-line management recommendations for mental, neurological and substance use conditions for non-specialist health-care providers in humanitarian emergencies where access to specialists and treatment options is limited. See WHO (2015) guidelines https://www.who.int/mental_health/publications/mhgap_hig/en/.

pyramid of needs and services (Annex B), the analysis of services revealed that non-specialised services (Level 3) remain very limited (small numbers of professionals trained) and Specialised services (Level 4) are largely limited to the only functional psychiatric care service located in Bangui.

Local level

Similar gaps exist in Kaga-Bandoro and in Sibut, where the effects of the national policy and action plan have not yet been felt. The specialised MHPSS expertise among professionals is greatly lacking among formal service provisions, and very few trained professionals exist. The MHPSS services locally available are:

- Level 1 services - Basic services (e.g. security, basic physical and health needs):
  - Some NGOs provide material, financial and economic empowerment opportunities, mainly for survivors of sexual and gender-based violence (SGBV).
- Level 2 services – Community and family supports (e.g. family and communal networks):

Note: Allopathic healing refers to health services using a biomedical model (e.g. doctors, counsellors), while non-allopathic healing refers to the group of diverse medical and healthcare systems, practices, and products excluded from this group (e.g. traditional healing, alternative medicine).

  - Informal community structures are in place and most seek help through non-allopathic[11] healing structures (i.e. traditional healers, religious networks, and community leaders) and most perceive the support as very effective (DCA, 2022).[12]
  - Some NGOs provide legal support to access some justice, particularly for SGBV survivors, although the number remains small.
  - Few INGOs (e.g. International Rescue Committee, INTERSOS, International Committee of the Red Cross) provide psychosocial support.

Most care providers in Level 1 and 2 are under the Protection cluster and have received basic MHPSS training provided by various INGOs.

- Level 3 services – Focused, non-specialist supports:
  - Some counselling services exist ("*Centre d'écoute*") but are limited in numbers and are usually SGBV-focused[13].
  - Few INGOS (e.g. ICRC, INTERSOS, ASA): have programmes offering more focused MHPSS services, but the resources are limited and very few MHPSS professionals with specialist expertise are available.
  - Non-allopathic sector: sought by the majority of the communities.
- Level 4 services – Specialised services).
  - Allopathic provision is unavailable locally, aside from some medical management in the hospital structure and the Primary Health Care Centres

[11] The systems involved comprise a wide range of therapeutic approaches that include diet, herbs, metals, minerals, precious stones and their combinations as well as non-drug therapies. WHO tends to use a more medical lens to refer to these systems as Traditional, Complementary, and Alternative Medicine [TCAM]. See https://www.who.int/health-topics/traditional-complementary-and-integrative-medicine#tab=tab_1

[12] Among the sample of adults interviewed by DCA (June 2022), 79,14% reported an improved situation after seeking support through religious and community leaders [DCA (2022), baseline report of the *Disarmament of the Heart* project].

[13] In Kaga-Bandoro, counselling structures are present in all of the project rural areas (4), more so than in urban areas; whereas in Sibut, they are concentrated in the urban town in Sibut.

(PHCs). A referral to the psychiatric unit in the general hospital of Bangui is a difficult option as it is hard to access[14] and overstretched.
- Non-allopathic sector: support is available. However, there are also issues with mal-practices, knowledge about the limits of their skills, and when to refer conditions to medical professionals.
- Few medical professionals are trained in basic clinical management (i.e. provision of psychotropics) in PHCs and in the hospitals.

The referral pathways between services are coordinated and facilitated by the Protection cluster working closely with the Red Cross/ICRC. The direction of the referrals is more horizontal between NGOs to ensure access to basic needs (Level 1 and sometimes Level 2), rather than vertically towards more specialised service-provision (Level 3 and 4). There seems to be a clearer and more formalised referral pathways and coordination between service providers regarding SGBV issues, as well as the existing monitoring of the baseline in reported cases. This is not in place for MHPSS provision in Kaga-Bandoro and in Sibut outside the main towns. The referrals between the allopathic and non-allopathic are also one-directional from health services towards the traditional practitioners, but not the other way around. This raises concerns as to what extent traditional practitioners are aware of the limitations of their practice.

[14] Kaga-Bandoro to Bangui (about 8 hours) and Sibut to Bangui about 3 hours using public transport.

2. Methods

The methodology developed for the research is in itself a finding in that it illustrates a way to design, implement, and analyse complex data in a unique and very complex environment by drawing from multiple disciplines (i.e. Peacebuilding, Psychology, Anthropology) in an integrated manner. (See detailed description in Annex J)

2.1 Data collection

A trauma-informed approach

The research adopted at its core a trauma-informed approach that considered both the welfare of the researchers and the research participants. A set of principles were adopted using principles elicited in previous contexts[15] that were also in line with UNDP (2022, p.19-23) guidance on "trauma-aware peacebuilding" (See Annex D):

- Training: all researchers had a basic understanding of concepts of trauma, MHPSS, secondary trauma and self-care.
- Engagement with trauma-affected individuals: A do-no-harm and a survivor-centred approach were implemented.
- Referral pathways: support services were vetted to be able to refer research participants who were identified as having been triggered or impacted by their participation.
- Self-care/Resilience: supporting the well-being of all researchers and respondents and ensuring it is supported further if needed (e.g. through the presence of DanChurchAid's (DCA) psychosocial agent who accompanied the researchers).

Sample

The total number of participants was 264 (around 62% male, 38% females). The variables considered in their selections were the following: socio-demographics (gender, age, current living arrangement, research field sites), social status, psychosocial profile (general population, type of war experience), economic activity (informal and formal economy), professionals involved in healing (community healers, (mental) health professionals), and community leaders (religious, political). Details of the sample were inserted in Annex E.

Methodological approach

The research team was composed of 20 members in the field[16] and remotely[17]. The methods used for data collection were the following: focus group discussions (n=12) and key informant interviews (n=62), using actors-resources mapping and mind-body mapping. The latter technique was used to elicit people's (articulated) conceptions of the mind, the various parts that constitute it, and their location on the body when they experience wellness or distress.[18] The tool was used to support the description and the explanations of young people during FGDs

[15] The main author (a MHPSS consultant contracted by Conciliation Resources) used her clinical experience formalising the trauma-informed approach in different contexts such as in the UK, Iraq, Kosovo, and Nepal since there are currently no international guidelines in this area in the settings of (post-)conflict or humanitarian emergencies.

[16] Researchers (15): 13 researchers affiliated to two local NGOs - Fondation Vegas in Sibut and Vision Enfant République Centrafrique in Kaga-Bandoro) and 2 independent researchers employed by Conciliation Resources. A supervision team (2): Conciliation Resources' East and Central Africa Programme Director and CAR Project Manager. A psychosocial support team (1): a psychosocial agent from DCA, present and available at all times during the training and the fieldwork in Kaga-Bandoro to provide counselling and support to researchers and/or interviewees.

[17] A technical mentoring team (2): the MHPSS consultant and Conciliation Resources' East and Central Africa Project Manager supported the research teams, in a remote manner due security constraints.

[18] Further description of this method can be found with a Nepalese population (i.e. former "child soldiers") in Medeiros (2014) and Medeiros (under review).

Research questions and their corresponding methods were formulated on the basis of the preparation work completed, mentioned above (See Annex C). The data was gathered through multiple dialects, and then subsequently translated in Sangô. The transcripts were mostly written in French, and researchers were encouraged to write the local concepts in the dialects in which this was collected. Informed consent was sought for every participant both orally and in writing.[19] Thematic inductive analysis was deployed to draw out themes and specificities among sub-groups with the data collected.

2.2 Limitations

The analysis presented has been shaped by a set of constraints quite typical to conducting this type of research in conflict-affected environments. They are detailed below together with the way in which they were mitigated.

Sampling

- Several vulnerable groups (i.e. LGBTQI+ and male survivors of sexual violence, the under-18[20]) could not be included in the sample of the participants due to the constraints previously mentioned. The specific needs of these groups will be explored in subsequent activities, as Conciliation Resources begin to build further trust with the communities.[21]

Mentoring

- The extent of the clinical supervision and technical mentoring of the researchers in the field had to be adjusted due the security risks associated with the ethnicity of the professionals (i.e. White European females).[22] As a result, some of the concepts and methods could not be convened as anticipated and that the extent of the technical MHPSS mentoring of the data collected and of the relationship of transference between participants and the researchers could not be drawn into the data collection. The challenge was mitigated by a handover of the research-mentoring role in the field to Conciliation Resources' East and Central Africa Programme Director with the remote support of the MHPSS consultant. A national psychologist was also engaged to deliver basic MHPSS training and a DCA psychosocial agent joined the team in a supportive capacity.

Data collection and analysis

- The gaps in the researchers' skills and experience are an important limitation in the quality of the data collected, as well as of the transcripts and verbatims. This affected the ability to disaggregate the social specificity of some of the data.
- Research in trauma and more widely in the field of Social Sciences has demonstrated the significance of analysing and making explicit the relationship of transference in research as part of the findings (i.e. What the researcher inherently brings of themselves in the particular way they engage with the subject, and, conversely, the ways in which the subject inherently shapes the researcher). In this context, the researchers were from

[19] Other templates were designed but not used in practice, such as a feedback form and analysis from the research after each interview.

[20] This would have involved gaining consent and the presence of their guardian, as well as specific training for the researchers.

[21] This is a gap in the study since research in other conflicts shows that the LGBTQI+ is often primarily targeted and is a group at risk when conflicts occur.

[22] This typically captures the challenges of recruiting nationally professionals this set of skills and training in MHPSS and Peacebuilding, as well as having gender representation in professionals practicing in conflict-affected settings.

the communities where the research was conducted and had themselves been affected by violence and trauma. They may have normalised or found it challenging to elicit the impact of trauma on themselves and on others in their communities. This dimension could not be analysed as much as desired, even though regular debriefings in the field with the researchers and subsequently remotely with those mentoring the teams were set up to understand these effects.

- Some of the nuances of the data capturing deeply cultural and abstract concepts would have inherently been lost through the filter of the multiple layers of translations from the dialects to English, the language used in this report. This may have also shaped the analysis captured in this report. This challenge was mitigated by the on-going involvement of Conciliation Resources' CAR peacebuilding staff, who had knowledge of some of the dialects and who were involved in triangulating both data and the analysis.

Part II: Findings

Section 3. People's conceptions: How did the conflict shape local experiences of distress in the communities of Kaga-Bandoro and Sibut?

Communities' conceptions of wellness and suffering are initially teased out in order to understand the specific ways in which the last crisis shaped them. Cultural constructions of the mind are explored through the identification of local idioms of distress in relation to the theories of causations participants attributed to them. The centrality of its relationship with the spiritual worlds and the underworlds is subsequently teased out to make sense of communities' perception of the violence that was perpetrated.

3.1 Local conceptions of the mind and well-being

Conceptions of well-being and happiness

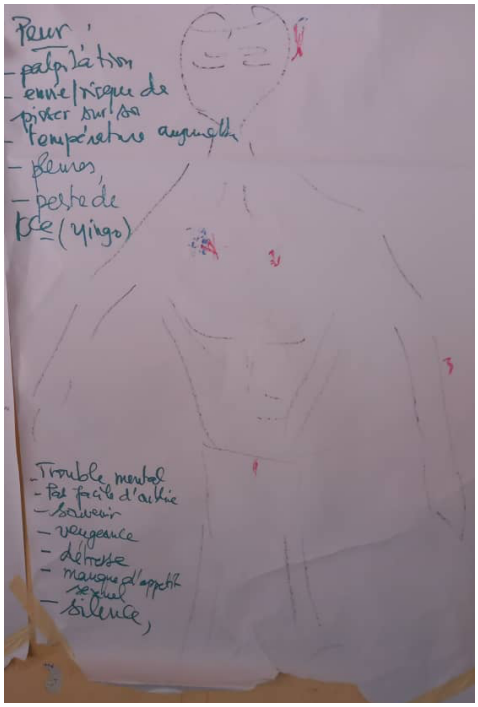
The research specifically explored local constructions of well-being, particularly teasing out what it looked like in the aftermath of the crisis. The participants, first, correlated the causes of happiness to their access to basic needs (i.e. a home, food) and to having the means to provide them for their loved ones and themselves. As a young man (25) from Doukouke village explained: "All your family is happy because they eat well and you have money for your health.". Other interviewees similarly drew the link between well-being to accessing freedom of movement, which means becoming self-sufficient by regaining the ability to work in the fields, fish or hunt in post-crisis context.

Second, respondents described wellness and happiness as interconnected with bodily experiences, behaviours and social attitude, as well as thoughts. Indeed, all respondents emphasised that they felt wellness across their entire body, which manifested itself in their facial expressions. They would then feel in good shape (physically and mentally) or energised, including regained sexual energy. Participants also explained that such a state of mind shaped their behaviours and social attitude, often in a gendered manner. Females described that wellness made them feel like dancing, they looked after their appearance (e.g. putting makeup on), they could perform their chores (i.e. cleaning homes). Male participants associated it with their physical capacity (e.g. being able to work, feeling safe, being healthy). All agreed that this shaped one's ability to socialise, engage with others (i.e. friends, parents), and commit to community solidarity. Finally, well-being was seen to shape positive thoughts by reducing how much people worried about their problems (i.e. "not thinking too much") and having increased pleasure-seeking thoughts (i.e. increased libido, enjoying having drinks with friends). Young people also described having more hopeful thoughts about the war and lasting peace.

The mind-body

Participants explained that, overall, the mind can be experienced in three locations depending on the emotion felt and this, regardless of genders: the head (all or its upper part), the centre of the chest (or underneath the breast area), and the overall body. Figure 2 below typically exemplifies their answers.

Figure 2: Mind-body sketch completed during the FGD with boys in Sibut



The wording used to describe various experiences of distress, in Table 1 below, sheds further light on the physical embodiment of the participants' mind.

Table 1: Descriptions of bodily experience of the mind through experiences of distress

Described experience of distress		**Bodily experience and presentation**
"Unhappiness"		• Sadness, crying • Limited appetite • Thinking a lot about people (partner or other person) • Heart beats very fast, palpitations • Withdrawn, do not socialise, not go for drinks with friends • Drink a lot, becoming too chatty. • Headache • Difficulties with sleep (insomnia) • Not talkative • Cannot perform any activities – does not do anything • Body aches from the head down to the feet • Physical neglect, decrease in hygiene
"Stress" (*Kota Mbito*) [Sangô]		• Not peaceful in the heart • *yingo* (the spirit) [Sangô] is not calm
'Traum a'-related	**"Being insulted" (leads to trauma)**	• Felt in the heart • Nervousness

	Loss of property trauma	● Heart palpitation ● Anger
	Physical violence	● Shock ● Anger
Life disruptions	**Loss of loved one, Divorce**	● Crying ● Stress ● Regret – reminiscing ● Memory loss ● Sleep difficulties – insomnia.
"Madness", "tormented"		● Body neglect (e.g. Way of dressing, not washing themselves) ● Incoherence in the thoughts and language, speaking to oneself or while walking. ● Aggressive behaviours towards others ● Inappropriate behaviours (e.g. Take their clothes off, pick up the litter, throw stones at people) ● Refusal to access treatment

The mind and the spirits

The spirits are another central component of individuals' minds in that it is a central point for their experience of themselves and of the world around them; in other words, it is a crucial feature of their subjectivity. They determine one's mood, emotional experience, thoughts, content and process, agency or decision-making, behaviours, and physical health. Spirits are experienced as a constant feature of the mind that is extremely powerful in that it can lead someone to lose their sanity ("madness") or to their death.

Individuals' spirits are organised into two categories: good spirits (*hime* [mandja], *yinze* [banda], *yonkee* [fulbe]) and the evil spirits, also referred as ghosts or spirits of the dead (*toro* [Sangô]*, ngandro* [Banda], *guinon* [Fulbe], *Bozon* [Mandja]). The good spirits are attributed to good things happening to the individual. With the presence of evil spirits, one cannot feel well, and wrongdoings, including violence towards other people are attributed to their attacks. Table 2 below summarises the participants' way of describing the spirits' influence over one's mind.

Table 2: Differences of influences on well-being between good and evil spirits

Spirits influence	**Good spirit**	**Evil spirit, ghosts or dead spirit**
Well-being	● Mood: makes you feel good, energetic, motivated, or enthusiastic ● Thinking: thinks and speaks coherently, makes one work, "is considered to be normal and upright"	● Thinking: people overthink or worry (most/all the time) ● Behaviours: hides or socially withdraws ● Emotions: always angry ● Body: loss of appetite

	● Body: has life, energy ● Behaviour: makes you do good things, readiness to work, obedience ● Socially: people will agree or at least understand your line of thought	

3.2 Local constructions of ill-health and their explanatory models

Structural violence and daily stressors

The challenges of the current social, economic, and political context is resulting in communities and individuals experiencing significant worry and stress in their day-to-day lives, due to the lack of money, food, and security. Entire communities were forced into displacement, such as the entire village of Grevai that was burnt down in May 2021 following an attack; the community is said to have lost everything. Populations had to move to an urban area like Kaga-Bandoro, disrupting in the process their cultural values and ways of life. Interviewees shared their struggle with feelings of loss and hopelessness about where to restart life, and reported how this context impacted people's psychological stability. Some participants mentioned the pressure of these conditions of life onto young people who had to become their family's breadwinner and protector in a moral, physical, emotional, economic manner, despite the impossibility for them at their age to have the capacity to fulfil all of these roles and bear this load on their own.

Vignette: Group of young males, FGD, Kaga-Bandoro

"We are fighting in wars we do not understand. We are not responsible for decision-making, but we are responsible for fighting. When we are psychologically or physically affected, the elders who led us into war are nowhere to be seen.

Another young man added:
- If we are organised, we have the capacity to work with other youths to stop them from joining war. Those who are there and experiencing mental challenges, we have the capacity to reach out to them. I'm sure they will believe in us."

The impact of the overwhelming weight onto their shoulders and the extent of their suffering after the crisis has sometimes been framed as "moral pain" during the interviews, as this quote illustrates: "Our children have a moral debt, and it does not get lost in their thoughts. The spirit of revenge, migration… poverty." (Female, 55, FGD with community elders, Boto).

The respondents explained further that if stress continues over a long period of time, this could lead individuals to *gbogbolinda*[Sangô]/*Angua*[Banda] (madness). However, when they were prompted about the local categories of 'madness', this was not attributed to the impact of daily stressors but to spiritual issues, such as ghosts and evil spirits [particularly when referring to negative acts]. Research participants explained that the stress of their day-to-day lives and the spirit of the person (*hime*[Mandja]) would be troublesome but that this would not lead to severe 'madness' (in the sense of disconnection with reality).

Local idioms of distress

The focus group discussions evidenced a range of idioms of distress used to describe an array of experiences, for which each had its own terminology in Sangô and, at times, in the local dialects. The terminologies were listed with their definitions in the form of a glossary in Annex F. They can be organised into four overarching themes that relate to: well-being, madness, categories of spirits, and emotional experiences. Additionally, the bodily experiences of suffering were described using the medium of the mind-body mapping. Table 1 p.13 captures the five overarching categories of distress the participants used to capture their subjective experience: unhappiness, stress, trauma-related, life-disruptions, being tormented or madness.

From gbogbolinda(madness)[Sangô] to unhappiness

The interviews demonstrated that the overarching cultural category *gbogbolinda* (madness, disturbed, stupid) [Sangô] captures the range of experiences of significant emotional distress, and similarly described with other terminologies in the local dialects[23]. The participants explained that the concept refers to something happening to someone's head (*Di mo do ko zou wa* [mandja] or *ye a sara li ti lo*[Sangô]), and has occasionally been associated with a virus (*Lingboma*[Sangô]). The category *gbogbolinda* can capture the most severe forms of psychological distress, with porous boundaries as to what it can encapsulate. There are multiple causes and contexts that can lead to *gbogbolinda* and to various degrees of psychological distress. Some respondents captured this spectrum by drawing a distinction between: "small madness", when someone gets lost, runs away, and comes back (which means that the ghosts from the forest or the water momentarily took away the individual); and "big madness", when the individual loses themselves in the forest or the water and are unlikely to come back (i.e. they cannot easily recover).

As captured in Table 3 below, *gbogbolinda* occurs in particular life conditions and contexts for the distress (2nd and 3rd to the left) that are attributed to six groups of causes (1st column to the left): Forced changes in life or ways of life; Close experience with violence or/and transgression; Drug and alcohol addiction; Ancestral supernatural alliances; Magic; and Issues of the heart/Troubles in the family.

[23] In Sangô and *Guinaro* [foulbe], *Guinado* [peuhl], *Moushodi* [Arabic], *Piuwiri* [ngbaka-mandja], *Ngoagoa* [banda], *Nguirango* [yakoma].

Table 3: Theories of causation for the cultural category *gbogbolinda* (madness) [Sangô]

Groups of attributed causes	**Type of issues**	**Local experience of distress/Impact**	**Responses (rituals and practices) and actors**
Forced changes in life or ways of life	**Loss of loved one**	● Unexpected loss of loved ones. ● Widowing rituals not adequately performed	To be freed from those bad spirits/ghosts from the deceased living inside one's body: ● *Sô-wi* and *Zo Ya Zo E* (Cleansing and washing ritual) [Mandja] by *nganga* (traditional healer) [Sangô] ● *Koya* ritual [banda] by *nganga* (traditional healer) [Sangô] ● *meadi* ritual (voyance) [mandja] needs to be thrown with the help of stones to understand causes of madness by *nganga* (traditional healer) [Sangô] ● "Prayers of deliverance" and via biblical reference by a church representative and by imams and *marabout* for muslims. To be freed from emotional sorrows and sins: ● Go to church for confessions by church leaders ● Go to the mosque for support by imams. To access emotional support and listening: ● Go to the health centres for guidance by counsellors and health professionals To seek justice, sanctions, and reparations: ● Report to justice mechanisms by justice professionals (police, chefs de quartiers).
	Loss of property or wealth	● Something taken from individuals by force, theft. ● Having been dispossessed (e.g. IDPs). ● Losing personal wealth due to "poor planning" or loss of business. People become destitute and this breaks their family. ● Land and property rights/ Conflicts over property: e.g. unknowingly buying a house or land that belonged to IDPs who were forced to flee, but later returned to claim their property.	
	Insecurity	● Fear of being killed, attacked, or robbed; not being sure of what next (e.g. for IDPs). ● Displacement: uncertainty about how to survive (e.g. IDPs in Sibut).	
	Conflict-	● Loved ones being killed	To access emotional support and medical treatment:

Close experience with violence or/and transgression	**related experiences of extreme violence**	● Witnessing crimes ● Direct experiences with the rebels (e.g. sexual violence, witnessing sexual violence or murder)	● Go to the *centre d'écoute* for support by counsellors and health professionals ● Go to hospitals for medical treatment ● Access emotional support/praying by religious leaders ● Appeal to the ancestors through sacrifice (*sandaka* [Sangô]) To wash yourself from the bad spirits/ghost related to witnessing crimes that live inside one's body or having been in contact with them: ● *Sô-wi* [mandja] and *Zo Ya Zo E* [Madjia], *Mbandji* [banda]*:* cleansing ritual. ● *Gingo:* A man takes multiple canisters of honey that have been collected in a *gingo* (part of a tree with holes that is placed in the tree to attract honey bees). ● Cleansing via "Prayers of deliverance" and via biblical reference by a church representative and by Imams or marabouts (for Muslims). To seek justice, sanctions, and reparations: ● Report to justice mechanisms by justice professionals (police, chefs de quartiers).
	Interactions with a crime or with blood	● Perpetrating crime ● Newly released from prison ● Witnessing a dead body or coming across a dead body (*Ngoangoa* [Banda]). The ghost of the dead person will follow you.	
Drug and alcohol addiction		*bangue, Yagaza, Ngbako* (local alcohol), smoking marijuana. ● As a result of madness: *Di mo do ko zou wa* (something happened to his head) [Mandja], *ye a sara li ti lo* (something happened to his head) [Sangô], *He fou* (He became mad) [Mandja]. ● As a result of traumas (e.g. former combatants, offenders) – people become ill intentioned under the influence of drugs.	To enforce the weaning process using physical constraint: ● Chained under a tree, isolated from others. This is managed by *nganga* [Sangô]. If this does not work, to send for medical treatment: ● Sent to access medication to the hospital (e.g. Psychiatric unit in Bangui). If this does not work, the individual is neglected and ostracised (social death): ● Individuals are left to their own devices ["*on le laisse tomber*"] (French).

Ancestral supernatural alliances	**Transgression of the ancestors' spirits**	*sioni yingo* (evil spirit with the ancestors)[Sangô]: ● If someone has not respected the terms of the alliances with the ancestors. ● When an evil spirit is to destroy someone's life or the peace of the community. ● The individual pays for the sins of their ancestors/ parents (e.g. if they were *marabout* or thieves) and they died before putting things right. Their ghosts can make the individual mad. ● May be genetically or spiritually inherited through the family.	To appease the spirits of the ancestors and restore the supernatural totemic ancestors' alliance pact that may have been broken or transgressed (intentionally or unintentionally). ● *makondji*(Village chief) [Sangô]: performed by the traditional chiefs and by the *nganga* (traditional healer)[Sangô] ● *Sandaka*(sacrifice)[Sangô]:The individual/ group/ families have to perform the sacrifices to the spirit of the ancestors asking for their guidance, performed through the elders.
	Non-respect of the clan's totem	*fio-boro* [manja]*, ngoangoa* [banda]. ● When an individual symbolically kills or eats the totemic animal of their clan (accidentally or intentionally). ● When the individual invades the sacred places(e.g Kaga-Bandoro hill, or the "*baba* camp" where young boys are being initiated).	
Magic	**Poisoning through traditions**	The ill-health or death is perceived as "unnatural" or "mystical". ● Happens when someone is under a spell by a rival who may try poisoning to take	To attack the perceived perpetrator of the sorrow using witchcraft (initiated by victims or victim's relatives): ● Ritual performed by *nganga* (traditional healer) [Sangô]: Use of fetishes (*voodoo* practice) made of roots or leaves, and tree barks. Depending on the target: for example, cut the nails, hair, pubic hair,

		revenge on their enemy with the hope they would suffer or die. (e.g. co-wife, family of the victim of violence).	and clothes from the deceased; a victim of crime or sexual violence may bring piece of clothes or items from the person targeted.
	Bad practice of magic	● People have tried to enter the world of magic but they have not followed the proper rules to do so. ● When the magic charm they used has not worked. ● Not respecting certain sacred places (e.g. a water point on River Mbombi at evening times for girls)	To get rid of the bad spirits/ ghosts that may have remained or attacked the individual because they may have not respected their side of the pact made with *mami wata* in exchange for the prosperity or protection they offered. ● Communication with *mami wata* (siren, bad spirits) [all dialects] and extreme sacrifices requested. Ritual performed by *nganga* (traditional healer) [Sangô].
Issues of the heart /Troubles in the family		● When events (e.g. death, great wound whilst hunting, loss of productivity in the fields) break the family's aspirations and this upsets them. ● Divorce/separation (e.g. not having a trusted partner), deception or being untruthful. ● When one does not take responsibility for a child born out of wedlock, the child can become mad.	To seek family or social mediation to problem-solve: ● Access to guidance and informal advice/counselling from other community members or from recognised authorities (i.e. chief of quarters, village chiefs) or from elders. This can also include social and financial mobilisation from the community members. To ensure the ancestral spirits are appeased and respected: ● Perform sacrifice rituals to the spirits of the ancestors by the elders, traditional chiefs, and/or *nganga* [Sangô].

3.3 Communities' understanding of the ways in which the conflict (or trauma) shaped local experiences of distress

Examining local experiences of ill-health, suffering, and madness helped to uncover that the order between the human world and the spiritual worlds was a central dimension of the mind, which was particularly affected by the conflict and therefore shaped the communities' perception of the violence perpetrated. The underworlds are made of two significant dimensions: *mamy wata* (sirens half human and half fish) who live in the water and are made of evil spirits or ghosts; and the ancestors' world who reside in *kala* [Sangô] the spiritual forest with the ancestors' spirits in the shape totemic animals from their clans.[24]

mamy wata

mamy wata is a central belief held by both Christian and Muslim communities. Its origin is located in the ancestral times of Noah's Ark in the flood narrative of Genesis.[25] The masters of magic (*nganga* [Sangô] traditional healers) are the only humans who can master the evil spirits, since they have the ability to communicate and mediate the relationship between the two co-existing worlds. People put forward requests to *mamy wata* often related to money or prosperity. The latter usually accepts but forwards conditions of actions that are almost impossible to fulfil, such as giving away everything or killing someone. The pact set between the individuals and *mamy wata* becomes sacred and binding for the individual. If not respected, people believe that the evil spirits will visit this individual and affect their ability to reason ('madness') and could lead to their death. Some participants argued that the violence towards the (non-)Muslim communities was a result from pacts made with *mamy wata* and with the ancestors.

kala kongba *and the ancestors' spirits*

The ancestors' spirits emerged as a central part of the collective psyche and therefore of individuals' subjectivity. The communities interviewed understood their ancestors' spirits resided in the underworld *kala kongba*, which constitutes the spiritual forest, mountain, or water source. They narrated that when someone dies, they transform into their totemic animal and enter this spiritual forest. The totemic animal is sacred and scrupulously respected because it represents the living spirit of one's ancestor. Interviewees often said that transgressing this pact, such as eating the totemic animal, would be unthinkable as it would be similar to eating your parents.

The underworld of the ancestors' spirits is a core component of the living world. Individuals, families, and communities see it as their duty to keep their ancestors satisfied in the form of sacrifices, good deeds, and good behaviours, such as with the ritual of *sandaka*[26]. The traditional elders *(tara)* [Sangô] are the mediators through which the communication with this underworld is made possible. Displacements and conflicts prevent the ability to cultivate this relationship with the ancestors' world (e.g. people are unable to perform *sandaka*). Communities' misfortune such as conflicts, death, or people "going mad" can be attributed to

[24] Note, *mamy wata* and the spiritual ancestors' forests are also commonly held beliefs across West Africa (e.g. Sierra Leone, Ivory Coast and Liberia).

[25] The belief is that God saved Noah and his family, as well as representatives of each animal before the world became entirely flooded. *mamy wata* is made of all the spirits of those who drowned because they stayed and refused to get onto the boat. They were transformed into spirits remaining in the water that cannot be seen, usually as evil spirits.

[26] See Annex G for the list of rituals.

this. As a result, they may perform the rituals related to their ancestors' spirits to please the dead, in order to counter their misfortune. Additionally, communities understood their misfortune through the historical supernatural alliances their ancestors had set up with the ancestors of another clan; they may not have been respected by individuals in the living world. Interviewees located the origins of the ancestors' alliances to ancestral times, when a tribe was in danger or had endangered another tribe, and intervened to save them. As a sign of gratitude, the saved tribe set up a sacred alliance pact with the other group or totem that protected them, which forbade future generations from these clans to attack each other. In fact, communities believe that the presence of the spirits of their ancestors in the living world ensures that the supernatural pact continues to be respected.

Individuals' intrinsic relationship with the ancestors' spirits is such that the latter can embody the individuals when people undergo spiritual vaccination (*yoro ti box* [Sangô] talisman for fighting). The ritual aims to protect themselves and their communities from death in the context of fights with the enemies. It involves the use of traditional medicines (i.e. *walaga*) and practices such as scarring or the use of fetishes and *gri-gri* (amulets). The ritual performer invites the ancestors' identity and agency in the form of an animal consciousness to supplant their human consciousness. The anti-balaka fighters, for instance, were believed to have become bees when fighting. Individuals who had been spiritually vaccinated made a pact with their ancestors' spirits stipulating that after victory, the spirit must leave their body and go back to its world so that the individual can regain a human conscience and be accepted into their community (e.g. for the anti-balaka fighters, the cleansing ritual is called *ani sombolotia* [Mandja] meaning a man who chases away evil spirits or ghosts).

The ancestors' spirits can play a vital role in the communities' framing of the perpetration of violence during conflicts. Violent acts (e.g. killing someone, eating the forbidden totemic animals) committed in the context of spiritual vaccination are seen as legitimate if they enable the preservation of their community, according to interviewees. Individuals are then not only accepted but also heroicised by their community. However, some fighters transgressed the pact with their ancestors, which they had committed to when undergoing the spiritual vaccination by not undergoing the cleansing ritual when they returned from fighting (and after having engaged in violent acts).[27] Communities uphold the belief that, as a result of this transgression, the ancestors' spirits are affecting their behaviours negatively by being out of control or by suffering from *gbogbolinda* (madness)[28], which resulted in their social exclusion. Other interviewees attributed these former fighters' madness to them having made a pact with the evil spirits instead of their ancestors. This resulted in these former fighters perpetrating violence considered as illegitimate by the community, such as burglaries or sexual violence during the conflicts.

Clans and totemic beliefs

Similarly to many parts of Central and West Africa, the clanic social structure of the communities is organised around totemic figures (such as an animal or a plant) that are a core part of their sense of self. Each totem is derived from a unique legend of origin that took place in ancestral times for this particular clan. The narrative usually involved a clan's ancestors being under threat or at war, which were saved and protected by a particular totemic animal

[27] Some interviewees referred to them as "false anti-balaka" in the context of the previous set of violence.

[28] Note, it is unclear from the interviews if the communities marginalise them in the first place because they are seen as suffering from madness, and therefore it is assumed that they have not respected the pact or if it is the other way around.

(See details in Appendix A). This led to a pact of alliance with that animal that became emblematic of this clan's totem. The transgression of this pact, knowingly or unknowingly, can lead to ill-health and madness, as the vignette below illustrates.

Vignette: Story from D, male, 50, Banda ethnicity, activist, Sibut

D relates the story of his sons, A and B, which underlines the totemic beliefs described above. Some clans within the Banda group have for totemic animals the snail (*(e)scargo* [Sangô/French] or *Kala* [Banda]).

A joined the army (FACA) when he was 25 years old. FACA used to give food to their fighters that contained or had been interacting with snails. A ate the food provided by the FACA, unaware that it contained snails. One day, A's brother, B, visited him and used the same plate that A had used to eat other local foods. A, who had accidentally eaten snails, became completely deaf. His brother B, who had eaten from the plate where the snails had been placed, became partially deaf even though he had never eaten snails himself. Despite treatment attempts by the medicine man, the two brothers remain with this hearing impairment to this day.

Section 4: People's actions - What are the specific social-psychological determinants of well-being of Kaga-Bandoro and Sibut?

The key social-psychological determinants of well-being elicited during the interviews related to accessing interventions that responded to the theories of causation attributed to their ill-health and to the ability to undergo the socially prescribed rituals at key points in communities and individuals' lives.

4.1 Maintaining well-being and addressing ill-health in practice

The practices that communities and individuals adopt to address or prevent their ill-health and distress is derived from the often multiple explanatory models they hold to explain their misfortune. Their explanations, therefore, are fluid, multiple, and sometimes co-exist or occur in a consecutive order. As previously discussed, the research participants tended to attribute their experience of distress or ill-health to the overarching category *gbogbolinda* [Sangô] that captures a range of issues from madness to "being (emotionally and mentally) disturbed" or intellectually limited ("stupid"). The type of responses and of actors involved in practice depends on the cause(s) individuals and/or their families attribute to the distress they experience.

Key actors and rituals in practice

Overall, the research identified five types of actors that are reached out to for support when individuals are distressed or affected by *gbogbolinda* [Sangô]. Each set of actors has particular knowledge and skills, which means they will offer individuals and their families particular practices to address the causes attributed to this affliction based on their unique expertise. The set of actors are as follows:

- The healers who are skilled in engaging and influencing the underworld (i.e. magic, ancestral spirits, evil spirits or ghosts, etc.) through the performance of various rituals (from the non-allopathic sector). They are usually referred to as *nganga* [Sangô], *Gbongo* [Mandja], *marabout* [Muslim groups], *Bokadjio* [Fulbe] or traditional healers in French. They will be referred generically in this report as *nganga*[29].
- The elders and traditional chiefs, who are knowledgeable of the ancestral worlds and the alliance pacts existing between the clan's ancestors and their totems. They are also knowledgeable of families and local conflicts, and skilled in mediation and conflict resolution.
- The faith leaders (i.e. church leaders and imams), who are skilled in understanding religious texts and practices (e.g. prayers) to help with understanding their experience using a religious framework, including the soul and possible evil spirits that may have possessed the individual.
- The health professionals (i.e. doctors and counsellors), who are skilled in listening and providing emotional support, as well as in medical support if necessary (from the allopathic sector). They are usually based in health posts or hospitals, or in dedicated centres (i.e. *centre d'écoute*).
- The "justice professionals" are identified as the individuals with a recognised authority. They range from the police to the quarter chief or village chief (and elders). Their skills seem to be about managing conflicts and considering sanctions and reparations.

[29] The author is aware of the debates surrounding the use of the term 'traditional healers' as a generic category, and its biases in what it can capture. However, the informants and the research assistants used its equivalent in French (*Tradi-praticiens*) so the term will be retained for this report to capture the local category.

For each set of possible causes attributed to their experience of distress or *gbogbolinda* [Sangô], the individual or/and their families reach out to the healer or the professional perceived as having the most relevant expertise to diagnose and to address this possible cause. The findings from the interviews are summarised in Table 3 p.18 with the theories of causation (left columns) and their corresponding responses (i.e. cleansing ritual, prayer, counselling session) recommended by the actors (right column). Also see Appendix G for a list of key rituals related to distress and ill-health identified during the research.

Specificity of SGBV survivors

Despite a high prevalence and a predominantly stigmatising environment, the pathways available to SGBV survivors remain largely limited in their quality and effectiveness.

Prevalence

Sexual violence emerged as a significant issue in the communities researched, both during previous conflicts and peaceful times. The prevalence during the last crisis is reported to be high, although specific data is not available. The interviewees described such incidents as occurring when the armed groups were present in the communities because they did not respect the state or traditional authorities, and because they were only accountable to their commanders. The years of violence experienced by the communities had the effect of breaking down some of the social norms, and to normalise such violence in the domestic and community arena during peaceful times.

Additionally, limited information could only be accessed in terms of the gender and age distribution for the incidents. Although interviewees often thought that sexual violence towards men was a rare occurrence, this is probably due to the additional shame experienced by male survivors, which also results in them having to leave their communities of origin to preserve their anonymity. However, for example, an interview with a quarter chief in Sibut confirmed he had been made aware of at least five cases in his quarter.

Social attitudes

The social treatment of SGBV survivors varies but overall, a stigmatising attitude prevails. As a result of this stigma and to save the honour of the family, the occurrence of sexual violence within the family is usually not reported to the authorities and internal arrangements (including performance of rituals) are made with some forms of reparation. Several interviewees mentioned that overt hostility towards survivors is mostly no longer openly present. This is due to multiple awareness campaigns conducted by NGOs and the fact that the negative behaviour is now illegal and, thus, can be sanctioned by the *gendarmerie* [local police]. However, social stigma remains covertly present in the social attitude of some community members, particularly towards male survivors.

Pathways of support

Only few help-seeking pathways are available for SGBV survivors and they are limited in their quality and effectiveness. They are organised as follows[30]:[31]

1. To cleanse themselves from the evil spirit of the perpetrator:

[30] See also Section 1.2 on MHPSS Referral pathways.

[31] The interviewees elicited additional rituals and practices that address various life stressors similarly to other community members (See Appendix G) but they did not focus explicitly on the incidence of sexual violence.

- Cleansing ritual (in all circumstances surrounding the identity of the perpetrator): This is performed by the *nganga* [Sangô] with the aim of eliminating the evil spirit to welcome them back into their community.
- Cleansing ritual through church rituals.

2. To seek justice in terms of sanctions, retaliations, and/or reparations
    - To seek justice (sanctions and reparation) through formal justice authorities (i.e. gendarmerie, police) and local authorities (i.e. chief of quarter, mayor).
    - To cast bad magic spells (i.e. *voodoo* practices) on the perpetrator when the perpetrator is unknown.
    - Setting up informal pacts for reparation when the perpetrator is family-related. This is done privately to preserve the reputation of the family and to avoid stigma for the victim.
3. To seek emotional support, being listened to, and access guidance
    - Reaching out to access informal emotional support to their family (e.g. parents, close relatives) and friends
    - Accessing the counselling centre (*centre d'écoute*).
    - Accessing emotional support and spiritual guidance from religious leaders (i.e. pastors and imams)
    - Accessing emotional support and guidance from local leaders and elders

Nevertheless, each trajectory and support system presents important limitations.

- Lack of accessibility. The counselling centres are not geographically well spread, and are few in number, particularly in remote areas.
- Lack of trust and skills in responding and feeling cared for (by local authorities).
- Lack of confidentiality and anonymity. The counselling centres specifically respond to survivors of sexual violence so its access is often publicly known. As a result, individuals are reluctant to use the counselling centres out of fear of being identified as SGBV survivors.

4.2 Practices that bind individuals to their communities

Rituals are core to the making of the social fabric of the communities in Sibut and Kaga-Bandoro. Their practice enforces and reinforces the multiple layers of collective identity (i.e. clanic, ethnic, religious), sense of belonging, and cohesion. It also addresses formally and informally the dimensions related to collective sorrows and traumas, particularly in times of hardship such as after conflicts.

The research identified two overarching sets of rituals in the communities interviewed that were crucial in binding individuals to their communities: rituals supporting transitions through life-cycles (e.g. mourning rituals, initiation into adulthood) and rituals aiming to prevent or address sorrows (e.g. rituals for cleansing, for clairvoyance, honouring the ancestors' spirits); (See Annex G). Clashing with the culture of emotional disclosure underpinning counselling centres, the socialisation process promotes gendered values around social duty and physical bravery, as well as shameful emotional display that must be repressed since it ultimately constitutes a threat to the survival of the group.

4.2.1 Transiting through life-stages

The first set of rituals elicited aimed at supporting individuals in their transition through the cycles of life. This socialisation process promotes gendered values around social duty and

physical bravery, as well as shameful emotional display that must be repressed since it ultimately constitutes a threat to the survival of the group. This is in sharp contrast with the value of emotional disclosure underpinning existing counselling centres.

Mourning rituals

Each ethnic group has in place a precise set of mourning rituals that supports the families of the deceased, and sometimes particularly widows, in this transition between life and death. The rituals elicited usually focused on ensuring that the soul of the deceased did not negatively affect the remaining family members (Annex G).

Initiation rituals

The initiation rituals are a crucial marker of maturity and of gendered identity that supports girls and boys in their transition into adulthood as women or men. These rituals are crucial to the socialisation process by enforcing social expectations regarding key aspects: gender markers and behaviours, as well as the management and disclosure of emotions. They are performed similarly across ethnicities, with different pathways for boys and girls, and each cultural group has their own terminology[32], as described in Annex H Table 4. Note that due to the secrecy of the ritual and to the sensitisation campaigns around some of the practices of circumcision, it was difficult to elicit a clear current picture of the ritual. Several participants explained that the circumcision ritual is no longer taking place due to the conflict, a general change in societal attitude, and also due to the communities being sensitised to the risks associated with some of the practices. Other interviewees argued that the practice still occurs but in more sanitised circumstances (i.e. the hospital), while others argued it had to be traditionally performed. Non-circumcised individuals are considered impure[33] and, for example, could not join a dance with circumcised individuals.

Furthermore, many research participants argued that undergoing the traditional education (i.e. the initiation ritual) was central to being socially accepted and to accessing adulthood (as a marker of maturity). They explained that young people who did not go through this ritual, are seen as weak, powerless, cowardly, lazy, irresponsible, and they lose the affirmation of their gender status (e.g. men considered "like a woman" [in a derogatory manner]). Without these characteristics, one has no place in society. They lose their social status and social capital and rejected by their community[34] as a result, which also affects their marriage prospect. Similarly, some interviewees argued that parents still have in mind the necessity to train their children and provide moral guidance to shape young people's behaviours to complement formal school education. Some elders interviewed lamented that discontinued traditional education can be blamed for "indiscipline and societal breakdown" and that young people were more focused on emulating what they saw on TV.

Gender markers and non-conformity

Overall, the social expectations and values promoted during these rituals across genders seem to be organised around the following themes: respecting authorities, carrying social duty,

[32] *Baba*[Sangô]; *Baba gazani* (transiting initiation for boys) and *Baba gazako* (transiting initiation for girls) [Mandja]; *Baba yache* (transiting initiation for girls) and *baba koché* (transiting initiation for boys) [Banda].

[33] For example, a boy who has not been circumcised is called *Kpassakara (*someone who has not cut their foreskin) [Mandja].

[34] They are then called with names such as from *bouba* (someone who is weak and fool) [Sangô], *ouali* [Sangô], *Avo* [Banda].

caring and protection of others, bravery and physical protection, being able to carry out physical labour necessary for the survival of the family. Each gender, however, had a particular socially prescribed way of fulfilling these values and expectations. The detailed findings were inserted in Annex H.

The social reaction to non-conformity to these gender norms were quite strong, as reflected by dedicated language categories in each dialect that condemn or disqualify these culturally transgressing behaviours. The social condemnation of behaviours transgressing gender expectations seems to take the form of ostracisation and mockery, using derogatory analogies with madness, stupidity, and inferiority. Men can be feared and framed with supernatural powers, and can use bad magic as a wizard. The social treatment seems to be even more harsh for women, who are referred to with metaphors of illness analogous to "being contagious to other women".

Socialisation of emotions

Throughout their young life, individuals are socialised with the idea that the experience of extensive emotion (e.g. sadness, fear, or anger) is shameful, to be hidden, and ultimately a threat to the survival of the group regardless of one's gender. This becomes apparent at an early age, where some respondents described: "Parents feeling ashamed when their child cries a lot in public". An elder female in Sibut explained: "A real man can never cry. If he does, then he is not good enough. If a boy cries in public, as a parent, you know that you have left shame to your family. You have left nothing. You can never be proud of such a boy!". Similarly for young girls from the Fulani group, the belief is that she will not be happy in her life (e.g. she may have failed marriages) if she cries excessively.

Avoiding emotional disclosure is a central message reinforced during the initiation rituals where young people must brave their physical pain and fear to survive. Some explained that if they were taught that if they were angry, they must improvise and find something to do to hide the emotion, such as looking for fruits in the bush. During the circumcision and healing process[35], display of emotions such as crying is looked down upon; emotions must remain in the realm of secrecy, particularly for boys. In Houssa culture, if your son is "brave" and does not cry during the circumcision, this is a parent's badge of honour and parents receive a present[36] "for raising good boys". Interviews also suggest that the public display of emotions is a threat. For the Fulani group, the belief is that if a small boy cries excessively, someone in the family will die. The way of enforcing this management of emotions may also serve a purpose for the group's survival in times of hardship. This is the case for young people who, as a result of the conflict, must become breadwinners, security providers, and bear a lot of responsibility (i.e. physical support, protection, economic, and moral support), since they are physically stronger than their parents or the elders. However, most of them are ill-equipped to handle these overwhelming responsibilities.

The way in which these emotions and experiences of distress are culturally enforced over individuals' psyche throughout their life has significant implications on the design of support services. Indeed, many of the formal services in the allopathic sector involve sharing intimacy with others or strangers that can be seen as conflicting with cultural norms, as the vignette below exemplifies.

[35] With the *nikla* (insects) used to heal the wound around the penis.
[36] Usually involves an animal with blood (sheep, goat, chicken).

Vignette: FGD with taxi-moto, young men in Kaga-Bandoro
"My elder told me that if you cry or show emotions in public simply know that you will suffer for the rest of your life. If something happens to you, and you feel that you are about to be embarrassed and show emotions in public, just go inside your house and take a rest. Never behave like a woman in public."

Other young males added:
"In the worst-case scenario, you share your problems with a fellow man or friend, and with your family, with magic people [i.e. traditional healers], but never with strangers. This is what I learnt during my initiation process."

Health clinics and counselling services require a culture of openness (e.g. ability to openly speak openly about emotions to a health professional or community counsellor) that is contrary to the community socialisation processes grounded on secrecy, particularly for boys.

4.2.2 Preventing or addressing sorrows

The second set of rituals enabling the binding of individuals to their communities that the research elicited is geared towards preventing or responding to individual or collective sources of sorrows in multiple ways (see Annex G).

Cleansing rituals

Cleansing or washing rituals are integral to the communal life across all ethnic groups. They are organised during multiple occasions (e.g. new widows, coming across blood, coming out of prison, madness). Their aim is to wash away the ghosts or evil spirits that could or have already affected individuals and their families, a crucial causal attribution for ill-health, distress, and misfortune. Below is an example.

Vignette: Cleansing ritual described during FGD with male and female local elder in Sibut
The ritual s*oukoula mo ndali ti ngoangoa* (Wash of body and mind to prevent madness [Sangô]) takes place as a precaution in the form of "vaccination" to protect them from the evil spirits or ghosts that would lead people to become "mad". The ritual takes place after witnessing death or if you suspect that you will come across a dead body or involved in killing. This ritual may be performed for professionals involved in the line of duty where they may encounter or witness dead bodies, such as United Nations or NGO workers, security forces (e.g. FACA, police).

Some traditional healers specialise in performing the ritual. *Gbongo,* a herb, is drunk by the person being washed to cleanse the body and the mind. After the washing process, the old clothes, shoes, and other items are left in the bush and new ones are provided before the person returns to their house and to their community.

Clairvoyant rituals

Clairvoyant rituals are complementary to cleansing rituals in that they support the traditional healer in his formulation of the cause and possible individual blame for the presence of ghosts or for unnatural deaths and harms. Based on the diagnosis, the healers can take the appropriate

actions to respond or take revenge about the perceived toxic action, usually through the practice of bad magic.

Honouring the ancestors' spirits

The rituals involving the honouring of the ancestors are focused on addressing the intergenerational relationship with the underworld of the clans' ancestral spirits and totemic animals. They can have a preventive or curative dimension, and can be performed collectively or individually. In this instance, recognised local authorities and elders mediate the relationship with the underworld, as exemplified below.

Vignette: *Sandaka* [Sangô] ritual - the ancestral alliances with the ancestors' spirits

The *Sandaka* ritual on the Kaga Hill serves the purpose of protecting and maintaining the well-being and fulfilment of the community in the Kaga-Bandoro area. The legend comes from a fighter named Kaga-Bandoro who died defending the local population. Since his death, people pay regular visits to the hill to thank him and the ancestral spirits for their protection. The ritual can provide individual fulfilment (e.g. luck, good health, success) or the collective good (e.g. good harvesting, bringing rain). Therefore, it is conducted individually or collectively. The process involves offerings that must be the fruit of one's labour (e.g. hunters bring meat, farmers take crops that they grow, e.g. maize or peanuts) and are brought to the sacred places of the hill. Elderly males and traditional priests perform the rite by bringing the offerings to the sacred location and by communicating with the ancestral spirits. The ritual can be done to encourage something positive happening or to thank the ancestors for the good things that happened to the community.

5. Recommendations

Principles for intervention

The premise for the research is to understand the ways in which categories of experience of distress are embodied (subjectivity) in conflict-affected populations, which then enables much further attunement to the needs of affected communities and, therefore, more effective design of MHPSS and peacebuilding interventions. Some researchers have advocated the centrality of this dimension in service development in arguing for culture as a human right (Jain and Orr, 2016; Kirmayer and Swartz, 2013). The research focused on understanding local psychologies of the populations of Sibut and Kaga-Bandoro derived from indigenous conceptions of the mind and the local impact of collective trauma, distant from the Western models that dominate the field of MHPSS programming and international research[37].

The various categorisations elicited in the report (i.e. conceptions of the mind and of the self, idioms of distress, theories of causation) should be used as the basis for the development of the following aspects of programming

Psychosocial and therapeutic interventions

Local categorisations of the mind and distress have been very effective when mental health professionals have used them as the medium for the delivery of the psychosocial (Chase and Sapkota, 2017; Chase and Bhattarai 2013) and psychotherapeutic intervention itself (Kohrt et al., 2012), particularly with survivors of violence. The healing professionals (e.g. counsellors from the *services d'écoute*), usually trained with Western and biomedical models of the mind, use the indigenous concepts instead in order to be as close as possible to the lived experience of the individuals they are supporting. This would shape the language and concepts used in the following areas:

- The way of engaging with the distressed individuals
- Their co-construction of the formulation of the problem
- Their joint-reflections and support in the processing of emotions
- Their delivery of their guidance and counselling interventions

Recommendation:

- Training the counsellors and other mental health professionals in this cultural-informed approach, using the concepts elicited in this report.

Monitoring and Evaluation

Similar to other programmes with conflict-affected populations or/and with young people in Kenya, DRC, and Nepal (SFCG, 2013[38]; Karki et al., 2009; Geisler, 1997), the local concepts of the mind and idioms of distress elicited in this report should inform the MHPSS and peacebuilding programming.

Recommendation: Use the local categorisations elicited to develop the following Monitoring and Evaluation (M&E) strategies:

- Young people-led or individual-led indicators to measure the impact/outcome of the activities designed (pre/post interventions).

[37] This is in contrast to globalised discourses on mind and health, such in the Global Mental Health movement (Bemme and Kirmayer, 2020; White et al., 2017)

[38] Search for Common Grounds (Blog August 7, 2013) retrieved from https://www.sfcg.org/removing-child-soldiers-scarlet-letter-body-mapping-and-photovoice-help-reintegration/

- Measures of individual and community well-being and psychological impact (each idiom with a scale).
- Use of body-mind mappings to measure the psychological impact and identify individuals' needs and resources.
- Used to decide group psychosocial interventions derived from these local categorisations.

Collaboration between allopathic and non-allopathic professionals

Drawing from existing research (Orr and Bindi, 2016) and considering the significant effectiveness (86%) of the non-allopathic intervention reported in the communities researched (DCA, June 2022), a stronger recognition and collaboration between types of healers needs to be prioritised. Similarly, research with people who are suffering from common mental disorders found improvement from general psychological distress and symptom-reduction when using the support of traditional healers (Pham et al. 2021). The WHO-Mental Health Action Plan (2003-2020) has advocated for programs and governments to incorporate faith and traditional healers in their interventions, but these initiatives remain marginal and there is little guidance on ways to navigate the relationship and malpractices.

Recommendation:

- Develop a better understanding of each set of healers' model of causation held, and the skills and expertise available (e.g. workshops).
- Support the non-allopathic professionals in setting up (or to strengthen) their state-approved professional registration and developing their ethos and commitment for their practice (as is already in place in many parts of Africa). A document could specify commitment to not adopt certain malpractices and upholding certain human rights standards, particularly in reference to the treatment of severe mental illness and of Female Genital Mutilation.
- Each set of healers could formalise the strengths and limits of their competencies, and when they could work together, and/or would refer to each other.
- Organise training from health professionals on criteria for traditional healers to refer to health facilities.
- Reflections could be held to discuss joint interventions in certain cases when deemed effective, in order to incorporate all the theories of causation held by the individual and their families to explain their experience of distress. Regular case discussions could be held between both sets of professionals to formulate an intervention plan.
- Establish a mapping of each group of healers and professionals serving in the local areas.
- Advocate to the IASC-MHPSS/WHO for the formalisation of guidelines for the collaboration between the allopathic and non-allopathic sector, and particularly traditional healing and mental illness.

Specific recommendations from the brainstorming session with the Conciliation Resources and DCA project team in July 2022

1. Supporting people and the identified vulnerable groups with socio-economic support to alleviate their daily stressors (Level 1: IASC-MHPSS pyramid)

Approach:

- Collaboration with existing partners in the field who have the mandate, expertise, and resources to offer the support.

Activities:

- Conciliation Resources and DCA to identify the most vulnerable and in need of such support.
- To set up partnerships with the relevant partners.
- Sessions with community members and elders/chiefs engaging with the explanatory models about wealth and prosperity (e.g. *mamy wata* and the ancestors' spirits): exploring the link, preventing harm, offering alternative pathways, shared reflections on how/why prosperity is brought about.
- Small funding can be made available for business development with the aim of mediating the opportunity to be together and to share with others similar stressors and their impact on their life.
    - In *Maisons de la Jeunesse*: groups activities of informal emotional support. Include the young breadwinners who are particularly vulnerable to stress.

2. Addressing gender norms linked to the management of emotions

Approach:

- The approach needs to be cognisant of the fact that many cultural norms are seen as essential for the survival and stability of the community.
- The aim is therefore not to change gender norms but to outline alternative options for young people to fulfil the purpose of these norms while enabling the well-being of the individuals.

Activities:

- Peer support groups – to share informal coping mechanisms. Focus on the young people who are the most vulnerable to being in that position of breadwinners in charge of the physical, economic, and emotional support of their own families.
- Opportunities for income generating opportunities.
- Awareness campaigns to be locally grounded:
    - Reflect on coping mechanisms
    - Suggest alternative norms – reinforce norms around emotional strength being enabling of being the protector of the family (e.g. play on the imagery).
- Using traditional healers/facilitators and young people of the initiation rituals to open up a dialogue about acknowledging the existence of emotions after a difficult time (i.e. the conflict, daily structural stressors) and ways to cope with what they feel.
    - Creating opportunities for sharing emotions: workshops, dialogue meetings, informal peer support groups (in maison de la jeunesse) – accompanied by trained facilitators.
    - Together think about activities to overcome the issues – funded awareness campaigns. Space is being created to discuss and to find the solution (e.g. create a movie, cinema discussion, drama/role play in the market place, etc.).
    - Create opportunities for discussion within family leads about the perpetuation of the norms around emotions.

3. Throughout the programme, every MHPSS and PB activity should be underpinned and reformulated in the light of the multiple layers of theories of causations held by the targeted communities or individuals.

Approach:

- ✓ All teams should articulate to their local teams and beneficiaries the importance and space created for the local belief-systems in the formulation and the implementation of the activities.
    - Shift in NGO/organisational culture to move away from the Western lens that indirectly frames the spiritual beliefs as separate and not essential part of the work.
    - The projects need to speak to the "heart and mind" of people.
    - Awareness of local power dynamics and local partners need to be aware of resulting discrimination from minority/majority groups.
- ✓ Every individual and community may hold different explanatory models that may conflict with each other or may be co-existing.
    - Allowing for community-specific or individually-tailored intervention plans that considers the resources, the beliefs and theories of causations they prioritise to explain and therefore to address their misfortune/sorrows.
    - Ensure that the most marginalised group associated with violence (e.g. former fighters, criminal groups disrupting the social order) have access to individually-tailored social-psychological support to find a form of integration to a community of their choice.
- ✓ During the design of MHPSS interventions, address first the issues related to the collective psyche such as trauma, and then only afterwards, target if necessary individuals or sub-groups (e.g. SGBV survivors, drug users) who may benefit from more tailored therapeutic interventions.

4. Models of therapeutic interventions should be culturally-grounded and trauma-informed.

Approach:

- ✓ Enable a less passive or Western model of therapeutic intervention that moves away from the listening/counselling position to engage with other therapeutic mediums (e.g. drama, other joint activity).
- ✓ Find out, in the formulation during the clinical assessment, the various theories of causations by the individuals and by the family in order to inform the most suitable therapeutic intervention for the individual or for the group.
    - Conducting joint assessments psychologist/traditional healer.
    - Facilitate joint interventions when appropriate (in parallel); can be devised so that the identified local healers can be embedded within the support and monitor the well-being during and after the intervention as focal points.
    - Ensuring a training and vetting of the healers involved.

Activities:

- Follow a decentralised approach of where the intervention (i.e. peacebuilding and MHPSS) can be delivered in the same locations where people can come together for their overall well-being (i.e. to connect, be together, platform for discussions, etc.).
    - Explore the multiple locations from MINUSCA buildings, *Maisons de la Jeunesse*, informal spaces where multiple targeted groups feel safe to meet and discuss (different groups will feel safe in different spaces).
    - Discussion with Conseil National de la Jeunesse to explore existing spaces and understand the activities they are planning to perform in those spaces.
    - Ensure the spaces chosen can serve multiple purposes for community activities.

- Train youth workers and community facilitators that can staff the chosen locations to embed themselves in the community and to be skilled to facilitate formal and informal reflections or discussions.
- Skilling up the counsellors/community counsellors who are used to deliver the counselling interventions in the centres d'écoute.
- Map out and vet safe referral pathways that ensure the access to safe MHPSS services for individuals suffering from more complex mental health difficulties.
    - Facilitating the logistics (i.e. transports, access to medication) and accompaniment of individuals/and their families to the services.
    - Mapping out and vet of all the traditional healers and their set of expertise. (See: Set up standards for their practice).

5. Address collective trauma by enabling a mediated reflection on the communities' theories of the origins of the trauma and by supporting the rituals that they decide to implement.

Approach

- Relates to the principle of multiple layers of cultural-religious-spiritual explanatory models that co-exist at the same time, and make sense to the individual or/and the community.

Activities

- Identify a small number of communities that have been severely affected by traumas (e.g. Grevai village).
- Create mediated spaces where reflections and conversations can happen with key representatives of the communities (i.e. different groups including those with limited capital and power in these conversations, including young people). Elicit key theories of causation to determine what rituals and peacebuilding approaches would suitably address the traumas.
- From these reflections, where appropriate, support communities (in multiple ways) to facilitate follow-ups and enable the restoration of some of the social fabric (e.g. intra or extra-communal relationships).
- Explore with the community memorialisation processes and other ways to address collective memory and collective grief and loss. Support finding metaphorical ways of repair, retribution, and restoration.

6. Ensure dedicated MHPSS and PB intervention targeting the most marginalised and psychologically fragile individuals

Activities

- Identify and train dedicated youth workers with the appropriate background and skills to engage with this population.
    - Ensure the approach of the caseworkers is tailored individually to their needs.
- Identify key young people who have the relationships, leadership, and skills in mobilising this sub-group.
- Within the Centres de Jeunesse, organise:
    - Activities of their choice with funding on the equipment.
    - Set up peer-to-peer support groups to draw out informal coping mechanisms.

- Ensure partnerships to offer basic health/reproductive/sexual health activities, and awareness campaigns + drop-ins with health professionals from primary health care centres.

List of Tables, figures and annexes

Figures and Tables

Annexes

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Annex A: Interconnection between ethnicities, clan, and totemic beliefs

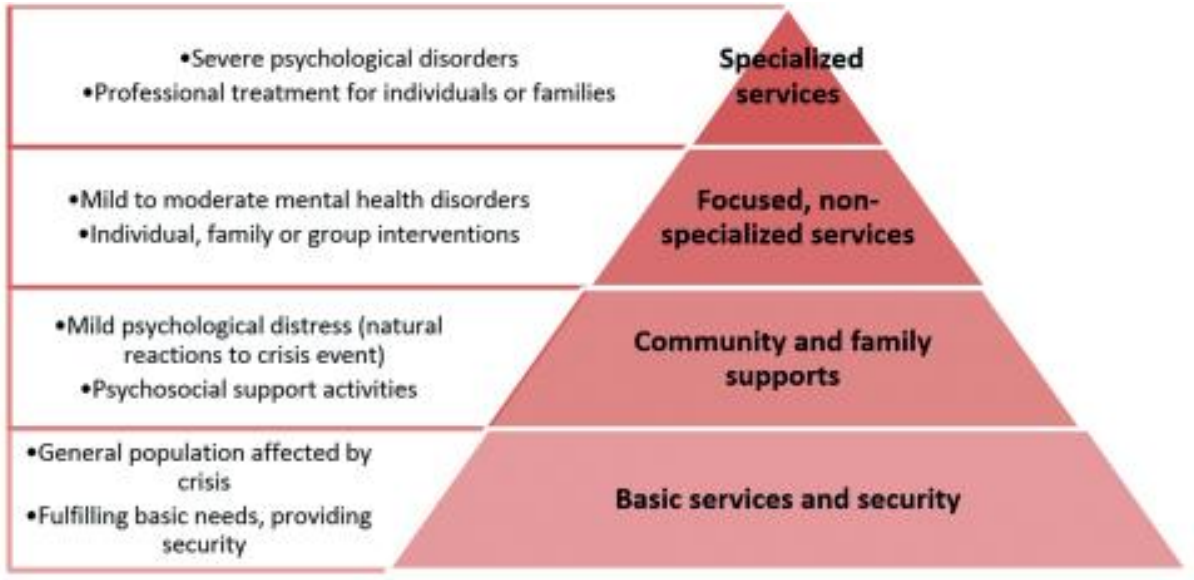
Table 4: Interconnection between ethnicities, clan, and totemic beliefs using the example of the Galafondo (Sibut sub-prefecture)

Commune	Ethnic group	Clan	Dialect	Totem	Totemic legend
Galafondo	Mandja	Gbogogo, Béya-sadé, Ngabdia, Boukoudou	Sango et Mandja	Panther	The story dates back to an alliance pact with the ancestors of the communes. The story tells that the ancestors turned into a panther at the time of their death.
	Banda	Bangba	Sango, Banda	Caterpillar	The ancestors of the Bangba clan transformed into butterflies and then from butterflies into caterpillars. It is therefore forbidden to eat caterpillars as this would be the same as eating the ancestors.
	Langbachis	Tongba Bondoukou	Sango et Lagba	Hippopotamus	Pact of alliance formed between the ancestors of the Tongba clan and the hippopotamus. The ancestor capsized during fishing. Faced with earth, the ancestor called the hippopotamus to save him. He climbed on the back of the animal which carried him to the land. The ancestor then formed an alliance with the hippopotamus for mutual protection.
	Gbaya	Gadjé	Sango	Monkey	This refers to an alliance pact formed between the ancestors of Gadjé clan and the monkeys. This pact dates back to a time when the clan's village was attacked. The monkeys warned the ancestors about this attack, which allowed the ancestors to prepare for the fight. As a result, they won the fight. This led to a pact between the ancestors and the monkeys.

Annex B: IASC-MHPSS (2007) Intervention pyramid for mental health and psychosocial support in emergencies

The IASC [Inter-Agency Standing Committee] developed Guidelines on Mental Health and Psychosocial Support [MHPSS] in Emergency Settings in 2007.

Diagram 1: Intervention pyramid for mental health and psychosocial support in emergencies (IASC-MHPSS, 2007)



This illustration is based on the intervention pyramid for mental health and psychosocial support in the IASC Guidelines (2007).

Extracted from IASC-MHPSS (2007 p.12)

- Level 1: Basic services and security. The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases).
- Level 2: Community and family support. The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family support.
- Level 3: Focused, non-specialised supports. The third layer represents the support necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialised care).
- Level 4: Specialised services. The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the support already mentioned, is intolerable and who may have significant difficulties in basic daily functioning.

Annex C: Research questions, Questions interview guide and associated methods

Research questions

1. **People's conceptions: How did the conflict shape local experiences of distress in the communities of Kaga-Bandoro and Sibut?**
    a. What are the local conceptions of the mind and well-being?
    b. What are the local conceptions of ill-health, distress, and their explanatory models?
    c. How do communities understand the way in which the conflict (or trauma) shaped local experiences of distress?

2. **People's actions: What are the specific social-psychological determinants of well-being of Kaga-Bandoro and Sibut?**
    a. What do/can people do in practice to maintain their well-being and address ill-health?
    b. What in practice binds people in the communities where they live (e.g. rituals, informal moments of togetherness)? What role do age, gender, ethnicity, and location (urban/rural) play?
    c. Who are the actors to engage to consolidate individuals and communities' well-being?

3. **People's recommendations: What are the implications for peacebuilding and MHPSS interventions?**
    a. What social mechanisms could be strengthened to promote individual and collective well-being?
    b. What community perceptions and resources should be considered in the design of MHPSS and peacebuilding interventions?
    c. How can the project's peacebuilding strategy be linked with the communities' spiritual and cultural framework to maximise impact take into?

1. **People's conceptions: How did the conflict shape local experiences of well-being and distress?**

1.1 What are the local conceptions of [the mind and] well-being?		
Local constructions of well-being	How does it look like when people are well/content? What is the difference when they are not? Has this changed since the war/recent violence? What helps/makes people feel content? How does it work within themselves/within their body? Does it work the same way for men and for women? Try to elicit the difference across age range: children, young people, adults, and elderly. Try to elicit local theories related to people's perception of themselves and what can cause them to be well/distressed (e.g. religious views, Good ghosts, energies, ancestral spirits).	FGDs [Focus Group Discussions] If needed, with strategic KII [Key Informant Interviews]
Local constructions of the mind	How does it work when people feel content or upset or scared? Where do they feel it? What happens within themselves? Please show me (on yourself, on the drawing).	FGDs + Use body mapping/drawing to support explanations and prompt explanations
Construction of gender norms,	<u>Construction of gender norms</u>	

identity, sexual identity	- How does the community expect [women/men] to behave? To look like? - What's important for them to define themselves as [men/women]? - Has this changed since the war? How? Why? <u>Conformity to the norms</u> [Prompt when men look or behave like a woman, and the reverse] - What happens when [women/men] do not look like the way they are expected to by the community? What is the reaction? How are they treated? Is it the same in towns or in rural areas? - What happens when [women/men] do not behave in the way they are expected to by the community? - How do community people react to them? How are they treated? - What are their options? What do they do? <u>Discuss sexual orientation here if it comes up, or continue with the LGBTQ+ section.</u> [Address stereotype of sexual violence towards men if needed]	
1.2 What are the local conceptions of ill-health, distress, and their explanatory models?		
Local experiences of distress	<u>Local ways of describing emotional difficulties:</u> What are the different ways in which people are distressed? [Keep vague at the beginning and then prompt] can you tell us all the ways in which people experience suffering? For each experience identified: - How does it look like? - Who is affected? - What happens to them? Where does it hurt them exactly? - How do you explain it? What are the causes? - Did it happen before the war? How different is it since the war? Why?	Groups + Use of brainstorming and post it notes for Free Listing methods. + Use support of a big person [ask someone to draw] on a big piece of paper. Ask people to locate during the explanations.
Culture-specific idioms of distress Since the conflict/crisis	<u>[Continuation of the above, when what you elicited was not clear]</u> How would an outsider recognise a child/a woman/a man/someone who is emotionally upset/ distressed by the war/the violence? - What does the [person] look like? - How do they behave? - Are there different types of being upset? What are they? - How can I tell the difference between [NAME ANSWER FROM ABOVE]?	FGDs with community members, and across the sample KIIs with key healing professionals

Local constructions of "madness"	Open the subject – Keep the terms purposely vague: - How does it work when people's "mind is working differently"? - What happens to them? - What are the causes? - What does it look like? Elicit terms used and use the same expressions to prompt following the template: - How does it work when [xxxxx]? - What happens to them? - What are the causes? - What does it look like? Some people talk about "madness", - What do they mean? - What happens to them? - Are some people in your community facing these issues? - What kind of problems do they have? - In general, what do community members think about them? How do they treat them? Explore the different concepts people used to describe 'madness', what happens to them, and how do people explain the causes.	FGDs with community members, and across the sample KIIs with key healing professionals
Attitudes towards vulnerable group: - Severe mental disorder - Domestic violence - SGBV survivors - IDPs? - Other? [Non conflict-related]	For each vulnerable group targeted: - What about [name vulnerable group], do you have people with such experience in your community? - What kind of challenges do they face? - In general, what do community members think about them? - How do they treat them?	FGDs
[Addition to construction of gender norms] Attitude towards the LGBTQ+ community	Sexual orientation [Statement to be refined so culturally appropriate] Sexual attraction can sometimes be towards both men and women, or men towards men, or women towards men. - In general, what do community members think about people who do not have a mainstream sexual orientation? - How is this perceived in your community? - How do they treat them? Is it the same in towns or in rural areas? - What kind of challenges do they face? - What kind of support can they access?	FGDs If relevant, KIIs with strategic subjects.

1.3 How do communities understand the way in which the conflict (or the violence) shaped local experiences of distress?		
Perception of the conflict (Focus on perceived causes and consequences from a cultural/spiritual angle)	<u>People's experiences of the conflict (perceptions of events and their importance, perceived causes, expected consequences)</u> What do people in your community believe has caused the [CONFLICT/VIOLENCE]? According to community members, what are the further consequences of the [CONFLICT/VIOLENCE]? According to community members, what will be the further consequences of the [NAME OF CRISIS]? How have people been affected culturally or spiritually? How has the [CONFLICT/VIOLENCE] affected daily community life? How has [CONFLICT/VIOLENCE] affected people's livelihood activities/work? How are people trying to rebuild and recover from this crisis?	FGDs KIIs with strategic subjects.
At risks group	Which people in your community are suffering the most from the current crisis. . . Who else? . . . and who else? How?	FGDs Free listing method
<u>Attitudes towards conflict-affected individuals:</u> - Conflict-SGBV survivors - Abducted or tortured - Formerly with armed group - Witnessed extreme violence - IDPs	- Do they face any challenges? If so, which ones? Specifically from a psychosocial angle? - In general, what do community members think about people [category of people]? How do they treat them?	FGDs KIIs

2. People's actions: What are the specific social-psychological determinants of well-being?

2.1.What do/can people do in practice to maintain their well-being and address ill-health?		
Mapping the provision of care	<u>Mapping strategies (step by step):</u> ● Identify key local healing systems and their significance, acceptance and role in the community. [Information may not be immediately volunteered when people fear judgement.] ● Ask local community representatives of both genders where they go for help with difficulties and to whom they turn for support. ● Ask primary health care providers and midwives (including Traditional Birth Attendees [TBAs]) what traditional systems exist.	Mapping technique includes observations, participation, KIIs. Will help plan the rest of the data collection. Note, some points will be further explored in-depth during some interviews.

	• Visit local pharmacies to assess what drugs and remedies are available and how dispensing takes place. Focus on identifying psychotropics (ie; to treat psychosis, depression, anxiety – use local terms and terms used in the primary health care) and drugs taken in the context of drug addiction. • Ask people seeking help at health service points how they understand the nature and origin of their problems, and who else they see or have seen previously for assistance. • Ask local religious leaders whether they provide healing services and who else in the community does so. • Ask any of the above if they will provide an introduction to local healers and set up a meeting. • **Remember that more than one system of informal care may exist, and that practitioners in one system may not acknowledge or discuss others.** • **Be aware that local healers may compete over 'patients' or be in conflict over the appropriate approach. This means that the above processes may need frequent repetition.** <u>If time allows:</u> • Observe. Ask permission to watch a treatment session, and visit local shrines or religious sites used for healing. There may be informal systems of institutional care, including those that hold patients in custody (i.e. This may include people unwell who may be chained). • Visit places of worship that conduct healing sessions, and attend services. • Discuss with the recipients of this care their understanding of the processes involved in illness and healing. [See other questions in this guide] • Determine whether traditional practices include measures that may be harmful or unacceptable. Note: this particular point will be covered during the induction sessions	
Community sources of support and resources	• In normal circumstances (before the war/violence), what did community members usually do to reduce the upset/distress? • What are community members doing right now for each other to reduce the upset/distress? • What else is being done right now to help people who are upset/distressed seek help? • Where do people who are upset/distressed seek help?	FGDs and KIIs

Cultural, spiritual, religious practice	[Based on the first questions: What do you believe are the spiritual causes and effects of the emergency?] ● How have people been affected culturally or spiritually? ● What should properly happen when people have [DIED, SEXUALLY VIOLATED, OTHER]? [add other serious experiences if needed based on initial findings] ● What mechanisms (e.g. rituals, festivals, women's discussion groups) have helped community members in the past to cope with tragedy, violence or loss? ● Are there rituals or cultural practices that could be conducted, and what would be the appropriate timing for them? ● Who can best provide guidance on how to conduct these rituals and handle the burial of bodies/rituals/crisis? ● Who in the community would greatly benefit from specific cleansing or healing rituals and why? ● Are you willing to advise us on how to support people spiritually and how to avoid spiritual harm?	FGDs
Coping methods of specific target groups of youths: - Former combatants - SGBV survivors - Single mothers? - Witness of violence/killing	● What kind of things do [NAME OF TARGET GROUP] do to deal with such problems? ● What things do they do by themselves? What things can they do with their families? What things can they do with their communities? ● Does doing that help with the problem? REPEAT THE QUESTION FOR EACH PSYCHOSOCIAL PROBLEM LISTED BY THE GROUP IN SECTION 1.2	FGDs KIIs with spiritual and religious leaders
2.2 What in practice binds people in the communities where they live (e.g. rituals, informal moments of togetherness)?		
Practices and rituals around: - Death and mourning - Coping with tragedy or violence	Death and mourning ● When someone in this community [DIES] how do the family and friends express their grief? ● What are the first things to be done? Why? ● How do other family/ friends/ community members express support? ● What happens to the body? What other things need to be done? How long does mourning continue? ● What happens if the body cannot be found/ identified? ● What happens if the process you described (for example, burials) cannot be done? Other rituals/practices ● Can you think about other important moments in	FGDs KIIs with local leaders

	the community where people get together for a specific purpose? (e.g. festivals, religious rituals, agricultural-related gathering, women's groups etc.) ● Can you think about any important gatherings where people get together for a specific purpose? ● [Prompt a particular ritual if the researcher is familiar with one that was not named.]	
Rituals and practices around age and gender	<u>Rituals about transition childhood to adulthood, and girlhood/boyhood to womanhood/manhood [if different]</u> ● When a child becomes older [find appropriate expression], what makes them to be recognised as older? What is he expected to do? ● How do families/communities help him in this transition to a grown person? ● Are there any specific rituals that can help with this? ● Is it different for boys and for girls? ● Are things different before and after the war/violence? <u>Rituals about transition from girlhood/boyhood to womanhood/manhood [if different from above]</u> ● Same template than above.	FGDs with local leaders KIIs with spiritual leaders
Moments of connection and togetherness	● What are the important times when individuals/families/communities come together? ● What do/should they do? What is the purpose? ● What (formal and informal) moments help people to feel connected to each other in the community? ● Are there differences between before and after the war/violence? (i.e. things that use to take place) [<u>Links with section 3.1:</u> What would you like to see more of? What would help?]	FGDs
2.3 Who are the actors to engage to consolidate individuals and communities' well-being?		
Culturally-specific beliefs	<u>Mapping exercise [based on a drawing of a big sheet of paper]:</u> Ask participants to draw (or guide you to draw) or add elements from the environment (e.g. stones, pieces of wood) on the piece of paper. Place the big sheet of paper on the floor or table, depending on what is appropriate. Explain this is not meant to be like it is, just a representation. One researcher facilitates the drawing, the other one takes the explanatory notes. ● Ask to locate on the drawing important physical aspects of the community life (e.g. river, road, market, clinic, fields, camp, church/mosque) ● Who are the people who are important in the community? Where are they? What do they do	Mapping of local powers [Note: CR may have tools to elicit this already]

	that makes them important? ● Elicit differences in types of leaders: of youths, elderly, village chiefs, religious leaders, spiritual leaders, etc.	
Human resources in the community	Identifying skilled and trusted helpers in the community: ● Who do you turn to for support at times of crisis? [Particular names or groups of people are likely to be reported repeatedly, indicating potential helpers within the affected population.] ● Who are the people you would trust to help you/your family? ● Who are the people you would trust to help [AT RISK POPULATION IDENTIFIED]? ● If not mentioned as trusted actors, prompt the following actors: What about….[elders, community leaders (including local government leaders), traditional healers, religious leaders/groups, teachers, health and mental health workers, social workers, youth and women's groups, neighbourhood groups, union leaders and business leaders]? Meet and talk with identified potential helpers, including those from marginalised groups, and ask whether they are in a position to help.	Use of mapping to locate and identify resources and actors Follow-up meetings with the potential helpers identified

3. People's recommendations: What are the implications for peacebuilding and MHPSS interventions?

3.1 What social mechanisms could be strengthened to promote individual and collective well-being?		
Ideas for interventions	● What more could be done to help members of the community who are upset/distressed? (Elicit formal and informal support) ● What more could be done to help [NAME OF TARGET GROUPs] who are upset/distressed? Note: List here from general to every specific sub-group identified (e.g. youths, specific conflict-affected populations, at risk group) ● You mentioned in our exchanges [NAME THE IDEAS], do you think this would help? ● Some people we have interviewed mentioned [NAME THE IDEAS], do you think this could work? ● What about [NAME IDEA], could this help? If some practices/rituals/support mechanisms have been identified but are no longer in place: ● Could this be revived to help meet the needs of the community?	FGDs

	● Could this be revived to help meet the needs of certain vulnerable groups?	
3.2 What community perceptions and resources should be considered in the design of MHPSS interventions?		
Culture-specific beliefs and practice involved in programmatic design	● What are the essential concerns, beliefs, and cultural issues that NGOs/we should be aware of when providing support for the [mind, well-being, FIND THE CORRECT LOCAL EXPRESSION] of the community? ● What are the essential concerns, beliefs, and cultural issues that NGOs/we should be aware of when providing support for the [mind/well-being/ FIND THE CORRECT LOCAL EXPRESSION] support for [NAME OF TARGET GROUPs]? <u>Ask questions in general and then probe across age group:</u> ● What actions should be avoided? ● What are the existing challenges in seeking help? ● What are helps or prevents the access to support? ● What should be in place to facilitate [WOMEN, MEN] accessing support? Anything specific about the providers of this support? <u>[PROBE IF NECESSARY] about the following:</u> ● Is there anything in the political situation or political environment [FIND APPROPRIATE PHRASING] that may affect the access to services? (e.g. issues of favouritism, corruption, instability) ● What has been the experience of the community with aid agencies? (i.e.; elicit former difficulties or bad experiences) ● What successful experiences of organisations have been seen in their and neighbouring communities. ● In general, are people accepting services organised by people from outside the community? ● Is there anything else that aid providers should know?	FGDs
Reviving healing practices (when appropriate)	<u>Steps for facilitating conditions for appropriate healing practices</u> ● Check if the healing practices identified are compatible with international human rights standards. If they are: ● Work with selected leaders to identify how to enable appropriate practices. ● Identify obstacles (e.g. lack of resources) to the conduct of these practices and what obstacles could be removed (e.g. provide space for rituals	Discussions within the team and together with project manager based on international guidelines Discussions with selected leaders

	and resources such as food for funeral guests and materials for burials). ● Formulate recommendations for existing mixed practices (e.g. local and Westernised), where appropriate.	

Annex D: Table on the trauma-informed approach developed for the CR research project in CAR

The main author (Medeiros, E - CR MHPSS consultant) used her clinical experience formalising the trauma-informed approach in different contexts such as in the UK, Iraq, Kosovo, and Nepal since there are currently no international guidelines in this area in the settings of (post)conflict or humanitarian emergencies.

Domains	**Standards**	**Implementation (How? Who?)**
Training	✓ *All researchers and research assistants have received a basic training on the understanding of trauma and its impact.*	The research team received a one-day training in psychological first aid by a local consultant psychologist in Kaga-Bandoro. This training included basic understanding of trauma and its impact and provided guidance to researchers on how to receive traumatic disclosures from research participants.
	✓ *All frontline staffs (researchers doing the data collection and delivering the programme) have received an advanced training in psychological first aid.*	Given the scope of the research, it was not possible to deliver an advanced training in psychological first aid beyond the one-day training mentioned above.
Engagement with trauma-affected individuals	✓ *A 'do no harm' approach is defined and implemented.*	● As much as possible, we did not directly target the psychologically vulnerable interviewees (trauma-survivors, SGBV survivors, individuals with mental illness). Instead, we focused on individuals in the community who had an understanding of the issues. ● We ensured the newly trained team would not promote or encourage SGBV survivors to narrate to them their own stories. However, a space was provided to them when they expressed their wish to tell their stories. ● The best interest of the vulnerable individuals was always prioritised over the objectives of the research and the desire to collect data on the subject first hand.
	✓ *A survivor-centric approach is defined and adopted in the research and programme.*	

		• We limited the interaction with vulnerable populations in instances where we felt that the researchers could not manage such interviews.
	✓ *A safeguarding policy and SOPs are formalised and familiar across staffs.*	CR has an internal Safeguarding policy (to be found here). All CR staff have been trained on our safeguarding policy. The research team were briefed on the safeguarding policy as part of the initial training.
	✓ *A provision for basic risk management is available through key trained staffs.*	As part of the training, researchers were briefed on safeguarding and security risks as well as strategies to mitigate these risks.
	✓ *Policies are available that specify all the standards mentioned above.*	Conciliation Resources has a code of conduct, which all staff need to sign (available here). CR also has a safeguarding policy (called Keeping People Safe policy), which outlines the organisation's survivor-centred approach to keeping people safe.
Referral pathways	✓ *Services are mapped and vetted in all sectors (Medical, Legal, Psychological, Protection)*	CR used a referral pathways document developed by DCA which mapped out and vetted the available services in Kaga-Bandoro and Sibut.
	✓ *Partnerships and MOUs are set up. [This includes covering the costs or not of transportation and possible medication]*	The partnerships and MoUs are set up by DCA directly. The MoUs will make reference to the project so that all activities related to the project, including this research, fall within the partnerships. CR has a duty of care to the participants of the research as well as all the researchers involved. If during the research we find that someone is feeling unwell as a result of the research, then we will discuss with our Safeguarding team and decide on a case-by-case basis on how we can best support the individual (including paying for transport, accommodation and/or medication if necessary). In case of individuals generally feeling unwell (but not as a direct result of our work), we will support them by sign-posting

		them to the right services available in Kaga-Bandoro and Sibut.
Self-care/ Resilience	✓ *A clear human resources policy is set up, including a provision for self-care.*	Conciliation Resources' HR policy is made up of a number of different policies including Bullying and Harassment policy, Disciplinary and dismissal policy, Equality and Diversity Policy, Grievance Policy, Health and Safety Policy, Well-being note, Leave policy, TOIL policy etc. There are also relevant policies such as the Safeguarding policy (Keeping People Safe Policy) etc. CR staff receive training on policies. These policies apply to UK and CAR staff equally. There is no CAR specific policy as the CAR office is a small satellite office which relies on the London office for decision making. As part of our due diligence we review our partner's policies. Where possible, we support them to strengthen their policies. However, it is outside of the scope of the research to influence the HR policy of partners.
	✓ Opportunities are available to learn about self-care practices.	Over the past two years, Conciliation Resources has offered Trauma and Resiliency training to staff. The training was about non-clinical skills to support mental health and well-being. The training focussed on building greater awareness of the trauma that might be experienced by us, colleagues at CR and partner organisations, and participants, receiving traumatic disclosures without further/re traumatising the person who made the disclosure; practicing self-care and resilience. The training was attended by CR's East and Central Africa Project Manager in 2020. When it became clear that the Project Manager would not be able to travel to Kaga-Bandoro in person, the training manual was shared with the colleagues travelling for the research.
	✓ Frontline staffs have access to clinical supervision and reflective spaces.	CR worked with a local psychosocial expert to provide a one-day training to the research team. In addition DCA's psycho-social agents accompanied the research and were

		available in case staff/researchers needed one-to-one support. At the end of each day, CR facilitated reflective spaces to check in with the research team and understand how everyone is feeling.
	✓ Presence of secondary trauma among staffs is regularly monitored by senior management team.	See above.
	✓ External specialist support is made available to all.	See above. CR staff have access to a range of specialised counsellors/psychotherapist. Staff know the contact details of these specialists and can get in touch with them directly. This does not require prior authorisation.

Annex E : Age and gender characteristics of the sample

Table 5: Sample distribution of the participants according to age, gender and location

Research participants					
		Male	**Female**	**Non-specified**	**TOTAL**
Sibut	**Young (< 35 years)**	55	36		**91**
	Adults (< 35 years)	15	13		**28**
Kaga-Bandoro	**Young (<35 years)**	76	44	1	**121**
	Adults (< 35 years)	18	6	0	**24**
TOTAL		**164**	**99**	**1**	**264**
		62%	38%	0%	

Annex F: Glossary of terms related to well-being and distress

Table 6: Terminologies related to well-being and distress with transliterations and definitions

Terminology	**Transliteration and translation in French and in English**	**Definition (in English)**
Terms related to well-being		
ndjoni doutingo ti zo na ya ti li ti lo, na tèrè ti lo nga na popo ti a zo [Sangô]	Le bien être d'une personne dans sa tête, dans son corps et parmis les autres/Well-being in their mind, body, and socially	Someone's overall well-being
Doutingo ndjoni, Seni ti li [Sangô]	Rester bien; santé de la tête/ Well-being state	State of well-being in which a person can realise his or her potential
Terms related to madness		
Kobela ti li [Sangô] *Pkale ti li* [Sangô] *Zo so ayeke na Kobela ti li* [Sangô] *Seni ti li ti lo ayeke ndjoni pépé* [Sangô] l*o yeke na kpalé ti li* *li ti lo a yeke tourné* [Sangô]	Maladie de la tete/ Illness of the head Problème ou trouble de la tête/mental problem Celui qui a une maladie de la tête/someone who has a mental illness La santé de sa tête n'est pas du tout bonne/The health of his head is not at all good Il a un probleme de la tete/He has a mental trouble Sa tete tourne/ His head is spinning	The different expressions describe someone who is not mentally stable or behaving in a manner that is not considered normal.
Ligboma [Sangô] *Zo ti gbogbolinda* [Sangô] *Zo ti fou* [Sangô]	*As li* (head) [Sangô] Quelqu'un qui a la folie/ Somebody who has madness (caused by a virus) Quelqu'un de folie/somebody with madness	*Ligboma* is madness likely caused by a virus that causes disorder in somebody mind. *gbogbolinda* is considered as madness but also as a virus being responsible for this madness. Above all *ligboma* and gbogbolinda are used interchangeably to describe madness both caused by a virus.

Gbogbo-linda [sangô] *Ngoagoâ* [Banda] *So téné* [Litos] *Guinaro* [Foulbe] *Bo Bizazi* [Mandja] *Piuwiri* [Ngbaka-mandja] *Ma-houka* [Aoussa] *Nguirango* [Yakona] *Guinado* [Pheul] *Moushodi* [Arabic]	Le virus qui pénètre la tête/The virus that breaks in the head the madness caused by meeting a person with bad spirit (ghost)	Virus that causes madness by creating disorder in somebody's mind. It is also considered madness itself.
Mo do ko zou wa [mandja] *ye a sara li ti lo* [Sangô]	Quelque chose est entrée dans sa tête/ Something entered his head (madness)	Attributed to someone who displays irrational behaviours and has lost reason. These individuals are considered as having been bewitched.
Bo biari [Mandja]	Petite folie /Soft madness	State of mild madness or someone who has experienced personality disorders without severe madness.
Iyango [Sangô]	Mad or stupid	Attributed to someone who behaves in a silly way and therefore not considered as normal
Wi Bô [Mandja]	Une personne folle/ A mad person	Talk of a person who is mentally insane, ill.
Category of spirits		
Yingo [Sangô] *Himè* [Mandja] *yinzè* [Banda] *youki* [Foulbe]	Esprit/ spirit	*yingo* [Sangô] (spirit) refers to a person who has died and therefore is immaterial in opposition to their human body
Torö [sangô] *Bözon* [Mandja] *Ngadro* [Banda] *Guinon* [Foulbe]	Fantôme, mauvais esprit/ Ghost, bad spirit	It is considered to be the apparition of a dead person which is believed to appear or become manifest to the living.
Emotional experiences		

voundou [sangô]	depression/Low mood-depression	A weakening of the personality with the loss of willpower and self-esteem. It is different from anxiety.
kota mbito [sangô]	Grande peur/great fear	An emotional state of nervous tension or strong fear that is often chronic and contrary to stress. A sudden reaction of a person to danger.
nzöroko ti a ye so a yeke si na ya ti tere ti zo na peko ti ye ti ngangou [sangô]	Signe de tout ce qui arrive dans le corps de quelqu'un après un dur événement/ Sign of everything that happens in the body of someone after a difficult event	Physical or psychological injury inflicted on the body. Emotional response to a terrible event like an accident, rape or natural disaster
gui ngo be [sangô]	Questionnement de son coeur/Wondering of the heart (stress)	A response or reaction of the organism to excitement of any kind, physical or psychological
Aoua [Banda] *Ma Sourati* [Aoussa] *Kouldah* [Pheul]	Peur/Fear	Emotional reaction when facing danger.

Annex G: List of key rituals related to distress and ill-health identified during the research

Table 7: Key rituals identified

Name, translations, language/ethnicity		**Who does it involve?**	**Explanation**
Washing or/and cleansing ritual – bad spirits			
Sô-wi (cleansing ritual) [Mandja] *Gbayou* [mandja] *Zo Ya Zo E* (washing him only)[Mandja]		For a person who has experienced or witnessed a crime or difficult situation. When people are deceased (for a burial) After sexual violence When people leave prison. The ritual can only be performed by: a) those who have lived through the same experience, b) the elders who know tradition well, c) healers.	Washing and purification ritual when people are seen as not having been freed from the bad spirit or ghost they have interacted with, such as the spirit from the deceased, from prison or from the perpetrator. For the widow, the ritual aims at ensuring that nothing bad will happen to them and to enable the widow/widower to get married again in the future. To generally reduce the risk to the widow/widower.
Gingo (cleansing ritual) [Banda]		A person who experienced or witnessed a crime, a widowed partner	Management: A man takes multiple canisters of honey that have been collected in a "gingo". (The gingo is a part of a tree with holes that is placed in the tree to attract honey bees)
Singbo [banda]		Someone who is experiencing difficult situations (crime, becoming a widow) The Aoussa ritual is performed by a traditional priest called "Boko"	Washing ritual in which the person is washed and given medicine to drink which is made out of the leaves and roots of a tree called *Ngbanguiri*. During this ritual, the person takes off all their clothes and never wears these clothes again. In the Aoussa ethnic group, the person is locked into a house and traditional leaves are burnt until the person passes out. When the person wakes up again, specific words are said. When the person wakes up, they are healed.

Songha (purification ritual) [Mandja]		Purification ritual for men or women who are guilty to have stolen from someone's field or farm.	That is why it is said: *a bouba kobe ni na yoro* (the food is being spoiled by the owner) [sango] The person concerned is purified early in the morning to be sure of the acceptance of the spirits. The person is being purified by taking the product.
sonwi fro bono (cleansing ritual) [Mandja] *ngbongo to bozon* (cleansing ritual) [Mandja]		Cleansing rituals for men	Traditional ritual to cleanse men and protect them against the dead (bad) spirits
Rituals engaging with ancestors' spirits			
Sandaka [sango] calling the spirits of the ancestors		The community and traditional priests The sacred hill of KG kept by a traditional priest	Every year on the 31 December, community members visit the hill of Kaga-Bandoro and its priests. They bring eggs, a chicken, and money (particularly silver coins). This visit to the hill and greeting of the ancestors is supposed to help community members to resolve their problems and find redemption in the face of difficulties. This process can be beneficial or spiritually detrimental (maléfiques) for the community. It has become *zo ti yoro* as in an evil act or act of magic.
Yassine (healing ritual) [banda]		For men and women	This healing ritual is used in case of mental troubles, which are occurring as a result of non-respect of the totemic alliances with the ancestors.
Clairvoyant rituals			
Kwa ti Nzapa (Godly death or natural death) [sango]		Ritual for all across gender and age	Following the death of a loved one, this traditional practice allows individuals to know who is responsible for the death. The elders will say words in the name of the dead through the wood. If the wood moves, it means the person has been killed by someone else and that this person will be held responsible. However, if the wood does not move, then the person died from a natural death. *Kwa ti nzapa*

Meadi [mandja] (to throw stones)		for men and women	Clairvoyance is thrown with the help of stones.
Gonda [sango] *Cigue* (hemlock charm)		Ritual for someone (men or women) who is accused of having killed someone using magic in order to find out whether they are guilty.	This is a potion made of leaves or peel. It is crushed in a cup and the person accused must drink the mixture. According to the ritual, if the person has indeed killed someone, they will die immediately. If they have been wrongly accused, nothing will happen to them.
Mourning Rituals			
Koya (purification ritual) [banda]		Mourning ritual involving purification for men, women and children [ethnicity: Banda and Mandja]	When somebody dies, everyone's contribution is needed. Some people will bring food items, cash, etc. After the burial within six to seven hours, the man or the woman is supposed to stay without taking their bath for three days if the person who died was a man and four days, if it was a woman. The purification is done in the morning and is intended to protect the family from evil spirits or ghosts.
Armara(mourning process) [Arabe]		Mourning practice in the Muslim tradition.	In the Muslim community, if someone dies, then the first thing is to wash the person's body and then to burial the person. Friends of the family show their support by bringing money or goods or just by providing moral support. The grieving period usually lasts for ten days: The first phase lasts three days, the second phase lasts seven days. In the first three days, the widow cannot talk to men. She stays inside her house and does not greet anybody. After three days, she can leave the house but needs to continue to respect the grieving principles.
Nguete mon han (ritual for the widow) [Mandja]		The widow and the children	A widow ritual is performed early in the morning after the death of her partner (three days after the death as it is a man). The widow is led to the river and washed with a

			mixture of leaves and water. Her clothes are taken off and her hair is cut.
Wene ba bozo han si do ma (bringing the dead body home) [Mandja]		For men, women, elders and performed by the *nganga*	If somebody dies in a foreign place (other than his home), the person's corpse needs to be brought home. In the process of returning the corpse, the dead person's name is being called repeatedly. This is supposed to allow the spirit to follow the voices. The dead person can therefore live with their parents and families in spirit.
A bouba kwa ni(the body is spoilt) [sango]		For family members of a deceased person	If the death of a person is surrounded by a mystery, then the parents of the victim cut the fingernails, the hair and the pubic hair before burying the corpse. The family members will 'poison' the victim so that those who are responsible for the death will also die. This practice is only used if death is considered to have happened under unnatural or mysterious circumstances.
Koua ti ngoa ngoa (sudden death) [banda]		Family members of a deceased person whose body cannot be found	Family members bring squash, sesame or roots (traditional medicine) and go to the forest to look for the ghost of the person who has died. The aim is to bring the ghost back home. Once they have brought the ghost home, the door of the house is closed for 24 hours. If someone attempts to enter the house during these 24 hours, they will see the ghost and will die. The woman of the deceased is called *wali ti Koya*.

Annex H: Gender markers, social expectations, and attitude towards non-conformity

Table 8: Description of initiation rites for each gender

The initiation rites are performed similarly across ethnicities, with different pathways for boys and girls, and each cultural group has their own terminology[1].

Gender	Description
Across gender	● The ritual aims to prepare young people for an active life. It is mandatory and conducted in secret in the forest for around three months in the presence of their mentors or guardians, and without contact with their families. ● The initiation ritual used to take place in the forest to learn how to be a man or a woman. Everything in the process is kept secret. Even in the case of death, family members were not informed until the group of young people came out of the forest again. This was to prepare young people to face the difficulties in their life and to be capable of feeding their family. ● Participants learn: autonomy (i.e. survival skills), gender identity (i.e. construction of masculinity/femininity - expected behaviours and skills), group affiliation (meaning and history of their clan/community), group belonging (e.g. Look after each in times of hardship or war). ● *Ganza ti kodro*[sango] (the village circumcision) is performed by the *wagzon* (traditional doctor). One can only return home once their wound has healed. If a child dies in the process, the family will only learn about this when the ritual is over and everyone has come back.[2]
Access to manhood	● Ritual - *Soumele* [mandja] traditional rite follows immediately the circumcision ritual: shows how to live life as a man focusing on knowledge, skills, and personal behaviour. ● Learned skills: hunting, fishing, agriculture, farming, self-defence.
Access to womanhood	● Aim of the process to learn expected behaviours and attitude (see Table 9) ● Learned skills: how to be responsible partners and mothers, and manage their families. ● Ritual – female genital mutilation: although FGM is illegal, many still practice it. The girls' education is therefore now completed in confidence (i.e. in private)

[1] *Baba*[Sango]; *Baba gazani* (transiting initiation for boys) and *Baba gazako* (transiting initiation for girls) [Mandja]; *Baba yache* (transiting initiation for girls) and *baba koché* (transiting initiation for boys) [Banda].

[2] The tradition is to put a white rooster in front of the house of the family who lost a child. If someone dies during the initiation, they consult the *nganga* [sango].

Table 9: Gendered markers and expectations, and nonconformity

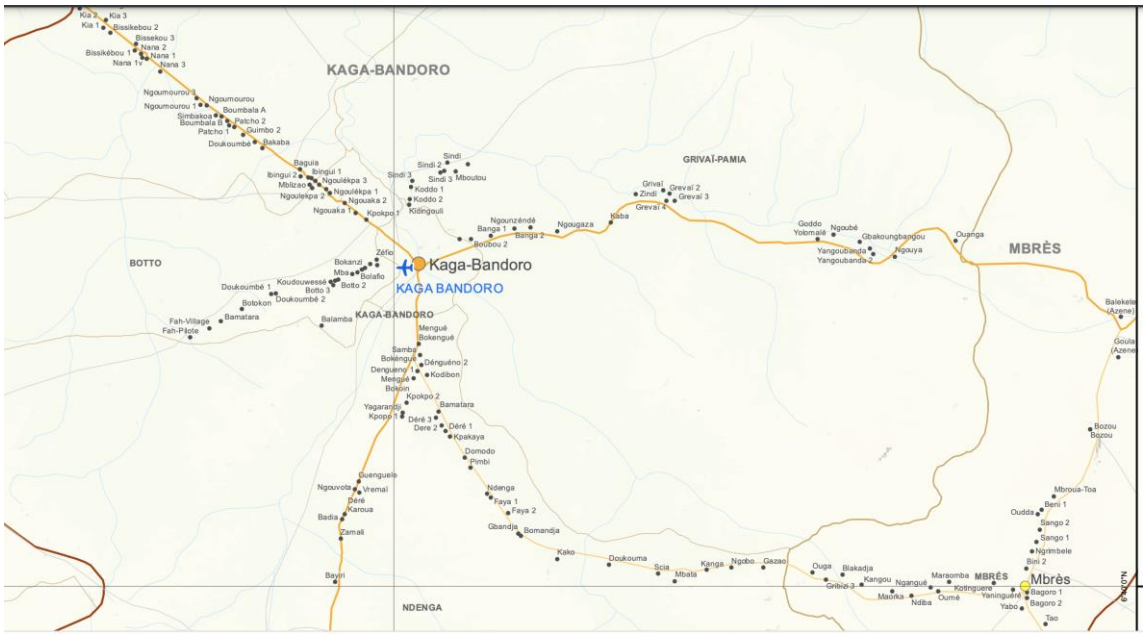
Gender	Markers and expected qualities	Non-conforming to expectations
Values across gender	✓ Build a house and a home ✓ Have accessed education ✓ Look after your parents ✓ Respecting authority figures (parents, elders, chiefs) ✓ Have the same emotions in the head and the body, but the reactions to stress and the conflict are gendered ✓ Not take drugs ✓ Having been circumcised, which includes the initiation process	✓ If they do not conform, they are ostracised by the village not to "infect" others. They can return with time, mediation, and support from the elders.
Man	✓ Physical strength, protector of family and community (in the village). Thus, carrying a weapon (e.g. a knife). ✓ Mental strength, resourceful [*debrouillard*], be smart and show that they are in charge and can take control. ✓ Display bravery (e.g. being able to join a fight if needed, being able to kill a snake[3]) ✓ Certain men who are equipped with supernatural forces like *gri-gris* (fetishes) consider the men who do not have them as not men due to their lack of strength. Since the crisis: ✓ Be able to build a home, love his wife and his children. ✓ Be loyal and respect others and authorities ✓ Ensuring economic survival, possessing skills for the family survival ✓ Can be vulnerable to the spirits of the dead. ✓ Be respectable in not creating difficulties for the society. Contributing to the advancement of their community. ✓ Not plating their hair. ✓ Not participating to violence in the face of threat is considered weak, as a 'women'[derogatory].	✓ Men are considered *Yogbo* [Weak], if they behave like a woman. ✓ Considered a *Lukundu* (wizard)[sango] with *grigri*(voodoo amulet) made of roots, herb and even the bones of some animals different from totem that protects you, if you do not marry, you are 'lazy', you do not work to contribute to the community. ✓ *boubouru*(Sango) (fool): a man who has lost his direction and who is unproductive [in this tradition, boys and men play key roles in their communities and so any behaviour contrary to the communities expectations cannot be accepted.]. "He is seen as being like a woman, who expects everything from others." ✓ If a man behaves like a woman or wears a dress, he is treated as if he is "*n'importe quoi*"(silly, loss of direction) He is seen as a weak man, weakened by his woman. ✓ Some notion of equality between man and woman so "it is ok if it is done positively". ✓ If a man plaits his hair, it means that he became a woman.
Woman	✓ High virtue and moral grounds, be respectful to others. ✓ Build a home, have children that she looks	✓ If a woman behaves like a man, she is qualified as *Koli ouali (*Man woman: a man who behaves likes a woman) [Sango]

[3] If you can't kill a snake, you are considered to be worse than a woman. You will be considered to be *ayawa* [banda], *mossourati* [Housa], *haouf* [Arabic], *kouldho* [Pheul, M'bororo]. The only exception to killing snakes is if you have twins, as the belief is that one of your child will then die.

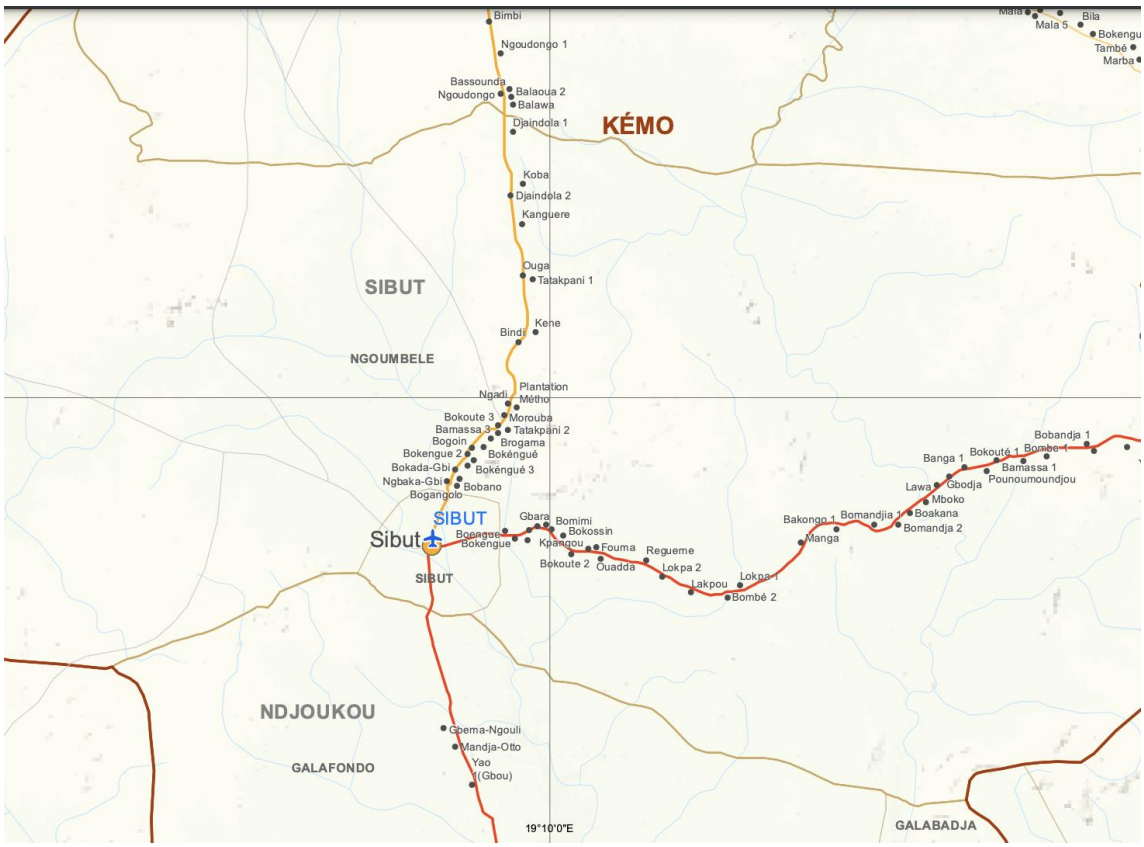
	after, and be respected by her husband. ✓ Maintaining harmony with husband and own parents (submission). Be a good sexual partner and loyal. ✓ Up-keeping of the household (cleanness, cooking) ✓ Potential suitors (in marriage) must find her at home (or meet through the church /mosque). Girls met in other places (e.g. clubs, markets) are not good enough ✓ Engaged in economic activities ✓ Bring a dowry ✓ Less valued at birth because she will not be staying within the family. ✓ Plating their hair	✓ *Wali a Fa ngbo* [sango] ('woman who kills snake' said about a woman of character, in the sense of she is lazy performing a useless task), the community has little esteem for them and separate them from other women in case she would "infect" others and other women may copy them. They are not rejected/asked to leave, but the wise/elders [*les sages*] or religious leaders try to advise/counsel them. ✓ In certain instances, if a woman pursues education or has a job (i.e. being financially independent), then society encourages her and congratulates/praises her.

Annex I: Maps of Kaga-Bandoro and Sibut

Map 1: Geographical location of Kaga-Bandoro region within CAR



Map 2: Geographical location of Sibut region within CAR



Annex J: Additional details of research methodology

Literature review

A literature review was conducted in April 2022 in French and English[1]. Key findings of the literature review were used to inform the design of the methods and the research questions guide (See Annex D).

Feasibility of the study

In April 2022, an exploratory visit was undertaken in Kaga-Bandoro with the aim of gathering initial data on the subject, testing the methodology, and identifying possible challenges in the implementation of the study. The team deployed KIIs and FGDs with 12 community members to explore the local understanding of MHPSS. The findings were used to further refine the research questions guide. The research guide and the methods deployed for data collection were further fine-tuned during the induction of the research teams (Annex D).

The approach was continuously reviewed during fieldwork using the feedback from the researchers as well as the debriefings and reviews from the technical team (in the field and remotely).

A gender-informed approach

A gender approach was also incorporated to the research design through the following measures:

- Gender representation was considered in the composition of the team of researchers and of supervisors.
- Gender was balanced in the selection of the participants and in the disaggregation of the specific issues experienced by each gender (but not with non-binary) and by various age groups in the data collected and analysed.
- Specific questions related to gender identity, sexual orientation, LGBTQI+ issues, and sexual violence (particularly towards males) were built-in the research questions guide, if the researchers felt they could explore these themes safely.[2]

[1] A Google search was performed using the following terms: MHPSS, Central African Republic, Trauma, Mental Health.

[2] The subject was at times new and uncomfortable for the researchers as much as for the communities researched. Considering the socio-cultural dynamics and misconceptions about MHPSS and the fact that this research was Conciliation Resources' first interaction with the communities of this region, the supervision team decided that the subject had to be dealt with sensitively and would be explored in subsequent research trips.

Research team

The research team was composed of 20 members in the field[3] and remotely[4]. The researchers collecting the data in the field were selected on the basis of their understanding of the local context and of their experience in participatory methodologies. Their level of education varied greatly (from High school level to university degrees) as well as the extent of their research experience (from none to some with other NGOs)[5].

The researchers' skills were strengthened through induction training, and on-the-job supervision and feedback mentoring sessions. All researchers participated in a seven day-long training in May 2022 on the methodology of the study. The first four days included a blend of research skills, concepts of MHPSS, and familiarising themselves with the research questions guide and the various tools designed for the data collection. The team also received a day-long training on Psychological First Aid by a local consultant psychologist in Kaga-Bandoro.[6] The researchers' skills were further strengthened by CR supervisors: when gaps emerged regarding the data collection during their mentoring feedback sessions, and during the guided fieldwork (i.e. researchers met with participants and were given feedback collectively) of the last two days of training.

[3] Researchers (15): 13 researchers affiliated to two local NGOs - Fondation Vegas in Sibut and Vision Enfant République Centrafrique in Kaga-Bandoro) and 2 independent researchers employed by Conciliation Resources. A supervision team (2): Conciliation Resources' East and Central Africa Programme Director and CAR Project Manager. A psychosocial support team (1): a psychosocial agent from DCA, present and available at all times during the training and the fieldwork in Kaga-Bandoro to provide counselling and support to researchers and/or interviewees.

[4] A technical mentoring team (2): the MHPSS consultant and Conciliation Resources' East and Central Africa Project Manager supported the research teams, in a remote manner due security constraints.

[5] One of the researchers had already received research training in participatory and listening methodologies and participated in three previous CR-led research processes related to listening of individuals associated with armed groups. Both local research assistants were part of a Local Peace Cell supported by CR as part of previous projects.

[6] The content encompassed basic concepts in mental health and clinical presentations, existing referral pathways as well as skills in the psychological management of the participants.