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Psychosocial Support and Follow-Up in Emergency Situations, the Mobile Intervention and Psychosocial Support Team: An Innovative Emergency System in Senegal

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Abstract

This article reports on the process of creating an innovative emergency mechanism in Senegal, the Mobile Psychosocial Intervention and Support Team (EMIS), by recalling how in the early 2000s a tragedy shook the country and triggered reflection on psychosocial follow-up in a political context subject to the idiom of resilience. The creation of the EMIS seems paradoxical since it requires and valorizes competencies in psychology and psychiatry which in ordinary times are little supported by social and health policies.

Keywords: Psychiatry, Psychosocial Follow-Up, Senegal, Emergency, Health Policy

1. Introduction

While the notion of resilience is more than ever saturating the scientific and political space in the world of development and humanitarian aid to express "the capacity of communities and systems to cope with shocks and also to prepare for them, or even to avoid them, and to adapt to them in the long term" [1], and while it tends to be associated with an ever more extensive set of actors (health system, agrarian systems, populations, society, States, hospitals, maternity wards, individuals, etc.), we propose to return to the creation and implementation of a psychosocial care system during crises or emergencies in Senegal, in an institutional context that has made the notion of resilience a priority. we propose to look back at the creation and implementation of a psychosocial care system during crises or emergencies in Senegal, in an institutional context that has made resilience its frame of reference.

1.1 The resilience paradigm

After two generations of Poverty Reduction Strategy Papers (2003-2010), followed by a National Economic and Social Development Strategy (2013-2017), Senegal adopted the Senegal Emerging Strategic Plan (ESP) in 2012. The aim is to promote economic growth with a strong impact on human development. The ESP serves as a reference framework for the State's action, which in its axis 2 (development of human capital, social protection, and sustainable development) promotes orientations aimed at increasing the resilience of populations: "better well-being in a society based on solidarity in a state governed by the rule of law, fighting against vulnerability and strengthening the resilience of populations, strengthening human capital, strengthening accessibility and care by reinforcing inequalities in the framework of better care" **[2]**. Resilience appears to be the paradigm that allows us to "better link the temporalities of emergency and development, to better coordinate support, to better consider local representations and practices", despite the criticisms associated with this "omnipresent idiom of global governance" [3, 4].

The idea appears that it is necessary to anticipate and prepare populations for various shocks or unavoidable developments, whether they take the form of an endemic or epidemic health crisis, the environmental consequences of climate change, or the socio-economic changes driven by the dynamics of modernization and globalization. The notion of crisis is itself polysemous and refers to situations of extreme variability [5]. States and international agencies are supposed to encompass and transcend family and community strategies given the increase in risks, higher societal expectations in this area, and increased knowledge thanks to development indices. Through the Millennium Development Goals, and then the Sustainable Development Goals, the

aim is to improve the living conditions of populations through the development of human capital [6] and by fighting against the various forms of inequality [7, 8].

1.2 Health systems and emergencies

In 1989, one of the principles structuring Senegal's health policy was that "the State must solve health problems through a four-dimensional approach that is preventive, curative, educational and social" [9]. The implementation of these plans has been accompanied by an increased demand to produce statistical indicators that make it possible to establish the state of a situation, to highlight the progress made or the bottlenecks, and to be placed in international rankings. While progress in statistical production in Africa is still insufficient and uneven [10], states are increasingly equipped with indicators to guide their actions.

In the case of Senegal, a series of reports aims to describe in greater detail the evolution of the health system, the information system, and health policy[1]. Nevertheless, statistical production is also a matter of institutional issues and the interplay of actors [11, 12] in health systems that are structured and constrained by international financing methods, political choices of governance [13], and management methods [14]. In the field that interests us here, that of health, the sectoral policy letter for the development of health and social action emphasized in 2018 the poor quality of reception and care in the Reception and Emergency Services of the country's public health establishments, while calling for densification of the offer [15]. In a booming private healthcare sector, private structures, such as "*SOS Doctors*" or "*SUMA Assistance*", have become established over the last twenty years, demonstrating the shortcomings of the public offer in the management of emergencies. In addition, the Covid-19 epidemic in Senegal has helped to highlight the importance of mental health[2] among patients affected by the coronavirus, their families, migrants who are stigmatized because they are suspected of having introduced the virus, caregivers confronted with the conditions of care, and the general population subject to health restrictions. The response to the epidemic has emphasized the role of the existing emergency mechanisms in Senegal, a country that has been praised in various international rankings for its management of the epidemic [16].

This article looks at the dynamics that led to the creation of an innovative emergency response mechanism, the Mobile Psychosocial Intervention and Support Teams (EMIS-PSY), which aims to provide care to populations in crisis or health emergencies. The construction of this narrative is based on documentary research (institutional reports, personal archives), interviews, and informal exchanges with certain actors involved in this institutional and medical adventure.

[1] For example: National Health Development Plan 2009-2018, National Health and Social Development Plan 2019-2028, Health Map Monitoring Report, Continuous Health Care Delivery Survey, Health Information System Strategic Plan 2012-2016, etc.

[2] Ibra Diagne, Véronique Petit et Jean Augustin D. Tine, The Conversation, April 8, 2021: « Senegal: how to ensure continuity of mental health care in times of Covid-19?"» https://theconversation.com/senegal-comment-assurer-la-continuite-des-soins-de-sante-mentale-en-temps-de-covid-19-158381

2. The genesis of the Mobile Intervention and Psychosocial Support Team (EMIS-PSY)

A historical review is essential to understand the creation of the "EMIS-PSY", which, along with the Emergency Health Operations Center (HEOC), reflects the Senegalese government's desire to acquire autonomy in this sector and to be an exemplary player in the regional health scene. Far from academic discussions on the concept of resilience, it was a collective trauma that initiated the process that led to the creation of EMIS-PSY.

2.1 The Joola disaster as a founding trauma

The social and political history of Senegal was marked at the beginning of the twenty-first century by the sinking of the Joola, a ferry that regularly shuttled between Dakar and Ziguinchor in Casamance, in September 2002 in Gambian waters. Almost 2000 people died, many of them from the same family. This event shook the country because of the number of deaths, the causes of the sinking, and the administrative and political responsibilities involved. The number of passengers greatly exceeded the capacity of the ship, and the safety standards were not respected. Subsequently, documentaries and works of fiction[3] echoed the individual, family, and community suffering that could not seem to be appeased. These productions maintain the survival of the images of the tragedy in the collective memory and translate the depth of the trauma experienced by the families concerned, and beyond that, the shock felt by the actors of the care and the population of the country.

Faced with the tragedy (1863 deaths, 64 survivors), health professionals were called upon to help the survivors and the families of the victims, and a medical-psychological support unit was created from scratch. It was integrated into the national emergency organization plan - the ORSEC plan[4] - which in the early 1990s marked the authorities' awareness of the need to anticipate future disasters. This unit has a triple mission: to ensure the medical and psychological care of survivors, to provide psychosocial support to the families of the victims, and to guarantee psychological support to the rescuers and the actors involved in the recovery, the restitution to the families and the burial of the victims' bodies. The "ORSEC" plan created in 1993 is triggered under the responsibility of the Minister of the Interior and has not been activated more than ten times since its creation. This plan is based on command staff and operational groups, including a "medical care and mutual aid" group. Decree 93-1288 mentions surgeons, doctors, veterinarians, pharmacists, social workers, midwives, and Red Cross volunteers as medical personnel belonging to this group [17]. The "psychological" dimension is absent, which explains why

[3] For Example, Babacar Fall, *Salt of the sea, poems for the shipwrecked and the survivors of the Joola*, Paris, Harmattan, 2003. Samba Diao, *the Joola we were there*, Paris, Harmattan, 2003. Bruno Parizot, *The Joola: the shipwreck of shame*, Paris, AAP edition 2008.

[4] Decree n°93-1288 of November 17, 1993, http://www.servicepublic.gouv.sn/assets/textes/orsec.pdf [accessed April 26, 2021], The Senegalese ORSEC plan is based on the ORSEC system, which is a French multipurpose emergency crisis management plan. It is repealed and replaced by decree 99-172 of March 4, 1999, http://www.servicepublic.gouv.sn/assets/textes/decret_orsec.pdf

the medical-psychological support unit was set up in a crisis. It also testifies to the intensity of the shock felt and the need for an appropriate political reaction to a population in a state of shock.

The conditions under which this cell was launched had consequences for the work of psychological care in the theater of operations, due to the unpreparedness of the care workers mobilized, the scale of the task, and the political and media interference [18]. Feedback from the experience describes how the management of care transformed actors who were not prepared to take on this work and to live this "unheard-of experience" [19]. Gounongbé [19] insists on the difficulty of the mobilized psychiatrists to put into action "the clinical function" once on the scene of the disaster and raises the question of the training and professionalization of the actors:

> "(...) faced with the suddenness and the magnitude of the unprecedented event, one was forbidden, and for lack of specific training or a special intervention unit in these exceptional situations, one believed oneself incompetent. Few "shrinks" were trained to intervene in disaster situations; because we did not imagine the psychological dimension operating in such circumstances; because we did not want to meddle in what did not concern us; because we did not want to put ourselves at the forefront of the scene; because we did not want to expose our competences to the possibly critical gaze of colleagues; because we did not want to give the impression that we were taking advantage of such a dramatic event by giving the impression that we were building a career on the back of dead bodies; because apprehensions were developing about the capacity to remain professional in an unexpected context of the collective suffering of such magnitude" [20].

If the sinking of the Joola caused a shock wave that continues to work underground in society, other smaller disasters (serious traffic accidents, train derailments, floods, building collapses, fires, tanker explosions) were subsequently managed by medical-psychological teams also trained in the emergency, without prior preparation and without formalizing intervention procedures. It was not until fifteen years later that Senegal set up a relief system dedicated to the psychological and social needs of disaster victims.

2.2 The Emergency Health Operations Center (HEOC) as a prerequisite

The creation of EMIS is inseparable from the creation of COUS in 2017, a structure to which it will be attached within MSAS. The issue of emergency appears explicitly in the latest National Health and Social Development Plan 2019-2028, drafted in the context of the Covid-19 pandemic, according to which "the changing epidemiological profile requires the strengthening of the institutional arrangement with COUS to reinforce the surveillance of diseases with epidemic potential and the response, as well as multisectoral coordination during disasters or catastrophes of national or international scope." The COUS was created by the Minister of Health and Social Action following the experience of the management of the Ebola crisis, which mobilized the entire Ministry of Health around a single case of Ebola, that of a young Guinean migrant, to the detriment of the other functions of the Ministry, which were then muted.

Currently attached to the General Management of Public Health of the Minister of Health and Social Action, the COUS has as its mission (Article 2):

> "to ensure the epidemiological surveillance of diseases with epidemic potential not targeted by the Expanded Programme on Immunization; to coordinate the implementation of an effective health control system at the level of maritime, air, and land entry points; to create an integrated surveillance system with the animal and environmental sectors, according to the "One Health" concept; to coordinate the response to any public health event of national or international scope; coordinate the activities of the different actors involved in the response to health emergencies; coordinate the response of the Ministry of Health within the framework of a multisectoral response to disasters; liaise with counterpart sub-regional and continental institutions; ensure notifications to the World Health Organization, regional and continental institutions for disease prevention and control; and coordinate the "Focal Point" of the International Health Regulations" [21].

As a coordination and steering structure, the HEOC does not appear in the latest health map, which reflects its specific place in the health organization chart [22]. Emergency care is included in curative care and only four categories of professionals are involved (emergency physicians, intensive care anesthesia physicians, intensive care anesthesia technicians, and medical regulation assistants). During Covid-19, HEOC coordinated the health response to the epidemic at the national level [23]. In an epidemic context, the “EMIS-PSY” is called upon to work in association with the “EMIS” Epidemic, which oversees the investigation and management of positive cases.

2.3 The structure of the EMIS

It was during framing and reflection meetings initiated by the HEOC, the Mental Health Division (MHD), and the psychiatry service of the national university hospital of Fann that the need to set up the EMIS-PSY became apparent. The decree n°19531 acts as the creation of the EMIS in 2017 [24]. Article 1 notifies of its creation and presents the human resources of this new structure on six pages. The organizational plan provides for the creation of a graduated, flexible, and adaptable system for the management of medical and psychological emergencies for victims of disasters or collective accidents involving many injured people or likely to have significant psychological repercussions. It follows the architecture of the country's political and health administration [25]. This system was conceived as a multidisciplinary "network of volunteers" providing psychosocial emergency actions throughout the country.

The operational procedures distinguish between the national and regional levels. The National Psychosocial EMIS is established by ministerial order. Attached to the HEOC and the MHSA, it is triggered by the Center's coordinator after advice from the Minister of Health. The missions of the national EMIS - PSY are to define the objectives of the medical-psychological emergency, to specify the methods of

intervention, to set up an educational team for training (for the members of the Regional EMIS), and research, to ensure the coherence of the whole system and to evaluate the actions conducted in the field. It includes psychiatrists, psychologists, doctors, nurses, social workers, associations, religious leaders, and the defense and security forces. The decree nominally stipulates the 94 people who compose it. It is provided with operating materials (intervention equipment, means of communication, emergency medicines, office equipment, etc.).

The regional level is constituted by the regional EMIS-psychosocial or Regional Psychological Support Cell (RPSC). It is composed of a regional referent (a psychiatrist from the region, or failing that, a psychologist, or a doctor) who can mobilize volunteers from a list of individuals identified and trained on an ongoing basis and ready to intervene in the event of a medical-psychological emergency. In case of major events justifying the intervention of the team, it is mobilized by the governor of the region or his representative, in liaison with the regional chief medical officer (RCMO). This level can intervene anywhere in the region and is always linked to the national level.

2.4 Missions and organization of a "volunteer network"

Article 2 of the 2017 order defines the missions of the EMIS-PSY, articles 3 and 4, the modalities of intervention, article 5 its means, and finally, article 6 reminds us that the director of the HEOC is responsible for the application of the decree. This document reveals the logic and intentions behind the implementation of this novel mechanism. The HEOC carries out the initial assessment of disasters since it is responsible for the coordination and deployment of interventions in the field. For its part, the Mental Health Division (MHD) is responsible for the technical aspect of psychology, making recommendations and proposing responders for deployment by the national psychology EMIS.

A table of more than four pages lists the 94 people who are part of the SJS at its creation. They were identified during the constitution process by the people in charge of this process: the HEOC, the Mental Health Division of MHSA, and the head of the psychiatry department at the national university hospital of Fann. During an intervention in the framework of the EMIS-PSY, they receive allowances, but they are not paid for this exceptional activity. The HEOC manages the logistical, financial, and administrative aspects of the deployment of the teams to the intervention zones. In addition to the fact that this activity is part of a form of professional ethics and personal values, it is undoubtedly implicitly considered to be professionally and socially rewarding. Moreover, in the very small professional universe of psychiatry and psychology in Senegal, it seems difficult not to get involved without marginalizing oneself. All the practitioners operating in the territory know each other, they are classmates, former students of the older ones, or close colleagues.

From a professional point of view, the members of EMIS-PSY were distributed as follows at its foundation: 38 psychiatrists, 16 psychologists, 28 social workers or assistants, seven nurses, one first aid worker, two clerics (imam and priest), and one socio-anthropologist. Two-thirds (64%) of them are health professionals (psychiatrists, psychologists, nurses, first aid workers), and the remaining third act on the social or community side through the two religious' representatives. For the most part, these professionals are active, except for two retirees. Most of them belong to the public sector, including 8 to the military health service and one to the presidency of the Republic; 12% of them are attached to the private sector or civil society. The vast majority are attached to the country's mental health centers and psychiatric institutions. The mental health of the Senegalese population is ensured by only 11 psychiatric structures and 35 psychiatrists in 2018 while the country has 14 regions [26]. Not all regions outside of Dakar and Thies have a psychiatrist and a service allowing hospitalizations. Patients are therefore referred to hospitals in Dakar for treatment [27]. Senegal has fallen behind in achieving the indicators of the 2013-2020 mental health action plan defined by the WHO [28]. Mental health provision in Senegal, as in many sub-Saharan African countries, suffers from a recurrent lack of investment [29].

The EMIS-PSY mobilizes almost all the human resources of the Mental Health Division, which is already understaffed (op. cit.). The spatial distribution of the staff (64 in the Dakar region, 22 in the other regions, 8 without precise location, but which can be thought to be in Dakar) is in line with the territorial inequalities in health care provision in an area marked by the macrocephaly of the capital [30]. These inequalities are more marked as they concern medical specialties [25]. The four most important psychiatric structures (National university hospital center of Fann, National psychiatric hospital of Thiaroye, Hospital militaria Principal, and Hospital militaria de Ouakam) are in Dakar. This bipartition (Dakar region / other regions) is repeated here. Staff located in the regions of Kaffrine, Kaolack, Saint-Louis, Tambacounda, Thies, and Ziguinchor are marginal. If Senegal is a country with a limited surface area and if in seven or eight hours one can reach all the points of the country, this concentration of "psych" resources constitutes a limit. These professionals are more accustomed to working in the Dakar area than with more rural populations, less educated, and less accustomed to a psychoanalytical posture. Even if there is a demand for mental health services in regions outside Dakar, the follow-up of consultations and interviews relating to therapeutic paths show that arriving in psychiatric services is often a long and chaotic process. Moreover, while Wolof is the vernacular language of the streets of Dakar, the linguistic situation in other regions is more plural. Psychiatrists in the regions sometimes call on nurses or orderlies to serve as interpreters.

The structuring of the EMIS-PSY means that interventions will be thought out and organized from the capital, whereas emergencies can take place anywhere in the country. The tragic experiences of Joola (2011) and Betty (2017) or more recently the Covid epidemic [19], all the health districts having been affected, have shown that distance coupled with an unbalanced health system could constitute a problem[5]. Diouf *et al* [23] explain that in the context of the Covid-19 screening strategy, the absence of analysis laboratories

[5] See the SITREP reports published each week, which indicate the number of health districts in which positive cases are reported https://www.sante.gouv.sn/activites/sitrep-30-coronavirus-riposte-%C3%A0-l%C3%A9pid%C3%A9mie-du-nouveau-coronavirus-covid-19-s%C3%A9n%C3%A9gal-rapport

outside Dakar was a handicap in the screening strategy and therefore a hindrance in the health response to the coronavirus. The psychosocial management of contact cases in “Touba” (the holy city of the Mouride brotherhood) highlights the lack of mental health facilities in a densely populated urban context, irrigated by international migration and strong religious mobility [31].

The use of professionals from the private sector, particularly psychologists, reveals the importance of this profession, even though there is currently no diploma training in Senegal. The few licensed psychologists in activity were trained in Europe. Sometimes the qualification of "psychologist" is problematic and raises the question of a profession whose practice is not regulated. These rare psychologists are mobilized by all the structures or innovative initiatives (SAMU, private structures, SOS doctors, NGOs, etc.). They cumulate functions, which can be an obstacle to their availability, but conversely, they acquire a great deal of experience by being confronted with multiple situations. Most of them work in Dakar.

2.5 Developing emergency psychology

The mission of the EMIS-PSY is to provide psychological support to victims of traumatic events, regardless of their location on the national territory. In collaboration with the medical, administrative, religious, and customary authorities of the locality, it is responsible for:

> "Conduct a needs assessment of those affected by the event; identify victims potentially affected by the traumatic event; identify the different forms of emergency psychological assistance appropriate to the context; plan and implement the different strategies of short, medium, and long-term medico-psychological assistance within the framework of emergency psychology; implement remote psychological assistance if necessary; provide emergency medical-psychological support from health care personnel or local responders if necessary; refer affected persons if necessary to a specialized structure for appropriate care, and plan and implement the various prevention strategies within the framework of emergency psychology" (Article 2 of Order No. 19531, September 29, 2017, MHSA).

The terminology explicitly refers to the psychological dimension as expressed in the terms used: "medical-psychological assistance, psychological support, emergency psychology, psychological help, and medical-psychological support". However, this psychosocial dimension, its content, its methods, and its theoretical framework, are not defined in this order.

3. Intervention doctrine and conceptual framework

The need to operationalize interventions led the HEOC to ask a psychiatrist from the Mental Health Division (MHD) and integrated it into the EMIS-PSY, to write a Guide to psychosocial care [32]. This document is also the reference manual for training in the management of medical-psychological emergencies organized by the Mental Health Division with the HEO. Dakar. In parallel, the Faculty of Medicine, Pharmacy, and Odontology of the Cheikh Anta Diop University of Dakar created 2017 a university diploma in psycho-trauma[6]. The training is open to doctors after their state doctorate, and to people with a master's level and it is planned to expand it to other categories (military, firefighters, police, and nurses) in Senegal and the sub-region. A Senegalese psychiatrist declared on this occasion:

> "We live in a context where disaster is imminent and causes severe suffering for the populations that are victims of it. The psychological and social consequences of psychological trauma can affect the mental health and psychosocial well-being of populations. Thus, to anticipate the facts, Senegalese psycho-traumatologists have launched a training program for professionals to solve the issues raised by the management of people who are victims of disasters or emergencies. We have arrived at a time when, in Senegal and Africa and general in the world, we are witnessing a globalization of misfortune".

This 120-page document defines the doctrine of emergency psychology interventions carried by EMIS-PSY. Let's see what the main principles are and what references structure the intervention approach.

3.1 The course of an intervention

In the event of a health emergency or a potentially traumatic event, the regional chief medical officer, or his representative (district medical officer) assesses the initial psychological and social needs in the field, in addition to somatic needs. Once the HEOC is alerted, it activates the psychosocial EMIS and sends an official note to the regional chief medical officer and the administrative authorities of the locality concerned. Responders are identified from the HEOC expert database, based on their availability, proximity to the location of the event, experience, and language skills. Members identified for this assignment are contacted by phone and email. If they do not respond, a second attempt is made 30 minutes after the first call. If they remain unreachable or are unavailable, other stakeholders are called. The selected members meet within four hours at the HEOC headquarters with their response packages (vest marked "EMIS-PSY", signage, emergency kits containing psychotropic medications, and briefing notes for victims and families) to be directed to the scene of the incident.

3.2 An expertise focused on and new to Senegal: psycho-traumatology

The management of psychological trauma is defined as "a priority" and must be carried out "without improvisation". In the introduction to the manual, Bousso develops professional rhetoric and insists that the interveners must have "a minimum package of knowledge in psychological trauma beyond their competencies and to speak a common language". It is intended for "field workers from specialized public or private structures, NGOs, professional, religious

[6] This training lasts 12 months for the academic year 2017-2018, with an hourly volume of 100 hours of which 80 hours will be devoted to theory and 20 hours for tutorials https://www.sudonline.sn/l-ucad-lance-son-diplome-de-psychotraumatologie_a_38787, https://orniformation.com/index.php/fr/programs/les-ecoles-superieures-publiques-et-privees-au-senegal/5043-faculte-de-medecine-de-pharmacie-et-d-odontologie

and community associations in charge of psychological and social support for disaster victims". It is supposed to reinforce the skills of professionals and those of community actors while creating a common professional habitus and a culture of emergency care through the mastery of this theoretical tool. The differences in approach and experience between a psychiatrist and a community or religious actor are not insignificant. The mobilization of associative, community and faith-based actors is pragmatic: these actors constitute a usual intermediary sociological level between the populations and the MHAS in the implementation of its different health action programs; associations are also mobilized by development partners, particularly in the field of international migration (IOM, German cooperation, Italian cooperation, German cooperation for example) without necessarily going through the Ministry of Health. For example, associations have been asked to train some of their members to become "psychotherapists" or "specialists" in "psychosocial follow-up" to receive and follow up repatriated migrants diagnosed as "traumatized" because of their confrontation with the death or disappearance of fellow travelers, the conditions of reception and the shame associated with the failure of repatriation. These support mechanisms also concern the relatives of deceased or missing migrants. The operationalization of these mechanisms (training and follow-up) raises a few questions, but that is not our subject here. Nevertheless, it testifies to the diffusion of this notion of "psychosocial" care in different strata of society.

The question of trauma is central to this approach because it is a question of identifying who should be the object of this care and therefore of sorting out the symptoms. The manual breaks down the training into 12 modules, and the first module introduces what psychotraumatology is:

> "Psychotraumatology is a medical branch that studies and treats psychological disorders of a traumatic nature. Psychological trauma is the set of reactions that a subject present when exposed to a traumatic event. The traumatic event can be experienced collectively or individually. Trauma is therefore the encounter of a subject (with his or her personality, weaknesses, and resources) with one or more traumatic events experienced frighteningly and helplessly. This encounter will leave the subject with psychological after-effects: in the short term: traumatic distress and dissociation, in the medium term: acute stress, in the long term: post-traumatic stress. However, not all subjects confronted with a traumatic event develop psycho-traumatic after-effects (the notion of resilience)".

Following this definition, a brief history of the concept is presented, concluding with the notion of post-traumatic stress disorder (PTSD). Epidemiological information on the prevalence and sociodemographic characteristics of people affected by PTSD is presented, as well as a model of understanding. According to the latter:

> "The person is confronted with the reality of death. The image of the event breaks through the subject's psychological defenses. The notion of psychic break-in designates a phenomenon of violent irruption within the psyche which overflows its capacity of defense and fundamentally upsets its mode of functioning. This image is unrepresentable and therefore not "digestible" by the psyche".

The clinic of PTSD and the symptomatology of the traumatized are then detailed by being placed in a nosography framework of the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association) and the CIM 10 (International Classification of Diseases of the WHO). In Senegal, several nosologically classifications coexist in the psychiatric system (CIM, INSERM French classification) [34], but it is the DSM-IV nosologically descriptions that the designers of the manual have chosen.

3.3 A word that saves

Once the presentation of trauma has been developed, the treatment of psycho-traumatic disorders is described in turn. In the preamble, the training manual states that it "combines a psychotherapeutic, non-medicinal and medicinal approach" [32]. Various techniques are presented, some of which are explored in greater depth during the training sessions. It is the technicality of the professional approach that is emphasized, as it is based on an internationally validated scientific substrate. To justify this psychotherapeutic approach, the authors refer to a theoretical consensus:

> "On the curative character of psychotherapeutic symptoms as well as the prevention of the appearance of after-effects, of a psychotherapy that is based on the appropriation of the traumatic experience through the verbalization of the lived experience in a spontaneous speech" [32].

Different methods are proposed depending on the exposure phase in which the affected person is located. In the immediate or post-immediate phase, reference is made to "defusing", which is a "brief interview that aims to defuse a situation that could become explosive, and to debriefing, an in-depth interview that seeks to initiate the process of integration of the dramatic event". In the acute stress phase, anxiety management programs and supportive psychotherapies are mentioned, which:

> "Do not aim at deep psychological changes, but at a reinforcement of the adaptation capacities of the subject, at a simpler and more efficient use of his means of defense, at a symptomatic improvement, at a release from external constraints by an action on the environment, and a psychological accompaniment in a period of crisis" [32].

Finally, other techniques are mentioned with a cathartic or meaningful objective (psychodynamic or psychoanalytically inspired therapy), or to reduce symptoms (behavioral and cognitive therapies, hypnosis, desensitization, and eye movement reprocessing). It is specified that these techniques can be completed by medication, which is listed according to the molecules available in Senegal, but that this medication is inseparable from psychotherapy.

Beforehand, the manual specifies that "psychosocial care is not a psychiatric follow-up" [32]. This reminder is important both from the point of view of the populations and of the

actors involved in Psychotrauma care. On the one hand, psychiatry in Senegal has a long history, with its roots in the process of colonization [35], and the creation of the psychiatric hospital modified the relationship to madness [36]. Regardless of social background and level of education, prejudice and stigmatization of patients remain strong and constitute an obstacle to access to mental health care. Sick people and their families try to keep consultations secret, to avoid the rumors and social discredit that surround people assigned the identity of "crazy". Interviews with psychologists show that people who consult take precautions to keep these appointments invisible to those around them.

On the other hand, psychiatrists constitute an important part of the EMIS-PSY staff. While their skills are recognized, when operating in the SJS they must adjust their practices to Psychotrauma. Being trained in the legacy of the Fann School, they are sensitized to the role of discussion groups, listening to the patient's life story, and to interacting with his or her carers [37]. When they experience professional practice or training abroad, most often in France, they recurrently testify in the interviews conducted to two observations that challenge their practice: more medicalized care and a doctor/patient interaction that is free from the family perspective in France. Without reifying either "French" or "Senegalese" psychiatry, within which various sensibilities coexist, these observations invite us to question the production of speech in a therapeutic framework that is at odds with the anthropological context, even if the latter is evolving with the psychologization of society.

3.4 A word that saves

This pedagogical phase is very interesting in a country with no training in psychology, and where the production and circulation of speech are subject to an anthropological framework that structures social relations [38]. Different rhetorical/language techniques have the function of avoiding any embarrassment by avoiding any questions that might undermine modesty (*Sutura*); it is also a question of magnifying the honor and qualities of the interlocutor (*Nafetaay and masala*) to "grow" him [39]. The codification and aesthetics of language distance the actors from a psychoanalytical posture attached to another function of language than that which aims to be part of the perpetuation of the social order. In the case of relations between migrants and their relatives in the country of origin. Día [40] evokes "an aesthetics of lies" that allows for negotiations around transfers and redistribution without anyone losing face either by asking for help or by refusing it. Individuals are not invited and accustomed throughout their lives to talk about themselves with spontaneity and naturalness; on the contrary, "traditional" education tends to repress the expression of effects and any questioning of family decisions quickly appears as a form of challenge to the social order and is frowned upon. On the other hand, doctors rarely offer explanations to their patients during consultations. In this context, psychoeducation prepares the victim for the therapeutic process that will be proposed to him to encourage his adhesion:

> "It is necessary to explain the benefits of such a process, to present the different therapeutic approaches, and to give them the list of resource persons and structures. The person leaves the psycho-education session feeling less guilty, reassured that what he or she is experiencing is normal, understands what is causing his or her symptoms, and knows that he or she can ask for help and where to get it" [32].

For example, Diagne *et al* [41] detail the implementation of medico-psychosocial care in the case of a pirogue shipwreck in 1997 in the Saloum islands. The actors involved in the intervention were chosen not only because they were trained in aid and listening techniques, but also because they speak "*Socé*", the local dialect. Speaking in the local language allows for a freer and more precise expression, thanks to the mobilization of representations, concepts, and ideas from the victims' socio-cultural matrix. Returning from an oyster harvest, a pirogue capsizes with 75 people, 21 people die and are quickly buried. The chief medical officer of the district indicates in his report psycho traumatic symptoms of overwhelmed stress, psychosomatic signs with a strong emotional charge, and requires specialized intervention. A psychiatrist and two social workers were sent to the site to implement a strategy of "psychological debriefing" through discussion groups, home visits to bereaved families, and individual interviews with survivors presenting certain symptoms [41].

3.5 Triage and diagnostic operations

As a medical-psychological emergency is defined as a request whose response cannot be postponed and which requires the implementation of an early care system for the psychically injured, the psychosocial team carries out a "triage-recognition" activity to identify psychological disorders and improve their prognosis" [32]. According to the recommendations, the screening must be carried out as quickly as possible, in an individualized space that ensures confidentiality, and must be carried out without discrimination against the patient or the subject of consultation, to categorize the victims and direct them to the appropriate care sector. The person in charge of the screening must have direct visual contact with the person being examined and be familiar with the clinical manifestations associated with the psychotraumatic crisis. This is expressed by physiological, verbal, psycho-emotional, behavioral, and cognitive reactions.

In concrete terms, the triage operation is carried out at the scene of the disaster. The team contacts the head of the medical authority's team on site, under whose orders they are placed for the duration of the intervention. The team leader indicates the location of the medical-psychological emergency station, which is positioned near an emergency medical station. The roles are divided: some examine the psychologically injured who are referred to them by the emergency medical station or who present themselves spontaneously. Others are called away from the medical-psychological emergency station to provide care or support to stressed casualties at the accident site. On-site monitoring of the least injured victims is established until they are in a condition to return home, after having recorded their identity, contact information, and condition. All psychologically injured persons and their families are given an information sheet explaining the nature and normalcy of immediate stress symptoms, and informing about the possible occurrence of other symptoms, with useful numbers. The clinical and therapeutic data recorded on the initial medical evacuation form ensures continuity of care. The psychosocial team also ensures regular debriefing

sessions with the intervention team so that they can each verbalize their emotional experience during the intervention. If some victims are hospitalized in the country's mental health centers, they are examined by the institution's psychiatrist. If they have returned home, they can come to one of the psychiatric services.

An entire training module is devoted to the symptom triage operation, which reflects the importance of this step in the overall system. This central concept (triage) is presented as the prerequisite in modern medicine, inherited from military medicine, for the effective care of injured and traumatized people. It is important to remember the importance of triage procedures and their sometimes-controversial effects, especially in saturated health systems. Moreover, in Senegal, some psychiatrists in the public sector and participating in the EMIS are military, which increases their proximity to this mode of operation.

4. Intervention doctrine and conceptual framework

The implementation of the psychosocial EMIS contributes to the evolution of the Senegalese health system in two sectors (emergencies and mental health) that are not part of primary health care. This recent mechanism and its actions have not yet been evaluated to assess the problems and dysfunctions it may encounter during operations and in the non-action phase. This mechanism must also ensure its sustainability, which raises the question of the materiality and human skills allocated to it in the context of stretched resources.

The EMIS-PSY procedures highlight Senegal's mental health needs, even though this public health sector suffers from a chronic investment deficit. The country still lacks a mental health policy, a nationally standardized statistical health information system, and no major survey to measure the mental health status of the population. In a context that is not conducive to more efficient management of mental health problems, the EMIS constitutes a paradox in that it values and requires psychosocial and psychiatric skills, while these are limited, and the State seems reluctant to take measures to strengthen them. It thus abandons many families and sick people in inextricable situations because of the multiple costs involved in the follow-up of mental pathology. The difference in treatment between the management of exceptional situations and that of "ordinary forms of life" [42] questions the relationship of politics to public health and the staging of its action.

The EMIS-PSY is rooted in an international culture of emergency and resilience brought about by successive crises. If this mechanism compensates for a lack in the country's health organization, it allows the political and health authorities to avoid thinking about mental health, which is partly dissolved in the discourse on resilience and psychosocial support reserved for crises or certain population profiles benefiting from international attention because of the migratory crisis. The day-to-day mental health of a supposedly resilient population remains largely unknown, and little considered, as do the local modes of expressing "resilience" [43]. The EMIS-PSY has been developed from external organizational models which, while they have forms of legitimacy and position it at the international level, have little basis in local skills. For example, the questions of listening and the disability of experience should be questioned: is it possible to establish a continuum between the practices of certain customary and religious actors and the therapeutic practices of Western traditions?

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