Article

Practices of Congolese Mental Health and Psychosocial Support Providers: A Qualitative Study on Gaps and Obstacles

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Abstract

Mental health and psychosocial support (MHPSS) services, including services related to sexual and reproductive health problems, are highly unaddressed in the Eastern Democratic Republic of Congo. We present findings of a qualitative study that reveals three gaps related to the knowledge and skills of staff in the Eastern Democratic Republic of Congo (DRC) to provide proper MHPSS, with integrated care for sexual and reproductive health. These gaps relate to reliance on western imposed approaches that only partly fit the local context, to a strong focus on medication, and to a lack of training. Further, the data show two main obstacles to improve current practices: persistent cultural taboos and misconceptions about what mental health and sexual health problems are and how they come to exist, and a very limited referral system. The gaps and obstacles illustrate the complex context in Eastern DRC, they highlight the importance of locally tailored education and training, and they stress the need for system changes to improve access to and quality of MHPSS. From a national and regional perspective, the results seem to call for a paradigm shift as to how mental health is approached and embedded in educational systems and society.

Keywords: Democratic Republic of Congo, MHPSS services, mental health, sexual health, trauma

Introduction

MHPSS Services in the Eastern Democratic Republic of Congo (DRC)

The population of North Kivu in the Eastern DRC has been exposed to multiple experiences of war, conflict, and crisis (Büscher, 2018), including a natural disaster caused by the volcano eruption (Oldenburg, 2018) in Goma in May 2021. Traumatic experiences resulting from such experiences are affecting the health and wellbeing of many women, men, girls, and boys (Altare et al., 2020; Rosenman, 2002). Despite the high exposure to multiple disempowering and traumatizing experiences, mental health and psychosocial support (MHPSS) services —including services that integrate support for sexual and reproductive health and rights (SRHR) problems— is a highly unaddressed area in the region (Cénat et al., 2020). The integration of MHPSS in primary healthcare centers, as recommended by the World Health Organization (WHO)—is included in the national plans on mental health in DRC, but lack of funding remains an obstacle to achieving full implementation.

Many services and programs on MHPSS and SRHR mainly focus on women and girls as survivors of sexual and gender-based violence (SGBV), such as those provided by the International Committee of the Red Cross (ICRC) (Andersen et al., 2022)[1] and UNFPA (UNFPA, 2022). However, no providers seem to have integrated MHPSS as a broader topic that includes men, women, and children. Further, most research on mental health in DRC also focuses on women and girls as survivors of SGBV and children associated with armed groups (Johannessen & Holgersen, 2014; Johnson et al., 2010; Liebling et al., 2012; Verelst et al., 2014), with several studies revealing the association between elevated stress and distress in war and conflict and increased levels of intimate partner violence (Koppell & Koppell, 2022; Slegh et al., 2014, 2021). Fortunately, international attention to the devastating consequences of war-related rape and high rates of SGBV in Eastern DRC has increased funding services. This has made it possible to offer integrated care packages for survivors of rape, including one-stop centers providing

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medical, legal, psychosocial, and economical support, such as in North and South Kivu (Bress et al., 2019; Goodfriend et al., 2014; Steiner et al., 2009).

However, the flood of donor money and narrow focus on SGBV also come with (unintended) negative side effects (Hilhorst & Douma, 2018). The narrow focus on rape as a weapon of war, singling this problem out as the "good cause"—without considering the complex context—has neglected the root causes and other forms of SGBV, which has resulted in effects like false victims and parallel services.

Donor-driven attention for SGBV programming may also have contributed to the artificial division between sexual health and mental health problems. Psychosocial support has become associated with survivors of sexual violence and rape, while a broader understanding of the intrinsic connection between sexuality, sexual health, and traumatic stress (in general and not only stress caused by rape) is unaddressed and neglected, as repeatedly found by Congolese NGO Living Peace Institute during their fieldwork (LPI, 2023). Traumatic stress and distress can generate as well as be consequences of sexual health problems, including SGBV.

Cultural Context: Perceptions on Mental Health, Gender Relations, and Psychosocial Wellbeing

Traditionally, mental health in DRC was seen as a misbalance in social and spiritual relations. Traditional healers, churches, and family ceremonies served to restore harmony in disturbed relations with others, including ancestors in the spiritual world. Problems related to sexuality, reproductive health, and marriage were often explained and approached from a similar perspective: imbalances in the spiritual world (Balegamire, 2021; Maisha et al., 2017). Psychosocial wellbeing, good health, and good luck were linked to cultural norms, supporting traditional notions of gender relations.

Men were supposed to be the chief and providers of the family and to dominate women, whereas women and girls were supposed to bare children, be caretakers, and work in and around the homes (Slegh et al., 2014).

The influx of humanitarian aid to respond to high rates of sexual violence against women in (Eastern) DRC since the late nineties came along with the introduction of new norms and values concerning sexuality and women's rights, as well as mental health. Western imported knowledge and concepts shifted the previous social and spiritual focus to the new notion of mental health and psychosocial problems being (medicalized) health issues (Akyeampong, 2015; Balegamire, 2021). More generally, western approaches to religion, human rights, and knowledge on MHPSS interact with local, cultural, and traditional explanatory models on health and wellbeing, dynamics that are not unique for DRC and observed in other parts of Africa (Gichinga, 2007; Kirmayer et al., 2018; Rutembesa, 2004). Further, broken social relations caused by war and loss, migration, globalization, and socioeconomic development contribute to family bonds and structures as primary psychosocial support networks falling apart (Chiumento et al., 2020; Koegler et al., 2019).

Moreover, stress levels of the Eastern DRC population increased enormously due to war, crisis, refugee problems, and deep poverty in a society influenced by complex global factors, including the extraction of ore, cross-border trade, forced labor, and imposition of taxes (Koya & Mpinga, 2022; Meger, 2015). Additionally, SGBV, in the context of war and chaos, has caused enormous suffering of women and girls, with them being raped and abused by rebels, uniformed men, and by husbands or ex-partners. Various studies on this topic show the high prevalence of SGBV at home, by intimate partners, at school, in the private domain by priests, teachers, aid workers, and others in the village (Johnson et al., 2010; Liebling et al., 2012). Furthermore, taboos on sexuality due to traditional values and norms make it hard for women and girls to disclose experiences of rape; they may be rejected and stigmatized as "wives of rebels" or "prostitutes" (Slegh et al., 2014) or carriers of bad spirits (Maisha et al., 2017). Men and boys, also victims of sexual abuse, do not disclose their problems as they are facing even bigger taboos than women and girls. They risk being stigmatized and rejected for "not being a man," for being homosexual, or being regarded as weak and useless (Dolan, 2018; Norwegian Red Cross ICRC, 2021). The social, cultural, political, geopolitical, and economic challenges referred to above cause mental and psychosocial problems at individual and community levels. Problems that are difficult to address by current mental health and psychosocial services in DRC.

Mental Health and Psychosocial Health Care in DRC

The state of mental health services today still shows the influence of colonizers and missionaries on mental health knowledge (Ratele et al., 2018; Waldron, 2002).

Currently, in DRC, specialized services for people with mental and psychosocial problems are provided by six neuropsychiatric hospitals using scientific-based biomedical support through medication, sometimes combined with psychological counseling by psychologists or social workers. Five neuropsychiatric hospitals are run by Catholic churches, and one hospital, Centre Neuro Psycho Pathologique (CNPP) Kinshasa, is state-owned. The neuropsychiatric hospitals work with reference hospitals in 500 *zones de santé* in DRC. A reference hospital is a general hospital; sometimes, they have a psychologist and/or a social worker to attend to patients referred to them by health centers. Most health staff have a background in medical education as generalists, and very few received specialized education on mental health-related topics. The CNPP at Kinshasa University provides education in neuropsychiatry with a biomedical focus to medical doctors and nurses. Some medical doctors and nurses are trained in the mhGAP training, a mental health education developed by WHO to build capacity in low-income countries (WHO, 2014). Current mental health education focuses on a biomedical perspective based on Western knowledge of psychopathology and medical interventions.

Over the last decades, researchers in the Western and non-Western world have revealed the shortcomings and limitations of a single biomedical focus on mental health problems and have highlighted the interconnectedness with psychosocial problems at the individual, family, community, and society levels. A growing number of Western and African researchers and practitioners are criticizing the Western-based views on mental health (Cooper, 2015; Hustache et al., 2009; Petagna et al., 2022), and they promote the development of new approaches as described in African psychology, ethno-psychiatry, anticolonial psychology (Chiumento et al., 2020; Kirmayer et al., 2018; Waldron, 2002).

New insights have contributed to shifting the focus from diagnosing disorders based on psychopathological symptoms to listening to people's narratives of their own problems and coping responses in dealing with their problems. In 2007, the term MHPSS was introduced by the Inter-Agency Standing Committee (IASC), which developed guidelines and frameworks for reinforcing MHPSS in emergency settings (IASC, 2007). However, no studies have been found about interventions at the levels of (focused) psychosocial support as defined under the IASC framework (Andersen & Buttigieg, 2024).

In conclusion, whereas MHPSS services for women and men that include—and are not limited to—problems related to sexual and reproductive health are scarce in DRC, research on the provision of MHPSS in DRC even appears to be nonexisting.

Therefore, the objective of this study was to assess current practices and challenges related to mental health and psychosocial services, with integrated SRHR, in the DRC.

Methodology

The study adopted an MHPSS approach as developed in the IASC guidelines in exploring narratives of people in describing problems related to psychosocial, spiritual, and medical health, with the purpose of learning how MHPSS providers in North Kivu are challenged to serve their patients adequately.

Method

A qualitative study was conducted using non probability convenience sampling as the research team was dependable on safe access to the study site (Etikan, 2016). Data collection was done through focus group discussions (FGDs) and in-depth interviews (IDIs). Both the FGDs and the IDIs were based on semi-structured protocols, allowing for probing where applicable. The semi-structured (interview) guides were drafted by the lead researcher after two rounds of meetings with healthcare professionals and local MHPSS experts. These meetings explored issues relevant to provide adequate MHPSS in order to be able to address those topics during the interviews. The guides were reviewed, tested, and finalized during a research training of 10 local MHPSS researchers. During the FGDs and IDIs, the researchers used a saturation grid (Brod et al., 2009) to make sure that all topics uncovered in the meetings with local MHPSS experts were discussed, whereby data saturation was confirmed (Fusch & Ness, 2015).

Study Site

North Kivu province borders Lake Kivu in the eastern DRC. The province is politically unstable and was the site of an Ebola epidemic (2018–2020) and of many volcano eruptions, with a recent heavy one (2021) that displaced many people. The continuing violence in the area is bewildering in its complexity, and North Kivu has been the epicenter of war in the DRC. A multitude of armed groups are present, feeding into ethnic violence and creating severe challenges to future stability (Stearns, 2012).

Research Team and Sample

A team of 10 Congolese mental health professionals and psychologists participated in a 2-week training, facilitated by the lead researcher, during which they developed the research tools as described above. Subsequently, the lead researcher formed a research team, consisting of two women and two men that showed the best understanding of the research topics upon completion of the training. The team selected four health centers for their FGDs and one referral hospital for interviews based on location and accessibility. They asked management to invite six to eight health professionals (a) working directly with patients, (b) consisting of a balanced mix of women and men, (c) with at least 2 years of working experience, and (d) from different positions in the organization. This resulted in 27 people participating in FGDs and in 4 IDIs held at a referral hospital. It turned out that these 31 respondents had limited basic knowledge on mental health problems as biomedical conditions. None of these respondents had received further training on MHPSS or training on contextual and culturally sensitive mental health and psychosocial wellbeing. In total, 14 of the 31 respondents received some training on treating survivors of SGBV. Additionally, five interviews were conducted with professional mental health workers from Le Centre Hospitalier Neuropsychiatrique de Goma (CHNP). The details of all 36 respondents are provided in Table 1.

Data and Analysis

The team, consisting of the four trained researchers, collected the data in August and September 2021 through FGDs and IDIs. We had aimed to reach between 30 and 40 healthcare providers at community level. FGDs lasted around 2 hours on average and were conducted in Swahili. The transcribed data are available in French. The IDIs took, on average, 1 hour and were conducted in French. Three participants of the FGDs did not meet the defined criteria as they did not have care-taking relationships with patients and were excluded from the data analysis. All FGDs and IDIs were transcribed and analyzed using a framework analysis approach (Gale et al., 2013). The research team verified and discussed preliminary findings during the

Table 1

Sample Details.

Location	Research	Number of Respondents	Sex	Position	Previous Training on MHPSS or SGBV
CHNP	IDI	5	1F 4M	Medical doctor (1) Psychiatrist (1) Neuropsychiatric nurse (3)	5 MHPSS 1 SGBV
Centre de Santé (CS) Majengo	FGD	7	3F 4M	Nurse (5) Social worker (2)	0 MHPSS 3 SGBV
CS Hebron	FGD	7	4F 3M	Nurse (5) Social worker (2)	0 MHPSS 2 SGBV
CS Muhanga	FGD	8	5F 3M	Nurse (5) Community health worker (2) Social worker (1)	0 MHPSS 5 SGBV
CS Ndoso	FGD	5	2F 3M	Nurse (4) Social worker (1)	0 MHPSS 2 SGBV
Hôpital Général de Réference Virunga	IDI	4	2F 2M	Medical doctor (2) Psychologist (1) Social worker (1)	0 MHPSS 2 SGBV
	Total	36			

analysis phase. The gaps and obstacles identified and elaborated upon in the results came to light quickly, overlapping all locations and multiple codes. From there, a new matrix was created, now coding specifically on gaps and obstacles to fit the purpose of the research.

Medical doctors, psychiatrists, psychologists, and (neuropsychiatric) nurses have academic qualifications. Community health workers and social workers completed secondary school, often complemented with secondary vocational education.

Verbal informed consent was obtained from the respondents—who all work at CHNP and affiliated centers—before the start of data collection. Asking for written consent is considered to be sensitive in the context of war, insecurity, and signature misuse. Verbal consent was deemed sufficient and in line with applicable ethical standards of all partners as respondents remained anonymous and were not forced to participate nor to answer questions, or contribute to the focus group discussions. The research team made sure that no information was directly traceable to existing cases and/or patients.

Respondents did not receive any compensation for their time.

Results

The analysis of current practices related to mental health and psychosocial services, with integrated SRHR, at the study site uncovered three gaps and two obstacles that are discussed in this results section. The gaps concern limited knowledge and skills among service providers that could have shorter-term solutions, and the obstacles concern more systemic challenges that will need much more time to change.

The three main categories of knowledge and skill gaps for staff in Eastern DRC hinder their provision of proper MHPSS services that integrate sexual and reproductive health care to both women and men. The gaps are related to reliance on Western-imposed approaches that medicalize problems and neglect the local and cultural sources of support, to the strong focus on sexual violence as a mental health problem, and to the lack of professionally trained staff. Further, the data show two main obstacles to improve current practices: persistent cultural taboos and misconceptions about the origin and causes of mental health and sexual health problems and the absence of pluralistic referral systems that go beyond medical treatment. For readability, we have structured the results by the three gaps and two obstacles that were found across the settings of all health centers.

Gap 1: Westernized medicalized knowledge on MHPSS does not match with local knowledge and perceptions on mental health problems

In key informant interviews, five mental health specialists working at CHNP in Goma (one psychiatrist, three neuropsychiatric nurses, and one medical doctor) acknowledged the lack of training and capacity of staff working with patients with MHPSS needs. They are all educated in Kinshasa based on knowledge from Western countries, but they observe huge gaps in knowledge among generally trained health staff in addressing mental health-related problems in a context where indigenous knowledge dominates explanations of mental health problems. While they use those psychiatric diagnoses and psychopharmaceutic treatments (when available), they kept highlighting the need for African and Congolese understanding of psychology and mental health.

A neuropsychiatric nurse said:

"The Congolese population does not accept that mental illness exists. They say that it is witchcraft (biheko or evil

spirits), that the patient is given as sacrifice to the ancestors. They take them to places of prayer instead of taking them to the hospital."

The team of specialists emphasized that a pluralistic therapeutic approach is needed to respond to mental health needs, and they acknowledged the healing effects and positive influences of religions, traditional ceremonies, and beliefs. Traditional healers and religious leaders are consulted, and family ceremonies are organized by families and patients, and all may positively contribute to the recovery of a patient. However, the specialists also warned for the dangers of so-called charlatans providing traditional or religious healing that may cause harm. Further, they said that they lack research and educational materials that are adapted to African psychology and the African cultural context. They are aware that mental health experts working in DRC need to learn and deal with cultural taboos on sexuality and mental health problems, and they need methodologies to respond to a wide range of problems, including trauma exposure and multiple adversities.

Further, while talking about the work they do and the patients they see, the data show that the answers of the respondents working at the health centers are very much focused on the medical side of their treatment.

As a nurse put it:

"It is really difficult for us to give answers to patients because we have no knowledge of mental health except that we can give Diaz [diazepam] or paracetamol to make the patient sleep a little, because I only know that."

Also, SRHR-related problems that may be accompanied by MHPSS needs are medicalized. Multiple respondents explain that they address the problems caused by sexually transmitted diseases (STDs), HIV AIDs and illegal abortions without also addressing (possible) mental health issues.

A nurse stated:

"Our role should be to help people who have been sexually abused but given the limitations we have, we just do what is necessary by referring them after giving them medication to prevent STDs."

Hence, the data show that the (often practiced) Westernized medicalized knowledge on MHPSS does not match with local knowledge and perceptions on mental health problems. Probing during FGDs to learn more about providing anything else but medication to patients who display abnormal behavior may have created awareness among healthcare workers. Respondents collectively highlighted their professional limitations in responding to the sexual health or mental health needs of patients at the end of the session (see gap 3 below). They stated that it is difficult to move beyond providing medication to their patients.

Gap 2: Focus on sexual violence as the main cause of mental health problems for women neglects a wider range of MHPSS-related needs among women and men

A specific topic related to MHPSS that kept coming back during IDIs and FGDs were problems related to sexuality, including—but not limited to—sexual abuse. Male and female patients searching healthcare for problems of STDs and undesired pregnancies, including malfunctioning of sexual organs such as infertility, impotence, vaginism, and premature ejaculation. These are problems that often lead to personal stress and shame but also to conflicts and violence.

A psychologist in a reference hospital explained how psychosocial problems and stress can affect men and their sexual relations. He states how this stress evolves into frustration and violence against partners:

"People like to hide because they think that talking about it [sex] is taboo, but throughout history we end up discovering that on the morphological, sentimental level, we find that men have problems that they manage alone. That could be an economic problem that on the sexual level pushes him to ejaculate prematurely, and at a certain moment because of that the woman starts to neglect him because he no longer manages to satisfy her sexually."

More visible for healthcare workers are problems of women and girls that are raped by rebels or bandits and cases of pregnancies after being raped. The health consequences of sexual abuse in terms of STDs, pregnancies, or HIV are well known, but all respondents make explicit that they have limited or no knowledge on how to provide psychosocial support, nor do they feel well equipped in asking questions to the women and girls about their psychosocial problems.

It is evident from the data that signs and symptoms of rape and/or sexual abuse are not recognized when patients do not have clear physical symptoms or when they do not disclose the cause of their injuries. Some respondents observed signs in cases where women or girls come to the health center with a husband or parents, and they do not want to tell what happened to them.

One nurse explained how she recognizes sexual abuse among girls who are traumatized by men: "*They developed a phobia for men and don't want to marry*." Respondents state that men and boys are also raped, but if they do come to the health centers, they are very reluctant to share the causes of their problems.

Further, SRHR-related problems appear to enhance the difficulty to adequately addressing the mental health problems of patients as respondents claimed that they themselves are also uncomfortable talking about sex and sexual health.

Gap 3: Lack of trained staff on MHPSS and SRHR-related problems

The demographic data show that half of the respondents in the health centers and in the reference hospital received additional trainings on SGBV, but none of them underwent any MHPSS training, except for one psychologist (the five key informants working at CHNP studied at CNPP in Kinshasa.) When explicitly asked, not one of the

respondents feels fully capable of responding to the psychosocial needs of their patients, even though they work with patients with mental health problems on a daily basis. Most of the respondents do emphasize that they are aware of typical symptoms.

Respondents working in the health centers say they recognize patients with mental health and psychosocial problems from a wide range of behaviors. They mentioned being restless, agitated, talking too much or not talking at all, being disoriented, distracted, aggressive, talking to themselves, and loss of intelligence. In general, patients with mental health and psychosocial problems are indicated as *ni mugonjwa wa kichwa* (a problem with the head), *les bashire* (mental distress), and les *bendabazimu* (crazy people).

A few respondents referred to medical terms such as hysteria, psychoses, or epilepsy, but those did not see a difference between disorders and labeled them as "mental diseases." A nurse explained:

"I can't tell the difference between the symptoms they show except that there are those who talk a lot and are unstable and others who break."

There is even a sense of fear among the respondents regarding their patients.

One nurse said:

"I view mental health problems as unexplained and scary."

Similarly, most respondents find it hard to define psychotrauma-related problems, but probing revealed that they do recognize the link between behavior change and exposure to a negative experience.

One of the male nurses states:

"It is poverty that is the source of mental and psychosocial disorders. Imagine a man who cannot even afford to pay the medical expenses for his family. He sees himself as a failure and is mentally disturbed."

Respondents show a common understanding that mental health illness is caused by high levels of stress as a consequence of poverty and other adversity, such as rape, violence, conflict, natural disasters, intimate partner violence, and drugs and alcohol abuse.

Obstacle 1: Taboos on sexuality and mental health

Related to the lack of training and therefore not too surprising, respondents explain that they find it difficult to directly ask patients, females and males, about sexuality-related problems. In addition to the skills and knowledge they say they need to learn how to do this, they feel hindered by cultural taboos.

While respondents show a good understanding of the relationship between mental health and negative experiences and stress, it is also believed that such experiences and stress may provoke bad spirits and demons from the cosmological world that manifest in symptoms of mental illness and deviant behavior such as restlessness, aggression, and isolation. Alcohol and drug abuse are also believed to cause mental health problems because "*the substances may call the demons and bad spirits*." Therefore, patients with abnormal or deviant behavior are also referred to "drogues et fou" (drugs and crazy).

A community health worker elaborates on the case of a neglected child with behavioral problems:

"On the streets, there is a 7-year-old child who has shown discontent since he was 4 years old. He was unbearable even at school because he would fight with the other children and destroy school property. When we tried to stop him from doing damage, he was stronger than we were and even hit us. Now his family has decided to take him to the prayer room. So far he is not cured. From this experience, I believe that demons exist. It is said that his father touched bad things. He gave his son as a sacrifice to the ancestors."

Most respondents explicitly ascribe the manifestation of abnormal behavior to demons and bad spirits activated by negative and adverse experiences in life. The perceptions of the respondents are logically fostered by local perceptions of the community on mental health problems, and these perceptions also prevent people from visiting the health centers.

Respondents agree that for the general population, mental health problems are the manifestations of demons and bad spirits manipulated or provoked through misbalances in the cosmological world. When people are talking to themselves, they are said to communicate with their ancestors. Most healthcare workers adhere to a similar belief as they do not have the knowledge to explain mental health problems differently.

One of the nurses summarizes this as follows:

"We really doubt ourselves about how to look at mental health problems, and sometimes we think like everyone else, especially since we don't know much about mental health."

Respondents perceive that being affected with mental illness can be dangerous for others because it is believed that demons and bad spirits are manipulated by people (with the power of sorcery) who will look for others to be sacrificed to ancestors. As a result from such beliefs, patients suffering from mental health illness(es) are rejected and stigmatized by the population, often also by their own family, and accused for not being of any use to the family or community. The respondents see that men and women suffer in different ways: girls and women are believed to more often be affected by problems related to deceptions in their love life, and they are most vulnerable to becoming affected by witchcraft (and then they can bring bad luck to others), while men and boys are believed to more often be affected by magic because they are looking for money.

When it comes to SRHR-related problems, the respondents find it even more difficult to open up the conversation and help their patients. Several health workers provided narratives that they feel hindered by personal norms and taboos

to address problems related to sexuality. They provided examples of cases in their health center of personal taboos and lack of sufficient knowledge in helping patients with problems related to sexuality.

"Patients are ashamed to talk about [sexual problems] because it is a taboo in our African culture and even we consider it a taboo." (nurse)

Obstacle 2: Absence of pluralistic referral systems

Respondents explain that they refer cases of severe mental health problems (such as patients who act very agitated and aggressive or display weird behavior) to a police station or to a reference hospital. The police are called in when a patient is aggressive and very agitated, and it is unknown what happens to such people after they are taken away unless they report back to the health center themselves. The reference hospital only employs one psychologist who is overwhelmed with cases and not able to deal with all of them, as explained by one of the medical doctors there:

"These [severe cases] concern us but we have nowhere to go for support. Even though we have a psychologist in our hospital, he complains a lot because there are cases that he should be treating but that escape him because we are not very well equipped to discover psychological problems."

Cases of rape and sexual violence are referred to a specialized hospital (Heal Africa) in Goma, but most cases remain in the community where victims only receive basic medical care—if medication is available at all. Respondents expressed the need for medication, including psychopharmaceutical medicines. And all ask for capability and capacity building on MHPSS as well as on dealing with cases related to sexual reproductive health.

Further, respondents talked about the use of informal referral systems, seeking support from religious groups and traditional healers, and joining in community-based structures such as women's groups, sports clubs, and cultural ceremonies. Respondents also highlighted, however, the risks of abusive and harmful practices in religious groups and among traditional healers. Additionally, they mentioned that stigma and shame hinder survivors to seek support in their families and communities.

Discussion

This study offers a structured and comprehensive overview of the challenges faced by Congolese healthcare professionals working in community healthcare centers providing MHPSS to their patients. The identified gaps and obstacles are prevalent and coherent and evidently hinder staff to serve their patients properly. The study results overall illustrate the complex setting of MHPSS in Eastern DRC. Both the gaps and obstacles are underexposed in existing literature, and the current research is the first to paint a systematic picture of MHPSS services in Eastern DRC.

In line with recent research (Hillel, 2023), the data show that the current state of mental health services is still mainly based on Western-based mental health knowledge systems as they were introduced by colonizers and missionaries. The biomedical perspective based on Western-based knowledge of psychopathology and medical interventions has created a mismatch with the local African situation. Further, the data reveal that cultural taboos and misconceptions on mental health and sexuality among the population cause serious problems, and the same taboos hinder MHPSS providers to address mental health problems, as well as issues related to sexual and reproductive health. Obviously, African-centered psychological knowledge and the shift from diagnosing individual diseased toward a focus on strengthening coping systems and social support networks have yet to arrive in Congolese mental healthcare systems. While mental health needs to be integrated in primary health care centers, staff does not receive appropriate training to carry out their tasks. Corresponding with other sources (Jones & Bedford, 2020), we learned that MHPSS services in community health centers and referral hospitals in Eastern DRC are provided by general healthcare providers who have received no education or training in this field. Many healthcare providers think that mental health problems are caused by supernatural powers, but they have no framework nor tools how to help and address the problems of patients. As fearing stigmatization already hampers disclosure, this also applies to help-seeking from healthcare providers (Muganyizi et al., 2004) that hold similar beliefs as the population.

Stigmatization of mental health problems leads to rejection and severe human suffering (Verelst et al., 2014; Wachter et al., 2018). Subsequently, stigmatization contributes to the burden of trauma and increases mental problems even more (Schmitt et al., 2021).

The strong focus on the consequences of sexual violence in eastern DRC has created the dominant narrative, among healthcare providers and the population that mental health and psychosocial care are for victims of rape and sexual violence of women. Men and boys may also have mental health problems, but those are believed to be related to money and poverty and not to sexual health.

If healthcare professionals have received training in SGBV awareness, they still lack the tools and skills to address the problems caused by sexual violence. In line with previous research (Hustache et al., 2009; Piwowarczyk, 2007, 2010; Scott et al., 2017), the data show that cultural taboos on sexuality lead to many problems at individual and family levels that often evolve into mental health and psychosocial problems such as undesired pregnancies, shame and guilt, substance abuse, rape, and sexual violence and other forms of violence. Men and boys are similarly affected and struggle with those issues as women and girls do. Moreover, unaddressed sexual problems may generate violence between couples and in families and can even develop into more severe symptoms of depression, suicide, and PTSD, among other disorders.

Comprehensive sexuality education in schools and communities may be an important prevention strategy to deal with SRHR problems. Additionally, health care providers, including mental health staff, need more profound training

to acquire skills in dealing with sexual-related problems that include but are not restricted to SGBV-related problems of women. MHPSS should integrate all problems related to sexual health and target all people, irrespective of age, sex, and background.

Further, all respondents face constraints as to where to refer their patients since there is hardly any referral system for this at all. It is remarkable that studies claim that participants were referred to appropriate local psychological services when needed (Johnson et al., 2010; Kohli et al., 2012), while other research shows that the reference system is very limited, may not be accessible due to distance and financial constraints or even absent (Moayedoddin et al., 2014). It may be that those referrals were made to medicalized/health treatment as opposed to the provision of adequate MHPSS. Equally important, the use of informal referral systems remains complex due to the reluctance and risks to benefit from those types of support.

The integration of MHPSS in primary health care is an important step, as defined in the national plans on mental health. However, the implementation should be accompanied by training and education of care providers in approaches and models that fully connect to African realities and psychological knowledge as produced over the last decades by several African scholars and practitioners (Cherepanov, 2021). Furthermore, referral systems need to be part of a shift from a single focus on medicalization toward strengthening of social support systems and social cohesion as described by the IASC on MHPSS (IASC, 2007), confirmed by the study's data where respondents indicated the need for culturally sensitive solutions. Men, boys, women, and girls need MHPSS and SRHR care that is comprehensive and appropriate for and suitable to the sociocultural context of Congo.

Strengths and Limitations

The main strength of the study is that it uncovered relevant challenges of healthcare workers providing MHPSS services in DRC that are hidden under the surface of their professionalism. The qualitative approach allowed for capturing the nuances of the local context. The FGDs and interviews encouraged respondents to open up about topics that they do not often discuss, providing contextually grounded insights that contribute to a better understanding of the challenges that MHPSS service providers in North Kivu face.

In terms of limitations, however, the scope and sample size of the study, as well as its specific contextual setting, limit the generalizability of the results to other humanitarian contexts and populations. Additionally, we did not ask respondents to come up with solutions to the challenges (categorized into gaps and obstacles) that came out of the qualitative analysis.

Conclusions

The aim of the study was to gain a better understanding of the challenges faced by staff working at community-based health centers and hospitals in Eastern DRC to provide MHPSS to their patients. The analysis reveals three main categories of knowledge and skill gaps. These are related to reliance on western imposed approaches that only partly fit the local context, to a strong focus on medication, and to a lack of training. Further, the data show two main, more systemic, obstacles to improve current practices: persistent cultural taboos and misconceptions about what mental health and sexual health problems are and how they come to exist, and a very limited referral system.

This qualitative research provides important information on MHPSS provision that is context and culturally sensitive, and that illustrates the complex context in Eastern DRC. The results can be used to inform locally tailored education and training, but they also stress the need for system changes, along with the integration of traditional and Western models, to improve access and quality of MHPSS, including services related to sexual and reproductive health. From a national and regional perspective, the results seem to call for a paradigm shift as to how mental health is approached and embedded in educational systems and society.

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[1]Even though the target population of ICRC's programs consists of civilian men, women, boys and girls, actual psychological support is generally offered to victims that present particularly high levels of psychological distress and low functioning which is associated with female gender.

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