

Practices in West Africa to care for children and adults with behavioral, psychological and mental disorders

“Behavioral disorders” is an umbrella term that includes more specific disorders, such as attention deficit hyperactivity disorder (ADHD) or other behavioral disorders. Behavioral symptoms of varying levels of severity are very common in the population. Only children and adolescents with a moderate to severe degree of psychological, social, educational or occupational impairment in multiple settings should be diagnosed as having behavioral disorders. For some children with behavioral disorders, the problem persists into adulthood (Definition from WHO MhGap program). Mental Health refers to a broad array of activities directly or indirectly related to the mental well-being component included in the WHO's definition of health: "A state of complete physical, mental and social well-being, and not merely the absence of disease". It is related to the promotion of well-being, the prevention of mental disorders, and the treatment and rehabilitation of people affected by mental disorders. (WHO, 2013)

Search terms:

English: Benin; Togo; Guinea; Ghana; Senegal; Burkina-Faso; Nigeria; Mental health; Behavioral disorder; Spiritual practices; Psychosocial; Psychiatry; Children
Français : Psychosocial- Afrique de l’Ouest, pratiques spirituelles, psychiatrie- enfants

Primary research question:

What formal and informal practices are undertaken in West Africa (7 countries: Benin, Togo, Guinea, Ghana, Senegal, Burkina-Faso and Nigeria) to care for children (0-18 years old) and adults with psychological, mental and behavioral disorders?

Secondary research questions:

- What are the existing formal mental health structures in the 7 countries of intervention?
 - How do these formal mental health structures operate?
 - What are the informal practices to care for children and adults with psychological, mental and behavioral disorders?
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Research aim and methodology

The aim of this research is to highlight the formal and informal practices that are undertaken in 7 countries of West Africa (Benin, Togo, Guinea, Ghana, Senegal, Burkina-Faso and Nigeria) to care for children (0-18 years old) and adults with psychological, mental and behavioral disorders. The WHO Mental health Gap Action Programme (mhGap) and the WHO Mental Health Atlas served as a baseline and in order to get a comprehensive picture of the mental health system per country, we used up-to-date country situation analysis reports on mental health by P.Koffi for Burkina Faso, S. Oyewusi for Nigeria, K. Dassa & CBM for Togo and K. Humphrey & MhLap for Ghana. Furthermore, in an effort to support our research, a survey was carried out with 8 key stakeholders from Nigeria, Guinea and Togo. Using a qualitative method, a questionnaire (Appendix 1.3.) with open-ended questions was distributed.¹ The survey aims at finding additional information on prevalence of mental disorders and psychologists, techniques and approaches of psychologists and psychiatrists, community care and beneficial traditional practices for children and adults with mental, psychological and behavioral disorders. Some results that were not found in our research will be added to the literature review accordingly.

Introduction

Although the idea of health without mental health sounds absurd, mental health is perhaps the most neglected aspect of health in developed and developing nations. Addressing mental disorders often appears to be an afterthought in health and social policy development, added to existing 'more important health issues' rather than a part of individual and population overall health and wellbeing (Ngui, Khasakhala, Ndetei, & Roberts, 2010). It is an essential and inseparable component of health – as per the Lancet series on global mental health – as it interacts with other health conditions, such as cardiovascular disease, diabetes, HIV/AIDS or malaria (Prince, et al., 2007).

Because of high rates of mortality from other communicable and other non-communicable diseases, mental disorders often receive little attention from governments, and are still at the bottom of the list of health priorities for policymakers (Moron-Nozaleda, Gomez de Tojeiro, cobos-Munoz, & Fernandez-Liria, 2011). Mental health disorders have never been ranked in the top ten priority lists of public health significance when mortality indicators alone have been used (Berdirhan Üstün, 1999). However, the Global Burden of disease included “disability” in the equation in calculating Disability Adjusted Life Years (DALYs) and as a result mental disorders are ranked almost as high as cardiovascular diseases and respiratory diseases and surpassed all different types of cancer and HIV. The Global Burden of mental disorders highlights the magnitude of the problem as loss of life years in terms of human productivity as well as social functioning (Berdirhan Üstün, 1999) and hence in terms of national economic development (WHO, 2002). The burden of unmet mental health needs is especially high among children and youths (Flisher, Kramer, Grosser, Alegria, Bird, et al, 1997 ; (Ngui & Flores, 2007) and about 10 to 20% of all children are affected by one or more mental or behavioral problems (Ngui, Khasakhala, Ndetei, & Roberts, 2010).

In Africa, it has been established that the figure is higher than the global prevalence rates of mental disorders (WHO, 1999). The prevalence of mental disorders among outpatients ranges between 20-40% in Africa. (Nyong'O, 2011)

As stated by Koffi (2012) from Burkina Faso, risks factors for mental disorders are:

- Internal and external migration flow is very important
- Uncontrolled urbanization and its consequences of promiscuity and disorganization of the old solidarities
- Youth unemployment and use of psychoactive substances

¹ The respondents were as follows: 1 mental health advisor (Nigeria), 1 CEO of an autism and related developmental disabilities center (Nigeria), 1 psychologist (Togo), 1 consultant psychiatrist (Nigeria), 2 project coordinators of community/national Mental Health program (Nigeria, Guinea), 1 project coordinator in a Mental Health Center (Nigeria) and 1 general and public health doctor, director of a NGO (with a mental health department, Guinea).

- The marginalization of women
- Poverty
- Malnutrition especially in children and pregnant women
- Early and unwanted pregnancy
- Endemic/epidemic diseases that cause significant morbidity and mortality especially among children
- Head injuries as a result of many traffic accidents
- Childbirth unassisted by a health professional

Prevalence of mental disorders in adults and children

Neuropsychiatric disorders² comprise 10% of the burden of disease in Africa (WHO, 2008). In all regions, neuropsychiatric conditions are the most important causes of disability, accounting for around one third of Years Lost due to Disability (YLD) among adults aged 15 years and over (WHO, 2004). The difference in the prevalence of mental disorders doesn't appear to be significant, although there might be less consultation for neurotic disorders.

Studies (Dassa & CBM, 2012) done in Togo shows that psychopathological decompensation among African refugees are more expressed in children through learning difficulties (25.64%), depression (15.38%) and enuresis (12.82%), and in adults through depression (29.85%), post traumatic stress disorder (14.92%) and acute psychoses (20.90%). Depression, Mood/affective disorders³, schizophrenia/delusional disorders are among the most common reason for consultation in psychiatric facilities (with different ranking according to countries and facilities- inpatient or outpatient). Some other reasons for consultation are: Epilepsy (considered as a mental illness), intellectual disabilities (especially in some areas of Togo due to iodine deficiency) and drug abuse related disorders. (Appendix 1.1.)

1. Formal elements of the mental health systems in West Africa

Government & Financing

Government budget and expenditures on mental health are often inexistent or very low. Table 1 shows the data available on health expenditure and the proportion spent on mental health per country. There are no data for Guinea, Togo and Senegal.

Countries	Benin ⁴	Nigeria ⁵	Burkina Faso ⁶	Ghana ⁷
Health budget	0.062 of national budget	5.82% of GDP	13,5% of total government expenditure	—
Mental health budget of health budget	Less than 0	3.30%	—	1.30%

Table 1

- Data Unavailable

GDP is the total amount that the whole country produces; Government expenditure includes all government consumption and investment but excludes transfer payments made by a [state](#). National budget have an economic, political and technical basis. It is the forecast of the likely levels of revenues and expenses.

² "Neuropsychiatry is a field of scientific medicine that concerns itself with the complex relationship between human behavior and brain function, and endeavors to understand abnormal behavior and behavioral disorders on the basis of an interaction of neurobiological and psychological-social factors. It is rooted in clinical neuroscience and provides a bridge between the disciplines of Psychiatry, Neurology and Neuropsychology". (Sachdev, 2005)

³ Mood disorder is the term designating a group of diagnoses in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR) classification system where a disturbance in the person's mood is hypothesized to be the main underlying feature. The classification is known as mood (affective) disorders in ICD 10.

⁴ WHO. (2007). *WHO - Assessment Instrument for Mental Health Systems (WHO-AIMS) report in the Republic of Benin*.

⁵ WHO. (2011). *Mental Health Atlas - Nigeria*.

⁶ Koffi, P. (2012). *Burkina Faso Country Situation Analysis*.

⁷ Humphrey, K., & MhLap. (2012). *Mental Health Care Situation Analysis in Ghana*.

In Nigeria, the National Health Insurance Scheme provides short-term coverage for “affective mental disorders”, but currently payment for drugs is out of pocket and this provision through the health insurance scheme is presently for workers in the formal sectors. (Oyewusi, 2012)

Legislation

Mental health policy is present and was recently revised in Senegal and Guinea (policy and plan). These legislative frameworks include timelines for the implementation of the mental health plan, shift of services and resources from mental hospitals to community mental health facilities, integration of mental health services into primary care and special care for handicapped children and adolescents. In Guinea, the mental health plan components include integration of mental health services into primary care. However, dedicated mental health legislation does not exist and legal provisions concerning mental health are not covered in other laws (e.g., welfare, disability, general health legislation etc.).(WHO, 2011)

In Nigeria (since 2003), Ghana (since 2011) and Togo, a mental health bill proposal is currently being discussed in parliament. In Nigeria the bill would enhance the provision of access and appropriate care for people who have mental disorders in Nigeria and also make adequate provisions for its implementation in the national health budget (Oyewusi, 2012). In Ghana, the Mental Health Bill adopts a human rights-based approach in accordance with international agreements for the health care needs of a person with mental disorder. The current act of 1972 is outdated and service to take away the rights of people with mental disorders. Secondly, the bill makes provision for decentralization of mental health services. In order to reduce the abuse of people with mental illness within informal treatment facilities, the bill recommends that a mental health authority and tribunal be established to regulate the practices of traditional and faith healers (Humphrey & MhLap, 2012). The government strategic choice is to promote the integration of traditional and alternative medicine practice into the formal health system and support strategies to improve the quality of care provided by these practitioners along with an established traditional medicine list with treatment guidelines (WHO, 2007).

Drugs

In West Africa there is an overall shortage of basic psychotropic medicines and the drugs available are very expensive with no system for monitoring prices. There is a unit responsible for drug policy only in Burkina Faso and Nigeria. In Burkina, the Generic Purchasing Generic Central (CAMEG) is responsible for the supply of drugs to health facilities. In Nigeria, it is estimated that roughly 50% of all drugs on sale are fake or sub-standard. The Nigerian National Agency for Food and Drug Administration and Control (NAFDAC) has a high profile and is matched by some success in prosecuting those involved in the trade.

Structures

Table 2 illustrates the availability of the different mental health services in the seven countries. A major problem found in those countries is the centralization of the facilities in the capital cities, with limited resources elsewhere.

In Ghana, the states hospitals are chronically overcrowded by as much as three times more mentally ill patients than beds. Inpatient stays are longer than required since families usually abandoned the patient due to the high level of stigma surrounding mental disorders.

- In Benin and Nigeria, less than 20% of primary health care doctors make referrals to mental health professionals. There are no formal avenues for professional interaction between primary health care staff and other care providers and traditional practitioners. (WHO, 2006, 2007).
- In Guinea and Senegal, official referral procedures for referring persons from primary care to secondary/tertiary care exist, as do referral procedures from tertiary/secondary care to primary care. (WHO, 2011).

- In Burkina Faso, despite the adoption of primary health care strategy, recent evaluation revealed that health districts do not include mental health into their action plan. (Koffi, 2012).

Countries	Benin ⁸	Nigeria ⁹	Togo ¹⁰	Burkina Faso ¹¹	Ghana ¹²	Senegal ¹³	Guinea ¹⁴
Community-based mental health service	4	3	5	0	4	1	_
Psychiatric hospitals	4	10	1	0	3	5	_
General Hospitals with psychiatry departments	0	24	12	11	10	_	1
NGOs/Associations	4	8	58	5	3	_	_
Medical and psychological Center	0	0	2	0	_	_	_
MH Consultation in General Medicine	0	0	3	33	_	_	_
Mental health out-patient facilities	_	_	_	_	_	10	2

Table 2

_ Data unavailable

Child psychiatry

Child psychiatry is often regarded as part of general psychiatry.

- Senegal is the only country with a child psychiatry department, the Kër Xaley Center (Fall, Diouf, Thiam, Sylla, & Gueye, 2007).
- In Nigeria, mental health services for children and adolescents are found within 4 psychiatric outpatient facilities.
- In Ghana, there are 45 beds available for minors in the psychiatric hospitals (representing 4% of the total). Additionally, there are 10 residential facilities for children under 17 with intellectual disabilities, one in each of the regions. (Ofori-Atta, Read, Lund, & MHaPP-Research-Programme-Consortium, 2010)

Human resources

Table 3 shows the total number of mental health staff in the different countries while table 4 represents the proportion of practitioners per 100000 population (allowing a comparison between the countries). The countries in table 4 are arranged in decreasing proportion of psychiatrists.

⁸ WHO. (2007). *WHO - Assessment Instrument for Mental Health Systems (WHO-AIMS) report in the Republic of Benin.*

⁹ Oyewusi, S. (2012). *Mental Health in Nigeria: a country situation analysis.*

¹⁰ Dassa, K., & CBM. (2012). *Santé Mentale au Togo: Etat des lieux sur les ressources humaines, matérielles et institutionnelles.*

¹¹ Koffi, P. (2012). *Burkina Faso Country Situation Analysis.*

¹² Ofori-Atta, A., Read, U., Lund, C., & MHaPP-Research-Programme-Consortium. (2010). A situation analysis of mental health services and legislation in Ghana: challenges for transformation. *African Journal of Psychiatry*, 13, pp. 99-108.

¹³ WHO. (2011). *Mental Health Atlas 2011 - Department of Mental Health and Substance Abuse.*

¹⁴ OSAR, O. S., & Kuthan, F. (2010). *Guinée Conakry: possibilités de prise en charge psychiatrique et traitement des PTSD.*

Country	Benin ¹⁵	Nigeria ¹⁶	Togo ¹⁷	Burkina Faso ¹⁸	Ghana ¹⁹	Senegal ²⁰	Guinea ²¹
Population	9,598,787	170,123,740	6,961,049	17,275,115	24,652,402	12,969,606	10,884,958
Psychiatrist	13	149	4	8	12	42	4
Psychologists	1	69	40	6	2	3	0
Other doctors	1	0	0	—	—	1	11
Social workers in mental health sector	1	114	0	2	80	12	0
Nurses	21	1460	29	116	210	101	7
Occupational Therapists	0	35	0	0	1	0	0
Neurologist	—	—	6	—	—	—	—
MH specialists	—	—	—	49	—	—	—
Other health workers	—	—	—	—	—	74	—

Table 3

Country	Senegal	Benin	Nigeria	Togo	Ghana	Burkina Faso	Guinea
Psychiatrist	0,32	0,14	0,09	0,06	0,05	0,05	0,04
Psychologists	0,02	0,01	0,04	0,58	0,01	0,04	0
Other doctors	0,01	0,01	0	0	—	—	0,10
Social workers	0,09	0,01	0,07	0	0,33	0,01	0
Nurses	0,78	0,22	0,86	0,42	0,85	0,67	0,06
Occupational Therapists	0	0	0,02	0	0	0	0
Neurologist	—	—	—	0,09	—	—	—
MH specialists	—	—	—	—	—	0,28	—
Other health workers	0,57	—	—	—	—	—	—

Table 4

— Data unavailable

In the mental health sector, the world median rate of psychiatrists is 1.27, psychologists is 0.3, social workers is 0.23, nurses is 5.80, others MDs 0.34 and other health workers is 2.65 per 100,000 population respectively. (WHO, 2011). Senegal, Benin and Nigeria have the highest proportion of psychiatrists per population. Senegal has 2.5 times more psychiatrists than Benin and 8 times more than Guinea. The mean number of psychiatrists per 100,000 population for the 7 countries is 0.1 (i.e 1 psychiatrist per 1M inhabitants).

Togo has the highest proportion of psychologist by six times the average proportion of the 7 countries. Senegal, Ghana, Nigeria and Burkina Faso have the highest proportion of mental health nurses with an average of 0.79 nurses per 100,000 population while Guinea has around 10 times less nurses than than.

¹⁵ WHO. (2011). *Mental Health Atlas 2011 - Department of Mental Health and Substance Abuse, World Health Organization -Benin.*

¹⁶ Oyewusi, S. (2012). *Mental Health in Nigeria: a country situation analysis.*

¹⁷ Dassa, K., & CBM. (2012). *Santé Mentale au Togo: Etat des lieux sur les ressources humaines, matérielles et institutionnelles.*

¹⁸ Koffi, P. (2012). *Burkina Faso Country Situation Analysis.*

¹⁹ Humphrey, K., & MhLap. (2012). *Mental Health Care Situation Analysis in Ghana.*

²⁰ WHO. (2011). *Mental Health Atlas.*

²¹ WHO. (2011). *Mental Health Atlas.*

Results from our survey show that child psychologists in Nigeria are mainly found in tertiary and research institutions. Treatment from child psychologist is usually better in the private sector. In Togo, child psychologists work mainly at: Terre des hommes Togo, SOS Children's Village, juvenile brigade, Child Protection department and Nursery Claire Site Lomé. Finally, one respondent stated that there is one child psychiatrist in Guinea.

Training

Training for mental health specialists are provided by most of the countries in the public sector. However specialization in psychiatry is not provided in Togo and Guinea. Table 5 represents the training available in the different countries. In some areas, training is provided by NGOs and local associations. Specialization in psychiatry exists in Benin (only 1 psychiatrist graduated from 2002 and 2007), Nigeria, Burkina Faso, Ghana and Senegal while training in psychology is available in Benin, Nigeria, Togo, Burkina Faso (via the MPhil programme) and Senegal (training in psychotherapy via the Senegalese Family Therapy Association and Belgian cooperation). There is little training for mental health social workers and nurses. (Appendix 1.2.)

Countries	Benin	Nigeria	Togo	Burkina Faso	Ghana	Senegal	Guinea
Training							
Psychiatry	Yes	Yes	No	Yes	Yes	Yes	No
Psychology	—	Yes	Yes	No	Yes	—	No
Psychiatric nursing	Yes	Yes	—	Yes	Yes	—	No
Social work	—	—	—	Yes	No	—	No
Occupational therapy	—	—	—	—	No	—	No
Psychotherapy	—	—	—	—	—	Yes	No

Table 5

— Data unavailable

2. Overview of ethnographic elements linked to mental health issues in West Africa

In general, for the population of the countries studied, mental illness is believed to be of supernatural origin (evil spirits, curse, witchcraft...). This usually encourages a high level of stigma around the mentally ill and healing is primarily sought from a traditional healer. Moreover, some healthcare workers share this belief as well (Bakare, et al., 2009). In rural Africa, some chronic diseases such as epilepsy are also regarded as a mental illness. Whether it is health professionals or the general population, regardless of the level of the people's education, the socio-cultural considerations are identical; the epileptic is stigmatized and is rejected by the family and surroundings. (Sow, 2008). Notions of causation suggesting that affected people are in some way responsible for their illness can also fuel negative attitude towards mental illness.

There are several issues that may contribute to mental illness:

- In Nigeria there is the widespread belief that misuse of drugs is the cause (Adewuya & Makanjuola, 2008). Furthermore, it can be noted that twins can be accused of being the root of their parent's illness and behavioral disorders (Ouango, Karfo, Kere, Ouedraogo, Kabore, & Ouedraogo, 1998).
- In Ghana, findings revealed that in the general community, mental disorders in women (and men) are commonly attributed to the work of 'witches', who are almost always women. It was highlighted that in many circumstances, women who are suspected of using witchcraft (usually those who have transgressed or challenged the patriarchal order) to cause mental problems are separated, or expelled from the community,

particularly in northern Ghana. They are forced to move to designated places, or 'witch-camps'.

- In Burkina Faso for the Mossi population (largest ethnic group in the country), God and ancestral spirits are believed to be the cause of illness, particularly in the field of mental disorders. Ancestral spirits are called "kinkirsi". The explanation of psychological disorders by family, social or intra-psychic conflict is borderline delusional for them. In Burkina Faso twins are called "Kinkirsi" (ancestral spirits). Twins are believed to have supernatural powers and can cause insanity to their biological parents if they disobey them. (Ouango, Karfo, Kere, Ouedraogo, Kabore, & Ouedraogo,
- Research shows a strong relationship between common mental disorders and exposure to domestic violence as well as to Female Genital Mutilation (Ofori-Atta, et al., 2010). This strong relationship exists possibly because violence against women encapsulates humiliation, subordination and entrapment (WHO, 2000), which are associated with depression.
 - In Lomé, Togo, 73 to 97% of the adults surveyed are victims of domestic violence. Lomé's population is very young; 60% is aged between 10 and 20 years old. Seventy-five percent of children and adolescents have been victims of a type of violence in 2006. (Dassa, Thiam, & Ahyi, 2007)
 - Social and religious constraints that characterize traditional societies in Africa, particularly in Burkina Faso and Guinea, endorse certain forms of violence as educational norms. This is the case for early and forced marriage of young girls and Female Genital Mutilation (FGM). The frequency of early marriages were recognized as important, especially in sub-Saharan Africa and Asia, where 20 to 30% of women marry or form a union before the age of 18. Some girls eventually adapt to the situation while others are left with important psychological disorders. (Siranyan, Ouedraogo, Karfo, & Ouango, 2007)
 - The high prevalence rate of Female Genital Mutilation (FGM) in Guinea and Burkina Faso is of major concern. In 1998, in 21 of the 52 Ministry of Health clinics of rural Burkina Faso, 93% of the women had undergone FGM. This proportion is considerably higher than the population-based prevalence of 72.5%(WHO, 2006). The median age for FGM is 9.5 years. (Jones, Diop, Askew, & Kaboré, 1999). FGM has been shown to cause immediate complications (pain, bleeding and infection) and delayed complications (sexual, obstetric, psychological problems). Education was found to be associated with a reduced likelihood of undergoing FGM for both Protestant and Catholic women but not for Muslim women. (Karmaker, Kandala, Chung, & Clarke, 2011)
 - As for Guinea, it is one of the countries in Africa where Female genital mutilation is almost universal with a rate of 99% (UNICEF, 2005). FGM is carried out at a very young age in some parts of the country; around 60 per cent of girls are younger than ten years of age, 80% are between the age of 6 and 14 years old and less than 10% are at the age of 5 or younger. It is important to note that most of the locals (all the men) believe that FGM should be abolished but a sensitization and awareness campaigns have to be undertaken. They found it useful to organize a traditional ceremony that only excludes the genital cutting and that some elements of modern sexual education could be included. (Keita & Blankhart, 2001)
 - In Ghana domestic violence is to some degree normalized and women is doubly insulted and ashamed when the results of abuse are obvious to all. A senior public health nurse indicates that women's abuse frequently goes unreported, due to the repercussions such reporting could entail (Since 2000, the International Action Against Female Genital Mutilation (INTACT) has been offering practitioners loans in to stop performing the practice in Ghana, in the hope that by 2005, FGM would no longer be practised in the country. However, the study by Ofori et al. shows that this practice may still occur). (Ofori-Atta, et al., 2010)
 - The extreme psychological trauma that this practice can invoke has received very little attention in the literature. It is revealed that this practice may have detrimental psychological repercussions for women. (Ofori-Atta, et al., 2010)

3. Examples of formal/informal and modern/traditional mental health interventions

As seen, due to the supernatural beliefs of the population of Western Africa, traditional healing is more appropriate and convenient for the people. Modern medicine, primarily lacking a spiritual dimension, does not fully meet the demand of the people. Other than cultural beliefs and price, traditional and faith healers are sought because of the limitations in resources of modern medicine. In this section, firstly, the common practices will be outlined and secondly, we shall attempt to bring out some of the practices that appear to be useful and innovative in this region.

Traditional healers use a mixture of practices comprising of prayers, sacrifices, exorcism, herbs and plants, and drinking of holy water. Some practices are against human rights: restraints (chaining, nailing), alienation, confinement, scarification and beatings. These often result in serious health complications. However, a common finding in Nigeria was that traditional healers could recognize symptoms of severe mental illness and psycho education could improve their understanding of etiology and reduce their tendency to use corporal interventions. (Ayonrinde, Gureje, & Lawal, 2004.)

Moreover, it appears that traditional healers are not the only one practicing abuses. In a Nigerian hospital, the medical staff used restraint to prevent patients from disturbing people (78%) and to punish patients (14%) (Nuhu, Yusuf, & Aremu, 2010). Another extreme example of inhuman treatment can also be seen at the “special ward” of Accra Psychiatric Hospital in Ghana, where about 300 men are locked in a set of cells designed for 50. These criminally detained inmates and “voluntary” patients have no access to the outside world or to therapeutic help. Associate professor of psychiatry at the hospital, Samuel Turkson, confirmed patients’ allegations of abuse. “Beatings with sticks are still used. Medication is used as punishment. Turkson estimates that half of the “voluntary” patients have no recognizable mental health problem (Roberts, 2001).

In our survey, most respondents have pointed out the high incidence of human right abuses in relation to community care (one respondent says: “physical restraint is the rule”).

A more positive aspect of traditional healing is the motherly role that a traditional healer may take during treatment. Counseling is common, especially among priests. Numerous stakeholders, including those at the policy-making level, directly indicated that traditional and faith healers may be appealing to many people as they provide psychosocial and spiritual support. They highlighted that traditional and faith healers are like ‘clinical psychologists’, providing ‘talk therapy’, ‘counseling’ and ‘asking questions and providing solutions’. A traditional healer’s approach takes strong note of how relationships within the family and community may be affecting the patient’s mental health. Traditional healing practices put the individual into a larger dimension; in relation to God, supernatural forces and with the group as a whole. Healers therefore not only have a crucial role in the health of individuals but also in the functioning of the whole community, as they help establish and maintain social codes, bind people together, and propagate local culture and faith (Ae-Ngibise, et al., 2010).

Some innovative practices from different countries are outlined below:

- In Burkina Faso, music and dance associated with group healing used by a traditional healer has been studied and the latter believes that it is the best therapeutic practice (Vontress, 1999). The traditional healer believes that the sound that is the force of change; the beat, rhythm, timing and the balance between action and rest are all vital to the therapeutic process. Music, especially drum rhythm, captures the movements of the human body, its sensations and nature itself. Drummers and musicians are an important part of healing. They are considered as assistants in healing. Furthermore, music triggers dance, and dance is magnetic; both contagious and important ingredients for healing. They restore peace and harmony in the individual and the group. Drumming for a sustained period of time at a steady rhythm does wonders for the whole body. If crops

are in danger or evil spirits threaten the group, people are eager to participate in the therapeutic festival; the entire village is reanimated after a night of music and dancing. However, we don't have enough information about the prevalence of this practice among traditional healers.

- In Senegal, the patient is never alone; the family feels as involved and distressed. For better efficiency, health professionals found ways to combine traditional concepts and a cultural practice that is difficult to remove in the African context, with the hospital's treatment process. Particularly in major psychiatric services, the practice consisting of the presence of a family member at the patient's side has been institutionalized since 1971 as the patient's "carer" ("accompagnant du malade"). This allowed the mental health workers to have a positive relationship with the family and therefore to ensure follow-up. A recent approach consists of each doctor receiving and following a family as long as he works in the service. (Sylla, Thiam, & Guèye, 2008)
 - Compromise between western clinical theories and cultural concepts of each region of Senegal is common. Clinical diagnosis is based primarily on medical examination. Exploratory, psychological, speech therapy and psychomotor tests allow better clinical descriptions to refine and improve the understanding of psychopathology. Systemic therapy, psychoanalysis and psychotherapy are widely used. Specific tools to assess Senegalese children's development has been made but not yet validated. (Fall, Diouf, Thiam, Sylla, & Gueye, 2007). Ker Xaley's child psychiatry center usually collaborates with other medical specialties.
 - Career orientation centers (CNOSP, CROSP), in line with the law of 1991, and medical training services play an important role in the assessment and referral of children with school adjustment difficulties. However, psychologists and/or counselors still provide guidance and psychotherapy despite the lack of proper training and suitable working conditions.
- In Benin, the government advocated for the combination of biomedicine and traditional medicine and hence, extracts of medicinal plants that have proven to be effective throughout centuries in Benin and African cultures were given to the patients. (Tall E. K, 1988)
- In Nigeria, a Public Awareness Program on Mental Health was financed by AUSAID and carried out by the Amaudo Itumbauzo local NGO. It was held in three states for 4 years. Its main focus was to highlight mentally ill patient's human rights and to challenge misconceptions about mental illness. It is interesting to note that their main tool was village-based health workers (VHWs), trained by them, who held a position of respect in the communities. The aim was to increase the number of people receiving appropriate psychiatric care by promoting referral to the network of clinics across the three states. There were statistically significant increases (33%-48%) in the number of patients who attended the community psychiatric clinics in the last 2 months of the year following the campaign in each state. The increased referral rate to the psychiatric clinics was marked, and seems to occur with a strong temporal relationship to the training of VHWs. Additionally, the creation of a public demand for new clinics and the political impetus to invest necessary resources to do this by local leaders was an unexpected benefit of the training. (Eaton & Agomoh, 2008)
 - Nigerian respondents from our survey outline that psychologists and psychiatrists use Cognitive Behavioral Therapy, Bell and Pad technique and counseling and that psychotherapy is being introduced in child and adolescent clinics in some part of the country.
- In Guinea, in 2002, a group of health care specialists, social workers, nurses and a European psychiatrist via the Medical Fraternity Guinea NGO (FGM), initiated a medical

facility for the mentally ill in a village called “therapeutic complex of Moriady” (123 km from Conakry). The aim was to bring medical, social and psychological support for the mentally ill and to decentralize the treatment of the mentally ill outside the city of Conakry. More importantly, the villagers were involved in the process from the beginning. The therapeutic complex is an infrastructure composed of a health center (open 24/24), a rehabilitation workshop for the mentally ill. Well-defined services and a monitoring system suitable for primary health care are available. It is also a teaching environment for the inhabitants (agricultural activities for women and socio-educative activities for the youth). The existence of adjacent activities facilitates the rehabilitation of patients. Through the combined efforts of the healthcare team and the village community, care is provided to such a significant number of patients that a specialized structure located in large cities could never achieve. (Sow & FMG, 2010)

Conclusion

Unmet needs for the mentally ill are not insignificant in West Africa. There has been progress concerning legislation in the majority of the countries except for Benin and Burkina Faso. Mental health facilities are usually centralized with limited material and human resources and child psychiatry is often regarded as part of general psychiatry. What characterizes the countries studied is the supernatural beliefs of mental illness. This usually encourages stigma around the mentally ill and treatment is primarily sought from a traditional healer. Traditional healing is valued because of the psychosocial and spiritual support it provides. However human rights abuses are reported among them but these can even extend to medical staff and hospitals. Despite the unpopularity of mental health care, this literature review has brought to light some innovative practices among traditional healers, health specialists, and locals. Some innovative practices involve using cultural practices as healing practices, mixing cultural practices with western clinical theories, Awareness Program on Mental Health with village-based health workers, decentralization of care in a village by the setting up of a self-sustainable medical facility with the involvement of the villages.

In this literature review we strive to be as resourceful as possible and for more detailed information, a report per country is available upon request. For some sections of the study (namely governance and financing, legislation, and training) more data is required. This could be done by adding a thorough field study within each country (as this was only a desk study).

As for potential future research, there would be a lot of specific issues that could be looked upon more exhaustively (such as mental health legislations, the feasibility of large-scale awareness and sensitization campaigns to reduce stigma and human rights abuses, etc.)- Looking at Tdh range of action, additional studies could be carried out at a field level on compiling good practices in terms of community mental health activities that impact on Children mental health care or its stigma consequences (endogenous practices as well as support from outside organization). Another focus could be to look at how to enhance the skills of the community workers in order to address mental health issues and stigma, especially when no specific training is available at national level.

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Appendix

1.1. Prevalence of mental disorders per country

Guinea

Because of cultural and economic context, a large number of epileptics do not receive appropriate treatment. In Guinea, there is only one Department of Neurology, EEG is not available in the public structures, and the number of specialists is very small with less than 10 neurologists, neurosurgeons and psychiatrists for 8 million inhabitants. Traditional therapeutic methods are numerous. In most African countries, phenobarbital is the cheapest most commonly available and prescribed drug for epilepsy. Unfortunately in Guinea, phenobarbital is not available in the central pharmacy of the country. The NGO "Fraternité Médicale Guinée", is the only structure that provides care for epileptics. (Sow,2008)

Respondents from our survey listed autism, post-partum psychosis and mutism as being part of the five most prevalent mental disorders in Nigeria.

Nigeria

In Nigeria, the users (adults and children) treated in outpatient facilities are primarily diagnosed with schizophrenia (52%) and mood (affective) disorders (31%). The admission diagnoses of inpatient units were primarily schizophrenia and related disorders (43%) and mood (affective) disorders (25%). The patients admitted to mental hospitals have the following primary diagnoses; Schizophrenia, schizotypal and delusional disorders (51%) and mood (affective) disorders (24%). (WHO, 2006)

Post-traumatic disorder, mental retardation, ADHD, and autism are considered by respondents from our survey as being part of the five most prevalent mental disorders in Nigeria.

Togo

In Togo, depression is among the main reasons for consultation and is often expressed through somatic complaints and delusions of persecution. However, it is estimated that the proportion of sufferers are more important; since depression is less disturbing than psychotic disorders, families are less motivated to bring them to a health specialist. Intellectual disability is a real public health problem in some areas of the country due to lack of iodine. Currently thirty to fifty thousand children in Togo have brain lesions due to iodine deficiency. (Dassa & CBM, 2012)

Mental and behavioral disorders often result from drug abuse. Withdrawal syndrome is the main reason for hospitalization at CHU-CAMPUS Lomé. At the psychiatric hospital called Zébé, common disorders are: deficit syndrome, acute psychotic disorders, paranoid reactions and schizophrenic syndromes

Furthermore, it is estimated that there are between 45,000 and 90,000 patients with epilepsy in Togo: each year, about 5000 people become epileptic. Current research confirms the role of hyperhomocysteinemia²² in the occurrence of stroke (46%) and dementia (12.4%) in Togo. In some regions, cysticercosis²³ represents a risk factor for epilepsy. (Dassa & CBM, 2012)

Benin

In Benin, people in the public mental hospitals are principally from the following three diagnostic groups, 50% depressive, 25% psychotics and, 25% nervosa. Less than 20% of the patients received one or more psychosocial intervention during the 2006. Neurotic disorders (30%), followed by schizophrenia (15%), are the most prevalent diagnoses in community based psychiatric units. Generally diagnoses of admission are: 43% of patients suffering from schizophrenia or schizotypal disorders, 28% of mood disorders and 19% of organic disorders,

²² hyperhomocysteinaemia is a medical condition characterized by an abnormally high level of [homocysteine](#) (non-protein) in the [blood](#). This condition is a significant risk factor for the development of a wide range of diseases.

²³ Cysticercosis refers to tissue [infection](#) after exposure to [eggs](#) of the pork [tapeworm](#), which migrate to the brain and muscles causing cysts.

such as epilepsy and dementia. Pr. M. Tognidé, director of the Jacquot National psychiatry Hospital states that in Benin there were 3,26% suicidal attempts and 60% of the patients suffer from mood disorders. He points to the uprise of drug addiction and depression. Furthermore the youth represents the majority of mentally ill patients. (Loko, 2010)

Burkina Faso

In Burkina Faso, neuropsychiatric disorders are estimated to contribute to 5.8% of the global burden of disease (WHO, 2008). The main reasons for consultation in psychiatric facilities are acute and chronic delusional disorders, disorders related to drug abuse, epilepsy, mental and behavioral disorders associated with somatic complaints and depression.

In the specific case of children and adolescents, parents consult for learning disabilities, mental deficiencies, epilepsy, and child psychosis.

At the university hospital Ouédraogo Ouagadougou in the capital of Burkina Faso (CHU-YO), between 1997 and 2007, one of five women in the psychiatric department suffered from depression. According to the ICD-10 classification, moderate depressive episode with somatic syndrome are found in 41% of the cases. Students represented 16% of the women diagnosed with depression. (Karfou, Sanou, Yaogo, Ouango, & Ouédraogo, 2009)

Senegal

In Senegal, neuropsychiatric disorders are estimated to contribute to 7.0% of the global burden of disease (WHO, 2008). Mental health facilities in Senegal receive children and adolescents suffering from all forms of disorders; from the most simple with children who only need some guidance, to more complex whereby no solution is yet available in Senegal (disharmonic or severely autistic children, (pre) adolescents with intellectual disabilities...). In between these extremes are the difficulties encountered to provide special education to children with more or less acute physical, social or psychological impairment. These children are often shuffled from one institution to another before being effectively excluded when they reach a certain age. Moderate intellectual disabilities, behavioral disorders, specific learning disabilities and language disorders are more common. They can evolve satisfactorily in institutions, but at some point they require other services that are no longer available. Sometimes it is not uncommon that they lose some acquired skills due to this lack of organization and low collaboration between health professionals. (Fall, Diouf, Thiam, Sylla, & Gueye, Handicap et école au Sénégal, 2007)

Based on prevalence rates from the World health Survey 2004, it is estimated that at least 2,816,000 people in Ghana (13 % of the adult population) are likely to be affected by mental disorders. Approximately 3% (650,000 people) are suffering from a severe mental disorder and a further 10% from a moderate to mild mental disorder. According to the annual report of the Ghana health services 2005, estimates show that only 1.17% receive treatment (for mental disorders including substance abuse and neurological disorder) (WHO, 2007). The four most common diagnoses in inpatient psychiatric hospitals are schizophrenia (25%), substance abuse (17%), Depression (12%) and hypomania (10%). In outpatient facilities patients are more treated for epilepsy (29%), followed by acute psychosis (28%), Neurosis (27%) and substance abuse (16%). (WHO, 2007). Child mental health in Ghana remains problematic and is still regarded as part of general psychiatry. The concentration has always been on adult mental health and so child and adolescent mental health has always been left in limbo, so it will appear as though within the circle of mental health, child mental health is further discriminated against. (Ofori-Atta, Read, Lund, & MHaPP-Research-Programme-Consortium, 2010)

1.2. Training available per country

Benin

From 2002 to 2007, only one psychiatrist graduated, no psychologists with at least a year of experience in mental health care, and no nurses specialized in mental health care were trained. Four percent of undergraduate training hours for medical students are devoted to psychiatry and mental health related subjects. Nurses receive about 10 hours of training on psychiatry and mental health related subjects during their undergraduate training. The government does not often support research in mental health or its development partners. (WHO, 2007)

Nigeria

It is estimated that about 3% of the undergraduate training hours for medical doctors is devoted to mental health, in comparison to 13% of the training hours for nurses and 3% for non-doctor/non-nurse primary health care workers. Fourteen percent of mental hospitals staff and twenty percent of inpatient psychiatric units and community residential facilities staff have had at least one day training, meeting, or other type of working session on human rights protection of patients in 2005.

The number of professionals graduated in 2005 in academic and educational institutions is 3,189 (11.65 per 100,000): 8 psychiatrists (0.03 per 100,000), 320 nurses with at least 1 year training in mental health care (1.17 per 100,000), 7 psychologists with at least 1 year training in mental health care (0.02 per 100,000), no social worker with at least 1 year training in mental health care, and no occupational therapists with at least 1 year training in mental health care. At least 25% of psychiatrists migrate to other countries within five of the completion of their training.

The majority of primary health care doctors and primary health care nurses have not received official in-service training on mental health from 2006-2011. Officially approved manuals on the management and treatment of mental disorders are not available in the majority of primary health care clinics. (WHO, 2011)

Togo

There is a paramedical personnel trained on the field and working in mental health facilities. Recently, the NGO Mercy Ship has formed fifty doctors and paramedics. The staff, while not being primary providers in mental health facilities, is a group to be targeted for future degree programs. It seems crucial that these workers who are not specialized in mental health but have acquired skills, should be deployed in mental health structures. Social workers, educators and specialized therapists (eg. speech therapists) are trained locally but are rarely integrated in the mental health care system. There is no specialized training in mental health for health administrators. There is no occupational therapist, psychomotor therapist, or specialized teachers in Togo. The University of Lomé trains neurologists (diploma of specialized studies in neurology for general practitioners), and psychologists (clinical, educational and industrial psychology). There is no specialized training in psychiatry (psychiatrist, psychiatric nurse). However, Mental Health courses (neurology, psychiatry and psychology) are provided during medical and psychosocial staff training. (Dassa & CBM, 2012)

Burkina Faso

The Ouagadougou University provides psychiatry training. Psychologists are trained in Europe. Social workers are trained in Ouaga and Gaoua and nurses are trained in Ouaga.

Health practitioners not specialized in mental health receive theory and practical courses in mental health:

Health nurses: 15h theory and 2 weeks practice

Doctors: 30h theory and 3 months internship in 5th year and 2 months in 7th year

Ghana

Psychiatrists and neurologists have 3 years of specialization and 2 additional years to become consultant on top of the 6 years of general medical curriculum. They have the obligation to take

2 professional courses every year. They are registered and are provided with a certificate for each course. Psychologists have a 3 years degree course via the MPhil programme. Psychiatric nurses have 18 months of specialization after general nursing training, or 3 years for straight psychiatric nursing training.

There are no degree courses for mental health social workers and occupational therapists. It is important to note the important migration of locally trained staff to more lucrative work abroad. (WHO, 2007)

Senegal

In Senegal 4 years of specialization in general psychiatry is provided but there are no training courses in child psychiatry. The creation of a chair of psychiatry by the African and Malagasy Council for Higher Education (CAMES) should contribute to an improvement in that area. Furthermore, students should be better sensitized concerning child psychiatry (the death of the father of child psychiatry in Senegal, discouraged the population to pursue this field).

Concerning psychotherapy, since a few years, the Senegalese Family Therapy Association with its systemic approach and Belgian cooperation, has been promoting sensitization and training. There are no schools for speech therapy or psychomotor education (Nevertheless, there is a Cameroon institute specializing in psychomotor education and body-oriented therapy which receives several African nationalities on affordable terms). (Fall et al., 2007)

Guinea

No training in mental health is provided in the public sector. (WHO, 2011)

1.3. Questionnaire

Practices in West Africa to care for people with mental, psychological and behavioral disorders

I am currently working on a literature review for the NGO Terre des hommes. The research aims at finding formal and informal practices in West Africa to care for adults and children with mental, psychological and behavioral disorders. The focus is on 7 countries: Benin, Togo, Nigeria, Burkina Faso, Senegal, Ghana and Mauritania).

This questionnaire should take 30 minutes. You can answer in bullet points.

Thank you for your valuable contribution,
Hanim Edo
Terre des hommes, Switzerland
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+41 78 79 70 975

1. Kindly provide us with some personal details

Name:
Country:
Place of work:
Position:

2. What do you understand by mental, psychological and behavioral disorders?

Mental disorders:
Psychological disorders:
Behavioral disorders:

3. What are in your view the 5 most prevalent mental, psychological and/or behavioral disorders prevalent among children (0-18) and adults in your country? Please mention if specific to adults or children.

1. 2. 3. 4. 5.

4. Are there psychologists working specially with children (0-18)? If yes, where (public institutions, private office...etc?)

.....

5. What are the methods/approaches/techniques used by psychologists and psychiatrists in your country (CBT, Psychotherapy... etc)? Please specify if there is a distinction between adults and children.

.....

6. How does the community cater for adults and children (please specify if different) with mental, psychological and behavioral disorders?

.....

7. Have you come across any local/traditional practices that are beneficial for adults and/or children with behavioral disorders? If yes, please specify.

.....