Social Sciences
2022; 11(1): 33-39
http://www.sciencepublishinggroup.com/j/ss
doi: 10.11648/j.ss.20221101.15
ISSN: 2326-9863 (Print); ISSN: 2326-988X (Online)

COVID-19 Among Internally Displaced Persons in Burkina Faso: Psychosocial Impact and Intervention Strategies

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To cite this article:

Sébastien Yougbaré, Aicha Nadège Ouedraogo, Bowendsom Valérie Claudine Rouamba/Ouedraogo. COVID-19 Among Internally Displaced Persons in Burkina Faso: Psychosocial Impact and Intervention Strategies. *Social Sciences*. Vol. 11, No. 1, 2022, pp. 33-39.
doi: 10.11648/j.ss.20221101.15

Received: January 19, 2022; **Accepted**: February 17, 2022; **Published**: February 25, 2022

Abstract: Since the onset of the health crisis caused by the COVID-19 epidemic in Burkina Faso, the already critical situation of Internally Displaced Persons (IDPs) following terrorist attacks, has worsened. IDPs – who face an existential crisis – are further stricken by the psychosocial repercussions of the health crisis that are undeniable and known all over the world. The coexistence of the security and health crises further amplifies the psychosocial impact of the condition, especially for individuals living in extreme poverty. Through a qualitative methodology based on individual interviews and clinical observation, this article analyses the emergence mechanisms of psychosocial conditions in Internally Displaced Persons in a COVID-19 context and aims to identify and assess the psychosocial disorders inherent to the coronavirus pandemic in this population. Thus, terrorist attacks, hasty departures, abandonment of land, houses, property, loss of close relatives, material and financial hardship, etc., are all challenges whose impact is far more distressing for this population. Although it is not perceived as a significant phenomenon, the COVID-19 crisis is an aggravating factor due to its effect on the country and the world. As such, a psychological support framework that promotes a locus of control focused on problem-solving is recommended. This will reduce peritraumatic dissociations and prevent post-traumatic disorders associated with the context.

Keywords: COVID-19, Internally Displaced Persons, Psychosocial Disorders, Trauma, Burkina Faso

1. Introduction

The year 2020 was marked by a global health crisis that is still persisting, caused by Coronavirus 2019 (COVID-19). In addition to its physical burden on patients and health services, the disease has had a huge psychosocial impact, causing mass hysteria, economic burden, and financial losses. Described as "coronaphobia", this mass fear of COVID-19 has generated a plethora of psychiatric disorders across different strata of Society [1], especially among already vulnerable populations.

Symptomatic manifestations of anxiety disorders, depression, guilt, and fear, have been massively highlighted in the literature. Besides, factors such as the speed of the spread, ignorance of the disease and its severity, the high death rate in several localities, the death of caregivers and the misinformation induced by mass media exposure, fear of contamination, etc., are causes of stress [2-4]. In addition, other risk factors such as lack of support, fear of infecting a close relative, isolation, stigmatization, and financial or job loss, can negatively affect the mental health, well-being, and safety of individuals and communities [4, 5]. Moreover, worldwide, poverty is identified as an aggravating factor of COVID-19 mortality, due to the promiscuity that is characteristic of these populations [6]. As Burkina Faso is a poor country in which security and health crises coexist, the psychosocial impact of the condition is further amplified, particularly for individuals living in extreme poverty, including IDPs.

While the entire country is facing both crises simultaneously, the vulnerability of IDPs makes them the most stricken population by these upheavals. Indeed, in October 2015, Burkina Faso recorded its first terrorist attacks, which intensified in early 2019, resulting in several killings and rapid and massive population displacements. Meanwhile, the country has been confronted since March 2020 with the COVID-19 epidemic, which has set the entire Burkinabe ecosystem in motion. This coexistence of crises has deteriorated the living conditions and needs of populations, and more specifically of the most vulnerable, including displaced people and children [7]. As of August 2021, the National Emergency Relief Committee (CONASUR) counted nearly 1,500,000 IDPs in the 13 regions, the vast majority of whom are in the North Central region (Kaya). More than 100,000 households share cramped spaces and are confronted with other inherent challenges, which leads to the emergence of harmful adaptive behaviours such as illicit activities combining child labour with prostitution, forced marriage, and rape, due to growing food insecurity [7].

In addition, extreme poverty has resulted from the health crisis and the impact of the response strategies. While all over the world, measures implemented to fight against the epidemic have had a deleterious effect on the quality of life and well-being of the population, the consequences are worse, as said, for already weakened individuals [8].

In Burkina Faso, for example, lockdown measures have resulted in significant household income losses and widespread food insecurity across the country [7]. These strategies, aimed to reduce mobility and impose social distancing included: closing educational institutions at all levels, imposing a nationwide curfew from 7 p.m. to 4 a.m., closing markets, quarantining cities that had recorded at least one case of COVID-19, etc. [6]. Thus, in less than two months, according to a survey by the Chamber of Commerce, the epidemic has resulted in an estimated loss of several billion dollars in sales. This situation has led to a significant drop in people's income, which greatly reduced their ability to meet vital needs, especially for initially precarious households [7, 9].

Similarly, we note a paralysis of beneficiaries' access to humanitarian aid, which makes their experience of displacement and loss of reference even more drastic. In addition, the shortage of health services and caregivers has led to massive morbidity among these populations, which increases their needs and undermines their quality of life [10, 11].

Furthermore, the psychological effects of the health crisis are considered more severe among already vulnerable populations [8], although it remains true that the extent of the impact of these disorders depends on individuals' ability to cope with them. Many authors argue that vulnerable populations are more likely to be adversely and permanently affected [2, 12]. As promiscuity is the main factor in the spread of the virus, the accommodation of IDPs is more of a vulnerability factor.

All these challenges increase these populations' poverty, thus aggravating the known psychosocial disorders associated with the health crisis prevailing in the country. However, while the pandemic has a definite psychosocial effect, it is necessary to look at the emergence mechanisms of these disorders as well as the context-based factors that generate them.

Indeed, periods of health crises are known to generate psychosocial disorders in the populations that experience them. It is therefore important to know the perceptible psychosocial disorders inherent to the crisis and the related prevention measures, as well as the support strategies required for their management.

This study aims, on the one hand, to identify and evaluate the psychosocial disorders inherent to the coronavirus pandemic that would be prevalent among IDPs, and on the other hand, to propose an intervention approach, based on the specificities identified.

2. Methodology

The study is based on a qualitative approach aimed to grasp the experience of the populations under study, and thus to identify the psychological disorders and their scope. The survey combines a literature review with qualitative investigative techniques such as clinical interviews and observations. For this purpose, individual interview guides and a clinical observation grid were developed and supplemented with a depression test administered to the target population, i.e. the IDPs. This is the Hamilton Depression Rating Scale (HDRS) which has the advantage of exploring depression symptoms and assessing their severity. The panel consists of IDPs and a few resource persons involved in camp management and/or supervision activities.

The field survey took place in two displacement camps in the Sanmatenga province, located between the communes of Boussouma and Kaya, in October 2021. The sample consists of 06 women and 10 men. A total of 16 displaced persons, including 9 at the Louda village camp and 07 at the Bisnogho Peulh site, took part in the study. Participants ranged in age from 22 to 69. Informal interviews were conducted with 5 resource persons.

3. Results

3.1. IDPs in Kaya's Shelter Camps

All of the people housed at the sites under study are families settled following the terrorist attacks. One thing the camps have in common is that they continually register new arrivals as terrorist attacks spread. The settlement is basic, although in Louda, the population actively participates by lending housing to IDPs, all of whom are located in the same geographical area. The Bisnogho Peulh site consists of a large fenced area owned by a private individual who is said to charter minibuses during periods of high movement to provide assistance to the displaced people. Both sites are supported, in addition to State services, by NGOs that assist IDPs, with the contribution of community representatives.

Most households experimented with other camps before settling in spaces they felt were more secure. The vast majority of families have split up to settle in several localities, as a way of guaranteeing the survival of certain members and the continuity of their lineages in the event of an attack on their accommodation sites. Life in these camps is marked by precariousness, as the residents are unproductive and many of their relatives are destitute, due to the fact that they had not been able to move with their belongings.

Moreover, few perceive the COVID-19 pandemic as an issue to be considered, except for the economic paralysis it has caused, which was the main concern for all participants.

3.2. Impact of the Response to the Epidemic

The methods of preventing COVID-19 have been well understood and accepted by all camp residents. These measures have been adapted to the population in order to facilitate their application. For example, recommendations for handwashing were supplemented with suggestions for the use of potash or ash in the absence of soap, as these products are more readily available to this population. Similarly, the residents are overwhelmingly Muslim, so for them, these precautions simply corresponded to their routine hygiene practices. However, measures such as the quarantine and the curfew, as well as the closure of markets, have amplified the difficulties faced by the displaced populations. Concerns about the future of children who are now on the street rather than in school, plague the lives of parents who are worried that their offspring will end up being employed in precarious jobs, as evidenced by the words of one respondent who said:

«It is a downfall to leave school and end up in a gold-mining site! However, there are no other alternatives here at the moment and we fear that our children will be reduced to low-paying or painstaking jobs such as gold panning...». Excerpt from an interview with a 38-year-old man.

Poverty persists, exacerbated by IDPs' inability to engage in income-generating activities such as trade and labour, and the lack of mobility caused by the quarantine. Similarly, due to growing insecurity, the most prosperous gold panning sites are now dangerous places, which caused gold miners to settle in unprofitable or even unproductive sites. The consequence is demotivation and the abandonment of this activity which used to be the only source of income for households with able-bodied arms.

The closure of markets has made it impossible for many people to work as sales assistants, leaving them unemployed, with no alternative source of income. Some women who barely had capital, borrowed trade items and resold them for profit, and payed back the purchase price at the end of the day. As for the men, some young people assisted merchants by helping sell their goods and attracting customers in exchange for payment at the end of the day. As precarious as they were, these activities, which no longer exist, seemed to suit these people, given the context.

In a nutshell, all these situations that caused a reduction of opportunities, have worsened poverty.

3.3. Psychosocial Disorders

Crisis situations are known to lead to psychological attacks, by disrupting the social environment. IDPs in particular, have been confronted with traumatic events that caused their displacement. The experience of a new crisis, in addition to potentially generating mental disorders, can reveal latent states of psychological distress, which resurface in case of a new traumatic episode.

Analysis of the data reveals a range of psychosocial impairments in the participants, the most recurrent of which are:

1) Symptoms of post-traumatic disorders through startle reactions occurring at every sharp noise (a falling object), or loud noise (starting a moped, etc.), reminiscences of a lost peaceful past, reliving of past traumatic events, are observed.
2) Depressive symptoms – such as feelings of sadness or helplessness, anxiety, sleep disturbance, lack of appetite, negative emotional state when talking about their future, crying – are common.

These characteristic symptoms of post-traumatic stress disorder, depression, and stress are common at varying degrees and are marked in some people. These disorders were severe at IDPs' arrival at the shelter camps, and tend to disappear over time, although they are still vivid in some subjects. Loss of appetite, difficulty sleeping, waking up in the middle of the night, sadness, apathy, crying – all characteristic of depression and stress – have been observed in many participants.

3.4. Factors Favouring the Emergence of Psychosocial Disorders Among IDPs

The issue of IDPs is multi-faceted. They are faced with various pathologies that persist over time despite the declining COVID-19 health crisis.

Different explanatory variables bear witness to the emergence of these disorders, which seem to be linked to the events that led to the exodus rather than to the health crisis, although the latter has exacerbated the situation by increasing IDPs' vulnerability.

Exile: conflicts represent the main factor causing IDPs to leave. While some of them left early as a precautionary measure based on events in neighbouring villages, others – survivors – left during or after bloody attacks. In any case, involuntary departure can cause traumatic stigmas, as expressed by some respondents who were heavily affected by these migratory episodes:

"When you have been uprooted and forced to leave, when you have moved under duress without your consent, when you have suffered your foundations… [using a lexicon testifying to the violence of departure], no matter the destination, you can only be sad and unhappy... I am deeply saddened to be here. At home we had our own life, it wasn't great, we weren't rich, but we didn't have to beg... Here, unless we beg, we can't get anything... that's not life …". Excerpt from an interview with a 62-year-old father.

Another respondent added:

"We could not take anything with us, neither money, nor gold, nor a single sheep or ox, nor clothing, nor millet... A lifetime of earnings lost…".

Excerpt from an interview with a young 28-year-old father.

In some cases, the departure was all the more violent as the attacks occurred abruptly in a usually peaceful environment where everything seemed normal and mundane, as revealed by some interviewees:

«We got up one morning, I was cooking, the animals were at the meadow, our husbands were in town and the children were at school... an ordinary day... I was cooking the meal when I heard these people parading [meaning the terrorists]. Everyone was running around, but we women are not afraid because we know that they only attack men; even 5-year-old male children are not spared... So I jumped in front of them, blocking their way... they ordered me to get out of their way and hide in the house [she is speaking in Fulfulde; then follows a dialogue in Fulfulde between the woman and the terrorists, which she then translated]. I told them that my husband was in the street and that I knew they would kill him, so I could not go and hide and leave my husband... I also added that they would have to go over my body unless they promised not to kill my husband... That day, we left, abandoning the meal on the fire, our animals in the meadow... I wanted to take some flour and the tô[1] I had finished cooking, but it was too heavy, the net broke, so I abandoned the flour, and took only the tô». Excerpt from a field survey with a 52-year-old woman.

Another woman speaking in the same way:

"On the day of our departure, everything seemed so peaceful that we did not suspect anything. All of a sudden, we heard sounds of gunfire; no one stopped to understand what was going on. We fled, leaving everything behind, even our children... Our children were at school, we couldn't go get them, so we joined our husbands who had taken refuge in the bush, then we reached a kind of rallying point and left thanks to the help of the owner of this courtyard who sent minibuses to pick up people and their luggage... It was only a few days later that we saw our children arrive, they had been able to follow the latecomers... Many people were killed behind us...". Excerpt from a field survey with a 48-year-old woman.

Loss of close relatives*:* The loss of a close relative is a shattering event for families, although the extent depends on the status/role of the deceased within the family, the circumstances of the death, etc. Many families lost close relatives in the attacks, some killed by the attackers, others died in other circumstances. For example, one respondent, the father of a large family, said he had sent his 16-year-old daughter – strategically chosen (women are usually spared...) – back to their abandoned home to get a motorcycle. Anticipating the tragedy, the father had sent his sons and their families to Boromo while waiting for the next event. Because of this, only he, his wives, and his young children, in addition to the girls, remained. The girl successfully carried out the mission, but died two weeks upon her return, following a seizure that the father, feeling guilty, associated with the fear she had experienced in the face of the horrible situation (corpses littering the path on her way).

Besides, some families have split up, sometimes deliberately for the sake of conservation, so that they would not all perish in the event of an attack on the shelter camps. Others were dragged by the displacement and had to disperse, although, as far as our participants were concerned, they were able to resume contact later.

Inability to meet basic needs: the inability to protect and provide for one's children, to assume one's role as a family leader, gives rise to castration anxiety, which is a difficult experience, particularly for men. This awakens a sense of decay associated with unproductivity, loss, and dependence. Many families are very poor and depend on the able-bodied yet unproductive arms, due to the paralysis caused by the health crisis. One participant, a 58-year-old father, moans:

"Are we still human beings? When you are reduced to begging to survive, you lose your humanism; living in such conditions is a total decay…".

Another respondent added [shedding tears during the interview]:

"The decision leave was not voluntary at all... [...] how can you sleep when you are shaken like this... I just think all night long; I wonder how one can get through such a situation…".

The loss of landmarks: Many people base their new identity on the quest for survival, while others are attached to the return ideology, in a logic of recovering a "confiscated" right, to paraphrase [13][2]. Among our participants, many are struggling to adapt to their new living environment, and unlike others who are ready to settle there if conditions become favourable, they really hope to return, even after two years spent in the camp. This refusal to give up further complicates integration, as one participant said:

"When we arrived, we saw women sweeping the sides of the hill, and we thought there was gold. But they said they were collecting rocks for sale; can rocks ever be sold? We thought we were doomed... being reduced to selling rocks... I'd never seen that before... I said I couldn't do that... So far this surprises me and speaks to the austerity of this area, unlike back home where there was abundance... Back home, when we swept the sides of a hill, it was to collect gold... gold was prolific, no need to dig... [...] Similarly, I see that here they sell grass... how can you sell something that grows wild, it's unbelievable... Even food is complicated to get here... no matter how long it takes, all of us [meaning her family], want to go back home…».

Forced to leave unexpectedly, the exiles were stripped of all their possessions. Ironically, however, some families who had previously suffered attacks and had taken refuge in the

1 local dish based on corn or millet flour.

2 Cited by [14].

commune of Barsalgho and then returned home because they thought the attacks were over, were able to anticipate by entrusting their belongings with relatives. Also, inspired by the unfortunate experiences of other people who, as soon as they returned, had to leave the next day, thus losing everything they had been able to keep, these families were proactive in managing to leave quickly with all their relatives and their belongings. They hence avoided huge losses.

4. Discussion

The psychosocial impact of the attacks and COVID-19 is widely discussed in the literature. The mental illnesses associated with the COVID-19 pandemic are undeniable. Several studies corroborate the existence of psychosocial impairments related to COVID-19 such as irritability, depression, anxiety, post-traumatic disorder syndrome, etc., [4, 8, 15]. All of these symptoms are visible in our participants.

It also appears that organizational aspects such as the lack of personal protective equipment, the disruption of daily family and social life, changes in consumption practices, the cancellation of activities and projects, the general economic slowdown, the scarcity of goods and services, are the most significant. In this study, these latter elements seem to better explain the conditions faced by our subjects, especially since no cases of COVID-19 have been recorded in the Kaya IDP camps. On the other hand, increased handwashing could have been burdensome because of the logistical demands of complying with such a measure. However, in these camps, measures were adapted to the population. In the absence of soap, ash and potash, which are good substitutes, were offered to IDPs, thus alleviating expenses, since ash is always available through wood-fired cooking.

Other aspects such as the lack of knowledge about the virus and therapeutic trial and error, rumours, contradictory statements and divergent opinions from authorities and experts that testify to a lack of control over the crisis, health recommendations, and coercive measures, all aggravate the generalized anxiety [16]. However, on this point, it appears that the symptomatology of COVID-19 recalls a known condition, described as a very contagious flu (requiring a quarantine of the subject and a close family member who would accept the risk of treating him), potentially lethal even though in general it evolves in a favourable way, over a period not exceeding one month. Therefore, despite the controversy surrounding the disease, it seems to be known to these populations who have various phytotherapeutic treatments that are reputed to be effective; they were therefore not worried by the epidemic and considered that the measures were excessive, especially since the death rate from COVID-19 in Burkina Faso is low compared to that of other local diseases such as malaria; a parallel noted by the general population, according to [6].

However, IDPs are characterized by their "traumatic" experiences in the face of war. The suffering caused by the disruptions of daily life, the confrontation with dangerous situations, the trauma related to the loss of close relatives, the circumstances of these losses, etc., can affect any human being. Although these manifestations may vary based on the individual, cultural differences in the expression of emotions and attitudes towards distress, the capacity for emotional regulation, and the means and resources available, they may be vivid or latent, and persist over a long time, in the absence of psychological care.

A comparative study of IDPs and People living in their Habitual place of Residence (PHR) in a conflict zone in Côte d'Ivoire revealed that IDPs had twice as much morbidity in general and psychosocial disorders in particular, as their PHR counterparts. Similarly, 6 out of 10 IDPs displayed psychological sufferings such as anxiety and depression. The study also shows that young adults (36-45 years) and adults (46-59 years) IDPs were relatively more affected physically compared to 18-35-year-olds, although psychologically, the latter and their young adult counterparts had higher instances of abnormality [17].

Thus, reactions to a crisis differ from one person to another in many ways. Nevertheless, suffering from a crisis is quite "normal".

While the COVID-19 health crisis is a highly disruptive phenomenon with a strong psychological impact, it must be said that periods of crises are known to generate psychological suffering of various kinds. Numerous studies have shown the existence of "normal distress" when a person is uprooted and forced to leave. In fact, in an emergency situation, between 30 and 50% of the population manifests mild to moderate distress that improves with psychosocial intervention in the first few weeks. Approximately 20% of the population will suffer from a mild to moderate psychiatric disorder, including post-traumatic stress disorder (PTSD), for which specific supportive intervention is needed, while approximately 4% will suffer from a major psychiatric disorder such as bipolar or psychoses, which require psychiatric management [18, 16]. Typically, PTSD is the "normal distress" experienced by people forced into displacement, says the French Development Agency [19]. Therefore, the vast majority of populations affected recover relatively quickly from the initial shock and focus on their survival and that of their relatives by activating their own resources, while for others, substantive psychological distress may persist and delay rehabilitation [20]. Indeed, it appears from our observations in the camps that several families have registered new births, and one of the participants got married for a second time during their migration, because he was worried that his fiancée would abandon him if he did not guarantee his loyalty through a sacred union such as marriage.

In short, this suffering is a logical reaction to a serious and life-changing event, from which many people recover, while others need assistance in order to stem it quickly. Therefore, a psychological follow-up, upon arrival in the sites, increases the chances of overcoming these disorders. In this respect, for example in Bangladesh, the intervention strategy with Rohingya refugees begins with group sessions that help them acknowledge their new situation, the objective being to

inculcate the idea that they are now safe and that the process of mourning for loved ones who were victims of violent deaths can begin [19].

However, it is important to emphasize that the precarious living conditions in the camps affect the exiles almost as much as the traumas suffered in the areas of departure. The precariousness of the situation is all the more difficult to live with as exile constitutes a decline for people who had a well-defined social role at home. Becoming abruptly homeless – losing all material properties, without a family, or even without access to essential services – sets in motion the identity of the exiled person who feels depersonalized [20]. This explains the feeling of decay expressed by our participants, a feeling that is all the more acute among older adults because they are the ones who used to play key roles within their community.

To this end, the provided support must be accompanied by balanced living conditions. In this regard, we believe that support to displaced persons must be psychosocial in a promotional or rehabilitative perspective. This begins with the "emergency assistance" phase to meet needs for shelter, health, hygiene, survival and protection equipment, followed by immediate post-trauma assessment and response. Finally, the psychological counselling phase supports and accompanies the psychosocial autonomy centred on the life project.

5. Conclusion

Periods of crisis are known to generate psychosocial disorders among the affected populations, but these situations should not be pathologized. Many people have the capacity to recover, although this may depend on accommodation conditions, including the guarantee of safety.

Overall, the issue of IDPs is multi-faceted. Depending on the context, different variables may influence the mental state of these populations in the face of a new crisis. Reminiscences of past trauma, individuals' and groups' capacities to respond to new trauma, the support strategies put in place and their effectiveness, the nature of the evolution of the health crisis, are all elements whose repercussions can be felt at various levels. Psychosocial support fosters resilience. However, it should be implemented as soon as possible after disasters occur, so as to contain mild cases, and to prevent the disorders from taking root in the most severe cases.

Finally, life in shelter camps generally results in a redefinition of community and neighbourhood ties, with the emergence of new community representatives. Good organization promotes the maintenance of certain social mechanisms such as assistance, sharing, and support when an event occurs, which further promotes resilience. Also, individual or group psychological guidance that supports the development of traumatic cognitions by promoting a locus of control focused on problem-solving, may reduce peri-traumatic dissociations and prevent post-traumatic disorders inherent in the co-occurrence of the COVID-19 pandemic and terrorist attacks.

Funding

The authors of this article thank the National Fund for Research and Innovation and Development (FONRID) of Burkina Faso for their financial support.

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