A review of the Mental Health and Psychosocial Support in Response to the Mental health needs of Internally Displaced Persons in North East Nigeria

McKing I. Amedari

Nigeria

56th Master of Public Health/International Course in Health Development.

KIT (Royal Tropical Institute)

Vrije Universiteit Amsterdam (VU)

A review of the Mental Health and Psychosocial Support in Response to the Mental health needs of Internally Displaced Persons in North East Nigeria

A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health

By

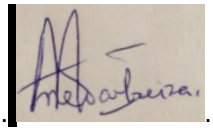
McKing I. Amedari

Nigeria

Declaration:

Where other people's work has been used (from either a printed source, internet or any other source), this has been carefully acknowledged and referenced in accordance with departmental requirements.

The thesis [A review of the Mental Health and Psychosocial Support in Response to the Mental health needs of Internally Displaced Persons in North East Nigeria] is my own work.

Signature……  …….

56th Master of Public Health/International Course in Health Development (MPH/ICHD)

16 September 2019- 4 September 2020

KIT (Royal Tropical Institute)/Vrije Universiteit Amsterdam

Amsterdam, The Netherlands

September 2020

Organised by:

KIT (Royal Tropical Institute)

Amsterdam, The Netherlands

In co-operation with:

Vrije Universiteit Amsterdam (VU)

Amsterdam, The Netherlands.

Table of Contents

Contents

List of Tables and Figures

Tables

Figures

Acknowledgements

I express my gratitude to the government of Netherlands for the scholarship given to me to complete the MPH/ICHD Course.

I am grateful to my thesis supervisor and academic advisor for the guidance and tutelage during the entire writing process.

I also extend my sincere gratitude to my dear family: my darling wife, Ifeoma, our beloved sons, David and Jason for their steadfastness with me during this year.

Above all, I owe all gratitude to my Lord and Saviour Jesus Christ who has been my anchor and my strength throughout this journey.

List of Abbreviations

ABBREVIATION	FULL DESCRIPTION
ACTED	Agency for Technical Cooperation and Development
BAY STATES	Borno, Adamawa, Yobe States
CBO	Community Based Organisations
CBT	Cognitive Behavioural Therapy
CCEPI	Centre for Caring, Empowerment and Peace Initiatives
CHAD	Centre for Community and Health Development
FMOH	Federal Ministry of Health
FMHDS	Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development
GBV	Gender Based Violence
GPON	Goal Prime Organisation Nigeria
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Persons
INGO	International Non-Governmental Organisation
IOM	International Organisation for Migration
IPI	International Peace Institute
IRC	International Rescue Committee
LMIC	Low- and Middle- Income Countries
MDM	Medecins du Monde
MhGAP	Mental Health Gap Action Program
MhGAP IG	Mental Health Gap Action Program Intervention Guide
MHPSS	Mental Health and Psychosocial Support
MHPSS-SWG	Mental Health and Psychosocial Support Sub Working Group
NET	Narrative Exposure Therapy
NFI	Non Food Items
NPHCDA	National Primary Health Care Development Agency
NGO	Non-Governmental Organisation
OCHA	United Nations Office for the Coordination of Humanitarian Affairs
PHC	Primary Health Care
PTSD	Post-Traumatic Stress Disorder
Q	Quarter
TWB	Translators Without Borders
UNICEF	United Nations Children's Fund
UNFPA	United Nations Children's Fund
UNHCR	United Nations High Commission for Refugees
WHO	World Health Organisation

Glossary

Cognitive Behavioural Therapy (CBT): A treatment for Post-Traumatic Stress Disorder (PTSD) that is focused on how to improve thoughts, feelings and behaviors in different domains.

Formal camp: is a planned settlement which is run by the government, civil society, Non-Governmental Organisation (NGO) or the United Nations (UN). It usually contains infrastructure, facilities and a purposefully built layout.

Informal Camp: This is an unplanned settlement with spontaneous collection of multiple houses in a location. Rental agreements may be made with a landowner, host population or local government. Basic services on-site are not planned in advance.

Internally Displaced Persons (IDPs): 'persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized border' (1: p.1)

Host community: The host community surrounds a camp. The displaced persons in the camp interact with the host community and are impacted by the displaced persons residing in the camp.

MHPSS: This is a composite term that represents internal or external support focused on the protection, promotion of psychosocial wellbeing and or the treatment of mental health disorder. (2)

MHGAP IG: This is an intervention guide prepared by the WHO and used in settings without a specialist for the management of mental, neurological and substance use disorders as priority conditions, following an algorithm in an integrated manner. Doctors, nurses and other health workers are trained to use the guide which aids decision making in the clinic. (3)

Narrative Exposure Therapy(NET): A therapy useful in treating persons who suffer disorders attributable to trauma. It can be offered to individuals or groups in community settings.

Abstract

Background and Problem Statement

At present, more than 2 million persons are displaced in North East Nigeria. The majority of these reside in informal camps and host communities where the provision of basic amenities were not initially planned. According to the World Health Organisation (WHO), one in five displaced persons are affected by mental health disorders. Their right to their mental health and needs are challenged because they live under difficult circumstances. This in turn causes social isolation, stigmatization and economic losses among those affected.

Study Aim

This study aimed to analyse the mental and psychosocial support response to the mental health needs of displaced persons in North East Nigeria. By examining evidence-based guidance and highlighting success stories of Mental Health and Psychosocial Support (MHPSS) in other settings, gaps in the current interventions will be identified and recommendations provided to policy makers and providers of MHPSS in the region.

Methodology

A desktop review has been conducted. The Inter agency standing committee intervention pyramid was utilized to analyse the MHPSS response to the mental health and psychosocial needs.

Results and Conclusion

Given the MHPSS Sub working group's coordination of activities in the region, there has been a considerable degree of response to the mental health needs of IDPs in the North East. However, the lack of basic needs such as food still creates psychosocial challenges. Additionally, adequate of coverage of MHPSS to the majority of IDPs residing in informal camps and host communities is not documented. To help translate success stories of MHPSS interventions to the context of the North East, a strong focus on solid leadership, holistic interventions across the pyramid and high quality training is needed to meet the mental health needs of displaced persons irrespective of their settlement.

Key words

IDPs, Mental health, Psychosocial, North East.

Word count: 12,927

Introduction

Mental health disorders and psychosocial needs are not visible like the other injuries commonly seen in the aftermath of a conflict. Also, mental health disorders may be associated with severe co-morbidities but are not associated with significantly high mortalities seen in some other diseases. As a result of this, little attention has been paid to the mental and psychosocial wellbeing in this population in the past. As a dentist, I conducted my dissertation during my postgraduate residency training in Nigeria, demonstrating the significant oral health and dental treatment needs of out-patients with mental health disorders. This drew my attention to the high burden of mental health disorders globally and nationally among Nigerians.

After a discussion with my mentor (Prof. Eyitope Ogunbodede), concerning potential research areas before traveling to Amsterdam, I was motivated to conduct my research to draw attention to a vulnerable population in Nigeria, namely the Internally Displaced Persons. Furthermore, as a student at KIT, where I was exposed to a mantra of inclusiveness, equity and fairness for all, the desire to work on this topic was reinforced, and I decided to pursue this research.

The Nigerian North East has experienced the torment of the Boko haram insurgency for over a decade, resulting in more than 30,000 lives lost and millions of people displaced across different parts of Nigeria due to the violence. The crisis has impacted individuals, families and communities, creating a humanitarian emergency in the region. The aim of this study was to analyze the mental health and psychosocial response to the mental health needs of internally displaced persons in North East Nigeria. The Inter agency standing Committee intervention pyramid was used to analyse the mental and psychosocial support services currently provided in the region. This is in the context of an aggregation of several agencies, international organisations and partners delivering aid in this humanitarian setting.

Due to the reliance on data from the available reports of agencies and organisations, a gap analysis of the level of response to the needs was challenging. Nevertheless, it was possible to identify notable gaps, and information from success stories and evidence based intervention is provided. I have also presented an acronym to help guide MHPSS interventions in the Nigerian context, known as project ***NORTH EAST*** recommended for MHPSS response to the mental health and psychosocial needs of displaced persons.

CHAPTER 1: Background Information On Nigeria and North-East Nigeria

1.1 Geography

Nigeria is a West African country located between Cameroon and Benin on its western and eastern boundaries respectively. It is bordered by the Gulf of Guinea on its south and Niger and the Chad Republic in the North. It occupies a landmass of about 910,768 km^2 (5,6). The North East is one of six geo-political zones in the country, the others are the North West, the North Central, the South East, the South West and the South-South. The North East is the biggest zone in the country with six states: Borno, Adamawa, Bauchi, Yobe, Taraba and Gombe. The region is located between the arid Sahara Desert and the southern tropical forest (spanning about 166,790 km^2) and it is known for its unique geographical features of mountain tops and plain fields (7).

Figure 1.1 Nigerian map and geo-political regions (4. p.38).

1.2 Demography

Based on estimates from the 2006 Census, the National Population Commission forecasted the population of North East Nigeria to be 26,263,866 in 2016, meaning that it makes up 13.5% of the Nigerian population (7,8). (Note that population movements due to the conflict may have influenced the validity of this measurement). The major ethnic groups in the region

are the Fulani, kanuri and hausa, but there are up to 100 minor ethnic groups in the north east alone (9). According to the Nigerian Demographic Health Survey (DHS) 2018 report, more than half of the Nigerian population is below 17 years of age (refer to fig 1.1.2). There is a slight male majority observed in the region's population with a male: female ratio of 1.04:1. The fertility rate in the North East (6.1) is much higher than the national value of 5.3, and second only to the North West (6.6) in the country. While 36% of females and 27% of males in the whole country have no education, the figures are much higher in the North East with 59.1% and 46.2% respectively having no education. The under-five mortality stands at 134 per 1000 which is the second-highest in the country compared with 62 per 1000 in the South West (7,10).

1.3 Economy

Nigeria is Africa's largest oil exporter and also has the continent's biggest oil reserve. This makes the country heavily reliant on oil prices when it comes to its growth performance. Between 2000 and 2014, the country's Gross Domestic Product (GDP) increased by 7% yearly. But between 2014-2016, the rate dropped to 2.5% and the economy shrank by 1.6% in 2016. There was however a marginal increase of about 1.9% and 2% in 2018 and 2019 respectively. The World Bank's 2018 Human Capital Index places Nigeria at 152 out of 157 nations (11). Poverty alleviation has been hampered by the existing inequalities concerning income and opportunities in the country. The terrorism brought about by Boko Haram in the North- East has slowed economic development in the region and widened the North-South economic gulf. Compared to the country's average of 40.1% below the poverty line, the average poverty head count in percentage in the North East is 71.8%. This excludes Borno State which had no records in the Nigerian Bureau of Statistics report (12).

1.4 Internal Displacement in Nigeria

As far back as 1967-70, Nigeria witnessed forced movements and displacements as a consequence of conflicts and violence. This is traceable to the Biafran War, Nigeria's civil war, 17 years after its independence as a sovereign nation. Decades later there were also very large influxes of people from Liberia, Sierra-Leone, Chad Republic, Ghana and Cameroon on account of unrest in these countries (13,14). A large number of forced movements also occurred following clashes in the North-central from 2000 to 2002. These were inter-communal clashes due to boundary disputes occurred in Plateau, Benue and Nasarawa States (15). Similar religious conflicts occurred in Kaduna which resulted in the displacement of about 30,000 people following 4 days of violence during this time (14). In 2008, it was reported that, following Nigeria's ceding of the Bakassi Peninsula to Cameroon, 750,000 people were forced to migrate to the Southern states of the country (Akwa-Ibom and Cross-Rivers) (16).

Displacements have also occurred due to natural causes. In 2012, Nigeria experienced its worst flood in history. This flood affected almost all 36 of the country's states. It was reported that about 7 million people were affected by the natural disaster that year. The Nigerian Emergency Management Agency stated that between 2010 and 2011 about 80 settlements for IDPs, across the 6 geo-political zones had been registered (16).

1.5 Internal Displacement in North-East Nigeria

Boko-haram was born in the North East in 2002. Initially referred to as "Yusufiyya", the group has a debatable ideology, but it is suggested that it relates to instituting Sharia laws, anti-modernism, the practice of pure Islam and advancing Jihad. (17) Their activities escalated to irrepressible proportions in 2009 after the leader of the Boko-Haram sect was killed. Members of the violent sect fled to border countries and were exposed to training in the use of weapons and sophisticated armoury that changed them into a more coordinated and violent terrorist

group. The effect has been an intractable period of attacks in the North East leading to loss of many lives, bodily harm to many individuals, displacement of persons and an escalating fear across the country. (18,19). The conflict mainly affected BAY states: Borno, Adamawa and Yobe.

According to the 2020 Data Tracking Matrix displacement report (20), there are 2,046,064 displaced persons in the North East (Refer to table 1.1) and an apparent plateau in the last six years (Refer to figure 1.2). Eight hundred and fifty-nine thousand one hundred and twenty-seven of them live in 290 camps in the North East. The remaining 1,187,477 reside in host communities. Borno state, the epicentre of the crisis, has about 228 of these camps. (Refer to Table 1.1) Out of these camps, 86% are informal camps, while the others are formal. Females make up a greater proportion of the displaced population (54%) compared to males. The age distribution is biased towards the younger segments. Children below 17-years account for 56% while adults aged 18-59 years make up 40% and the elderly (60year and above) make up merely 4%.

Table 1.1 Displacement according to states in North East (20)

State	IDPs in Camps	IDPs in Host Communities	Total Number of IDPs
Adamawa	15,056	191,366	206,422
Bauchi	1,691	62,745	64,436
Borno	807,467	699,070	1,506,537
Gombe	-	37,028	37,028
Taraba	26,828	72,170	98,998
Yobe	8,085	125,098	133,183
Total	859,127	1,187,477	2,046,604

Adamawa, which shares a border with Borno state, has also been impacted by the insurgency, with many IDPs migrating from Borno into the state. The state witnessed its peak of the displacement between 2014 and 2015. Similarly, Yobe state which was carved out of Borno, has felt the impact of the crisis on its already weak social structures (14). With more than a decade gone since the violence escalated, resilience appears to be giving way to increased vulnerability in the region.

As a consequence of the conflict and insurgency in the North East, economic activities have been limited. Major means of livelihood like farming activities and livestock rearing have been crippled due to the crisis. This has increased the vulnerabilities of the region's predominantly rural communities. Among people that were previously independent, one now sees heightened food insecurity and begging. In most situations, displaced persons lack protection and adequate supply of food as well as access to water, sanitation and proper hygiene services. (Refer to Figure 1.3). Education is limited, and access to health services is also constrained. Living under these circumstances is inherently difficult due to the lack of infrastructure. Women and children are identified as the most vulnerable groups in the population and are often victims of sexual violence. In some cases, these dastardly acts are perpetrated on women and girls in camps by the camp officials (14,21,22). The national policy on Internally Displaced Persons in Nigeria which would provide a framework for the protection of displaced persons' rights by the Federal and State Governments is yet to be passed into law by the legislature (14).

Figure 1.2 Trend of population displaced between 2014 and 2020 in North East Nigeria (20: p. 6)

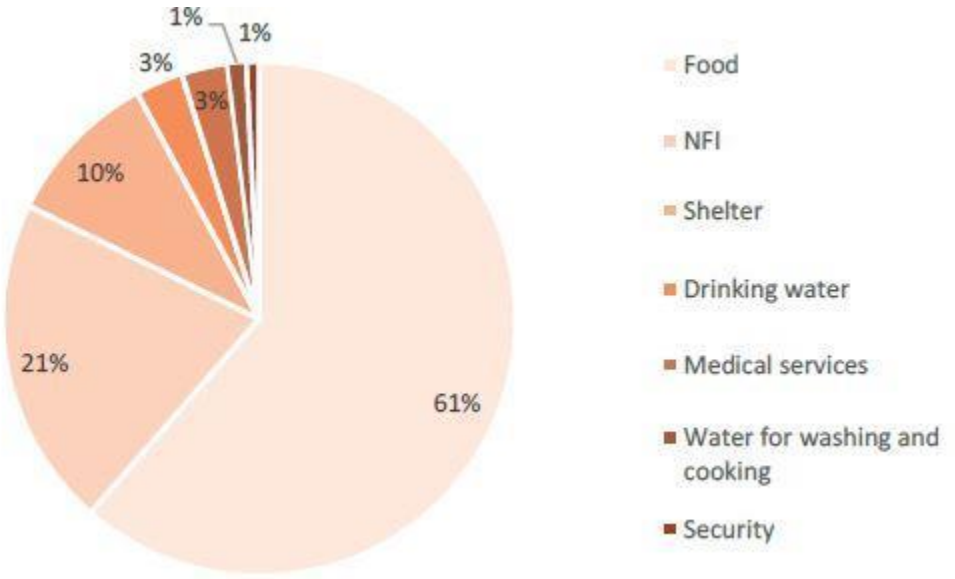


Figure 1.3 DTM 2020 Report of unmet needs among IDPs in North East Nigeria (20: p. 10)

1.6 The Nigerian Health System

The organization and delivery of orthodox healthcare in Nigeria is driven by the public and private sector. In addition, traditional health care also remains a vital component of the health system. The Federal Ministry of Health spearheads the three-tiered public health system in Nigeria by issuing guidelines and policies with a nationwide reach. The primary and secondary tiers of health care are the responsibility of the local government and the State governments respectively. The primary health care level also receives support from the State Ministries and

administrative leadership from the National Primary Health Care Development Agency(NPHCDA) (23). Out of the over 40,400 health facilities counted during the last national FMOH census of health facilities, Primary Health Centres are the majority with 86.0%. 13.6% are Secondary Health Centres and 0.4% are the Tertiary Centres (24).

According to the available world bank data report of 2018, there are 0.4 medical doctors and 1.2 midwives and nurses per 1000 people in Nigeria (25). These estimates are far lower than the index value for Sustainable development goals at 4.45 skilled health care workers per 1000 people (26). Prior to the conflict in the North East, there was already a shortage of health workers, and this has far worsened by the insecurity and poor welfare conditions (27).

Out of pocket expenditure make up the bulk of Nigeria's domestic health expenditure, totaling 77% of the current health expenditure (Refer to Figure1.4). This is far higher than the 20% benchmark for Universal Health Coverage (28). The public health care system has been hampered by poor funding, and in 2016, it was stated that the country had the lowest budget for healthcare in Africa (29).

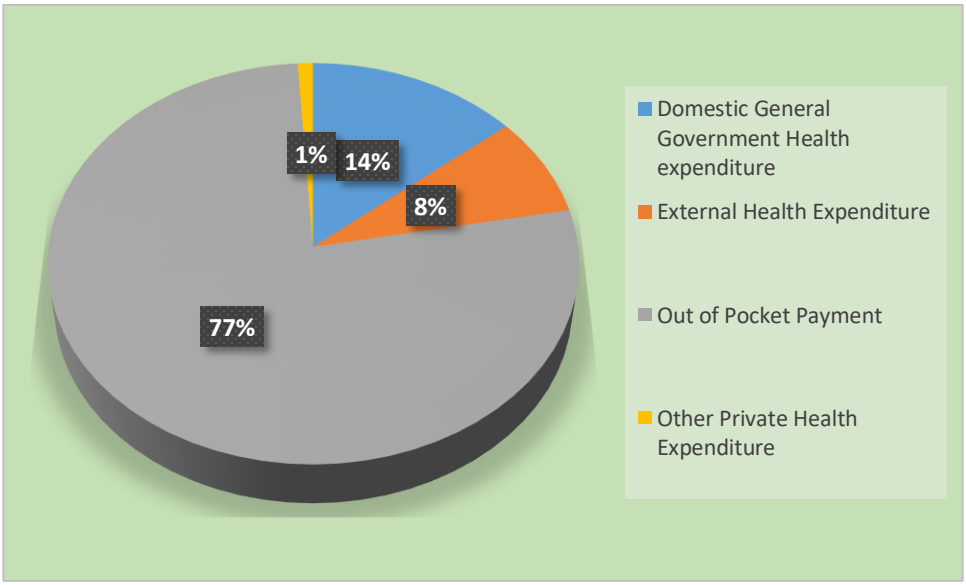


Figure 1.4 Sources of funding for the Nigerian Health Sector (28).

In the North East, the public health care system has long been operating at a suboptimal level, and it has further been negatively impacted by the ongoing crisis. This impact has and continues to be significant in the states affected directly by the conflict. Over 90% of the IDPs in the North East reside in these states. However, the impact also extends to the Displacement affected states. These are not directly affected by the conflict, but about 10% of the IDPs reside there (20). (Refer to tables 1.1 and 1.2). In these areas, service delivery is limited, health facilities have been destroyed, and the movement of human resources for health care and necessary medical supplies are seriously limited by the insecurity concerns. At present (2020), 58% of the health care facilities are operative, while about 15.8% have been damaged due to the conflict affecting the BAY States (30). Secondary health care delivery in Borno

State is almost non-existent beyond the State capital, Maiduguri. Moreover, the services at most of the primary health centres are not comprehensive. The FMOH and the State Ministries in the region have developed a National Health Sector Response to the on-going situation. This outlines the key objectives of increasing access to health care, expansion of surveillance for disease outbreaks as well as strengthening the health sector coordination. In improving access to health care it suggests a minimum essential package which includes the provision of immunization, maternal and child health care as well as mental health and psychosocial support among other services. It would require up to 56.7 million dollars to meet the health sector requirements in these States (30-32).

Table 1.2 Operational Hospitals and level of care in the North east from Health Facility Register as at 2019 and population size from Nigeria Bureau of Statistic estimates of 2016 (7,20,24)

Security	State	Primary	Secondary	Tertiary	Total	Population
Conflict Affected states (81.2% of IDPs in N/EAST reside)	Borno	650	53	5	708	5,860,183
	Adamawa	946	64	2	1012	4,248,436
	Yobe	561	26	1	588	3,294,137
Displacement Affected states (9.8% of IDPs in N/East reside)	Gombe	628	40	0	668	3,256,962
	Bauchi	1153	30	4	1187	6,537,314
	Taraba	1293	46	1	1340	3,066,834

1.7 Mental Health Service

The state of mental health care in the North East is not different from the rest of the country. The State Governments in the region allocate about 1% of their health budgets to mental health. Out of this allocation, 76% is spent on mental health hospitals. This resource allocation is far lower than the national average of 3%, and lower than other African countries like Uganda with 4% allocation (33,34). Like other regions in Nigeria, the North-East lacks adequate supervision at all the tiers of the healthcare system. This owes to the lack of administrative representation at the State ministries for mental health (35)

The entire North East region has just one specialist tertiary centre, (The Neuropsychiatric Hospital at Maiduguri) that serves more than 26 million people in the region (36). Schizophrenia, affective mood disorders, psychoactive substance use disorders, epilepsy and other neurologic disorders are reportedly managed at the mental hospitals. Cases of schizophrenia, psychoactive substance use disorder and mood disorders have also reportedly been managed at the general hospitals. Patients admitted to the community based psychiatric units, are said to receive psychosocial interventions there (35).

One in five of the PHCs refer patients to mental health specialists. Furthermore, the presence of traditional caregivers, though not negligible, share no formal interaction with orthodox care (35). It is estimated that the mental health specialists to population ratio in the region is 0.069/100,000. Comparatively, the national average is 1.44/100,000. The ratio of psychologists to population in the region is also far below the national average with 0.01 psychologists per 100,000, compared to the national ratio of 0.11 per 100,000 (35).

Nigeria's mental health policy stipulates the need to integrate mental health care with general health care at all tiers of the health system as well as the need to promote all-inclusive access to mental health care through the primary health care approach. (33). The policy's guiding principles include governance at the Federal, state and local levels, human rights for all, and inter-sectoral partnerships together with decentralized comprehensive community service provision (37). The government of Nigeria is currently focused on facilitating mental health care integration with Primary health care (38). Notably, contextualisation of the WHO's Mental Health Gap Action Program Intervention Guide (mhGAP IG) to improve coverage of mental health services especially in Low-middle-income countries via non-specialist care has been carried out in Nigeria. The process of contextualisation highlighted the need for supportive supervision of workers to improve their performance (36).

Due to the intractable nature of the conflict and its impact on the region, the Federal Government has advocated for rebuilding the healthcare systems in the region. By partnering with stakeholders including the WHO and the Borno State government, a Mental Health Strategic Framework for Borno State was developed. This outlines the structure and processes for improving mental health care and the access to psychosocial support, thereby reducing the future burden of mental disorders in the State (39).

CHAPTER 2

2.1 Problem Statement

According to the WHO, Mental health is defined as 'a State of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community' (40). Mental disorders on the other hand include a wide spectrum of problems with varied symptoms 'characterized by abnormal thoughts, emotions, behaviour and relationships with others' (41). Mental disorders account for about 19% of the total years lived with disability across the world, and over 1 billion people were affected in 2016 alone (41,42). The burden of lifetime prevalence of mental health disorders in the Nigerian population ranges from 12% to 26% in available community surveys. This implies that over 20 million Nigerians risk having a mental health disorder during their lives and up to 25% of years of healthy lives lost is due to mental, neurological and substance disorders in Nigeria (36,43,44).

According to the WHO, one in five persons who have been displaced from their dwellings suffer from mental health disorders. It is an estimate that translates to 409,320 displaced persons in the North East. The common disorders mainly include depression and post-traumatic stress disorders. But there are also pre-existing mental health conditions that may be exacerbated by conflict, such conditions include schizophrenia, mood and anxiety disorders and substance use disorders (20,46). Kaiser et al in 2019 reported that 60% and 75% of persons displaced in North-East Nigeria experienced a symptom or an impairment related to mental health respectively (47). Depression and post-traumatic stress disorders (PTSD) are commonly reported among internally displaced persons in Nigeria (48). The prevalence of a comorbidity consisting of depression and PTSD was as high as 68% of the population surveyed in a study carried out in 6 IDP camps in Maiduguri, Nigeria (49). Similarly, at a camp in North-central Nigeria, the prevalence was 59.7% for suspected depression and 16.3% for confirmed depression with both having a significant coexistence with PTSD (50).

Trauma is a leading factor in the development of mental health disorders among Internally Displaced Persons alongside other identified factors such as personal behavioural characteristics, and environmental characteristics. It has also been suggested that among the IDP population factors including poverty, the displacement and superstitious beliefs are major contributory factors to mental health disorders in addition to concerns about the humanitarian responses to their mental health (47). Mental disorders reported among displaced persons which maybe pre-existing or are magnified by the conflict do not receive the necessary attention due to a lack of available social services in the camp (51). The length of stay in the camp, the state of the camp's organization and the volatile security situation aggravate pre-existing psychosocial problems and contribute to the increased unmet mental and psychosocial needs among IDPs (52). Ekezie et. al. in 2018 reported that the quality of life and the wellbeing of displaced persons was affected by the poor living conditions in the camps. These living conditions have been reported to be far below the minimum humanitarian standards described in the Sphere handbook (22,53).

In the general population, people with mental health disorders already face difficulties with respect to the fulfillment of their right to health care. This was described by the WHO as a 'global human rights emergency in mental health' (54). The challenge is even bigger for displaced persons in Nigeria, as populations living with Mental health disorders in the camps face major challenges to their mental health needs and rights. They are isolated in the camps, ignored, labelled with certain negative stereotypes, insulted and face discrimination. Additionally, the stigmatization also impacts the family of the affected individual leading to

isolation of the family (47). Affected persons in the camp are also faced with food insecurity, unemployment, financial indebtedness, premature termination of education as well as marital separation (55). These problems have significant economic impact due to the loss of productivity, consequently with large financial losses recorded annually (46).

Given the size of the IDP population in the North East which amounts to an estimated 7.8% of the North East population (7,20) together with the estimated 7.9 million people affected by the conflict (56), earnest consideration should be given to the needs of these persons and their mental health needs. Without this consideration an opportunity to introduce future reforms to mental health care in the region may be missed.

2.2 Justification

Interventions directed at mental health and psychosocial support as well as non-communicable diseases were considered a high priority by the Nigerian government's humanitarian plan in 2018. To date, this plan has not received the requisite attention. (27) The mental health psychosocial support programs coordinated by the WHO and the Borno State government has reached tens of thousands of persons through integrated mental health services at primary health care levels (57). There is however little known about the MHPSS for the majority of the IDPs who reside in the informal settlements and host communities. These populations are commonly less visible to humanitarian interventions compared to those in the formal settlements (58). In its 2019 bulletin, the Nigerian health sector identified healthcare service delivery and a lack of skilled health care workers as major public health gaps in response to the nation's health needs (59) Studies analysing the mental health psychosocial support for IDPs in Nigeria are rare and the evidence available are mainly from reports of humanitarian agencies.

This study will contribute to the body of knowledge by providing information on the mental health needs among internally displaced persons in North-East Nigeria, as well as on the mental health and psychosocial support offered in response to these needs. Gaps in the support services will be identified, and appropriate recommendations to inform and guide future actions to respond to the mental health needs of internally displaced persons will be made.

2.3 General Objective

This study aims to analyse the Mental Health and Psychosocial Support in response to the mental health needs of the internally displaced persons in North East Nigeria and to make recommendations for an improved response to the mental health needs of IDPs.

2.3.1 Specific Objectives

1. To describe the mental health and psychosocial needs among internally displaced persons in North-East Nigeria.
2. To analyse the coverage of MHPSS for mental health needs among IDPs in formal camps, informal camps and host communities in North-East Nigeria.
3. To provide evidence-based interventions and guidance on MHPSS for mental health needs of IDPs globally.
4. To make recommendations to the Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development, the Ministry of Health, MHPSS Sub working group in the North East, and Academics on approaches to improve the humanitarian and mental health response to the mental health needs of IDPs in Nigeria.

2.5 Methodology

2.5.1Search strategy

This study is a desktop review of existing literature. Searches were conducted on databases like Science direct, Pubmed and psych Lit. Search engines including google scholar and google search engines were utilized to retrieve articles. Additionally, snowballing was used to obtain relevant additional publications. A set of inclusions were used to screen and select relevant peer reviewed literature and grey literature that was eventually used for the review. Websites such as MHPSS.net and National Institute of Mental Health also served as a source of resources. The principal reports used were obtained from: The International Organisation for Migration (IOM), The United Nations Fund (UNFPA), The United Nations Children Fund (UNICEF), The Inter Agency Standing Committee (IASC), The Mental Health and Psychosocial Support Sub Working Group in the North East (See table 2.1 and Appendix I for more details).

2.5.2 Inclusion Criteria

1. Peer reviewed literature and grey literature published between 2009 and 2020
2. Peer-reviewed articles and grey literature utilised only if the full details were available.
3. Publications only in the English language since it is the official language of communication in Nigeria
4. Publications on mental health needs/disorders and psychosocial support among IDPs from only the North East geopolitical zone was included.

Table 2.1 Search Strategy

	Specific Objective	Internet source	Publication/Literature	Keywords
1.	To describe the mental health and psychosocial needs among Internally displaced persons in the North East Nigeria.	Google, Google scholar Pubmed Science direct	Peer reviewed articles	"Depression", "Distress", "Post traumatic stress disorder", "Mental health", "mental disorders", "psychosocial needs" "Internally displaced persons", "IDPs", "North East Nigeria", "Nigeria". Using Boolean operators: 'AND' 'OR'
2	To analyse the MHPSS coverage for mental health	Google, Pubmed,	Peer reviewed articles, Grey literatures	"MHPSS coverage"

	needs among IDPs in formal, informal settlements and host communities in the North east Nigeria.	Science direct		"North East Nigeria" "Nigeria" "Psychosocial needs" Mental Health and "Psychosocial Support" "Mental health" "IASC pyramid" "North East Nigeria" "Nigeria". Using Boolean operators: "AND" "OR"
3	To provide evidence based interventions and guidance on MHPSS for mental health needs of IDPs globally.	Google, google scholar, Pubmed	Peer reviewed articles, grey literature	"mental health" "psychosocial support" "MHPSS" "effectiveness" "LMIC" "conflict settings" "Implementation" "mhGAP" Using Boolean operators: 'AND' 'OR'

2.6 Analytical Framework

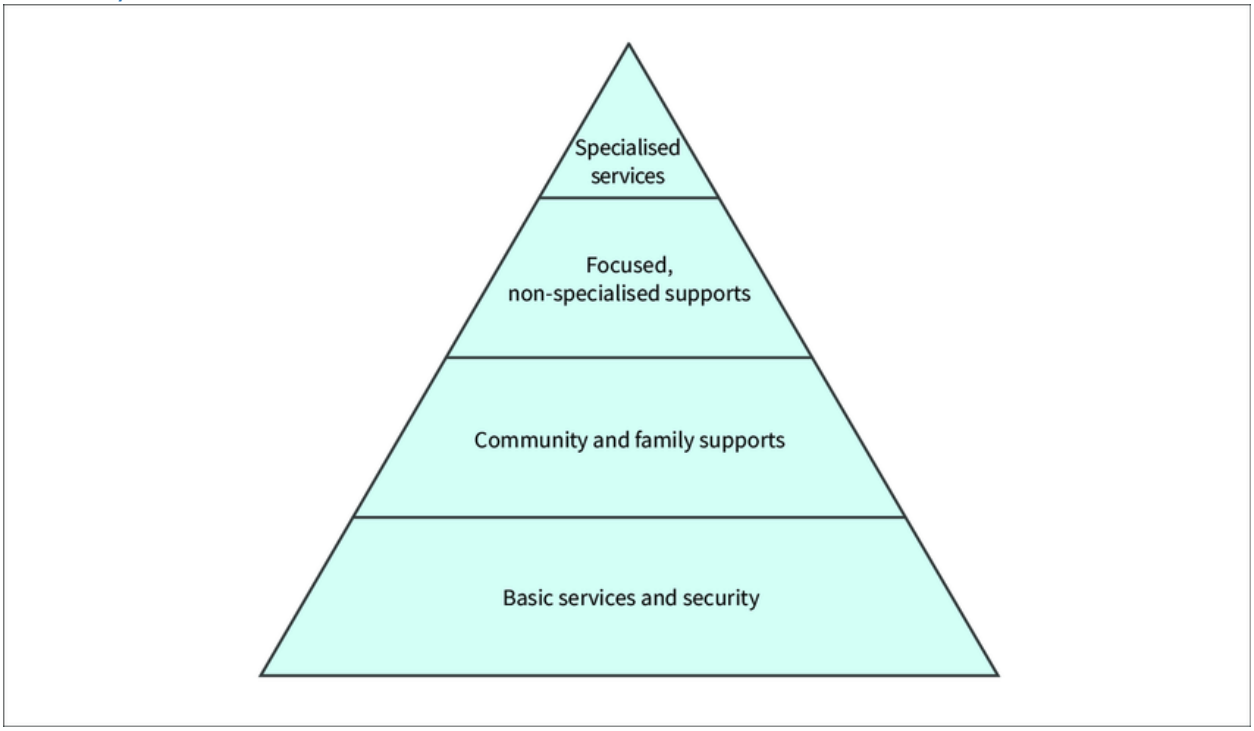


Figure 2.1 Inter-Agency Standing Committee intervention pyramid for MHPSS (2: p. 12)

2.6.1 Inter-Agency Standing Committee Intervention Pyramid for MHPSS

The framework was selected as a basis for analyzing MHPSS to IDPs in the North east considering the number of organisations providing psychosocial support in the region and the need to harmonise the response. In order to analyse the coverage of MHPSS to the displaced persons in the North East, the framework is very relevant because the activities within these guidelines cannot be executed by a single agency or authority. Similarly, based on this framework and evidence from success stories, gaps in the service provision will be identified and discussed.

Because affected persons react in diverse ways to crisis, the MHPSS is developed as a multilayered pyramid which meets different levels of needs but simultaneously extends support to all.

1. Basic Services and Security: The whole population is considered and the provision of adequate protection and essential physical services such as food, health care and shelter. Advocacy to ensure the availability of these services, recording the impact on mental health and psychosocial wellbeing as well as making sure the key actors provide these services in a way that promotes mental health and psychosocial wellbeing.
2. Community and Family Support: This layer of support reaches a proportion of the population who require important community and family support to maintain their mental health and psychosocial wellbeing. Such individuals may be faced with mild mental distress as a consequence of the emergency situation. Responses such as formal and non-formal education, strategic coping methods and family reunification are provided.
3. Focused Non-Specialised Supports: At this layer, the focus is on a smaller proportion of people who may require extra support from non-specialists who have undergone

training and are usually supervised. These target individuals face mild to moderate mental distress and are attended to by the primary health care workers. Psychological first aid is also offered in this layer, as well as emotional support for persons who have faced gender-based violence.

4. Specialised Services: At the top of the pyramid, the support rendered is for an even smaller proportion of the population who despite the initial levels of care still face severe mental disorders. Specialised services may be rendered for some of these persons, but the main responses are referrals to specialist care and the commencement of training for general or primary health care providers in the long term

The operationalization of these response levels requires a strong inter-agency collaboration and proper coordination. The activities referred to as "minimum" may vary depending on the local context for its implementation (2,60).

Although this framework is simplistic and suitable for this particular humanitarian setting (the crisis is still on-going and efforts at rebuilding the healthcare system also continues in the North East), it has little or no focus neither on the role of self-care nor on the informal structures within a community that provide support which are considerations for systemic change and are represented in the WHO Service organization pyramid (46). Since the WHO service organisation pyramid would be more applicable for long term programing it was not used in this review.

CHAPTER 3: Results

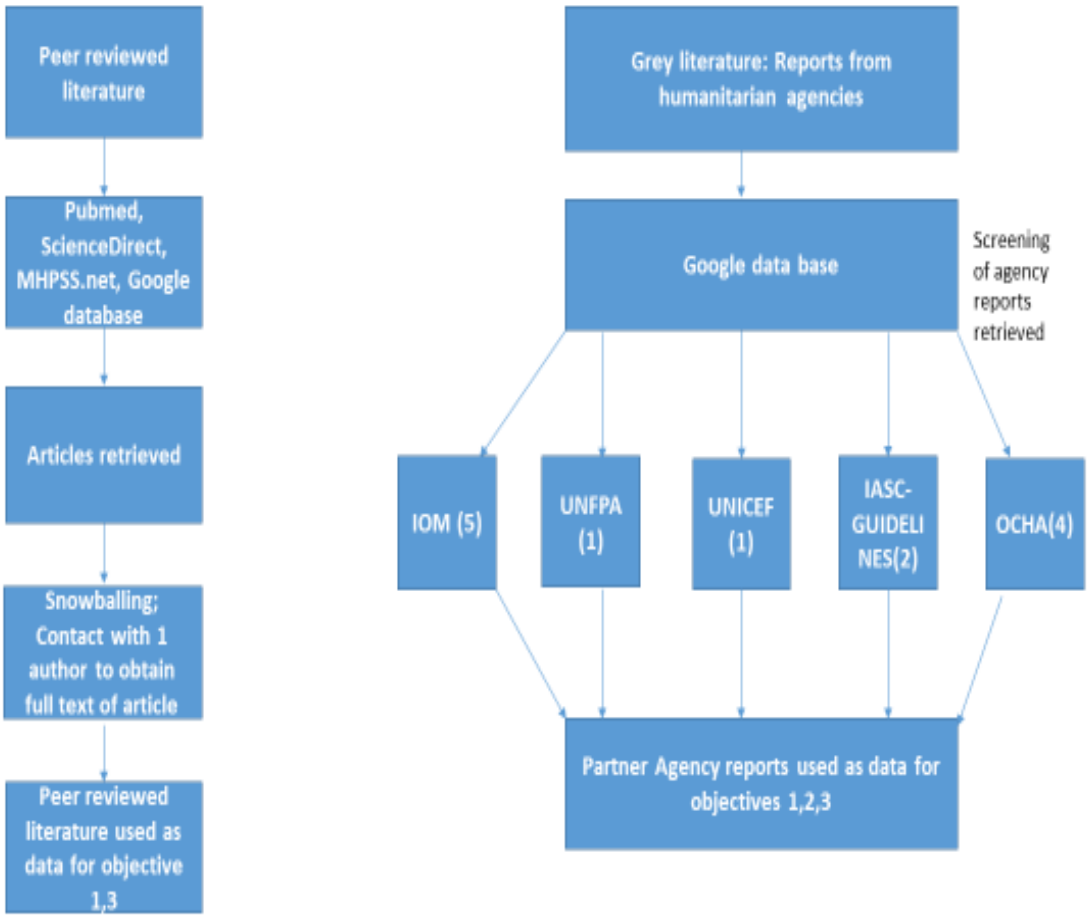


Figure 3.1 Flow chart for literature search

3.1 Mental Health Disorders and Psychosocial Needs Among IDPs in North East Nigeria

This section describes the findings of the search on the burden of mental health disorders and psychosocial needs. Mental health disorders exist on a wide continuum including symptoms ranging from mild to severe. Moreover, it is typically challenging for researchers to identify specific mental disorders due to sensitive diagnostic criteria. More conveniently, symptoms of impaired functions used to identify these conditions are usually descriptive of the mental conditions. In this review, findings on specific mental health conditions from the available literature: depression and post-traumatic stress disorder are presented. No full publication on other mental health conditions including schizophrenia, substance use disorder and anxiety disorders were found in the search. Studies on the composite term of mental and psychosocial needs are also presented for men, women, and children.

3.1 1 Depression

Depression as defined in the text box (61)

> *Depression is a common mental health disorder characterized by symptoms ranging from mild to severe. These symptoms include feelings of sadness, no interest in past-times, difficulty sleeping, worthless feelings, loss of appetite suicidal thoughts among other symptoms for at least two weeks*

3.1.1.1 Prevalence

From a sample of 1,200 internally displaced persons in the 6 '*safest'* IDP camps at Maiduguri, Aluh et al., 2019 (49) reported a prevalence of mild to severe depression in 96.1% of the respondents, using the Patient Health Questionnaire Diagnostic tool. This substantial figure was attributable to the measuring tool which is principally a screening tool rather than a diagnostic tool. The author further reported that the strongest predictors for depression was an existing comorbidity with PTSD and unemployment. According to Nwoga et al.,2018 (62) that surveyed a sample of 422 IDPs in 'government approved camps' in Yobe State using the Hopkins symptoms checklist, probable depression was reported in 39.3% and definite depression in 18% of the IDPs. No data on depression from informal camps or host communities was found.

3.1.1.2 Factors Associated with Depression.

The risk of a diagnosed depression was found to increase with age. Nwoga et al. (62) and Aluh et al. (49) both reported significant associations of depression with older demographic tiers in IDP camps. Aluh et al. reported a 3.08 greater chance of depression in persons aged 51-60 years compared with persons between 18 and 30 years. (49) A gender bias was also reported with respect to the likelihood of suffering a depression, with the males having a 22 % lower chance to be depressed compared to their female counterparts. (49) Employment proved to decrease the likelihood of suffering from depression. Respondents that were unemployed or retired were 3 times more likely to be depressed (49). According to Nwoga et al. (62), the act of residing in the camp, regardless of the living conditions predicted the incidence of depression. Moreover, both studies reviewed reported the propensity for comorbidity with PTSD. Aluh et al reported a 4.1 fold increased likelihood of having a comorbid depression with PTSD (49).

3.1.2 Post-traumatic Stress Disorder

PTSD as described in the text box (63)

> *PTDS is a mental disorder affecting persons who may have experienced events which are dangerous, scary or shocking. The symptoms could be: Intrusive (flashbacks occur due to re-experiencing of the traumatic event); hyper arousal (irritable, poor sleep, startled easily) and constriction (distortion and numb from reality).*

3.1.2.1 Prevalence

From a sample of 1200 respondents from 6 IDP camps in Maiduguri using the Impact of events scale", the prevalence of PTSD was 75%. Out of the respondents with PTSD, 68% had a comorbidity with depression. (49) All of the respondents had been impacted by the insurgency and the traumatic experience of the conflict. It was also suggested that the actual burden of PTSD could be higher in the more remote and inaccessible areas, considering the fact the study was carried out in the 'safest' camps in Maiduguri, the epicentre of the conflict.

3.1.3 Other Mental Disorders

There were no specific publications in the literature search on severe mental disorders such as schizophrenia, anxiety disorders and others such as substance use disorder {defined in textbox (64-66)} affecting IDPs in North East Nigeria. These conditions present high mental healthcare demands in normal times, which invariably worsens under conflict. It is notable that on average, there is an estimated rise in prevalence by 1% above the estimated baseline value during and after conflict. These conditions may have pre-existed prior to the conflict, or may have been induced by the conflict. (2,46). The perceptions about persons engaged in Substance abuse in IDP camps was reported by Kaiser et al. 2019 These perceptions chiefly concern aggressive behaviors, poor physical hygiene and poor interpersonal relationships due to the addiction. Consequently, most affected individuals are avoided and often despised by peers (47).

- *Schizophrenia is a severe mental health disorder that starts earlier in males than females characterized by psychotic symptoms including abnormal thinking, mood and occupational disability*
- *Substance use disorders are associated with the abuse of drugs including alcohol in a harmful hazardous manner.*
- *Anxiety disorders are a group of mental disorders where an individual present with fear and anxiety which can worsen with time and interfere with normal activities.*

3.1.4 Psychosocial Needs

3.1.4.1 Individual Level

Kaiser et al. 2019 reported feelings of fear, inability to control one's anger, disinterest in activities, hopelessness, and an overall upset about life events in about 65% of IDPs in formal and informal settlements as well as host communities in Borno State. The same study also revealed that 75% of these respondents had functional impairment due to their negative feelings (47). Similarly, Onyencho et al reported that 79.1% of IDPs in both formal and informal camp settlements precipitated negative feelings of worry, sadness, anger and fear. 43.3% of these respondents felt they did not get the respect they deserved, and that they were humiliated due to their circumstances. 61.6% considered the inability to go back and forth to towns and villages as a serious problem, and 59.8% felt they had too much idle time (67). A large survey on the psychosocial needs of IDPs conducted by IOM in Adamawa State in 2015 also revealed that at the individual level, almost 80% endorsed negative emotional feelings. These were attributable to uncertainty about the future, the loss of loved ones and the loss of goods and property. (68)

In its report, the Nigerian subsidiary of UNICEF stated that younger children tend to forget about the conflict while playing, unlike the older adolescents who already think a lot. On the other hand, the potential to be misled into joining armed groups was higher in younger age groups, whilst older children were found to cope better with the available education (69) Comparing adults to teenagers, Kaiser et al. (47) reported that increasing mental health scores were associated with increasing age (68% in adults against 52% in teenagers). Among children, the UNICEF Nigeria report stated that 90% of the participants claimed that girls are more at risk to threats than boys, and also at higher risk for sexual violence. Generally, neither boys nor girls were encouraged to engage in schooling, but boys had a better chance to go to religious schools (69).

3.1.4.2 Family Level

Kaiser et al. highlighted that problems related to the family were reported in about 12% of respondents. These problems were mainly a product of the separation and losses of family members experienced causing worries described as "overthinking", sometimes leading to cognitive problems. The impact on the family was stronger in persons who engaged in illicit drug use, as wives and mothers were often victims of physical assault by those who engaged in such. Similarly, families of persons with these habits were often stigmatized and also insulted (47). Onyencho also reported serious problems at the family level. In this research, 76.9% reported separation from family, 69.3% reported the inability to provide care for the elderly and the youngest in families and 52% claimed their families did not feel safe (67). The IOM survey also reported similar negative feelings as experienced at the individual level (described above). Also in this study, over 80% described negative feelings of separation and losses as well as the uncertainty about the future of their children (68).

There is a willingness to go back home. However, this is challenged by the uncertainties surrounding a return. Some are not sure about the safety of their destination and also lack the necessary financial resources to return. (68) More worrisome than the physical return itself are the challenges that children often face regarding reintegration, because they become stigmatized for being part of armed groups. These barriers create negative views for the affected persons. (69)

3.1.4.3 Community Level

According to Kaiser et al., in a free listing exercise, 11% of the respondents identified stigmatization of the IDPs by the host communities. The stigmas typically faced by IDPs during interactions with the host communities presents as a serious psychosocial problem. Notably, it was reported that the community plays a role in amplifying psychosocial needs such as isolating and insulting persons with mental and psychosocial problems as well as stigmatizing rape victims (47)

Furthermore, information circulation influenced psychosocial needs. According to Onyencho, over 70% of respondents felt that information about aid was not well circulated in the camps and 52% also felt their children were not able to get a good education (67). According to Kwajaffa et al., information about their hometowns was retrieved from NEMA/SEMA (43.7%), religious centres (38%) and mobile teams (8.8%). Reportedly, nothing was provided via pamphlets (70).

The IOM survey identified the following services as needed in the community: education, income generating activities, recreational activities, farm land allocation as well as mobilization of the community for peaceful coexistence (68)

3.1.4.4 Factors Associated with Psychosocial Needs of IDPs at the community Level

Harsh Living Conditions: Camps are often overcrowded, and lack basic amenities. Food is insufficient, and/or delivered in unacceptable and undignified ways. IDPs commonly feel insecure and lack adequate shelter (68,71).

Lack of access to educational and social services and health care: Some respondents attested to the fact some displaced persons had pre-existing mental health conditions, and these cases relapsed in the absence of medications (68) Onyencho et al. reported that 50% of households considered their children's inability to go to school as a serious problem (67). Similarly, Kwaffaja reported that only 4.4% of displaced persons were allowed to participate in camp construction activities (70).

Traditional and cultural beliefs: Some IDPs attribute mental and psychosocial distress to be due to supernatural beings. It is believed that girls were more likely to be possessed by the demons than boys (47,69).

Lack of Trust: The IDP camps usually accommodate persons from different ethnicities as well as different religious backgrounds. This has been reported to breed a lack of distrust among different sub-populations (68). Similarly, women and girls who have been victims of sexual violence feel a lack of trust in the social networks they formerly belonged to, which causes them to isolate themselves. (71)

Repeated Displacements: With almost 75% of the IDPs in Borno alone, being displaced from home to IDP camps or to host communities and to local governments, the experience of multiple displacements affects psychosocial wellbeing. Vulnerable groups of particular consideration include children, elderly, females heading households and disabled persons. (69)

3.1.5 Psychosocial Needs Among Vulnerable Groups

3.1.5.1 Women

Women, especially widows, pregnant and breastfeeding mothers are considered vulnerable in the context of conflict and crisis. Though all groups of people face similar hardships, Kaiser et al. stated that women are considered to be more at risk (47). Since the conflict started in 2009 and up until 2017, as many as 2000 women and girls have been victims of rape, forced marriage, psychological abuse, and forced labour following abduction. Unfortunately, some of these women who manage to escape face stigmatisation and marginalization from their communities. The main stigma derives from fear that the women are now radicalized. Also, in the absence of family protection, the women and girls are easy victims of violence and abuse (71).

A Refugee International field report stated that women feared to live in a formally run government camp because of the threat of gender-based violence. This led some women to abandon these settlements for the host community. However, host communities are also not secure, as some women attribute the risks for gender-based violence to be due to food insecurity also in the communities (72).

Some of the women are also forced to deal with a "gender identity crisis" that occurs due to the changing roles they encounter, in situations such as burying their husbands, and heading households (72).

3.1.5.2 Children

In a mixed method study in the North East, it was reported that many children become victims of conflicts by becoming orphans, being forced to drop out of school or having no one to provide for them (47). Also, in a UNICEF Nigeria rapid assessment survey that adopted a qualitative methodology, it was reported that children spent long periods in overcrowded tight spaces, which caused much distress. These caused a great deal of anxiety among the children such that the only thought was how to escape captivity. Without viable role models to turn to for guidance, the children were left without community support. They felt lonely, unsafe and considered joining armed groups to make a living. Children who had previously been involved with armed groups were isolated and separated from social activities. Parents refused their children from mingling with other children who had previously been sexually violated. Some girls who had been victims of forceful captivity, and abused became pregnant or young mothers. This in turn posed an imminent challenge to re-integration of these children (69).

According to the UNICEF Nigeria report, every girl interviewed in the survey reported sexual violence occurring in the camps. Moreover, the toilets were not safe and only separated by metal sheets from the male counterpart. These sheets had holes and their privacy was compromised. The girls also claimed that support from leaders in the community was lacking, even when cases of sexual violence were reported. Girls were also not allowed to go to school for cultural reasons and gender roles (69).

3.1.5.3 Men

According to Kaiser et al, participants in his study claimed that adult men suffered more because they could not fulfil the family responsibilities. The study also revealed poorer mental health scores in men (10.6) compared to women (8.7) (47). Living as displaced persons in camps following a loss of property, means of livelihood and loss of headship in their household causes great anxiety and frustration given the fact that they belong to a patriarchal society. The lack of freedom in the camp also denies the men their decision power, prevents them from achieving employment and pushes them to aid dependence, thus creating a downward spiral of despair. Some young men had to leave their families behind, not knowing if they are alive or not because they have been forcefully drafted into armed groups (68).

3.2 Analysis of MHPSS for Mental Health and Psychosocial Needs of IDPs in North East Nigeria

3.2.1 Coordination

The National Emergency Management Agency and the State Emergency Management Agencies co-chairs the inter agency Mental Health and psychosocial support along with the International Organisation for Migration. This forms the MHPSS Sub working group in North East Nigeria with about 68 partners including International NGOs, international organisations, national NGOs, UN agencies and Government agencies (73,74).

The MHPSS Sub-working group provides quarterly updates of MHPSS activities of the various partners in the North-East region. These activities are coordinated by the sub working group to maintain standards in the procedures for MHPSS delivery in order to achieve the expected outcomes, while at the same time reducing the likelihood for duplication of interventions. There is also a harmonized understanding among the partners to avoid inadvertent harm from the interventions by following principles such as community engagement and relevant information sharing (73,75).

MHPSS activities are usually cross cutting between different clusters coordinating an emergency response. The interventions are relevant to camp coordination and camp management, education, heath, protection, nutrition, shelter, WASH and protection (76).

The MHPSS sub working group's partnership with the WHO and the state ministry of health has supported the creation of a Borno State Mental Health Strategic Framework for 2018-2021. Simultaneously, WHO is also working towards developing a mental health strategic framework for the North-East (including Adamawa and Yobe) (76).

3.2.2 Basic Services and Security.

The IASC matrix for minimum interventions stipulates that the provision of security, food and nutrition support as well as shelter planning, water and sanitation are expected at this layer of the pyramid. This should be delivered in consideration for the social and psychological support of the recipients, and carried out in a dignified, safe, socially and culturally acceptable manner (2).

According to the Displacement Tracking Matrix's 2020 report in North East Nigeria, camps and camp-like settlements for displaced persons have different conditions with respect to shelter. A majority of IDPs dwell in emergency shelters (40%), while others utilize government buildings, family houses, schools and individual houses (60%). The larger proportion of displaced persons (87%) residing in host communities, live in the family houses of the hosts, while 13% live in make-shift shelters and houses of individuals. Water supply to camps was chiefly through piped water (70% of sites surveyed), while in the host communities it was via hand pumps (53%). Food was accessed offsite in 43% of the camps, onsite in 41% and 17% of the sites had zero provisions. In host communities, access to food was 59%, 21% and 20% for on-site, off-site and zero provisions respectively (20).

The MHPSS Sub working group (Q2 2018) update (75) reported that actors within shelter response were trained on MHPSS mainstreaming. NEMA which is the leading government agency on camp coordination and camp management had joint training with the MHPSS sub working group. Included in this training were 28 participants from INGOs, NGO participants, UN agencies and representatives from the sector. The Q4 MHPSS sub working group report also states that workshops were organized with key actors to guide programing on reception at the camp, site facilitation as well as mainstreaming MHPSS with camp coordination, camp

management and shelter. (77) Also reported was the introduction of a "bunny and friends costume" by a partner agency (GPON) in some camps. This initiative involved the participation of up to 5000 children, and the objective was to sensitize the children and the care-givers on the avoidance of socially inappropriate behaviours such as using neighbours firewood, defecation in the open or pilfering in the camp (77). According to an earlier survey carried out in 2015 at formal, informal settlements and host communities in Adamawa state, it was reported that the formal camps received more attention from NEMA/SEMA and the government agencies when it came to providing basic necessities such as non-food items, informal education and security (68).

3.2.3 Community and Family Supports

The principal activities at this layer should be to enable ownership and facilitate the mobilization of the community towards responding efficiently to emergencies. Social support and Community self-help should be facilitated. Similarly, healing via religious and spiritual means in the context of the community should be appropriately facilitated (2).

Child friendly spaces (CFS) were formed by the International Rescue committee and other partner agencies in the North East. Three hundred and fifty children were reached with integrated psychosocial and nutrition interventions. Eighty-two community workers trained to identify parents who suffered trauma. Cheap and locally made toys which were easily accessible were used in this CFSs, and parents were also encouraged to use the toys as a sustainable way developing and stimulating the child's senses (75,78,79)

Similarly, the MHPSS Sub working group (Q2 2018) reported that the agency, Street Child, provided empowerment for children through education, while focusing on special groups such as children who have been linked with armed groups as well as children separated or unaccompanied. The agency provided individual and group psychosocial support in child friendly spaces. Foster parents were also trained on the effects of psychological distress. The agency set up CFS in communities in the three BAY states (the number CFS set up was not reported in the Q4 2018 update of the MHPSS SWG). Counselling and recreational services were provided by about 54 facilitators trained by Street Child, reaching 13,550 children. (Refer to Appendix 3 for key indicators). These children were given counselling and play activities, and were enabled to share personal experiences with the end goal of strengthening coping strategies especially among children who faced distress (75). The MHPSS Q4 update also reported that Save the Children also established 28 CFS reaching about 2,400 boys and 2,800 girls (77).

Mobile MHPSS mobile teams organized by the IOM in the BAY states (the number of teams/outreaches not reported) also provided informal education, culturally accepted recreational activities structured appropriately for adults, youth, children and teenagers. These activities were contextualized and age and gender tailored for the benefiting groups (75). Family tracing and reunification processes were carried out by a partner agency CHAD, while further mentorship and coaching were also planned following the reunification by the Goal Prime Organisation of Nigeria spanning across 15 camps and host communities in Borno state. IOM psychosocial activities also included "bereavement support" to IDPs as well as host communities in BAY states through the mobile teams (77).

Kaiser et al. studied IDPs and host communities in Maiduguri, Borno State, and identified self-help, community leaders, members of the community, NGOs and the government as sources of support. Interestingly, there were mixed findings regarding the community (positive and negative) as a source of support. Most of the respondents in the study identified praying and

interpersonal activities such as socializing and storytelling as coping strategies to deal with the mental health and psychosocial problems present in the IDPs context (47). In a survey in Yola, Adamawa State, coping strategies among families included participating in religious rituals, playing and watching soccer, as well as engaging in income generating activities (68).

Translators without borders (TWB) have aided the ethnical sensitivity and communication in the delivery of MHPSS to communities. A glossary for North East Nigeria provides MHPSS in kanuri, hausa and English translations. This aids correct interpretations of mental health, as well as what is meant by 'safe places'. TWB has also planned trainings on humanitarian aid interpretations for the MHPSS partners (75).

3.2.4 Focused, Non-Specialised Supports

Services provided in response to mental and psychosocial needs at this layer of the pyramid of care are directed at a smaller proportion of the population. Individuals, families or groups are targeted for interventions such as motivational interviews and interventions that are basic and low in intensity. This support is focused on and intended to enhance the integration of vulnerable persons socially. The services are provided by trained workers who may act under supervision to provide psychological first aid and counselling for victims of sexual and gender based violence as well as to make possible and necessary referrals. The workers may not have advanced knowledge or training in mental health, but are taught how to deliver the aid. Characteristically, persons who have suffered distress and disaster induced subclinical stress would respond to psychological first aid even without medication (2).

According to the UNFPA, about 30 safe spaces for women and girls were set up in North East Nigeria over a 10-year period from 2009 to 2019. These have provided individual and/or group counselling as well as empowerment activities for women. Up to 300,000 have been reached via information dissemination mechanisms from about 400 medical and non-medical workers trained on the provision of GBV services. (Refer to table 3.1) (80).

The MHPSS Sub-working group Q4 update reported that IDPs who returned to about 4 camps in Maiduguri, received GBV risk alleviation and emergency MHPSS from the IOM MHPSS mobile teams. These services reached more than 600 in one of these camps. The returnees benefited from psychological first aid which brings a sense of calm and safety. Information on available services and referral for further care or for health related services was provided (77).

Table 3.1 Number of beneficiaries and services provided at safe spaces according to UNFPA between 2018- July 2019(80: p. 3)

Services provided at safe spaces in Nigeria, 2018-July 2019

DESCRIPTION	2018	JAN-JULY 2019
Individuals reached through specialized services	—	11,797
Individuals benefiting from empowerment skills building and livelihood activities	32,320	2,769
Women and girls who accessed various services through engaging Women Friendly Spaces	7,082	2,576
Women and girls who received GBV protection items and critical materials needs	50,874	10,892
Community engagement outreach sensitization on principle and GBV	701,294	324,000
Individuals benefiting from specialized GBV response (medical and clinical care)	133,083	—
Number reached with mental health services, including Psychological First Aid	29,320	—
Total number of people reached with all services	—	807,191

3.2.5 Specialised service

Services provided at this layer of the pyramid are for the smallest proportion of the population such as persons with severe mental health disorders. The services include psychological support, referrals to specialized care where indicated and the commencement of long-term training of health care workers in the PHC or the general hospitals. The stakeholders at this layer includes local authorities, the international and local medical organisations and the local health workers. The task of these stakeholders is to facilitate a route from the current minimal response towards a comprehensive response to severe mental health disorders (2).

In a collaboration with the Federal Neuro-psychiatric hospital, the State Primary Health Care Development Agency and the Ministry of Health, the WHO has focused on the provision of specialized mental health services in Borno State (refer to table 3.2). These services are provided through the PHC facilities as well as the clinics in some of the camps. About 53 female- and 17 male- primary health workers were trained using the mental health gap action intervention guide (mhGAP IG). These workers were to be supported by the specialists while carrying out treatments for mental health disorders (79).

Table 3.2 WHO Mental health specialized services in 2018 (75,77-79).

2018	Mental Health Outreaches	Mental Health Specialists	Mental Health Patients	Referrals	Admissions	Mental Health Disorders
Q1(Jan-March)	251	10	4,290	1,028	124	• Alcohol and substance use disorders • psychotic disorders, • epilepsy, • seizure disorders, • severe emotional disorders.
Q2 (April-June)	294	10	5,031	282	99	Same as above
Q3 (July-Sept)	301	10	5,610	546	160	Same as above
Q4 (Oct-Dec)	298	10	6,468	N/A	N/A	Same as above

The international organization, Medecins du Monde (MDM) also provides comprehensive services integrated with other Primary Health Care services (refer to table 3.3) (78). MDM has ensured referrals of IDPs in need of specialized services for their mental healthcare needs in camps and host communities in Borno State. This was made possible through a vital

collaboration with WHO and other agencies including IOM, IRC, Christian Aid, and Save the Children. A psychiatric nurse assists with case follow up, drug dispensing as well as referral to Tertiary hospital when needed (77) MDM also offered training on MhGAP to team members. The NEEM foundation has also aided with provision of specialized services to 2 host communities and 1 IDP camp in Maiduguri, Borno State. Approximately 1000 clients with PTSD, Depression, Anxiety and Stress were attended to by clinical psychologists or the trained counsellors and protection officers (78).

Table 3.3 MDM Mental health comprehensive PHC services (77,78).

Coverage	Intervention	Referral Pathway	Supervision/Training of health workers	Mental Disorders
3 IDP camps and host communities	One-on-one counselling Psychoeducation Mental health sensitization Clinic based services	Collaboration with WHO, IOM, IRC, Christian Aid, and Save the Children	External supervision at 3 months' interval Training of team members on mhGAP and MHPSS understanding	PTSD Depressive Episodes Anxiety disorder Psychoses

Although the intent of this review was to provide details about IDPs living in formal and informal camps and host communities; much more data would be needed to clearly show the level of benefit to MHPSS interventions.

3.3 Guidance and Evidence Based MHPSS Interventions for Mental and Psychosocial Needs of IDPs

3.3.1 Implementation of MHPSS with The Human Rights Framework

The effective delivery of MHPSS demonstrates a close link between the promotion of psychosocial wellbeing and mental health care on one hand with human rights protection and promotion on the other (2).

As the minimum, the community should be engaged in the delivery of MHPSS in humanitarian settings. These engagements could be formal or informal with the goal to facilitate the coordination and implementation of the programs. Community partnerships, mobilization and sensitization are required to support the program uptake of MHPSS. Moreover, all Engagements should provide information about how concerns about confidentiality and the presented ethical guidelines and standards should be raised (2,81).

Partnership with the existing government is also critical for implementation of MHPSS. The support received from the government agencies will be a prerequisite to overcome challenges with implementation. Furthermore, this partnership can be utilized to advocate for the alignment of government policies, programs and legislations with global standards for human rights (2,81).

The providers of MHPSS must be trained for efficient delivery of programs such as Cognitive Behavioural Therapy (CBT), Narrative Exposure Therapy (NET) and basic counselling. As these workers may have been affected by the conflicts themselves, quality training is crucial in order to mitigate that their self-lived conflict experience influences how they provide the

intervention to recipients. Trainings on the IASC also recommends an integrated focus on human rights and protection during the training of these workers (2,81)

Kamali et al. (82) identified barriers to MHPSS implementation, including a lack of adequate security and poor access to affected persons especially in the context of on-going conflicts. A lack of basic understanding of the means of communication and cultural appropriateness may also hinder the programs. Similarly, the diversity of the IDP population, the lack of infrastructure such as adequate network coverage and the use of improperly trained workers were also identified as barriers.

3.3.1 Acceptance of MHPSS

Kamali et al. (82) identified 3 factors that facilitate MHPSS interventions. First, the programs should be integrated into the already available PHC services and established referral networks. Second, there needs to be a broad adoption of improved services geared towards specific information on mental health care for children at PHC. Thirdly, interventions must be adapted to the prevailing conditions. or instance, to deliver psychosocial support through family involvement or the use of teachers to reach children who attend school. The approach involving the schools is an effective way to reach large numbers of children that potentially suffer distress related to the conflict. Through the schools, MHPSS can be provided in an environment which is non-stigmatizing. Notably, Kamali et al. also found that delivering the interventions for children in groups was cost-effective, while also determining the ideal lengths and intensity of programs to achieve the required outcome (82).

3.3.2 Outcomes of MHPSS

In a meta-analysis by Bangpan et al. (83) that examined the delivery of MHPSS, found limited evidence that the use of CBT can help improve the functions of MHPSS, including a reduction in grief, anxiety symptoms, depression and PTSD. Furthermore, the analysis showed that NET and psychoeducation alone or with medication also reduced anxiety symptoms, depression and PTSD. However, the research did not produce sufficient evidence regarding the reduction of anger, other symptoms and emotional challenges (83).

It is likely that unintended consequences of the delivery of MHPSS could occur in humanitarian settings as a result of the abuse of power and positions. The key actors must be aware of the potential for this to occur in order to be able to mitigate it (2). Bangpan et al. (83) also revealed that studies where the MHPSS programs for depression were not culturally and socially adapted resulted in such unintended consequences. Similarly, in the context of on-going conflicts, the timing of the delivery is important in order to avoid unintended harm to the recipients. This implies the need to ensure longer pilot periods before scaling up the interventions in the face of security threats. The likely unintended effects include anxiety like symptoms or social problems as a result of bypassing the community structures (2,83).

3.3.3 MHPSS for IDPs in The Covid-19 Outbreak

The global pandemic has impacted humanitarian activities across the world. Vulnerable groups are the hardest hit, including groups with coexisting systemic diseases and persons with mental and psychosocial needs. During the pandemic, displaced persons face increased anxiety and stress levels which in turn multiply the chances for increasing mental health challenges and the risk of long term consequences. In the context of limited resources which many countries face, MHPSS services are frequently interrupted. Lockdown measures to limit the spread of the outbreak may invariably disrupt and constrain MHPSS programs and school programs which serve to carry out MHPSS activities (84,85).

The IASC guidelines stipulate that the different layers of MHPSS should be integrated with the response programs for the outbreak. Such response programs must be aligned with community strategies, outreach within the community, contact tracing, and the usual activities within the health facilities. In order to achieve this, there is a need for country preparedness, especially in areas where there to date have not been any outbreaks yet, together with solid support for frontline health workers that provide mental health care (86).

The "whole society" approach is also recommended. This involves tackling the mental health and psychosocial needs of the whole population without segregating based on contact or non-contact with the virus. Furthermore, all groups need to be targeted, regardless of ethnic background, gender or age group. The central tenant of this approach is the provision of consistent messages which are clear about COVID-19 and what to be done if one feels ill. Regulation of messages about anxiety and how to support oneself should be provided, and individual/self-care responsibilities should also be promoted along with cultural practices (86)

3.4 Case Studies

In this section, two case studies are presented where IASC guidelines for MHPSS was implemented. The first is from a similar context of an on-going conflict and the other from a country in the aftermath of a natural disaster.

3.4.1 Syria

A crisis which started in April 2011 has spiralled for close to a decade creating the biggest IDP population in the world. About 6.2 million persons have been displaced in Syria due to the on-going conflicts. There are also Syrian refugees in Egypt, Jordan, Iraq, Lebanon, and in Turkey due to the unrest. (87) The UNHCR has taken direct implementation of MHPSS programs in the absence of partner agencies. (88)

A three-fold approach consisting of community based psychosocial outreach, case management, and the use of a psychosocial centre formed the MHPSS response by UNHCR in Syria. The community centres were set up to provide community support, thereby reducing social isolation and addressing the barriers to accessing psychosocial support services. These centres were located the areas with highest need. Similarly, the outreach programs provided mobile services to persons in need. A peculiar aspect of the response is the case management approach for MHPSS that is implemented by the International Medical Corps. This approach was adopted because the displaced persons require a comprehensive mental health response to their different and complex needs. This offers protection and recovery to the vulnerable persons affected. The IMC reported that the operations cut across the community and family support, focused non specialized support as well as specialized service provision depending on the needs of the individual. This ensures an efficient and effective means of optimizing the client functioning. The IMC has established a case management team consisting of psychologists, psychiatrists, nurse, social worker, and primary health worker that meet weekly to review the progress of each client. Members of this team are trained to ensure referrals across the layers of the pyramid with informal support thereby providing comprehensive and accessible services. This model provides a multi-sectoral and integrated approach to the spectrum of mental health needs that is based on proper coordination of care as stipulated in IASC guidelines (2,88). In a review of the MHPSS response in Syria, it was described as "a unique method of addressing psychological disorder among targeted groups" (88: p. 45).

3.4.2 Nepal

Nepal suffered a heavy magnitude earthquake (7.8) in 2015 which led to a loss of 8000 lives, injuring more than 22,000 people and left over 2.5 million persons without shelter. The country has a mental health policy which has also suffered hiccups in its implementation, owing to the absence of strong representation in the Ministry of Health. Although the country had validated and also translated the IASC guidelines into its language, it lacked a focal person to drive the MHPSS response in the previous emergencies. Coordination of the response to the 2015 emergency was on this occasion conducted at the central as well as the district levels through mechanisms that were mediated by the IASC clusters. It was a multifaceted response: basic services and security were prioritised as well as formidable resilience was derived from the strong bonds that existed between families and the community. Furthermore, training of health workers with mhGAP humanitarian intervention guide was conducted and over 500 health workers including doctors, nurses, female community health workers and other paramedics from the affected districts benefited. The result was an improvement in the competence of these workers in detecting and managing common mental disorders. Having faced challenges such as overlap of interventions (due to several agencies seeking to provide mental health services), as well as delay in the mental health sub-cluster operations, the health sector also developed a progressive response to address its challenges. Refer to table 3.4 for details (89).

Table 3.4 Nepal's MHPSS Response (89).

Immediate plans	Long term plans
Form a unit for mental health in the Ministry of Health	Create mental health specialist units in the region with solid referral structure available
Establish a representation for MHPSS in the Ministry of Health	Follow a stepwise integration of Mental health into existing PHC
Circulate a developed plan for MHPSS in the event of a disaster	Organise a diploma to run as a short course for health workers
Form a strong monitoring and evaluation to ensure the interventions received are of adequate quality.	Conduct programs that increase the population awareness about mental health.

CHAPTER 4: Discussion

Through a review of the existing available literature, the burden of mental health disorders among IDPs in North East Nigeria has been presented. Based on this review, the MHPSS response to these needs has been outlined and additionally, guidance and evidence based MHPSS interventions from other similar settings has been highlighted.

Research on mental health among IDPs in the region mainly focused on depression and PTSD (which were notably prevalent). Similarly, studies carried out among IDPs in the North central and North west of Nigeria focused on the same conditions and reported high prevalence of depression and PTSD (50,90-92). Most authors agree that the high proportion of depression and PTSD may be related to socio-demographic variables (including age and sex) as well as the difficult living conditions in the camp(s). With regards to other mental disorders like schizophrenia, substance use disorder and bipolar disorder, there is paucity of available data. Perhaps researchers focus more on the less dramatic mental disorders ("acceptable") like depression rather than the severe mental disorders which may be pre-existing prior to displacement and further exacerbated by the crisis. The lack of reliable research on these disorders presents a notable gap for future research endeavors.

Mental and Psychosocial needs were also examined based on different inherent vulnerabilities. This was done as a means to highlight gender differences and age-related considerations. While the population of women is notably higher than men among the IDPs, Kaiser et al. reported higher mental health scores among men. This is however not consistent with other local and international studies that report to the contrary, namely that women suffer a greater prevalence of mental health conditions than men. It is plausible that the differences are attributable to a higher proportion of women residing in the other locales studied (49,93,94). It is nevertheless recognizable and alarming that women face significant gender biased challenges such as rape, forced labour, gender identity crisis, subsequent stigmatization and marginalisation. For males, the gender biased ailments include challenges of frustration over the lack of freedom to make decisions which increase their distress. Children were found to lack community support and were identified as victims. The situation was most dire for, the female child who faces high risk of sexual abuse living in the camp(s).

The factors contributing to the mental and psychosocial needs identified in this review include the harsh living conditions in the camps, the inaccessibility of educational and social services and so on. These factors are more likely worse in the informal camps and the host communities compared to the formal camps, given the IOM's 2015 report of more attention being received at the formal camps by the government agencies (68).

4.1 Gaps in The Service Provision for The Mental and Psychosocial Needs

Due to the reliance on the available reports which are mainly spontaneous, sporadic and convenient data from agencies working in the region, it is difficult to produce a gap analysis of the response to the mental health and psychosocial needs of IDPs in North East Nigeria. Nevertheless, some notable gaps are presented. First and foremost, there are indications of an unfair delivery of services between the formal camps, informal camps and host communities as presented by the IOM (58,68). Although much more disaggregated data about services to formal camps, informal camps and host communities would have been desirable, the hypothesis drawn from this research is that the informal camps and host communities are underserved with MHPSS. This is further buttressed by the fact that there is a lack of a legal backing that enables proper planning for all IDPs not regarding their destinations (14,58).

The background information of this update shows that food remains the highest unmet need among the IDPs. It was identified that a high percentage of persons accessed food offsite, and that a proportion had zero food provisions. This doubtlessly contributes to the negative feelings of anger, sadness and anxiety among IDPs. Furthermore, the high percentage of displaced persons living in host communities and/or ad hoc houses serves as evidence that shelter provision remains inadequate. While it is expected that the training on MHPSS integration received by the actors in shelter, camp coordination and camp management could ensure service delivery with dignity under safe conditions, there is scarce evidence to confirm that this has materialized in the field. Camps are reportedly overcrowded, lack amenities and the living conditions are harsh.

While the interventions described in the 2nd layer of the pyramid are useful, the community ownership and participation in the various activities still remains a challenge. Given that only about 4.4% of displaced persons could participate in the design of activities at a given camp indicates that community participation remains minimal. According to the IASC guidelines, community participation can range from a minimal involvement to a complete control of aid activities (2,70). Given the context of an on-going conflict in the North East, a middle-of-the-road level of participation for both the community and humanitarian agencies is needed. Moreover, the involvement of religious and traditional leaders is still not regulated or documented despite the heavy reliance of religious activities to support coping mechanisms among the populations in question. This also calls for the establishments of trado-orthodox (traditional and orthodox) mechanisms for delivery of care.

Mobile MHPSS teams are highly relevant given the context of insecurity concerns and have been useful in the delivery of community based support. The coverage of this strategic approach is mainly in Borno State. Due to the significant amount of lost healthcare infrastructure from the conflict, mobile MHPSS teams could serve as an opportunistic means of delivering support. The WHO acknowledges and utilizes mobile health teams to deliver health care to remote areas without access to services (95) This option should be explored as a means of expanding coverage of MHPSS to the spontaneous settlements (informal camps) and host communities in the North East.

Other gaps in the 2nd layer include a lack of trust within the community which is partly due to existing ethnic variation; this is also partly due to the lack of confidence in the existing structures of aid delivery. For this reason, there is an urgent need for accountability systems with sound reporting mechanisms for cases of power abuse and human rights compromises. Additionally, services in this layer can be expanded through the use of schools to reach children in need of psychosocial support considering the age distribution of IDPs. However, this has not been fully explored in North East Nigeria though evidence from a systematic review highlights its importance (82). Furthermore, considering the evolving situation in the region it is germane that these interventions are well timed in order to reduce the likelihood of unintended consequences as described by Bangpan et al (83).

A further consideration at this layer would be a response to the current covid-19 pandemic which can accentuate mental health needs among displaced persons because of the anxiety it causes and an apparent neglect by key actors due to diverted attention. As recommended above, a "whole society" approach will be useful in facilitating an integrated response. The imminent threat to the response however, is the inconsistency in planned and executed delivery of services by the past successive arms of government. It is therefore imperative that displaced persons understand their role(s) in cultivating the response to promote sustainability of interventions.

As regards the third layer of the pyramid, whilst UNFPA have set up 30 safe places for women and girls over the past decade, this may be inadequate considering the large population (1.1 million) of displaced women and girls who are potentially at risk for gender based violence and other forms of abuse and victimization. Similarly, there is a need to train more workers to deliver psychological first aid for the existing and new community support centers.

Interventions at the apex of the pyramid are predominantly driven by a nexus between the agencies and the conflict affected public health system in the region. Sadly, this is hampered by the failure to fully integrate mental healthcare with general health care at all tiers of the Nigerian health system and hence limits the accessibility, availability and the affordability of mental healthcare. This resonates especially for severe mental disorders in the conflict- and displacement affected states of the North East. Similarly, the low ratio of mental health specialists in the region (0.069/100,000) (35) implies the need for adequate referral pathways and more training of workers with contextualised guides like the mhGAP IG. As most services are provided at the PHC through a reliance on international organizations, the current delivery may not be sufficient to offer a sustainable and comprehensive response to mental healthcare needs in the long term. This also calls for more community ownership, government commitment and less dependency on aid.

While the framework used in this analysis is universally acceptable for analysing MHPSS interventions in humanitarian settings, it is not without its drawbacks. Firstly, the framework is very generic and lacks considerations for the role of self-care as well as the informal structures that need to be considered in MHPSS delivery. It also segregates services into layers even though there may be cross-cutting issues across the different layers such as layers 1,2 and 3. Finally it does not highlight the cost-effectiveness of interventions which may be necessary to guide programing.

4.2 Translating Interventions to The Nigerian Context

This section discusses the potential to translate the key learning points from the evidence-based guidance and case studies presented in this research, into the North East Nigerian context. Notably, more interventions focusing specifically on informal camp settlements or vulnerable groups including girls and women are needed especially considering the larger population of displaced persons in the host communities and the informal settlements.

Holistic Interventions across the Layers of the Pyramid: As highlighted in the Syria and Nepal case studies MHPSS services may be delivered holistically and simultaneously across the layers of the pyramid in an efficient, effective and comprehensive manner. Additionally, cross-cutting issues such as gender, age, culture, which are predominant factors in the North East must be considered while adopting a case management approach such as outlined in the Syria case study.

Strong Leadership: From the Nepal case study, strong leadership demonstrated by the Ministry of health was pivotal to successfully scaling up the mental healthcare services in the country. Nigeria has leadership structures such as the Inter-ministerial task force coordinating humanitarian response, FMOH, FMHDS, MHPSS SWG etc. that pose as potential candidates to be called upon for the type of strong leadership that is necessary to ensure sustainability of future interventions towards reforms in the health system. (Refer to Table 3.4 and Appendix 5). The dilemma that thus remain is whether these candidates have the requisite forbearance for implementation.

Focus on Training: Evidently, as shown in the case of Nepal, competency in delivering mental health service improved with increasing numbers of trained health workers. This leads to a corresponding rise in the number of patients diagnosed and treated. Although mhGAP has been contextualised in Southern Nigeria (36), similar implementation of the guidelines in a conflict setting such as the North East would be useful in expanding coverage of services in the region as demonstrated in the Nepal case study.

This review has developed an acronym to provide guidance for MHPSS interventions: the project ***NORTH EAST***

N: ***Necessities*** including food, shelter and protection should be considered priority. These must be provided in a dignified way at all IDP residencies: the formal and informal camps and in host communities (Refer to Figure 1.2; As discussed in Sections 3.2.2 and 4.1).

O: ***Ownership*** of interventions by the community is critical for the sustenance of any interventions (As discussed in sections 3.1.4.4 and 4.1).

R: ***Referral*** of severe cases of mental disorders through established pathways in order to provide comprehensive and specialized care (As discussed in section 3.2.5 and 4.1).

T: ***Traditional*** and religious actors must be recognized as important resources for coping, and hence also be documented and regulated (Refer to sections 1.6, 1.7, 3.2.3, As discussed in 4.1).

H: Mobile ***Health***; mobile MHPSS teams should be used strategically to expand coverage of psychosocial support in the region, particularly in the context of on-going conflict (As described in sections 3.2.3,3.2.4,4.1).

E: ***Empower*** medical and non-medical staff through training on MHPSS as well MhGAP IG for PHC staff (As described in sections 3.2.5, 3.4.2,4.1).

A: **Awareness** and mobilization of the community on MHPSS together with the adoption of a "whole society approach" in the face of outbreaks such as covid-19 (Refer to section 3.3.3, 4.1).

S: **Schools** form an efficient platform for reaching broader groups with MHPSS and should be harnessed as such (As discussed in sections 3.3.1, 4.1).

T: Well***-Timed*** intervention; interventions must be piloted before scaling up to prevent unintended consequences of interventions (As discussed in 3.3.2, 4.1).

4.3 Limitations of The Study

Although the author has attempted to present recent data, including unpublished literature, in a systematic way, the study is not without limitations:

1. There was a lack of adequate qualitative and quantitative data, thus certain issues may have been unwittingly omitted.
2. Perceptibly, the issue of stigma and discrimination may have added to the difficulties for researchers in general to report valid and comprehensive results.
3. There was a striking scarcity of disaggregated data describing formal and informal camps and host communities. Data was also scarce with regard to sub demographic groups such as age groups and gender.
4. Satisfactory information on the cost effectiveness of MHPSS interventions in the North East was not available.

CHAPTER 5: Conclusion and Recommendations

5.1 Conclusion

Internally displaced persons represent a large vulnerable population in North East Nigeria. Their mental and psychosocial needs are considerable, with a high prevalence of depression and PTSD. The consequent effect at levels, from the individual, their families and the community they belong to cannot be overstated. The response to these needs is spearheaded by the MHPSS Sub working group and comprises several international and local organizations as well as other partner agencies. This initiative has resulted in appreciable efforts in the provision of basic services, community and family support, focused non-specialized sand specialised services. Nevertheless, the fact that a majority of displaced persons in formal, informal camps and host communities lack basic supplies (figure 1.1), and the unfair service provision between settlements calls for more robust attention to expand the provision and coverage of MHPSS irrespective of the type of settlement. There is a strong need to develop increased community ownership through trust building and mobilization of community members while acknowledging the important roles the traditional and religious leaders in the community play.

Considering the fact that more than half of the IDPs are below the age of 17, urgent attention must be directed to the utilisation of schools to expand the delivery of MHPSS. Furthermore, the use of mobile MHPSS teams is crucial in providing informal education and psychosocial support in the context of the on-going conflicts while rebuilding the health system.

Finally, in order to effectively translate the learning points from the case studies presented to the North East Nigerian context, key areas have been discussed including a holistic delivery of cross-cutting interventions across the pyramid, a demonstration of strong leadership by the government, and a greater focus on the training of more community health volunteers and health workers using mhGAP IG to expand the coverage of MHPSS in North East Nigeria.

5.2 Recommendations

The recommendations derived from this review is hereby presented to the following important stakeholders: The Federal Ministry of Health (FMOH), The Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development, MHPSS Sub Working Group in the North East as well as for academics. The objective of the recommendations is to enhance and secure a solid mental health policy and delivery in North East Nigeria.

5.2.1 The Federal Ministry of Health (FMOH)

1. Prioritise of MHPSS and the full, broad integration of mental healthcare with existing PHCs in line with the Mental Health Policy.
2. Demonstrate strong leadership in the development of the Mental Health Strategic Framework for the North East.
3. Monitor the integration of MHPSS with the current covid-19 outbreak response, and adopt the 'whole society' approach in an eventual outbreak at IDP camps.

5.2.2 The Federal Ministry of Humanitarian Affairs, Disaster Management and Social Development.

1. Strengthen the focus on its food security program for all IDPs, both in formal and informal settlements as well as in the host communities while maintaining dignity and humanity in all its provisions.

2. Facilitate the incorporation of MHPSS in the educational sector in the humanitarian setting to expand MHPSS coverage.
3. Update guidelines for camp coordination and management, while considering splitting and expanding camps to accommodate more displaced persons.

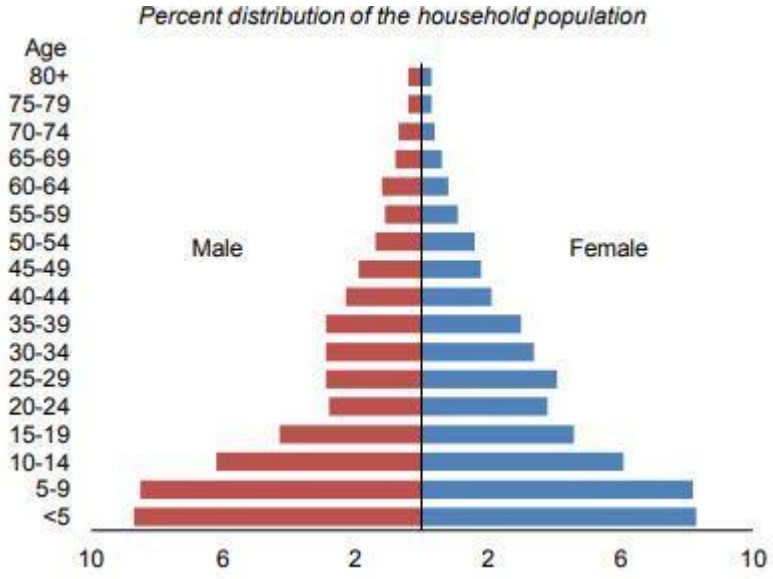
5.2.3 MHPSS Sub Working Group in the North East.

1. Develop accountability mechanisms that ensure the implementation of the MHPSS through a human rights perspective: maintaining equity, community participation, and the reduction of unintended consequences of interventions.
2. Proper documentation and regulation of traditional and religious groups which play a role enabling coping strategies for the IDPs.
3. Adopt a joint, contextualized monitoring and evaluation framework for partner agencies INGOs, NGOs to harmonise each organisation's indicators and targets according to the multi-layered IASC pyramid.

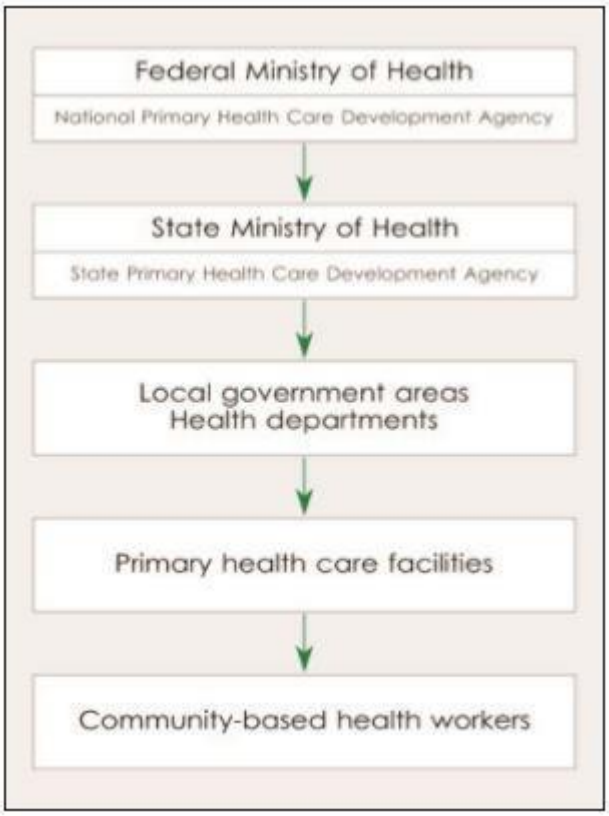
5.2.4 Academics

1. Conduct quantitative and qualitative research on MHPSS interventions at formal, informal and host communities with a focus on disaggregated data.

Appendix 1 Nigeria's population Pyramid (7: p. 17)



Appendix 2 Nigerian Health System (26: p. 2)



Appendix 3. Mental Health Key Indicators in a humanitarian response (96: p. 340).

Key indicators

Percentage of secondary healthcare services with trained and supervised staff and systems for managing mental health conditions

Percentage of primary healthcare services with trained and supervised staff and systems for managing mental health conditions

Number of people participating in community self-help and social support activities

Percentage of health services users who receive care for mental health conditions

Percentage of people who have received care for mental health conditions who report improved functioning and reduced symptoms

Number of days for which essential psychotropic medicines were not available in the past 30 days

- Less than four days

Appendix 4: Literature Reviewed for Mental health and Psychosocial needs in the North East.

	Purpose of study	Design	Setting of study	Key Findings
Aluh et al. (2019)	To assess the prevalence of depression and post-traumatic among IDPs.	Cross-sectional study Sample size: 1200 Face to face interviews with selected members of households	6 IDP camps in Borno State.	96.1% of respondents were depressed. Severe depression seen in 11.3%. Screening positive for PTSD and being unemployed were the significant predictors for depression
Nwoga et al. (2018)	To investigate the prevalence of depression, disability, and correlates among internally displaced persons.	Cross-sectional study. Systematic sampling. Sample size: 422 adults	2 IDP camps in Yobe State.	Prevalence of probable depression: 39.3% Age, marital status, living condition, and general health were significantly associated with depression.

Literature reviewed for PTSD

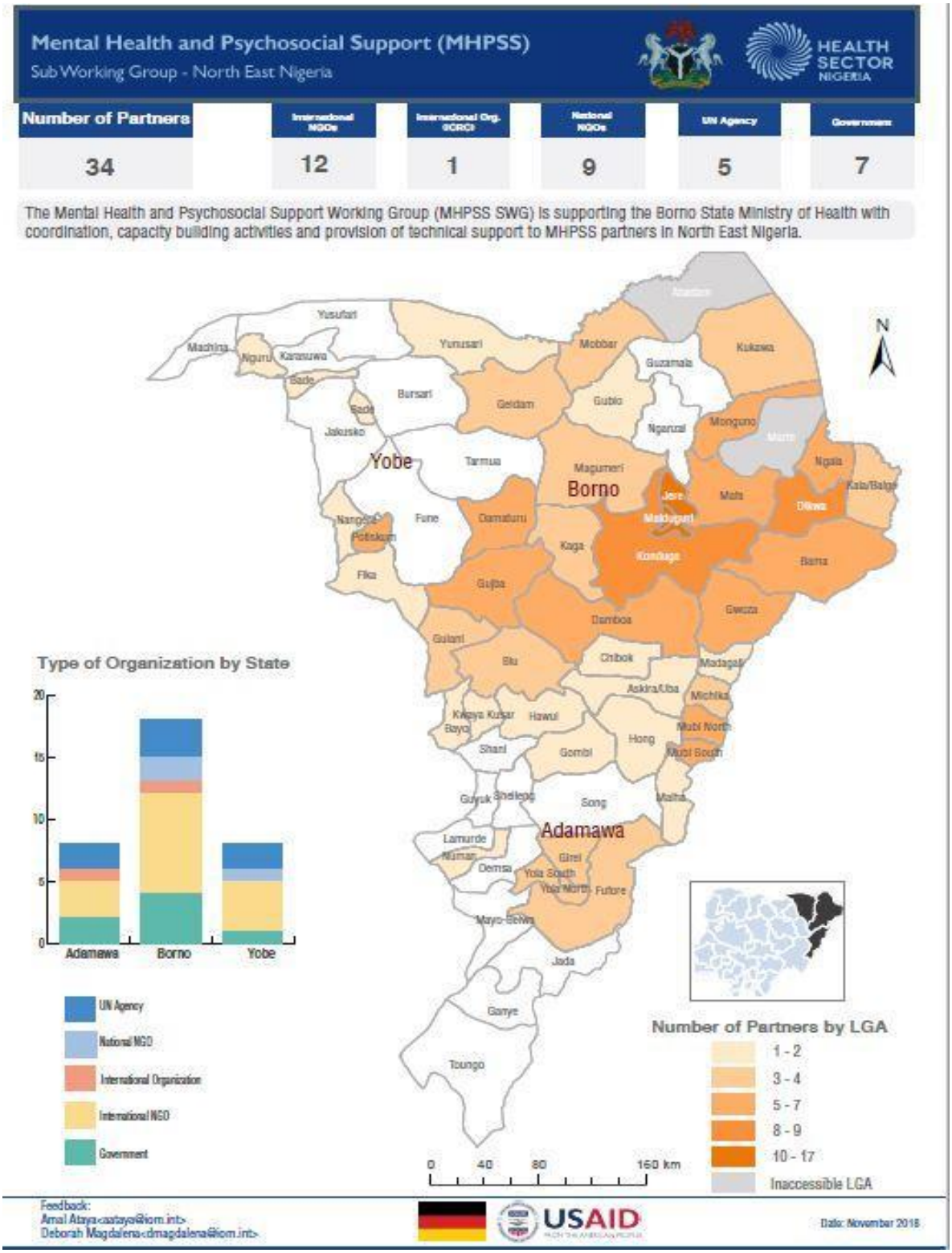
Author	Purpose of Study	Design	Setting of study	Key Findings
Aluh et al. (2019)	To assess the prevalence of depression and post-traumatic among IDPs	Cross-sectional study.	Cross-sectional study Sample size: 1200 Face to face interviews with selected members of households	75% Prevalence of PTSD with 68% comorbidity with depression.

Literature reviewed for Psychosocial Needs of IDPs in North-East Nigeria.

Author	Purpose of Study	Design	Setting of study	Key Findings
Kaiser B. N. et al. (2019)	To explore the mental health and psychosocial needs, resources and coping strategies among IDPs and host communities	Mixed methods study Free list interviews, Focused group discussions	Four IDP communities in Borno State.	High burden on mental health needs. Males had higher mental health symptoms. Psychosocial health associated with Loss of means of livelihood, collapse of political and leadership structures.
UNICEF Nigeria, (2019)	To identify MHPSS needs and the available support as well the perceptions of MHPSS for children	Rapid needs assessment survey-Qualitative assessment.	IDP camps, transit centres and host communities in 6 LGA areas in Borno State	Psychosocial needs were identified in 3 themes: growing with armed groups, stressor continuation and repeated displacements.
Luana Giardinelli (2017)	To explore the mental health and psychosocial	A Review.	North East Nigeria	Victims of the conflict suffer psychological

	needs and the response in the north east Nigeria			distress which may be severe Negative emotions mainly exacerbated by difficult living situations in the crowded camps
Kwajaffa P.S. et al. (2018)	To evaluate the psychosocial support services available at IDP camps.	Descriptive cross-sectional study. Multistage and systematic sampling technique. Sphere-based Assessment.	9 IDP camps at Maiduguri	Awareness of social amenities varied. Majority aware of religious activities (96.8%) and about 4.4% could participate in building activities in the camp.
Onyencho V. C. et al. (2017)	To assess the psychosocial needs and services at an IDP camp	Descriptive cross-sectional study Multistage and systematic sampling techniques Humanitarian Emergency Settings Perceived Needs Scale(HESPER) used.	9 IDP camps at Maiduguri	Serious problems identified include food shortage (91.6%), accommodation (85.1%), and WASH services.
IOM, (2015)	To carry out a psychosocial needs assessment of the internally displaced population.	A Report. Utilised 32 interviews with national Key players Participation at working groups at state-level 261 interviews with 746 camp residents.	Official and Unofficial camps ; Host communities in Adamawa State	Sadness, fear, sense of loss and worry common. Major factors responsible include a desire to return home but without the ability and the loss of loved ones and possessions

Appendix 5: The MHPSS Sub working group and Partners in the North East (74:p.1).



References

1. OCHA. Guiding Principles on Internal Displacement. 2004. Available from: https://www.unhcr.org/protection/idps/43ce1cff2/guiding-principles-internal-displacement.html [Accessed on 08/08/2020].

2. Inter Agency Standing Committee. Iasc Guidelines on Mental Health and Psychosocial support in Emergency settings. 2007 Available from: http://www.humanitarianinfo.org/iasc/content/products [Accessed on 07/03/2020].

3. World Health Organisation. mhGAP Intervention Guide - Version 2.0 Available from: https://www.who.int/publications/i/item/mhgap-intervention-guide---version-2.0. [Accessed on 04/08/2020].

4. World Atlas. Geography of Nigeria, Landforms 2017 Available from: https://www.worldatlas.com/webimage/countrys/africa/nigeria/ngland.htm [Accessed on 07/03/2020].

5. Central Intelligence Agency. The World Factbook - Nigeria 2020. Available from: https://www.cia.gov/library/publications/the-world-factbook/geos/ni.html [Accessed on 05/04/2020].

6. IBRAHIM AZ. North-Eastern Nigeria from the 19th Century: A Unit of Historical Study. 2012 Available from: https://www.researchgate.net/publication/298352849_North-Eastern_Nigeria_from_the_19th_Century_A_Unit_of_Historical_Study. [Accessed on 05/04/2020].

7. National Populatiion Commission (Nigeria). Nigeria Demographic and Health Survey 2018. Available from: www.DHSprogram.com [Accessed on 20/05/2020].

8. National Bureau of Statistics. Demographic Statistics Bulletin. 2017. Available from: https://nigerianstat.gov.ng/elibrary?queries[search]=Demographic statistics [Accessed on 06/04/2020].

9. My Guide Nigeria. North East Region 2017. Available from: https://www.myguidenigeria.com/regionalinfo/north-east-region [Accessed on 04/08/2020].

10. Knoema. Nigeria | Data and Statistics 2018. Available from: https://knoema.com/atlas/Nigeria [Accessed on 06/04/2020].

11. World Bank. Nigeria Overview 2019. Available from: https://www.worldbank.org/en/country/nigeria/overview [Accessed on 06/04/2020].

12. National Bureau of Statistics. Poverty and Inequality in Nigeria. 2019. Available from: https://nigerianstat.gov.ng/elibrary?queries[search]=poverty [Accessed 07/07/2020].

13. United Nations High Commission For Refugees. Multipartite Agreement For The Local Integration Of Liberian And Sierra Leonean Refugees In Nigeria Between The Government Of The Republic Of Liberia, The Government Of The Republic Of Sierra Leone, The Government Of The Federal Republic Of Nigeria, 2007. Available from: https://www.unhcr.org/49e479ca22.pdf [Accessed on 07/04/2020].

14. Mohammed FK. The Causes and Consequences of Internal Displacement in Nigeria and Related Governance Challenges. 2017. Available from:http://www.swp-berlin.org [Accessed on 06/04/2020].

15. Samson Adesola A, Ola A. A Historical Analysis Of Violence And Internal Population Displacement In Nigeria's Fourth Republic, 1999-2011. Int J Peace Confl Stud.

2015;2(3):13–22.

16. Oluyemi F. Displacements in the Context of Social Crises in the Oil-Rich Niger-Delta of Nigeria and Oil-Rich Bakassi Peninsula in Cameroon. Vol. 2, Int J Soc Work. 2014. 2(1):28 - 34. DOI: 10.13189/ijrh.2014.020104

17. Anugwom E.E. Origin, Growth and Ideology of Boko Haram. In: The Boko Haram Insurgence In Nigeria. New Directions in Islam. Palgrave Macmillan, Cham. 2019 Available from: https://doi.org/10.1007/978-3-319-96959-6_4. [Accessed on 01/08/2020].

18. Emmanuelar I. The case of Boko Haram. Afr J Pol Sci Int Rel Hum N Nig:. 2015;9(7):284–296.

19. Olanrewaju FO, Olanrewaju A, Omotoso F, Alabi JO, Amoo E, Loromeke E, et al. Insurgency and the Invisible Displaced Population in Nigeria: A Situational Analysis. SAGE Open. 2019;9(2):1-12

20. DTM Nigeria. Nigeria — Displacement Report 31 (February 2020). Available from: https://dtm.iom.int/reports/nigeria-%E2%80%94-displacement-report-31-february-2020 [Accessed on 05/05/2020].

21. Human Rights Watch. Nigeria: Officials Abusing Displaced Women, Girls 2016. Available from: https://www.hrw.org/news/2016/10/31/nigeria-officials-abusing-displaced-women-girls Accessed 06/05/2020

22. Ekezie W, Timmons S, Myles P, Siebert P, Bains M, Pritchard C. An audit of healthcare provision in internally displaced population camps in Nigeria. J Public Health 2018;1–10.DOI: :10.1093/pubmed/fdy141

23. Government of Nigeria. Nigeria - National Primary Health Care Development Agency Decree 1992 (No. 29) Available from: http://www.ilo.org/dyn/natlex/natlex4.detail?p_lang=en&p_isn=58758&p_country=NGA&p_classification=14 Accessed on 05/07/2020

24. FMOH. Nigeria Health Facility Registry 2019. Available from: http://hfr.health.gov.ng/statistics/tables [Accessed on 05/07/2020].

25. The World Bank. Physicians (per 1,000 people)- Nigeria | Data 2018 Available from: https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=NG [Accessed on 05/08/2020].

26. World Health Organisation Global strategy on human resources for health: Workforce 2030. 2017 Available from: http://www.who.int/hrh/resources/pub_globstrathrh-2030/en/ [Accessed on 17/07/2020].

27. Debarre A. Providing Healthcare in Armed Conflict: The Case of Nigeria. 2019 Available from: https://www.ipinst.org/wp-content/uploads/2019/01/IPI-E-RPT-Providing-HealthcareNigeria.pdf [Accessed on 05/08/2020].

28. World Health Organisation. Global Health Expenditure Database 2017. Available from: https://apps.who.int/nha/database/Select/Indicators/en [Accessed on 05/07/2020].

29. Punch Newspaper. Nigeria has lowest health budget in Africa —Adewole. 2016 Available from: https://punchng.com/nigeria-has-lowest-health-budget-in-africa-adewole/[Accessed on 07/04/2020].

30. Health Sector Nigeria. Health Sector Bulletin 2020: North East Humanitarian

Response Available from: https://www.who.int/health-cluster/countries/nigeria/Nigeria-Health-Sector-Bulletin-January-2020.pdf?ua=1 [Accessed on 05/08/2020].

31. Kinzli L. NIGERIA: Humanitarian Needs Overview 2018 Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/01022019_ocha_nigeria_humanitarian_needs_overview.pdf [Accessed on 24/01/2020].

32. FMOH. Northeast Nigeria Health Sector Response Strategy-2017/18. 2015. Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/11052017_nga_health_sector_strategy_2017_2018.pdf [Accessed on 05/08/2020].

33. World Health Organisation. Who-Aims Report On Mental Health System In Nigeria Ministry Of Health Nigeria. 2006. Available from: https://www.who.int/mental_health/evidence/nigeria_who_aims_report.pdf?ua=1 [Accessed on 05/08/2020].

34. World Health Organisation. Who-Aims Report On Mental Health System In Uganda Ministry Of Health Republic Of Uganda. 2006. Available from: https://www.who.int/mental_health/uganda_who_aims_report.pdf. [Accessed on 05/08/2020].

35. Ibrahim AW. The mental health system in North-eastern Nigeria: A WHO-AIMS generated assessment of state of mental health in a sub-Saharan African region. Nigerian J Psych. 2012; 10(3): 2- 7.

36. Abdulmalik J, Kola L, Fadahunsi W, Adebayo K, Yasamy MT, Musa E, et al. Country Contextualization of the Mental Health Gap Action Programme Intervention Guide: A Case Study from Nigeria. PLoS Med. 2013;10(8):1-8

37. Federal Ministry of Health. National Policy For Mental Health Services Delivery. 2013. Available from : http://cheld.org/wp-content/uploads/2015/02/national_policy_for_mental_health_service_delivery__2013_.pdf [Accessed on 05/08/2020].

38. FMOH. FEDERAL REPUBLIC OF NIGERIA REVISED NATIONAL HEALTH POLICY 2004 Available from: https://cheld.org/wp-content/uploads/2012/04/Nigeria-Revised-National-Health-Policy-2004.pdf [Accessed on 08/04/2020].

39. Mental Health and Psychosocial Support (MHPSS) Sub Working Group - North East Nigeria; QUARTERLY UPDATE Q2 | April – June 2018 Available from: https://reliefweb.int/sites/reliefweb.int/files/resources/MHPSS SWG QUARTERLY UPDATE - Q2 2018 - Updated.Large_.pdf [Accessed on 05/08/2020].

40. World Health Organisation. Mental health: strengthening our response 2018 Available from: https://www.who.int/en/news-room/fact-sheets/detail/mental-health-strengthening-our-response [Accessed on 28/04/2020].

41. World Health Organisation. Mental disorders 2017 Available from: https://www.who.int/en/news-room/fact-sheets/detail/mental-disorders [Accessed on 26/06/2020].

42. Rehm J, Shield KD. Global Burden of Disease and the Impact of Mental and Addictive Disorders Available from: http://link.springer.com/10.1007/s11920-019-0997-0 [Accessed on 07/03/2020].

43. Global Burden of Disease. Global Burden of Disease Collaborative Network Available from: http://ghdx.healthdata.org/gbd-results-tool [Accessed on 02/03/2020].

44. World Health Organisation. 2014 World Mental Health Atlas Available from: https://apps.who.int/iris/bitstream/handle/10665/178879/9789241565011_eng.pdf?sequence=1 [Accessed on 05/08/2020].

45. Gureje O, Lasebikan VO, Kola L, Makanjuola VA. Lifetime and 12-month prevalence of mental disorders in the Nigerian Survey of Mental Health and Well-Being. Br J Psychiatry. 2006;188(5):465–471.

46. World Health Organisation. Building Back Better Sustainable Mental Health Care after Emergencies. 2013 . Available from: https://www.who.int/mental_health/emergencies/building_back_better/en/. [Accessed on 05/08/2020].

47. Kaiser BN, Ticao C, Boglosa J, Minto J, Chikwiramadara C, Tucker M, et al. Mental health and psychosocial support needs among people displaced by Boko Haram in Nigeria. Glob Public Health 2019;15(3):358–371.

48. Morina N, Akhtar A, Barth J and Schnyder U (2018) Psychiatric Disorders in Refugees and Internally Displaced Persons After Forced Displacement: A Systematic Review. Front. Psychiatry 9:433. doi: 10.3389/fpsyt.2018.00433

49. Aluh DO, Okoro RN, Zimboh A. The prevalence of depression and post-traumatic stress disorder among internally displaced persons in Maiduguri, Nigeria. J Public Ment Health. 2019. DOI 10.1108/JPMH-07-2019-0071

50. Sheikh TL, Abdulaziz M, Agunbiade S, Joseph I, Ebiti B, Adekeye O. Correlates of depression among internally displaced persons after post-election violence in Kaduna, North Western Nigeria. J Affect Disord. 2015;170:46–51.

51. World Bank Group. Mental health among displaced people and refugees: Making the case for action at the World Bank Group. 2016 Available from: http://documents.worldbank.org/curated/en/270131468187759113/Out-of-the-shadows-making-mental-health- [Accessed on 05/08/2020].

52. Schininá G.; Nunes N., Birot P., Giardinelli L, Kios G. Mainstreaming mental health and psychosocial support in camp coordination and camp management. The experience of the International Organization for Migration in the north east of Nigeria and South Sudan, Intervention 2016;14(3):232–244.

53. Sphere. The Sphere Handbook. Humanitarian Charter and Minimum Standards in Humanitarian Response. 2018. Available from : https://spherestandards.org/handbook-2018/ [Accessed on 08/08/2020].

54. World Health Organisation Mental health, human rights & legislation. 2018 Available from: http://www.who.int/mental_health/policy/legislation/en/ [Accessed on 28/06/2020].

55. Siriwardhana C, Adikari A, Pannala G, Siribaddana S, Abas M, Sumathipala A, et al. Prolonged Internal Displacement and Common Mental Disorders in Sri Lanka: The COMRAID Study. PLoS One 2013;8(5):e64742. Available from: https://dx.plos.org/10.1371/journal.pone.0064742 [Accessed on 29/06/2020].

56. OCHA. Humanitarian Needs Overview Nigeria. 2019 Available from: www.humanitarianresponse.info/en/ [Accessed on 28/08/2020].

57. World Health Organisation. Psychosocial Support – Borno State Government and WHO scale up efforts to fulfil unmet mental health need. 2019 Available from: https://www.afro.who.int/news/psychosocial-support-borno-state-government-and-who-scale-efforts-fulfil-unmet-mental-health [Accessed on 03/02/2020].

58. Olanrewaju FO, Olanrewaju A, Omotoso F, Alabi JO, Amoo E, Loromeke E, et al. Insurgency and the Invisible Displaced Population in Nigeria: A Situational Analysis. SAGE Open. 2019;9(2):215824401984620. Available from: http://journals.sagepub.com/doi/10.1177/2158244019846207 [Accessed on 03/03/2020].

59. Health Sectior Nigeria. Northeast Nigeria Humanitarian Response: Monthly Health Sector Bulletin #8, August 2019 Available from: https://reliefweb.int/report/nigeria/northeast-nigeria-humanitarian-response-monthly-health-sector-bulletin-8-august-2019 [Accessed on 05/08/2020].

60. UNFPA. mental health and Psychosocial support: Healing when crisis strikes .2019 Available from: https://www.unfpa.org/featured-publication/healing-when-crisis-strikes [Accessed on 05/08/2020].

61. National Institute of Mental Health. Depression 2018. Available from: https://www.nimh.nih.gov/health/topics/depression/index.shtml [Accessed on 28/07/2020].

62. Nwoga CN, Dakwak SJ, Agbir TM, Audu MD, Goar SG, Tungchama FP et al. Functional Disability and Depression among Internally Displaced Persons. J Biomed Res Clin Pract 2018;1(1):37-45.

63. National Institute of Mental Health. Post-Traumatic Stress Disorder. 2019 Available from: https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml [Accessed on 28/07/2020].

64. National Institute of Mental Health. Schizophrenia. 2020 Available from: https://www.nimh.nih.gov/health/topics/schizophrenia/index.shtml [Accessed on 28/07/2020].

65. National Institute of Mental Health. Anxiety Disorders. 2018. Available from: https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml [Accessed on 28/07/2020].

66. World Health Organisation. Substance abuse. 2019. Available from: http://www.who.int/topics/substance_abuse/en/ [Accessed on 28/07/2020].

67. Onyencho VC, Kwajaffa PS, Abdu WI, Ali MA, Placidus O, Mohammed JS, et al. Assessment of Psychosocial Needs among Internally Displaced Persons (IDPS) In Maiduguri Based On the Humanitarian Emergency Settings Perceived Needs Scale (HESPER). IOSR J Humanit Soc Sci. 2017;22(07):17–22.

68. Giardinelli L, Kios G, Abubakar B, Schinina' G, Hammen C. An Assessment of Psychosocial Needs and Resources in Yola IDP Camps: North East Nigeria International Organization for Migration. 2015. Available from: https://www.iom.int/sites/default/files/our_work/DMM/Migration-Health/MP_infosheets/Yola-Assessment-MHPSS-2015.pdf [Accessed on 05/08/2020].

69. UNICEF Nigeria. Psychosocial Support For Children: A Rapid Needs Assessment In North-East Nigeria. 2019. Available from: https://www.unicef.org/nigeria/sites/unicef.org.nigeria/files/2020-

06/UNICEF%20Nigeria%20PSS%20Assessment%20Report%20June%202020.pdf [Accessed on 05/08/2020].

70. Kwajaffa PS, Onyencho VC, Abdu WI, Ali MA, Placidus O, Mshelia AI. Sphere Based Assessment of Psychosocial Support Services at Internally Displaced Persons Camps in Maiduguri. Ment Heal Hum Resil Int J. 2018;2(2):1–4.

71. Giardinelli L. Mental health and psychosocial needs and response in conflict-affected areas of north-east Nigeria. 2017. Available from: https://odihpn.org/magazine/mental-health-and-psychosocial-needs-and-response-in-conflict-affected-areas-of-north-east-nigeria/ [Accessed on 05/08/2020].

72. Vigaud-Walsh F. A Powerful Voice For Lifesaving Action Field Report Nigeria's Displaced Women And Girls: Humanitarian Community At Odds, Boko Haram's Survivors Forsaken. 2016. Available from: https://static1.squarespace.com/static/506c8ea1e4b01d9450dd53f5/t/572ce8f8f699bb5f617d2319/1462561020546/20160421+Nigeria.pdf [Accessed on 05/08/2020].

73. Internation Organisation for Migration. Nigeria Crisis Response Plan 2020. Available from: https://crisisresponse.iom.int/response/nigeria-crisis-response-plan-2020 [Accessed on 05/08/2020].

74. OCHA. Mental Health and Psychosocial Support (MHPSS): Sub Working Group - North East Nigeria - Nigeria 2018.Available from: https://reliefweb.int/map/nigeria/mental-health-and-psychosocial-support-mhpss-sub-working-group-north-east-nigeria [Accessed on 16/06/2020].

75. OCHA Mental Health and Psychosocial Support (MHPSS): Sub Working Group - North East Nigeria, Quarterly update Q2 | April – June 2018, Available from: https://reliefweb.int/report/nigeria/mental-health-and-psychosocial-support-mhpss-sub-working-group-north-east-nigeria-0 [Accessed 16/06/2020].

76. International Organisation for Migration. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement | International Organization for Migration. 2016, Available from: https://www.iom.int/mhpsed [Accessed on 16/06/2020].

77. OCHA. Mental Health and Psychosocial Support (MHPSS): Sub Working Group - North East Nigeria, Quarterly Update Q4 | October - December 2018. Available from: https://reliefweb.int/report/nigeria/mental-health-and-psychosocial-support-mhpss-sub-working-group-north-east-nigeria-2 [Accessed on 16/06/2020].

78. OCHA. Mental Health and Psychosocial Support (MHPSS): Sub Working Group - North East Nigeria, Quarterly update Q1 | January – March 2018 Available from: https://reliefweb.int/report/nigeria/mental-health-and-psychosocial-support-mhpss-sub-working-group-north-east-nigeria [Accessed on 16/06/2020].

79. OCHA Mental Health and Psychosocial Support (MHPSS): Sub Working Group - North East Nigeria, Quarterly update Q3 | July - September 2018, Available from: https://reliefweb.int/report/nigeria/mental-health-and-psychosocial-support-mhpss-sub-working-group-north-east-nigeria-1 [Accessed on 28/07/2020].

80. UNFPA. Women and Girls Targeted by Insurgent Violence in Nigeria. 2019 Available from: https://www.unfpa.org/sites/default/files/resource-pdf/19-255-MHPSS-Case-NIGERIA-2019-10-04-1308.pdf [Accessed on 07/06/2020].

81. Bangpan M, Felix L, Dickson K. Mental health and psychosocial support programmes

for adults in humanitarian emergencies: A systematic review and meta-analysis in low and middle-income countries. BMJ Global Health 2019;4: e001484. doi:10.1136/bmjgh-2019-001484.

82. Kamali M, Munyuzangabo M, Siddiqui FJ, et al. Delivering mental health and psychosocial support interventions to women and children in conflict settings: a systematic review. BMJ Global Health 2020;5:e002014. doi:10.1136/ bmjgh-2019-002014

83. Bangpan M, Dickson K, Felix L, Chiumento A. The impact of mental health and psychosocial support interventions on people affected by humanitarian emergencies: A systematic review 2017. Available from: http://policy-practice.oxfam.org.uk/our-work/humanitarian/humanitarian-evidence-programme [Accessed on 02/07/2020].

84. UNHCR. Regional Bureau for Middle East and North Africa Mental Health and Psychosocial Response during COVID-19 Outbreak. 2020. Available from: https://data2.unhcr.org/en/documents/download/77112 [Accessed on 02/07/2020].

85. UNITED NATIONS. Global Humanitarian Response Plan Covid-19. 2020.Avaialable from: https://www.unocha.org/sites/unocha/files/Global-Humanitarian-Response-Plan-COVID-19.pdf [Accessed on 05/08/2020].

86. Briefing note on addressing mental health and psychosocial aspects of COVID-19 Outbreak-Version 1.1. Available from: https://www.who.int/emergencies/diseases/novel- [Accessed on 02/07/2020].

87. UNHCR. Syria-Internally Displaced People 2020. Available from: https://www.unhcr.org/sy/internally-displaced-people [Accessed on 02/07/2020].

88. UNHCR. Mental health and Psychosocial Support For Persons of Concern. Available from : https://www.unhcr.org/51bec3359.pdf [Accessed on 04/08/2020].

89. Sherchan S. Samuel R. Marahatta K Anwar N A Van Ommeren MH Ofrin R. Post-disaster Mental Health and Psychosocial Support: Experience from 2015 Nepal Earthquake.WHO-South East J Pub Health. 2017;6(1):22-29

90. Atsua GT. Prolonged Internal Displacement and Common Mental Disorders among Internally Displaced Persons in Benue State, Nigeria. Niger Educ Psychol. 2017;15(1):167–177.

91. Sheikh TL, Mohammed A, Agunbiade S, Ike J, Ebiti WN, Adekeye O. Psycho-trauma, psychosocial adjustment, and symptomatic post-traumatic stress disorder among internally displaced persons in Kaduna, Northwestern Nigeria. Front Psychiatry. 2014;5(9):1–6.

92. Dp O, Jesper D, Ismaila Y, Si A. Insomnia , Depression and Anxiety as Associated by Traumatic Events , Coping Strategies and Coping Resources among Internally Displaced Adolescents in North-East Nigeria. Psychol Psychol Res Int J. 2019;4(3):1–15.

93. Roberts B, Browne J. A systematic review of factors influencing the psychological health of conflict-affected populations in low- and middle-income countries, Glob Public Health; 2011;6: 814–829.

94. Morina N, Akhtar A, Barth J and Schnyder U Psychiatric Disorders in Refugees and Internally Displaced Persons After Forced Displacement: A Systematic Review. 2018 Front. Psychiatry 9:433. doi: 10.3389/fpsyt.2018.00433

95. World Health Organisation. Delivering health in some of the worlds' worst crises through mobile clinics and medical teams. Available from: https://www.who.int/news-room/feature-stories/detail/delivering-health-in-some-of-the-worlds-worst-crises-through-mobile-clinics-and-medical-teams [Accessed on 07/08/2020].