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JOINING THE DOTS ADDRESSING TRAUMA AND EXCLUSION TO REINTEGRATE COMMUNITIES IN THE CENTRAL AFRICAN REPUBLIC

Learning paper



JOINING THE DOTS: ADDRESSING TRAUMA AND EXCLUSION TO REINTEGRATE COMMUNITIES IN THE CENTRAL AFRICAN REPUBLIC

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Partners

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INTRODUCTION

The Central African Republic (CAR) has a mental health crisis. Several brutal internal conflicts in the last quarter century have led to mass displacement, sexual and gender-based violence and human rights abuses leaving the country's population deeply traumatised. At the same time, the conflicts tore apart many of the support structures that community members relied on, and often their livelihoods and homes.

A joint study conducted in March 2025 by the Ministry of Public Health and Population and the World Health Organization (WHO), found that 59% of the population in CAR is living with mental health disorders, with women and young people most affected.¹ Those living with these conditions are often left without proper care or treatment, allowing symptoms to remain or worsen. They also face stigma, social exclusion and in some cases, harmful treatment by traditional or religious healers or their own families or communities.

Working closely with its civil society partners (Fracarita, Plateforme des Confessions Religieuses Centrafricaine (PCRC)), the University of Bangui, Government ministries and with support from the European Union, Conciliation Resources has sought to do its part to navigate and even address the mental health crisis by integrating Mental Health Psychosocial Support (MHPSS) into its peacebuilding work. In doing so, we hoped to remove some of the psychological barriers to dialogue and reconciliation by improving communities' access to

MHPSS in Bossangoa and Bangui. At the same time, MHPSS was provided in a way that made sense within local belief systems. This collaboration has helped establish a new referral system that connects family members and mental health first aiders in communities to clinical MHPSS providers as well as trained religious and traditional practitioners providing psychosocial support. With a space to process past trauma, more community members were able to engage in dialogue more effectively to address the drivers of conflict and help reintegrate former combatants and excluded groups into their communities.

As the Government and its international partners embark on a broadened disarmament, demobilisation and reintegration programme to reintegrate former combatants back into society, this paper provides some insights about how mental health could be similarly factored into these efforts. The paper begins with an overview of the mental health crisis in CAR, and its implications for peacebuilding and reintegration efforts in the country. It then details our approach to this issue, and shares some of the practical lessons emerging from this work. Finally, it lays out recommendations for how CAR authorities, international partners, MHPSS practitioners and communities themselves can better address the psychological legacies and ongoing drivers of violent conflict.

BACKGROUND: THE MENTAL HEALTH CRISIS IN THE CENTRAL AFRICAN REPUBLIC

The dire psychosocial legacy of CAR's conflicts presents a major barrier to lasting peace. Many of the trauma-related mental health issues that Central Africans suffer from can put a strain on their relationships and threaten their livelihoods. They can also make it difficult for individuals to contribute to community life and in dialogues that are fundamental to reconciliation as well as complicate the reintegration of ex-combatants and individuals at risk of recruitment into community life.

How individuals experience and are impacted by trauma is often shaped by gender, which also determines community expectations of how individuals should respond, how they can access support and how the wider community interacts with them. For example, women are expected to take part in spiritual cleansing rituals, whereas men are expected to internalise their emotions and demonstrate bravery and endurance – qualities instilled in community initiation rituals they take part in from a young age.² At the same time, gender norms can also have a negative impact on mental health, when men or women are unable to meet gendered expectations of them, while also shaping which coping mechanisms are deemed appropriate or otherwise. Young men, for instance, often feel less able to disclose how they're feeling or seeking help, as they try to maintain an outward appearance of strength, with some turning to potentially dangerous coping mechanisms such as isolation and self-medicating.

Despite the scale of the mental health challenge in CAR and its role in conflict dynamics, it has often been overshadowed and overlooked as the country has faced frequent humanitarian crises and simmering geopolitical rivalries. CAR is ranked near the bottom of human development indices (191st out of 193 countries)³ with over 2.2 million people qualified as severely food insecure,⁴ and 2.4 million people categorised as extremely vulnerable⁵ in 2025. While the state no longer faces an existential threat from conflict, pockets of insecurity persist in rural areas, particularly the north and southeast of the country, where armed groups engage in illicit mining and banditry.

While national and international focus is on the ongoing conflict's hotspots and pressing humanitarian needs, the more hidden and pernicious psychological scars from conflict are allowed to fester. The mental health needs in CAR are widespread, urgent and far beyond what the country's meagre mental health services can cope with.⁶ Specialist MHPSS services are scarce and too expensive for the vast majority of people in CAR. A country of six million people, CAR has only one hospital specialising in

mental healthcare (in Bangui, the capital) and while only 20% of urban hospitals (*centres hospitaliers universitaires*) and 40% of rural hospitals (*hôpitaux ruraux universitaires*) claim to provide mental health services and the care that these provide can be insufficient or even absent entirely.⁷

Without Government's investment, the majority of professional MHPSS is still provided by national and international NGOs and UN bodies – albeit through a small number of mental health facilities – with most programmes focusing on survivors of sexual and gender-based violence. Though an important issue in CAR, this focus has unfortunately contributed to stigmas and perceptions that MHPSS is 'just' for women and girls, who represent the majority of survivors. In addition, people suffering from mental health issues more often seek help through traditional practitioners (*tradipraticien*), religious figures and alternative medicine, many of whom have not been trained or equipped with skills on Mental Health First Aid or trauma healing. Meanwhile, CAR's psychology graduates from the University of Bangui's psychology department have very few opportunities to continue their training or employment within CAR, so tend to move abroad or take on unrelated roles with NGOs.

Recognising the scale of the crisis, there is increased interest in MHPSS among Government ministries but also international embassies and NGOs. Since 2015, the Ministry of Health has chaired a Working Group on MHPSS (*Groupe de Travail Santé Mentale et Soutien Psychosocial*), which involves various civil society organisations including international organisations and UN agencies (UNICEF, WHO) to coordinate MHPSS programmes throughout the country. In 2019, the CAR government revised the national mental health policy, trained core health professionals through the Mental Health Gap Action Programme and in 2022 validated the national protocol for psychotherapeutic management of post-traumatic disorders. More recently, nascent efforts have begun to integrate MHPSS into the process to reintegrate former combatants back into communities.⁸

The spiritual dimension of mental health and reintegrating former combatants

The mental health crisis in CAR poses conflict risks for the country. Conciliation Resources began working on the issue in 2022, having seen how mental health issues could pose challenges for relationships and dialogues within communities. Participants experiencing mental health problems were often unable to contribute to dialogues in a constructive way, or would self-censor themselves, which reinforced their exclusion. As such, it presented a serious barrier to reconciliation among communities and also to the reintegration of ex-combatants.



Yet addressing these problems and supporting the individuals and communities concerned requires solutions that are sensitive to the socio-cultural dynamics in each community. For many Central Africans, their understanding of the world is tightly bound to the interaction between the physical, material world and the spiritual world influenced by ancestor spirits. In this understanding, someone's mental state reflects their relationship with the spirits. If evil spirits attach themselves as a result of transgressions or other negative experiences common in violent conflicts, they could be afflicted with 'Gbogbolinda', or 'madness', which requires a traditional healer to address. The explanations given for men and women's mental health experiences also differ. For example, women experiencing Gbogbolinda are often deemed to have carried out immoral behaviour whereas men may have broken a pact with a spiritual animal.⁹ Understanding and integrating this cultural and spiritual framework is therefore an important part of addressing mental health issues not only for the affected individual, but also for the surrounding community to absolve them of any perceived transgressions and address any corresponding stigma or exclusion.

This has significant implications for the Disarmament, Demobilisation and Reintegration (DDR) of former combatants, which has been central to peace processes taking place in CAR. Launched in December 2018, the National Programme on Disarmament, Demobilisation, Reintegration and Repatriation (PNDDRR) focuses on 14 armed groups which signed the Peace Accords with the aim of integrating their members into the national military or supporting them to enter other livelihoods while reintegrating into their communities. This programme is also backed by Community Violence Reduction (CVR) programmes, which can include vocational training, weapons collection and peacebuilding activities.¹⁰

Yet both DDR and CVR processes in CAR have both tended to focus primarily on livelihoods, and therefore have struggled to address the widespread psychological barriers that prevent former combatants from returning to and being accepted by their communities. Many fighters that hope to be reintegrated have experienced severe and often sustained trauma, having been involved in and impacted by violence, while being isolated from loved ones and other support networks. All these factors can weigh heavily on ex-combatants and their communities, and contribute to mental health issues that may create further distance between them.

As in peacebuilding programmes, the psychological barriers to reintegration can look different for men and women. In Sibut and Kaga-Bandoro for instance, we found that without MHPSS support, ex-combatants struggled to deal with a perceived loss of manhood, feeling they have failed to protect their communities, alongside cycles of resentment, guilt associated with acts of violence they had committed, and ongoing threats of reprisals and future recruitment by armed groups.¹¹ Women ex-combatants, who are less likely to have weapons to relinquish, often lack access to any support granted through the DDR processes. Women also experience severe challenges on return to their communities, with their involvement in armed groups perceived to transgress gender norms and consequently stigmatised. These problems can be compounded where community rituals around 'purification' – a means of ridding the individual of Gbogbolinda and a precondition for meaningful reintegration by the community – are not supported.¹²

ADDRESSING THE PSYCHOSOCIAL AND SPIRITUAL BARRIERS TO PEACEBUILDING IN THE CENTRAL AFRICAN REPUBLIC

Seeing how mental health issues were impacting our peacebuilding and dialogue work, and were themselves often understood in spiritual and gender-specific terms, Conciliation Resources and its partners, with support from the European Union, sought to “join the dots”. This meant leveraging our dialogue spaces and relationships with different parts of the community to facilitate a more holistic and collaborative approach to peacebuilding and MHPSS work that build on the existing strengths of these communities. This involved the following activities:

- **Outreach to build awareness and train mental health first aiders:** We developed a gender responsive and conflict sensitive MHPSS toolkit and training manual to train community focal points, MHPSS practitioners and religious and traditional healers. In total, we trained 358 people (including 155 women). As a result, those who were trained could more effectively raise awareness about mental health in their communities, identify mental health issues impacting community members and provide them with initial care and advice on where to seek more advanced support. On a broader scale, we launched a weekly radio programme where MHPSS practitioners, peacebuilders and community representatives would discuss various mental health issues facing Central Africans, and answer questions from listeners. The programme reached an estimated 845,000 people¹³ in total.
- **Community dialogues underpinned by MHPSS best practice:** We facilitated MHPSS-informed dialogue processes in target communities involving over 432 local community members (including 170 women), local leaders, women and youth representatives, traditional healers, and healthcare providers. In each case, the dialogue process was accompanied by mental health practitioners who provided group therapy preparatory sessions, and individual counselling sessions where needed. This resulted in constructive discussions amongst previously opposed groups, who were then able to jointly develop and deliver nine culturally grounded and gender-sensitive MHPSS action plans, leading to evidence of reconciliation between previously opposed communities, and of increased reintegration of marginalised groups (ex-combatants, Aka or Pygmees).
- **Building collaboration between clinical, religious and traditional practitioners:** We established formal mechanisms of collaboration between healthcare providers, traditional healers, religious leaders, and community members, including marginalised groups like former combatants. In line with the existing national protocol, we set up a case referral mechanism where these different support systems could refer individuals to one another. During the project, we recorded over 300 cases where community members were referred from one model of care to another one deemed more appropriate for the issues at hand. Throughout, information about the system and the different referral pathways was shared by the radio programme which explained how the system works and how to access it.
- **Responding to different experiences and expectations based on gender:** Our project sought to respond to the different challenges faced by men and women, ensuring MHPSS is accessible and destigmatised for young men, while providing essential psychosocial support for women and girls excluded from formal processes. To do this, we integrated gender considerations into our conflict sensitive MHPSS toolkit, so that mental health first aiders could understand and navigate how gender shapes experiences of mental health issues and cultural expectations around them. As a result, we noticed not only a shift in how young men talked about their mental health and sought support but also in how largely male cultural guardians acknowledged the danger and negative consequences of some of the traditional practices associated with MHPSS.

LESSONS LEARNED

This work integrates the respective fields of mental health, psychosocial support and gender responsive peacebuilding, each with different foundations, methodologies and ways of working. Consequently, it has resulted in multiple lessons, which will inform our future practice as well as recommendations to other practitioners and policymakers in CAR. These lessons come with implications for various stakeholders in CAR's peace processes, which the paper will outline at the end.

Integrating MHPSS can strengthen dialogue initiatives, including for reintegration efforts

Mental health issues can be all-encompassing, shaping all parts of an individual's life and those of their loved ones. Ex-combatants are no different here, and any mental health issues they experience can present considerable challenges for their reintegration into communities, which in turn increases the chances of them re-joining armed groups. This project shows that integrating MHPSS into community dialogues can support individuals to recover and relate better to themselves and others, help address the effects of experiences of marginalisation and exclusion, and empower those who have been marginalised to create new narratives and take action in support of inclusive transformation.¹⁴

We integrated MHPSS into our Bossangoa and Bangui dialogues by providing participants with preparatory group therapy sessions, one to one individual counselling (where requested) and raising awareness of mental health, prior to the dialogue process, during and after. What we observed as a result is that participants came to the dialogues more prepared, having had a space to process their own emotions and feelings with the support of mental health and psychosocial care providers. It also allowed participants to attend who otherwise may not have felt able to, due to mental health issues, while enabling them to engage in the process in a way that went beyond processing or expressing their own trauma or emotions. Meanwhile, it allowed other participants to understand how trauma can impact relationships. This was particularly helpful for young male ex-combatants, who had not had the safety, encouragement and possibility to do so in the past. It further enabled the inclusion of marginalised communities (Bitikiri in Bossangoa, Aka in Bimbo and Soumas in Gbadé), who were accompanied through the dialogue process with other community members.

As a consequence, the communities involved were better able to use dialogue as a tool to develop collective solutions. In Bossangoa, for example, diverse community representatives signed a commitment to contribute to improving the mental health of members of the returning Muslim community and young ex-combatants so that they could reintegrate into the community and the ongoing peace activities in the area. This commitment reassured the members of the Muslim community, who resolved not to resort to violence or revenge when re-settling. Meanwhile, the approach has proved successful where previous demobilisation exercises had failed. For example, the project was able to work with a group of young female ex-combatants who had recently come out of an DDR process but remained isolated from their community. Here, the project's psychologist spoke with the group about their mental health and, using their understanding of mental health issues and how gender norms and expectations impact the group, was able to develop a tailored approach to reintegration, for each individual. This led to the group returning to their community, with some resuming their studies and others joining the military.

A holistic, culturally sensitive approach involving clinical, religious and traditional actors made it possible to work with limited MHPSS resources

By strengthening rather than undermining the existing capabilities and cultural frameworks in communities, it was possible to strengthen both the understanding of mental health issues across society as well as its access to MHPSS support with limited resources. Having understood the important support roles that religious and traditional institutions provide in communities, and having a network of peacebuilding focal points working within communities, the project already had natural partners to work with. Once trained using the MHPSS toolkit, these community institutions became mental health first aiders. This increased the number of individuals able to provide basic MHPSS and advice on accessing different kinds of support, without disrupting pre-existing community structures.

Rather than face resistance, the project found traditional and religious healers receptive to the ideas and training provided, having been proactively included in previous community dialogues due to their important role in their communities. Many have been happy to improve their own knowledge on MHPSS, engage with the referral mechanisms, and ultimately to recognise when the issues they faced went beyond their expertise. As a result of



the project, some cultural guardians in the communities have become powerful voices raising awareness of mental health issues and, in some cases, combating harmful rituals or practices which were discriminating against women, for example the widowhood rite and *fioboro* rituals for those who have “seen blood”.¹⁵ The project has also supported mental health practitioners in clinical settings to better understand the value of non-clinical approaches and when to suggest that people visit traditional practitioners or religious leaders in accordance with their or their family’s beliefs.

The project was also mindful to avoid creating a system that undermines or duplicates the Government’s own responsibilities. The referral system is aligned with the national protocol on mental health, and while the project is represented at the national Working Group on MHPSS it has also seen close involvement of the Government. The Ministry of Health and Population has deployed the Head of its Non-communicable Diseases Department as well as the psychiatrist in charge of coordinating the national MHPSS programme, to participate in the project’s Advisory Group, and they have since contributed to the development of training tools, the validation process for the project’s local referral mechanism, and the facilitation of MHPSS technical sessions. Such involvement could help smoothen the future absorption of the project into the Government’s own evolving health system, once resources allow. This system, though still in development, offers a substantial potential resource for DDR initiatives, which could refer individuals to receive care from different sources.

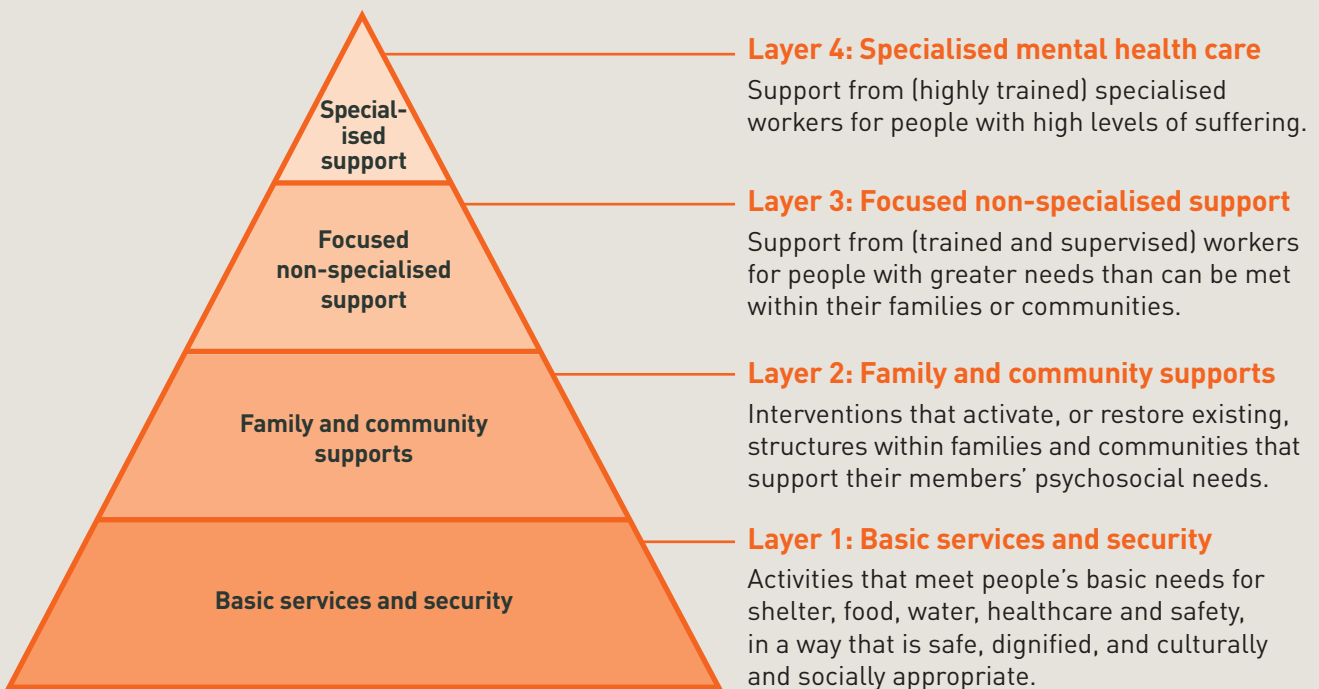
Investing in local capabilities and deploying radio programmes helped the project raise mental health awareness when access was impossible

Communities in CAR face many practical barriers to accessing mental health services. These range from bad weather, difficult roads, poor or non-existent phone signal and internet connection, to language barriers and ongoing localised violence and insecurity. These coincide with social and cultural barriers which include stigma around mental health issues and their association with witchcraft, as well as important financial barriers. The time and money required to access and speak to medical and specialised doctors often make these options untenable for anyone seeking out MPHSS.

To overcome these barriers, the project has focused on improving basic support at the family and community level, and among non-specialist care providers, (equating to Level 2 and 3 of the Inter-Agency Standing Committee (IASC) pyramid). Alongside the training of mental health first aiders in communities and the development of the referral system, the project also worked with communities to design and implement action plans addressing their MHPSS and peacebuilding needs. This created both a more dispersed network for the project to work with, and an opportunity for actors within the mental health and peacebuilding sectors to work together at the community level.

The IASC MHPSS Pyramid

A system of layered, complementary supports should be established, which meets the varying levels of psychosocial and mental health needs of the population affected by the emergency. All layers should be accessible to the population concurrently.



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

Alongside, the project launched a weekly radio programme (broadcasted on radio Ndeke Luka from Bangui and radio Ndoye in Bossangoa) which reached an estimated 845,000 listeners throughout the country. The radio programme provided listeners with reliable information from medical experts and practitioners on mental health, access and referral pathways, the roles of different actors (including traditional practitioners and religious leaders) and the connections between conflict, peacebuilding and gender. The episodes were structured in such a way that listeners could call in, explain their cases or the issues they were facing and receive feedback and guidance from the experts. The radio programme helped raise awareness of referral pathways but also to dispel myths and stereotypes around mental health that prevented community members from seeking help. A psychologist associated with the project who spoke on one of the panels shared that despite ten years of practice, following her intervention on the radio she noticed a significant increase in the number of people turning up to her practice, and she received calls from relatives living in remote provinces who had heard the programme.

Left: The studio at Radio Ndeke Luka where mental health programming was broadcast. © Radio Ndeke Luka



Without sustained support from international donors or the Government, demand has begun to outweigh supply

As the project increased awareness and understanding of mental health among communities in Bossangoa and Bangui,¹⁶ and developed a working referral system that makes the most of communities' own capabilities, referrals started to increase at an unmanageable rate. The demands and expectations on medical practitioners associated with the project (psychologists, psychosocial assistants) grew significantly, with long queues in front of their offices, making it difficult to provide individual counselling sessions (Level 4 of the IASC pyramid), and requiring a shift to group counselling. This was in some cases met with disappointment from community members who felt let down.

The lack of official national mental health infrastructure or resources is a major challenge that must be addressed if the considerable mental health needs of Central Africans are to be accommodated in the long term. While the project provides access to a selected number of communities, it required international funding to be brought to scale. The care it provides also comes at a cost that many families cannot easily afford. This is unlikely to change in the short term, and with international assistance to CAR (and globally) falling drastically, it is more likely that funding for this project and others like it will decrease rather than increase. As we advocate for providing similar support to ex-combatants as part of reintegration programmes, it will be critical to think of the model of support, for example prioritising Levels 2 and 3 of the IASC pyramid, and how resources and collaboration can be jointly pooled towards that aim.

Peacebuilders are well placed to create space and build cooperation across sectors and connect different levels

While integrating MHPSS can strengthen peacebuilding approaches, this project also shows how the involvement of peacebuilders can help MHPSS systems work in more inclusive ways that are more sensitive to the context they are in. Peacebuilders are specialists in building collaborative ways of working between different stakeholders with different priorities, understandings and approaches. This project was particularly complex in this regard, involving a whole range of diverse stakeholders working in communities, civil society, the aid sector and Government focusing on mental health, conflict and gender respectively. Even at the community level, it was crucial that the project managed relationships with and among community structures, local leaders, representatives of youth and women structures, local peacebuilding initiatives,¹⁷ and also MHPSS providers.

Here, peacebuilders can bring different advantages. First of all, they bring a sophisticated analysis and understanding of the context, including pre-existing capabilities, tensions and prevalent cultural understandings within communities. This helps them identify and navigate relationships with important stakeholders. Using gender-sensitive conflict analysis the project partners could see that it would be necessary to work closely with local leaders and institutions, including chiefs, youth and women's representatives, religious leaders and traditional practitioners.¹⁸ These local bodies and individuals were both influential but provided crucial coordination and support roles for community members, which it would be better to complement and strengthen rather than undermine. Not involving them held significant risks as the project might then have risked offending them or undermining their authority and important function they fulfil. As such, the programme took a proactive and collaborative approach with these stakeholders, inviting them into community dialogues and training them in MHPSS. Not only were they receptive to the training, they then became critical in raising awareness of mental health issues in their communities and mobilising community members to take part in future project activities and in ensuring that community members and authorities developed and delivered local action plans. This meant the project was able to build on existing strengths and support systems within society and create more complementary, hybrid ways of delivering MHPSS rather than inadvertently duplicating or even undermining pre-existing institutions, whether traditional or clinical.

At the same time, peacebuilders can use conflict analysis methodologies to identify excluded or marginalised groups in society, and find ways of building inclusive spaces for collaboration where they are fully involved. In this case, we were able to identify how different groups had additional distinct barriers to MHPSS access, and address them. For example, Conciliation Resources' use of gender-sensitive conflict analysis helped us identify gender dynamics relevant to peacebuilding and MHPSS activities.¹⁹ It showed that while young men are expected to internalise their emotions and demonstrate bravery and endurance – something instilled by the community initiation rituals they take part in from a young age – women are more likely to speak about trauma but are often held to higher standards in adhering to prescribed community rituals. Lastly peacebuilders are experienced in facilitating constructive dialogue, managing painful or sensitive conversations and building trust between often conflicting stakeholders. This has been crucial to ensuring communities involved in the project have been able to process trauma and seek access to MHPSS while also developing and implementing their own MHPSS-focused Local Action Plans.



Working with, rather than against, existing cultural frameworks can open entry points to reduce inequalities and support men and women to address mental health issues

Going into the project, we knew that while young men and women have both experienced trauma and distress as a result of ongoing conflict, the ways in which they are expected to manage this differ due to their gender roles (See Background). To navigate these dynamics, the project worked with existing belief systems, leaders and institutions to develop openings for reframing harmful norms and practices without undermining the important cultural institutions which they are part of. More broadly, this meant emphasising that mental health issues could *also* be caused by conflict and trauma and not *just* by the events in the spiritual world. This allowed traditional healers to maintain their authority, and ability to provide care and guidance, while acknowledging some issues were beyond their expertise.

The same can be said for addressing sensitive gender dynamics around mental health access. For example, when engaging a group of young men who were ex-combatants in dialogues around mental health, facilitators leaned on local gender roles and relations, and men's aspirations around faith and family, to help them reflect on how their actions and unresolved trauma might impact the women figures of their families. As a result, the young men publicly asked their community for forgiveness, which would have otherwise been seen as a sign of humiliation in a culture that

encourages displays of strength among men and discourages the display of emotions, laying critical groundwork for their reintegration into communities. At the same time, the project helped facilitate important changes in perceptions and behaviour within communities and families that addressed previous gender inequalities. For example, as a result of training sessions on gender, male community leaders began sharing household duties with their wives while others allowed their wives to work and earn an income. Meanwhile, male cultural guardians and elders spoke to community members of the risks associated with certain rituals, in particular of widowhood and community reintegration, for example *fioboro* rituals in the Bossangoa area for those who have seen blood.

The harmful beliefs and norms around mental health issues continue to exist and barriers preventing women and ethnic minorities, for example, from expressing themselves freely in dialogues remain. However, by working directly with the guardians of many of the social norms and cultural beliefs in communities, this project has been able to subtly shape and harness those norms and beliefs in a way that allows more space and better support for both men and women as well as groups facing different forms of exclusion. To do this, they did not need to use concepts or terminology around 'gender' explicitly – as they are often seen as part of a Western-imposed agenda – but have still been able to promote the inclusion of women and ethnic groups in activities, encourage the display of emotions and broader acceptance of mental health by men including ex-combatants, and make concrete improvements towards equality between men and women at the family level.

RECOMMENDATIONS

From the lessons above, we have identified a series of recommendations for different stakeholders in CAR, which would help authorities, MHPSS and peacebuilding practitioners and communities themselves better address the mental health crisis in the country and its impacts on peace.

Strengthen existing MHPSS capabilities before deploying them to support the reintegration of former combatants, as part of national DDR processes

While efforts to build mental health awareness and cooperation among communities and their traditional and religious healers have significantly improved access to mental health support, clinical mental health services require urgent investment. The country has widespread mental health issues as a result of conflict and former combatants are no different. While much needed mental health support should be provided to former combatants as a formal part of their reintegration into communities, this is likely to absorb a lot of the limited resources available in the health system. It will be essential that pre-existing community expertise, such as that strengthened in this project, is deployed, but this must be accompanied by investment in new facilities and trained mental health specialists, particularly outside Bangui. Useful investment could be made, for instance, in re-establishing mobile clinics or remote forms of contact like telephone hotlines, to expand access beyond major urban centres.

Create more spaces for clinical, traditional and religious practitioners to learn from each other, improve coordination and strengthen practice

Existing sources of care and healing in the community, such as traditional healers and religious leaders, play pivotal roles in maintaining the wellbeing of community members, and must be supported to ensure individuals with mental health issues have the right support. State authorities at national and provincial level, as well as international donors and organisations working on MHPSS, should ensure their MHPSS interventions create spaces for these community healers and clinical mental health practitioners to interact, learn from one another, identify best practices and complementary ways of working. Peacebuilders can play an important role here, with expertise in facilitating inclusive dialogue as well as conflict and gender sensitivity.

Mental health support to community members and ex-combatants should continue to work with existing community systems to address harmful gender norms and inequalities

Gender norms and inequalities mean that men and women have different experiences of conflict and mental health issues and therefore, different needs. This is especially true when dealing with often patriarchal community institutions and belief systems. Nevertheless, it is important that efforts to challenge harmful gender norms and respond to the gendered needs of community members does not inadvertently undermine integral community values and belief systems. Instead, both MHPSS and peacebuilding programmes should proactively engage traditional and religious institutions providing care for community members to determine appropriate ways to respond to mental health needs in a gender-responsive way.

Embed MHPSS into local peace architectures

While the project has integrated MHPSS into its own dialogues in different locations around CAR, there are important structures within the local peacebuilding architecture that would likely benefit from adopting a similar approach, including Committees for the Implementation of Peace Agreements (CMOP) and Local Committees for Peace and Reconciliation (CPLR). These structures fulfil crucial peacebuilding and mediation functions in communities. Training these structures and embedding MHPSS into their work and mandate would bring broader scale and strengthen the capability to the referral system. In turn the project could share resources and lessons learned to support their integration of MHPSS into their own dialogues and conflict resolution practices.



Encourage and support community-led funding for mental health and psychosocial support

While increased investment from the Government and its international partners would make an important difference to mental health access, it may not fully address financial barriers to access mental health support. As part of initiatives to build understanding of mental health issues in communities, efforts should be made to mobilise and pool community resources to help individuals fund the care they need. This could be through local village savings cooperatives or “*tantines*”. Local associations could be set up to facilitate fundraising and build up small “slush funds” to pay for transport to the services people need, for example. Similarly, awareness raising around MHPSS could be integrated within the mandate and annual workplans of local structures representing young people and women (including Organisation des Femmes Centrafricaines OFCA). With international aid reducing globally and Government investment unlikely to match the levels needed to subsidise mental health support, resources might need to be pooled at a more local level.

Pairing systems for MHPSS aftercare with livelihood support will be critical for reintegration initiatives

Long-term livelihood support will be essential for the sustainability of MHPSS and reintegration initiatives. Livelihoods play an important role in mental health and can yield development and peacebuilding outcomes in conflict-affected contexts²⁰. In a context like CAR, pairing livelihood support and MHPSS aftercare within peacebuilding interventions will be critical to address multifaceted needs. For example, the project has seen how enhancing women’s access to livelihoods and financial autonomy can increase their credibility and effective participation in community life, offering significant opportunities from a reintegration perspective.

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Conciliation Resources is an international organisation committed to stopping violent conflict and creating more peaceful societies. We work with people impacted by war and violence, bringing diverse voices together to make change that lasts.

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