Mental Health and Psychosocial Support

Mapping in Niger, Nigeria, Burkina-Faso, Ghana and Gambia

Nigeria - Mental Hospital vs traditional care (Benin City)

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Research Objectives & Methodology

This mapping was planned to identify mental health and psychosocial resources available for returnees in Ghana, Gambia, Burkina-Faso, Niger and Nigeria. The overall goal of the mapping was to identify available resources, gaps and reinforcement opportunities.

The field work for this assessment was conducted from the 24 of December 2017 to the 15 of February 2018.

Documents review took place before, between and after fields' visits in the period from December 1st to 4 of March 2018.

Methods included: web research to identify key stakeholders, document review, semi-structured interviews, observation and field visits at service providers and health facilities. The tables in annex provide an overview of the interviews carried out at field level and the stakeholders identified in the area.

Fields visits in MHPSS facilities were conducted with the WHO QualityRights Tool Kit in mind.

Constraints and limitations

This work posed a few challenges among them, timing was especially difficult to tackle.

First, the field visits started during Christmas & end of the year holiday's period (from the 23/12 to the 76/01), a two week period when most stakeholders were unavailable.

Secondly, the limited period of time dedicated to the field visits (reduced to 7 consecutive weeks for 5 countries including official holidays and travel between two sites) meant that activities took place in parallel and in the end, only 36 working days over a period of 7 weeks were available for the entire process.

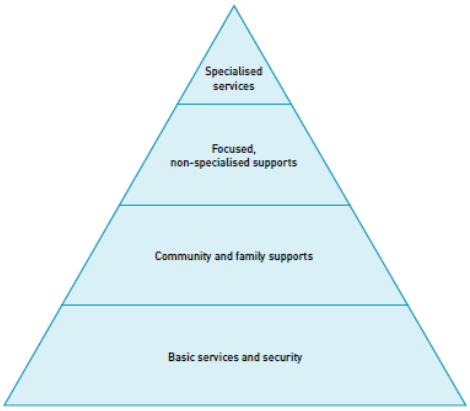
As a result of these different limitations, the geographical scope of the mapping had to be limited especially in Niger and Nigeria where it was mainly and respectively focused on Niamey and Edo State.

The mapping concentrated essentially on specialised services (see below the Intervention pyramid for mental health and psychosocial support /IASC guide line). Some others PSS service providers were identified but there was no time to meet.

Finally, limited interaction took place with traditional healers and community health workers with the exception of one traditional healer in Birkhama (Gambia). Due to the importance of traditional healers in the Central African Communities, this would have been a relevant assessment point but would have require to travel to the community and the time dedicated to each country did not permit it.

Mental Health & Psychosocial services (MHPSS)

The term "mental health and psychosocial support" (MHPSS) is commonly used in the literature to describe any type of local or outside support /non-biological interventions that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders for people in crisis situations (Inter-Agency Standing Committee [IASC], 2007).



Intervention pyramid for mental health and psychosocial support (IASC guidelines, 2007)

'A comprehensive approach for MH and PSS support need the integration of specialized MH services at the health facility level but also a strong community based component in order to identify, refer and follow up people in need'.

Executive Summary

This mapping found similar environments of great need and limited resources across the region. In comparison with European standards, mental care is in the 5 assessed countries is very low and as in all low income and middle income countries, the treatment gap for mental illnesses (the number of people who required treatment but do not access treatment) is wide.

In all countries, traditional and religious healing prevails over the formal health sector.

Keys findings

➨ **Institutionalization** (with very little community component), **medicalization** (care based almost exclusively on medicines which themselves are supplied irregularly and inadequately) are largely the mainstay of treatment with very little of other components like clinical psychology, occupational therapy and other non-medical approaches.

➨ **Existing mental health services** are unevenly distributed geographically (with the great majority based in the capital), almost nothing is available at the primary level and very little at secondary care. Distance is then a key barrier to healthcare use as it results in additional costs (people must travel long distances to access treatment) and a lack of social support when the patients stay in the hospital.

➨ **Specialised human resources** (psychiatrists, clinical psychologists, psychiatrist nurses, social welfare officers, occupational therapists) are very few in numbers and far below the WHO recommendations.

> In Burkina Faso, there is one psychiatrist for 2, 3 Million; in Nigeria, 1 for 1 million habitants and 4 Cuban psychiatrists in Gambia. In comparison, in 2011, there were 15.6 psychiatrists per 100 000 population on average across OECD countries[1].

➨ In addition to being scarce, most MH professionals are based in mental hospitals which are concentrated in large cities; yet these facilities provide care for only a small proportion of services users. These facilities also consume most of the available finance.

➨ There are some **social insurance schemes** in place. However, there are characterized by their heterogeneity and low coverage. For most people involved in small scale subsidence farming or operating in the informal sectors in the peri-urban and urban areas, the only social protection available is the informal extended family social security networks.

➨ **Direct patient's out-of-pocket payment** is still the norm for consultations and treatment (including psychotropic medication)[2] making long-term use of services difficult for most of the population.

➨ **Psychiatric hospitals** generally face multiple challenges: overcrowding, understaffed with poor building conditions.

> Especially in English speaking countries (Nigeria, Gambia and Ghana), at the time of our visit, patients were locked down and privacy was minimal.
> In Burkina and Niger, dormitories are smaller and the facility is open allowing in theory, the possibility of the patient to come and go freely.

➨ **Psychotropic medication is not available** in most health facilities especially at the secondary and primary levels of the health pyramid. Psychotropic drug supplies are much more readily available at the tertiary level and in the largest private pharmacies but can also be intermittent especially in the regions[3].

➨ Everywhere, **traditional beliefs** are prevalent; Supernatural or spiritual factors are believed to cause psycho/iatric disorders and contribute to perpetuate the stigma of mental illness.

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[1] http://dx.doi.org/10.1787/health_glance-2013-en

2 Although, affordability is largely dependent on choice of therapeutic class, product or sector from which the medicine is purchased, it's still unaffordable to the majority of who live below the income level of US$ 2 a day.

[3] There is research evidence that sudden stopping of medication is likely to both cause relapse and worsen the long term outlook for those who suffer from psychiatric illnesses.

➨ **Unformal care:** due to the prevalence of traditional beliefs along with the scarcity of others medical resources, traditional healers and religious leaders are the first points of contact for many people with mental disorders. Due to their role especially in rural communities, a direction of traditional medicine has been established by the MoH everywhere and many traditional healers have received some training in MH.

➨ **Psychosocial support** at the community level is mainly religious driven. **Other forms of psychosocial support** at the community level are weak and mainly NGO dependant, hindering the sustainability of programs in the longer term.

➨ The **Who Mental Health Gap Action Program** (mhGAP) is being slowly implemented in Nigeria, Ghana, Gambia, Niger and Burkina Faso.

➨ As psychiatry is virtually non-existent, a growing number of **innovative groups** have begun experimenting with an approach providing therapy without clinics or doctors, relying instead on mobile nurses[4], cheap generic drugs and community support systems.

Among others challenges, we can add: government budgetary allocation to the health sector is still below the 15% target Abuja Declaration everywhere and there is no dedicated budgetary allocation for Mental Health. The lack of halfway homes, day care facilities, lack of services for children and teenagers, the limited number of residential facilities and outdated legislation along with human right abuses within the traditional system, are also prevalent.

Mental health of returnees

➨ **Mental illness is stigmatized everywhere.** In Gambia, the stigma even extends to the family (*'this is the mad family')*. Consequently, mental illness is hidden and mental health patients rejected which compromise the access to MH care.

➨ **The returnees face a double stigma** as they are seen as '*a failure project*' by their community Besides returning 'empty handed' and falling to meet the expectations of their families, they may also be at the heart of 'a conflict zone' as the families cannot reimburse the debts linked to the migration trip.

In addition, our attention has been drawn on the following issues:

- Ghana has faced a rise of suicides[5] in 2017; even if no research can document it, these suicides occurred in the main area of return (Central Region). Besides, regional psychiatrists confirmed to meet each week 3 or 4 returnees with PTSD, depression and 'all with suicidal thoughts'. They do not exclude a link with the rise of suicide and are willing -as teaching hospitals- to do some research on the subject.

- The problem of substance abuse has been a consistently reported by health providers as being a source of concern for the returnees as for the rest of the population. The most widely substances are tobacco, alcohol and cannabis with an increasing consumption of tramadol in some countries. It has been mentioned to us on several occasions, that 'most of returnees face addiction issues[6].

[4] Such as volunteers organizations in Gambia like No Health Without Mental Health (NHWMH)
[5] Suicide is illegal and according our interviewees, pretty rare
[6] It however should be taken with caution as the diagnosis of addiction seems to be very common in some of the countries.

NIGER

'In Niger, everyone visited a traditional healer' We do not recommend but we do with it'.
Mr Boureima, MH National Coordinator

General Information

- With a poverty rate of 44.1% and a per capita income of $420[7], Niger is one of the world's poorest nations and occupied in 2016 the 187th spot out of 188 countries ranked at the Human Development Index.
- The population was estimated at 17 million in 2014. Majority are subsistence farmers and over 60% of people live on less than US$1 a day and 81.7% or 2.1 million of the urban population live in slums[8].
- Health indicators for Niger are poor. The average life expectancy at birth is 61, 8 in 2015[9]
- The share of the State budget allocated to the Ministry of Health is 7,6% in 2014%[10].

About Mental Health

According to the National Strategic Plan for Mental health Coordinator, the problems are as follow:

- The insufficiency in structures and resources that can provide quality mental health care in Niger.
- Understaffing in terms of both quantity and quality of human resources, coupled with their concentration in large cities.
- The limited funding for Mental Health
- The poor availability of psychotropic medicines
- Widely held beliefs that mental illness has a spiritual cause; low levels of literacy, huge distances and poverty are all factors that compound poor access to orthodox psychiatric services. Thus, traditional medicine is the only option available for the majority of the population.

I. Mental Health Organisation

Governance, policy and legislation

- A dedicated mental health legislation does not exist. However, legal provisions concerning mental health are covered in other laws (e.g., welfare, disability, general health legislation etc.).

[7] http://www.worldbank.org/en/country/niger/overview
[8] Niger Urban health Profile -WHO-
[9] http://www.who.int/countries/ner/en/
[10] https://data.worldbank.org/indicator/SH.XPD.PUBL.GX.ZS

- A mental health legislation was drafted in 2003, but never adopted.
- A national mental health strategic plan for 2016-2020 was developed. Practical implementation of the plan did not progress beyond some training activities.

The priorities of the National Mental Health Program are: (i) strengthening access to quality mental health care; (ii) the availability of psychotropic drugs; iii) public awareness and involvement in the prevention and management of neuropsychiatric diseases; and (iv) integration of mental health care at the primary care level.

- At the national level, a coordination of mental health activities was established in 1993 as well as regional coordination.

Insurance scheme

Niger has a low health insurance coverage rate, barely 3.2% of the population mainly civil servants or working in the private sector.

Financing

There is no specific government budget for mental health other than what is spent in the general hospitals. Mental hospital expenditures are unknown.

According to the WHO[11], in 2011, the annual budget allocated to mental health, represented less than 1% of the total budget allocated to health. Households (individuals) finance 61.88% of health (December 2014).

Some funding for mental health is also received from the WHO and other technical and financial partners (WHO, CBM, BID, PAI/MSP…)[12].

Human Resources

According to the MoH, in 2016, there were 4 Nigerian psychiatrists, 30 psychologists and 5 neurologists.

The 4 Nigerian psychiatrists have all been trained abroad (Burkina Faso, Benin). Among them, 1 is still abroad. All of them are based in the psychiatric unit of the National Hospital in Niamey and run also a private practice in Niamey.

3 **psychiatrists** are presently under training abroad. There is no training in psychiatry available in Niger.

Psychologists attend a 5-year training but are not trained in psychotherapy. The psychologists we met, however, have received a few trainings generally provided by NGOs (on Ebola, management of post-traumatic disorders, narrative therapy ...). There is no supervision or ongoing training.

The psychologists are mostly employed by NGOS. 3 of them are employed in the psychiatric unit of the National Hospital of Niamey (part time).

Since 2005, Niger has established Mental Health Institute that is affiliated with the Faculty of Health Sciences at the University of Niamey and trains **senior technicians in mental health** (3 year program).

[11] WHO Mental Health Atlas 2011

[12] National Strategic Plan for Mental Health

So far, about 20 senior mental health technicians have been trained. Typically, seven or eight specialist nurses graduate from here every 2 years, all of whom are employed in government services.

According to one of our interviewees, senior technicians in Mental Health are *'mini psychiatrists'*. They are habilitated to diagnose and prescribe. But, *'it was a mistake'* says one of our interviewees, '*Psychiatric nurses do not know how to conduct an interview: they only provide medication and that is the easiest part of the psychiatric care.'*

The majority of primary health care doctors and nurses have not received official in-service training on mental health within the last five years.

However, since 2012, a pilot integration project funded by Christian Blinden Mission (CBM) of integration of mental health care in the PMA of peripheral health units (Dosso and Doutchi districts) has been implemented[13].

Officially approved manuals on the management and treatment of mental disorders are not available in the majority of primary health care clinics.

The basic mental health training for primary care staff is not reinforced by ongoing supervision.

Drugs and medication

The availability of psychotropic medication is poor despite an official national list of generic essential drugs that includes psychotropic drugs and a relatively well organised national medication supply system based on the Bamako initiative (Eaton, 2008).

Only phenobarbital, carbamazepine, chlorpromazine, haloperidol, diazepam, benzhexol and amitriptyline are readily accessible in major hospitals. Beyond these hospitals, only phenobarbital and diazepam are routinely available.

According the psychiatrists we met, the treatments are *'sometimes available, sometimes not'*.
Second-generation antipsychotics drugs are not always/never available (or have to be ordered which requires a 2 week delay). The therapeutic protocol is then modified to prevent a shortage of medication.

Average cost of monthly anti-psychotic treatment: (e.g. Haloperidol)
One injection costs 4 750 FCFA (€ 6, 86)
Average cost monthly treatment (3 or 4 injections): 19 000 FCFA (29€)[14]

Cheapest treatments exist but are less effective and have more side effects.

Some medicines may sometimes be given to the most vulnerable patient after evaluation by the social worker and upon availability. If not, patients (or their families) must purchase them.

[13] This pilot was documented and accompanied by an action research funded by the Institutional Support Project (PAI / MSP) of Belgian Technical Cooperation.
[14] Average per capita income : $420 World Bank http://www.worldbank.org/en/country/niger/overview

II. Mental Health and Psychosocial Services

Psychiatric Care

There is no psychiatric hospital in the country.

But four of the eight regional hospitals have a psychiatric unit (Niamey, Tahoua, Zinder and Maradi). Outside Niamey, the psychiatric units are run by psychiatric nurses and a few district hospitals have a psychiatric nurse.

Table: Summary of existing public and private health facilities offering mental health care in relation to all health facilities in the country[15]:

Health Facilities	Total Number	Nb of those offering Mental Health Care
National hospitals	3	2
Maternity	1	0
Health Center for Mother and child	7	0
Regional hospital	6	6
District Hospital	33	3
Integrated Health Center (CSI)	895	61
Health offices	2458	0
Clinics and polyclinics	36	2
Medical & care offices	257	1
Private hospital	5	0
Ophthalmological hospital	1	0
Total	3 692	75

Source : Programme National de Santé mentale

The psychiatric ward of the National Hospital of Niamey

The psychiatric ward has 53 places; there is no isolation room (but use of physical and pharmacological contention). ICT is not used. Consultations and treatments must be paid[16].

There is no IT equipment and the Vidal (therapeutic guideline) is dated of 2008.

The staff is composed of 3 psychiatrist part time, psychiatric nurses and 4 psychologists (specialized in HIV, addiction and mental retardation).

[15] Mental Health National Strategic Plan

[16] Cost of a consultation at the national hospital: 3,500 FCFA .In a private clinic, the cost of a psychiatric consultation goes up to 15,000 FCFA.

Psychiatric Unit National Hospital –Niamey- dec 2017

Conditions are very rudimentary: building is not in a good state (windows are broken, paint is peeling from the walls). The bathing and toilet facilities are not clean and do not allow privacy.

Besides the rehabilitation of the psychiatric unit building, the priorities expressed by other professionals are: Capacity building and data collection (IT, software).

Before, there was a dynamic international cooperation with the Ville Evrard Hospital in France. It stopped in 2013 due to the degradation of the country's security. There is some professional contacts with other Francophone African countries (e.g. through the West African Health Organisation, WAHO) and French universities have some academic collaboration with Nigerian institutions. The division between Francophone and Anglophone traditions is a significant barrier to accessing information, given that the majority of medical papers and online resources are in English

Niger also has community health workers trained by vertical programs (Malaria, Guinea Worm, Diarrheal Diseases etc.) more or less operational but often left on their own. In all, there are in 2013 about 100 villages with 1 539 community health workers.

Other service providers in MHPSS

There is no national mental health professional association or users' groups but some NGOs provide MHPSS support especially to refugees or returnees.

Organisation	Location	Activities	Partnership Opportunities
COOPI	Diffa Niamey Agadez	Niamey: MHPSS center (1 psychiatrist, 3 nurses, 2 psychologists). 'Cases de passage' for teenagers and women (60 places) in Niamey and Agadez Regions: Training of health care personal in MH Gap, training in child psychiatry of CSI staff and midwives. Support the CSI with psychotropic drugs, among others activities focal point for MH in Diffa	
HANDICAP INTERNATIONAL	Niamey	Temporary shelter for migrants and reinstallation program - Social support Inclusive education project for children with mental and physical disabilities among other projects	*Not visited*
CBM (NGO)	Diffa	Advocacy and Capacity building (Community agents training?)	*Unmet. But this is a major stakeholder working closely with the MoH*

Several local NGOs, associations, women's groups and other organized structures (traditional practitioners, religious leaders, artists and schools) are involved in the organization of awareness campaigns and communication to communities.

Unformal Care

It remains very often the first resort of patients, particularly in rural areas, in a context where traditions and spirituality are extremely marked.

These patients only turn to modern medicine after the failure of this first treatment even if the prices are not more competitive.

MoH

In Niger, traditional healers are organized in association and are supervised by the Ministry of Public Health. They receive training (including in MH) and are regularly monitored.

Specific recommendations

According to the national MH Coordinator, priorities are the following: integrate MH in the PHC, training of the Community Health workers in MH, raising awareness, training of community leaders (identification and referral), rehabilitation of the existing psychiatric units, develop home visits.

Besides, IOM may consider:

- To support the development of the national MH plan especially in the aspects of capacity building on MH Gap at PHC level.
- To further investigate opportunities of partnership with CBM (and possible others PSS actors) in the action of training and support of community health workers.

BURKINA FASO

'We calm down the patients, then, it is the pastor and the traditional healer who treat''

Dr Desire Namena, Jan 2018

General Information

- Burkina Faso is a low-income, landlocked Sub-Saharan country with limited natural resources. Its population was estimated at almost 18.6 million inhabitants in 2016. The economy is heavily reliant on agriculture, with close to 80 percent of the active population employed in the sector.

- With a per capita income of $620, Burkina is one of the world's poorest nations and occupies in 2014 the 183th spot out of 188 countries ranked at the Human Development Index[17].

- Poverty rate is 43,7 %(2014) and the life expectancy at birth is 59 years (2015).

- The share of the State budget allocated to the Ministry of Health increased from 9.1% 2011 to 12.5% in 2013[18].

About Mental Health care

Problems identified in the Strategic Plan for Mental Health and confirmed by our own observations, are as follow:

- The insufficient number of structures and specialized staff makes psychiatric care very limited and inaccessible to the population.
- Human resources in mental health are quantitatively and qualitatively inadequate.
- The mental health staff is unequally distributed: the large cities of Ouagadougou and Bobo concentrate the bulk of the medical and psychological staff, but also the nursing staff.
- Mental Health infrastructure are poorly equipped and maintained.
- Availability of psychotropic drugs is irregular
- There is no specific funding for Mental Health
- People with mental disorders are victims of stigma and discrimination resulting both from local socio-cultures and from the lack of specific laws protecting them.
- The majority of people routinely use traditional care before, during or after psychiatric care[19].
- Psychosocial support is extremely limited

[17] http:// www.who.int/countries/en/
[18] Dashboard 2013 - Ministry of Health.
[19] Mental Health Plan 2016 -2018

I. Mental Health Organisation

Policy, plans, and legislation

An officially approved mental health policy does not exist and mental health is not specifically mentioned in the general health policy. However, legal provisions concerning mental health are covered in other laws (e.g. welfare, disability, general health legislation etc.).

A 2014-2018 mental health plan was developed with the support of the CBM association.

With the adoption of the National Mental Health Program in 2012, a coordinator was appointed to manage the program, under the direction of the Non-Communicable Disease Branch.

The WHO MH Gap Action program has been adapted to Burkina Faso and slowly implemented through a pilot project[20] in 5 main regions (including the East Center which is one of the main areas of return).

Financing of mental health services

Financial allocations for mental health are part of the overall funding of health facility activities. Information about mental health and mental hospital expenditures is not available. The main sources of funding for the program are the state budget.

In relation to public health activities, partners such as OCADES through its various projects, also allocate annual funds for the implementation of their mental health activities. Decentralized cooperation, particularly twinning, has also made it possible to mobilize material and financial resources.

Insurance scheme

Formal state insurance exists but is limited to certain sections of the population (formal sector and state employees) largely excluding the rural population. Social protection in Burkina Faso although providing in theory free care for indigents, is currently characterized by its heterogeneity and low coverage.

Drugs & Medication

There is a national list of essential medicines (LMEs). The LME was last updated in 2014 and includes anti-psychotics, antidepressants and mood -stabilizers. According to the WHO country strategy, the availability of essential generic medicines is 74,5%.[21]

100% of mental hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility all year long. The availability of psychotropic drugs (generic form) in public facilities at the tertiary level (mental health hospitals) has been confirmed by our interlocutors.

However, availability of psychotropic drugs is not effective in all health facilities especially at the primary and secondary level.

[20] Training of non-specialised agents to the detection and the referral of people with mental disabilities.

[21] World Health Organization 2016

Human resources

Caregivers working in the mental health sector as of December 31, 2012 are made up of the following professional categories: psychiatrists, psychologists, psychiatric nurses [22]and social workers.

- In 2016, there were 8 psychiatrists, 6 psychologists, 118 psychiatric nurses and 2 social workers hospital based. There were no speech therapist, occupational therapist.

- All psychiatrists are in Ouagadougou, Bobo-Dioulasso and Ouahigouya and all psychologists in Ouagadougou. The psychiatric nurses[23] are mostly in the regional hospitals (CHRs).

There are 12 psychiatrists currently under/on training. The training of psychiatrists which was before 2003 provided in the universities abroad is now organized at the University of Ouagadougou. Since 1987, Burkina Faso has also opted for on-site training of nurses specialized in mental health.

In the Central East region, where the majority of the returnees come from, the community health workers have been trained (CBM pilot project) on the identification and referral of the psychiatric patients.

II. Mental Health and Psychosocial Services

Over the past two decades, Burkina Faso has made efforts to improve the accessibility of mental health care to people. Since 1987, projects, plans and programs have been developed and their implementation has allowed:

- In terms of infrastructure, the construction of psychiatric services in the CHRs and some CMA[24]s as part of the hospital reform, the addition of new units in the Bobo-Dioulasso and Ouagadougou university hospitals;

- In terms of care provision, decentralization was achieved with the establishment of psychiatric care units in the 9 CHRs in the country and in 31 CMAs;

- In terms of training, a training unit for specialist nurses was opened within the National School of Public Health (ENSP).

- The offer of care has improved through the recruitment of doctors in child psychiatry, clinical psychologists and the professional development of psychiatric nurses.

Psychiatric Care

The supply of psychiatric care has existed since the colonial era. In fact, psychiatric services opened their doors to patients in 1958 in Bobo-Dioulasso and 1959 in Ouagadougou. It has gradually expanded and nowadays it is provided by several mental health services located in the three (3) teach

[22] Les 'attachés de santé mentale'

[23] Psychiatric nurses are habilitated to diagnose and prescribe psychiatric patients. They refer to the psychiatrist whenever there is associated somatic disorder or a need for a medical certificate.

[24] Medical Centers

hospitals (CHU) in Ouagadougou, Ouahiguya and Bobo-Dioulasso, the nine (9) CHR (Regional Hospital) and thirty one (31) CMA (Medical Center).

All Regional hospitals have a mental health service run by psychiatric nurses. They have an overall capacity of fifty-seven (57) beds with an average of six (6) beds.

ORGANISATION	CAPACITY	COMMENTS	AREA OF PARTNERSHIP
Psychiatric hospitals[25]			
Yalgado Ouedraogo Teaching Hospital		Ouagadougou	
Case management and hospitalisation of common and severe cases of mental disorders, pharmacological treatment and psychological support/	40 beds Staff : psychiatrists, 3 psychologists, 3 psychiatric nurses and social worker 2 isolation room with no sanitation No ECT	Payable[26] . Rooms to accommodate 2 people. Different standing accommodation according the price (private room with shower, toilets and ventilation) Poorly maintained, basic furniture (no bedsheet, no furniture in the room,1 water tap in the courtyard, collective toilets have no door)	Diagnosis and follow-up of MH of returnees (cf Pr Aruna).
Ouahigouya Teaching Hospital		Ouahigouya	
In and Outpatients facility	8 beds Staff: 1 psychiatrist, 3 psychiatric nurses ,no dedicated social worker 300 consultations/month No ECT, 1 isolation room	Paid New psychiatric unit; 1st psychotropic generation mostly available at the hospital pharmacy. Occasional shortages	Diagnosis and follow-up of returnees
Bobo-Dioulasso Teaching hospital		Bobo Dioulasso	
In and Outpatients facility	30 beds Staff: 2 psychiatrists, 7 psychiatric nurses 2 isolation rooms No ECT	Payable[27] Dormitories (10 beds each) plus individual rooms. International cooperation with psychiatric hospital 'St jean de Dieu' in France (Lyon) Friendly atmosphere	Diagnosis and follow-up of returnees
Psychiatric Private Clinics			
Clinique CIPHRA (Ouagadougou)	1 psychiatrist nurse	Payable	
Psychiatric Clinic (Koupala)	1 psychiatrist (Pr Ouango)	Payable	To be considered as a referral place as located in one of the main areas of return. And as a

[25] In all psychiatric hospitals, patients must be accompanied by one relative.
[26] Prices vary from 500 FCFA to 4500FCFA/day. Between 2000 et 20 000 FCFA/Monthly
[27] From 500 FCFA to 4500 FCFA/day

			private facility, it has an impact on reducing stigma.
Psychiatric Clinic BETESTA (Bobo Dioulasso)	1 psychiatrist	Payable[28]	*Not visited*

The 3 teachings hospitals each have a psychiatric ward with a total capacity of seventy-nine (79) beds. There is no specialized structure for substance abuse.

Room and Kitchen CHU Ouagadougou

The patient must be accompanied by a relative.
Accommodation is poor but surrounding environment is nice (open/with a green country ward where patients can freely move)
There is a dynamic international hospital public cooperation between the Burkinabe and French psychiatric hospitals
All psychotropic medications are available at the hospital pharmacy but must be paid through the patient's own financial means.

In addition to public structures, Burkina Faso has a few private facilities concentrated in the cities of Ouagadougou and Bobo-Dioulasso.

Other stakeholders

Organisation	Activities	Capacity	Comments	Areas of partnership
Community Residential facilities				
Association SAULER (Ouahigouya)	Shelter for psychiatric patients Family tracing Socio economic reintegration activities 24 people (8 women; 16 men) including migrants	Financial support of CBM Staff: mostly volunteers Occasional support from NGOs	Well maintained facility Convention with the Ministry of Health Steering committee include Municipality and MoH	Need support for international family tracing (migrants) May be a structure of referral
Centre Notre dame de l'Espérance (Bobo-Dioulaso)	Shelter for people with psychiatric disorders 80 people (women and men) Project of creation of income generation activities and vocational training	Faith Based. 2 permanent staff and 30 volunteers (including psychiatrists) and peers workers[29] who assume the daily	Conditions are rudimentary. Large dormitories Drugs are administrated by stabilized patients with little supervision	

[28] From 10 to 15 000 FCFA
[29] Stabilized patients

	Advocacy	functioning of the center	Freedom of movement seems restrained.	
Other Stakeholders involved in Mental Health (NGOs)				
CBM	Have participated to the elaboration of the MH strategic plan Run a pilot project of training on MH of non-specialized community agents (MH Gap) Support SAULER	Permanent staff based in Ouagadougou Actions in (Centre Est-Centre Sud Centre Nord - Centre Ouest et plateau Central)	2nd phase with OCADES in 2019 Work in close collaboration with the Ministry of Health	they have action in the communities located in the area of return: Could be integrated to a referral system
OCADES [30]	Social support and follow up of the community agents in MH	Unknown		*Unmet - To be checked*

SAULER Shelter

Traditional Care

According to the Coordinator of Mental Health Strategic plan, the traditional interpretations of mental illness in addition to the poverty of the population explain why traditional healers are most often the first point of contact for most people with mental disorders.

The importance of traditional medicine is recognized by Law No. 23/94 / ADP of 19 May 1994 on the Public Health Code and a technical direction was created to coordinate the traditional subsector.

Traditional care is also presented in the 2014-2018 Mental Health Strategic Plan as "a delay in using the modern health care system[31].

Specific recommendations

- Develop a Memorandum of understanding with the 3 public psychiatric facilities and the private clinic in Koupala to guarantee a free access for care to the returnees.
- Communicate on the work of IOM especially towards private shelters and to consider assisting them into the process of return of non-Burkinabe people (especially Sauler which hosts a few migrants)
- Develop a referral system with CBM and ACADES for the community follow up.

[30] Organisation Catholique pour le Développement et la Solidarité
[31] National Strategic Plan on Mental Heath 2016 - 2018 ; p 16

NIGERIA

'Individuals coming back seem like a failed project'[32]

''The Government and people of Nigeria hereby reaffirm that health, including mental wellbeing, is the inalienable right of every Nigerian, and that mental, neurological and substance abuse (MNS) care shall be made available to all citizens within the national health system at the level of primary health care (PHC) and in communities''.

'Vision' National Policy for MH Services delivery in Nigeria- 2013

General information

- With a population of about 186 million, Nigeria is the most populous country in Africa According to the 2016 report released by the United Nations Development Programme (UNDP) in Abuja, Nigeria ranked 152 among the 188 UN member states in the Human Development Index (HDI).
- Nigeria's GDP Per Capita reached 2,156.84 USD in 2016 but despite its vast oil riches and economic growth, poverty still remains significant at 33.1% in Africa's biggest economy. 62.7% or 47.6 million of the urban population live in slums[33]and the life expectancy at birth is 53 years (2015).
- The public health system in Nigeria is weak, particularly at the primary care level. The share of the State budget allocated to the Ministry of Health increased from 9.1% 2011 to 12.5% in 2013[34].

About mental health

- Nigeria's huge population, high levels of poverty and illiteracy and weak health, education and social sector infrastructures present a big challenge for general provision of healthcare and mental health care in particular.
- Modern mental health services at the moment are only available at specialized hospitals (Federal Neuropsychiatric Hospitals, teachings hospitals, and a few Federal Medical Centres). Some States have psychiatric hospitals and some federal medical centres have a psychiatric department.
- The focus of all mental health services is in large cities, with little decentralisation across the country to communities which makes access to care difficult for the majority of the population[35].
- The specialists, such as psychiatrists, clinical psychologists, psychiatrist nurses, social welfare officers, occupational therapists are very few in numbers, grossly inadequate.

[32] Dr Ndudi Oseyemwen
[33] Urban Health Profile- WHO
[34] Dashboard 2013 - Ministry of Health.
[35] According Dr Obayuge, some patients have to travel 5 hours to visit the outpatient facility. Specialist teaching Hospital Urorura/Edo State/02/01/2018

- Treatment gap is assessed from 70% to 90%[36]. For example, the Neuro federal psychiatrist hospital in Bénin City is covering 6 states. According to his medical coordinator, 2/3 of the patients do not come back to the hospital for follow-up (relapse is therefore very predictable).
- Supernatural or spiritual factors are believed to cause mental illness[37]. Traditional healers and religious leaders (pastors, priests) are currently the first point of contact for most people.
- University of Ibadan's Department of Psychiatry is a WHO Collaborating Centre which runs a large number of research programmes, including multi-site international collaborations. They have a strong international reputation in this field, as well as being seen as a source of expertise by the Nigerian Government and local State Governments, particularly in MhGAP[38] implementation.
- Psychosocial support is almost inexistent, exclusively provided by private structures/NGOs offering basic social counselling along with other services (vocational trainings...).

Mental health issues among returnees

- Observations from a psychiatrist[39] in Irruroa region confirm that[40]returnees with acute psychosis, depression and PTSD are present but they are not consulting due to funding issues.

I. Mental Health Organisation

Policy, plans, and legislation[41]

Recent years have seen a significant increase in interest in mental health which has resulted not only in the national Policy being adopted (a national policy for Mental Health Services delivery in Nigeria was adopted at the National Council on Health, August 2013) but in the official launch of the MhGAP implementation plan, an increase in resource allocation and several new programmes now under way, mostly integrated with Government services.

- The WHO has identified Nigeria as a priority country for roll-out of its MhGAP programme in Africa,

- FMOH (Federal Ministry of Health) now encourages Federal tertiary hospitals to support decentralised services, and there has been significant new investment.

- A dedicated desk officer for mental health was recently appointed.

[36] International Psychiatry, Vol. 9, Issue 3, august 2012
[37] Kabir M, Iliyasu Z, Abubakar IS, Aliyu MH. Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria. BMC Int Health Human Rights 2004;
[38] Mental Health Gap Action Program -WHO-http://www.who.int/mental_health/evidence/mhGAP/en/
[39] Dr Obaguye who has a double hat: psychiatrist and pastor.
[40] However, this psychiatrist being also a pastor - He emphasised that he mainly meet them in his church rather than in the psychiatric ward.
[41] National policy for mental health services delivery -MoH 2013 -Adopted at the National Council on Health, August 2013.

MH Insurance Scheme

Mental health insurance scheme (NHIS) has been in the process of implementation since 1999. However, the coverage of the scheme is limited as it presently only covers workers in the formal sectors.

In theory, Vulnerable Group Social Health Insurance Programmes are designed to provide health care services to individuals who, due to their physical status (including age) '*cannot engage in any meaningful economic activity'*[42]. Vulnerable groups include: prison Inmates, pregnant women, children under 5, aged and theoretically physically/mentally challenged persons.

Financing of mental health services

According WHO in 2011, about 3.3% of the health budget of the central government goes to mental health, with over 90% of this going to mental hospitals. There is no updated information available.

Human Resources

- There are less than 150 psychiatrists in the country (around 1 per 1 million people) and many states have no psychiatrist. There are very few neurologists with many newly trained specialists leaving the country to work abroad. There are around 5 psychiatric nurses per 100,000 people and only very few other mental and neurological health professionals like clinical psychologists, social workers, neuro-physiotherapists, and occupational therapists[43].
- Most of the psychiatrists and the clinical psychologists are hospital-based.
- Counselling services are available in some places; however the level of qualification is uncertain[44] and most often basic health or socially oriented.

Drugs & Medication

A list of essential medicines is available. These medicines include: antipsychotics, anxiolytics antidepressants. Though the list of essential medicines exists, they are not always available at health centres.

- **Availability**

According our interviewees, all psychotropic drugs are available at the tertiary level in the Mental Health hospitals (including second generation antipsychotic medications such as olanzapine). However, at the tertiary level, in the Ururora region, provisions may also be 'seasonal' and psychotropic drugs of last generation are not always available.

According Dr Obaguye, psychotropic drugs are almost not available at the primary and secondary health care level.

- **Affordability**

[42] https://www.nhis.gov.ng/vulnerable-group/

[43] National policy for mental health services delivery -MoH- 2013

[44] Counsellor is a function. Therefore, one can be counsellor with one week training or a BA in social work.

Affordability is an issue as all drugs should be paid using the individual's own personal funds. 2nd generation antipsychotic medications are expensive and medicines are unaffordable to the majority of Nigerians who live below the income level of US$ 2 a day.

Example: Cost estimation of monthly antipsychotic treatment

Haloperidol: 10 mg/1 month: 1 000 - 2 000 NGN (2,2 to 5€)
Xyprexia (2nd generation): 20 000 NGN (45€)

II. Mental Health and Psychosocial Services in Lagos and Benin City (Edo state)

Mental hospitals in Lagos and Benin City

- At the moment, government services are provided mainly in large tertiary institutions (Federal Neuro-psychiatric Hospitals) and University Teaching Hospitals' psychiatric departments.
- Mental hospitals: infrastructures are in poor conditions, understaffed, poorly maintained and overcrowded.[45]
- Consent to admission in MH institution is also mostly given by the caregiver. According our interviews and WHO AIMS report, around 60% of the mental health institutions inmates are unwilling to integrate the facilities.
- Treatment is medication based and occupational therapies are rare.
- Use of ECT is usual with a large spectrum of indications (depression, maniac, schizophrenia resistant to drugs, those who keep attempting suicide and do not take their drugs…according to one of the interviewees).

LAGOS

Organisation	Capacity	Cost	Comments
Psychiatric services			
Lagos neuro psychiatric hospital Case management and hospitalisation of	550 beds 16 psychiatrists, 15 clinical psychologists, 48 psychiatrist	Payable[46] All psychotropic medications are	Overcrowded - Lack of privacy. Patients are locked down and mostly get medications and ECT. One asked us to document the sanitary conditions as he said '*this is disastrous'.*

[45] Psychiatric wards in large MH hospitals look like most of the time detention rather than rehabilitation centers. The admission ward is completely closed during the time of the initial assessment while on the other wards, patients can walk around during certain hours.

[46] Estimated costs: Outpatient program: 3 000 NGN for assessment/ Consultation fees: 500 4000/months Registration fees (3 months): 4 500NGN

common and severe cases of mental disorders, pharmacological treatment, individual therapy and family support Forensic unit- Drug Rehabilitation Unit- Occupational department	residents, 1000 support staff	available but paid out of the pocket.	 Department of psychology and occupational therapy & vocational training was full and busy when visited: with ongoing vocational training on hairdressing, sewing, shoe-making, computer room, and cooking
Grace Hill Hospital In an outpatient **private facility** (MH and addictions)	14 beds; 4 nurses,1 psychiatrist part time, 1 metro (ward manager), pool of psychiatric nurses	Payable. Registration fees and initial assessment 20 000 NGN plus daily admission rate (10 450 NGN) plus drugs & medications and lab examinations	Rooms are ventilated and rudimentary furnished. Presently IOM patients are accommodated there. The manager expresses the will to have a nominative referral system with Benin City professionals.
The Happy Family Hospital In an outpatient private psychiatric facility	6 beds 1 psychiatrist, nurses	Payable. Indicative registration fees: 30 000 NGN then 1020 NGN/Week	Dynamic team, small space, ventilated rooms with 2 persons per room. Patients are seen every day by the psychiatrist; Focus on addictions.

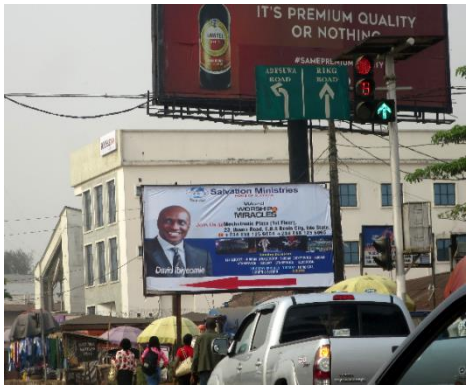
Other MHPSS services

In Lagos and Benin City, many organisations provide shelter for women victims of human trafficking. One organisation is also addressing the needs of male victims of forced labour.

Organisation	Activities	Capacity	Cost	Comments
Residential facilities				
Genesis House Freedom foundation	Shelter for women victims of human trafficking.	2 -18 months, encompassing counselling, therapy, social & educational vocational job training and job placement assistance 1 program director + staff	Free of charge.	Good accommodations conditions (rooms sanitation..); dynamic and professional management

Naptik Shelter	Shelter for female victims of Human trafficking and children	9 Counsellors[47]; head of unit, support staff	Free of charge	Accommodations conditions are poor. The place lacks everything: running water, electricity, poor infrastructure. Areas of reinforcement: - Capacity building for staff - Basic equipment (recreational room for children.), infrastructure rehabilitation
Christ Against Drug Abuse Ministry	Residential facility for people with drug abuses difficulties	55 residents 10 support staff 4 counsellors	Free of charge	Faith based One year programme mainly based on 'spiritual therapy' and total abstinence (no substitution treatments).
Other MHPSS services				
Mental health Foundation	Advocacy center (raising awareness. Lead the MH stakeholder Initiative (network of 40 NGOs)[48].	Staff are mostly volunteers according to the manager. 3 clinical psychologists. Presently 25 people are enrolled in psychotherapeutic sessions	Free of charge or not (those who can afford pay 5000 NGN for 6 sessions) (depending on the financial means of individuals)	Experience in working with communities -Need to be investigated more but might be a resource to train the community leaders. No clear information about either funding or present activities.

BENIN CITY



In Benin city, one pastor's advertising praising his miracles

Benin City is the epicentre of the trafficking trade for tens of thousands of Nigerian women who have been trafficked into Europe for sexual exploitation.

As a result, there is a number of PSS services dedicated to women victims of human trafficking (and thus, mostly gender-polarized).

Due to the major role of tradition, religion and witchcraft in the Benin society, mental health care go hand-in-hand with religion and superstition.

[47] Naptik counsellors have various educational background: some are social workers, one have one week training.
[48] According to the manager.

Public attitudes towards the mentally ill are also known to be generally negative including in clergy surveyed in Benin City[49].

Organisation	Capacity	Cost	Comments	Partnership Opportunity
Neuropsychiatrist hospital Benin city /The Uselu psychiatric hospital				
Case management and hospitalisation of common and severe cases of mental disorders, pharmacological treatment, training, research	250-bed institution Coverage: 6 states (13 million inhabitants) Staff: 7 psychologists, psychiatrists, nurses	Paid[50]	Overcrowded. Accommodations conditions are very poor (large dormitories, dirtiness). Patients are locked down. Occupational therapy (tailoring, carpentry, shoe-making, art) lack of basic furniture. Staff expressed serious shortages of energy supply. Time of consultation per patient estimated by one psychiatrist to 5/10 min	Possibility of MoU with regulation of interview session
Private facilities				
Capital Health Center Outpatient facility	Psychiatrists, Clinical psychologist and occupational therapist.	Payable[51]	New private general clinic - Dynamic and committed young psychiatrist (also engaged in neuro psychiatrist hospital) This is a generally well-maintained clinic	To be considered as a referral place for patients.

Other PSS services				
Organisation	Activity	Target Group	Capacity	Areas of partnership
The Committee for the Support of the Dignity of Woman - COSEDOW- **(NGO)**	Shelter Awareness campaigns in the communities -family tracing Reintegration: vocational training, life skills acquisition.	Victims of human trafficking Presently 12 women and 3 children	A few Catholics sisters and 1 social worker	
Path Finder Justice Initiative	Vocation training	Women victims of	Staff: 5 permanent	Young organisation - Funding dependant

[49] The attitudes of clergy in Benin City, Nigeria towards persons with mental illness. Igbinomwanhia NG[1], James BO, Omoaregba JO. Afr J Psychiatry (Johannesbg). 2013 May;16(3):196-200. doi:

[50] Initiate the treatment: 7 100 NGN and then 40 000/month

[51] Estimated cost : Psychologist/Occupational therapist/session: 5 000 NGN Psychiatrist (per session): 7 000 NGN

(NGO)	Counselling services Shelter in project	human trafficking& Sexual abuse Presently 50 women are enrolled in vocational trainings.	staff, volunteers. including 3 clinical psychologists volunteers In Abuja, Lagos and Bénin City	Capacity building for staff on identification/referral and care.
Idia Renaissance **(NGO)**	Youth resources Center Skills acquisition Center (photography/videos/tailoring..); social, educational and counselling services -Advocacy-Library -Recreational activities	Youth (mainly from 13 to 26 years old both male and female) and victims of human trafficking	12 permanent staff and volunteers.	Profiling of the returnees is not properly done according to IDIA Renaissance; the most vulnerable are not identified. Establish a referral system with IOM for access to PSS services
Society for the empowerment of young persons **(NGO)**	Shelter & transit center Support In-kind to vulnerable families, family-tracing; awareness campaigns against irregular migration, Individual reintegration package (vocational training, in kind business assistance) Co-ordinating body for the Edo State Child Protection Network	Female victims of human trafficking and male victims of forced labour (40 places) adults and children Families and community	18 permanent staff and volunteers	No clear information about present activities /fundings beyond the shelter Capacity building Establishment of a referral system between partners
Ministry Of Women Affairs And Social Development	Shelter for people with mental health disorders	People with Mental health disorders	*Not visited*	*Not visited*

URURORA CITY (EDO STATE)

Organisation	Capacity	Cost	Comments	Partnership Opportunity
Teaching Hospital with psychiatric unit				
In and Outpatient facility Treatments, training, research	15 beds in all departments (project of building a specific ward) **Staff:** 3 consultant psychiatrist - 4 residents -No clinical psychologist	Paid[52]	**Volume:** Outpatient facility: Psychiatric consultation twice a week: between 200 to 300 patients/day Small dormitories. Nice environment. Access to 2nd generation of antipsychotics drugs is 'seasonal'.	The psychiatrist in charge is also pastor and meets returnees with MH issues in his church. i/ based in region II/ a human scale facility III/ no dedicated psychiatric unit (avoid stigma): Memorandum of Understanding to be considered
Private clinic (outpatient facility)	Run by Dr Abugaye	Paid. Indicative Consultation fees: 10 000 NGN	*Not visited*	None

Specific recommendations

- Implement a referral system from the Grace Hill hospital in Lagos to Capital Health Clinic in Bénin City (Dr Oseyemwen Ndudu) and/or Ururora Specialist Teachning Hospital (Dr Abugaye) .
- Establish a Memorandum of Understanding with both facilities to guarantee a free access to treatment and follow up.
- Develop the referral mechanisms and coordination between PSS stakeholders in Benin City.

[52] Estimated Admission fees: 2 000 - Initial deposit: 20 000 Cost (feed and housing 1 week) 1 750 NAR

GHANA

'The Borgho loose'

'If you are a Ghanaian with a mental illness there is only a 2% chance you'll receive any treatment. Local mental health services simply don't exist for most people. 'The Kitampo project[53].

General Information

- Ghana has a population of about 28 million (2016).
- The country attained the middle-income country status in 2010. In the 2015 Human Development Index, Ghana is ranked 140th out of 188 countries.
- Between 1992 and 2013, Ghana's national level of poverty fell by more than half (from 56.5% to 24.2%)[54]. However, 40.1% or 4.8 million of the urban population live in slums[55]. The life expectancy at birth was 63 years in 2017.
- Ghana's 2016 budget allocated to the health sector is 10%[56].

About Mental Health

- 1.4% of the overall health care expenditure was devoted to mental health in 2012; majority (nearly 80%) of which was allocated for the running of the three psychiatric hospitals (2012 WHO-AIMS report). The funding for mental health care in the general hospital and community-based services is almost non-existent
- People with psychiatric disorders receive care mainly in the broader community, the country's three public psychiatric hospitals and residential prayer camps (especially those from rural areas who most often visit traditional and faith based practitioners before or after seeking medical advice from the health system).
- According to the Mental Health Authority, the treatment gap in mental health services is currently estimated to be 98%[57].
- The World Health Organisation (WHO) AIMS report which was commissioned by Department For International Development (DFID) in Ghana for the review of mental health services, revealed the followings gaps:

    - Inadequate awareness on the Mental Health Act
    - Inadequate funding for mental health services
    - Lack of services for adolescents and children
    - Unavailability of Psychotropic medicines at service delivery points

[53] http://www.thekintampoproject.org/
[54] The Ghana Poverty and Inequality Report: Using the 6th Ghana Living Standards Survey 2016 By Edgar Cooke Sarah Hague Andy McKay.
[55] WHO Country profile
[56] https://oxfordbusinessgroup.com/overview/expanding-care-new-projects-and-initiatives-rolling-out-sector-shoring-its-existing-strengths
[57] Based on the interview with the MHA on the15th of January 2018/

- Difficult to access community based clients for Community Mental Health Nurses amongst other

- However, the Ghanaian government has taken some steps to improve the care of people with psychiatric disorders including reducing overcrowding in state psychiatric hospitals and passing the Mental Health Act in June 2012.

- The WHO Mental Health Gap Action Program has been adapted to Ghana. The implementation started gradually focusing on the training of Community Based Nurses

Mental health issues among returnees

- At least, 'Borgho lose' is a term identifying those 'who failed' and return 'empty-handed'. Although there is no research to document it, in one of the main area of return, the sudden rise of suicides in 2017 (although suicide is illegal) doubled with the concern of the regional psychiatrists who notice the avenue of 3 or 5 returnees each week, all of them with suicidal thoughts, may generate questions.

I. Mental Health Organisation

Policy, plans, and legislation

A Mental Health Policy and a strategic plan[58] exist. A new Mental Health Act was passed in 2012 and emphasizes community care. Parliament has also tabled the Traditional and Alternative Medicine Bill, which seeks to regulate traditional health practices.

The MH Act established the Mental Health Authority (MHA) as an agency of the Ministry of Health to supervise and implement modern Mental Health Care in the Country.

Specifically, the provisions of the new Mental Health Act include:

- Improving access to in-patient and out-patient mental health care in the communities in which people live.
- Human rights protection through regulation of mental health practitioners in both the public and private sectors and traditional healers too, everywhere in communities and hospitals.
- Combating of discrimination and stigmatization against people with mental illness and promoting their human rights.

[58] Mental Health Strategic Plan 2013 – 2017. MoH

- Promoting voluntary treatment and clearly defining and limiting the circumstances under which treatment may be given to people with mental disorders without their consent[59].

The MHA has both regulatory and service delivery roles and provides MH services via the psychiatric hospitals and collaborates with other service delivery agencies at the primary, secondary and tertiary level.

Financing of Mental Health Services

In 2011, mental health had a ring-fenced budget of 1.4% of total governmental health expenditure[60]. Almost 100% of the budget was spent on the 3 mental hospitals.

In addition to public funding, mental health in Ghana is also funded by international development partners (DFID) and to a small degree, by internally generated funds.

Establishment of Mental Health fund is one of the major requirement of the MH Act. But, the MH fund is yet to be operationalized as in 2015, the MHA did not receive any money from the MoH but DFDI funding.

Insurance Scheme

In 2003, the government established a National Health Insurance Scheme (NHIS), which aimed to make healthcare readily available and more affordable to Ghanaians.

In 2010, 35% of the population is registered as paying subscribers[61].

The NHIS, at any rate, does not cover psychiatric services because, by policy, treatment for mental illnesses is free at the public psychiatric hospitals and through community psychiatric nurses.

Drugs & Medication

A list of essential medicines is present and was last revised in 2004. These medicines include: antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs.

However, these medicines are currently not included in the NHIS list of free drugs.

Availability

Availability of psychotropic medicines is estimated in 2011 by WHO as follow: in the outpatient's services: 40% in the General hospital and clinics inpatients: 57% and in the psychiatric hospitals: 100%[62].

According one of the psychiatrist whom we interviewed, in 2017, less than 10% of psychotropic drugs were in fact available at the regionals hospitals.

However, since 2012, government didn't supply medicaments and thus, most psychotropic drugs are not available in publics facilities. After its launch in 2015, the Mental Health Funds has virtually received no inflow.

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[59] The new Mental Health Act establishes a tribunal and an appeal procedure which seeks to address this. It remains to be seen how structures will be set up to ensure that persons with mental disabilities can challenge both admission and treatment against their will. However, it still allow for forced admission, involuntary treatment, and guardianship.

[60] Who-AIMS Report -Ghana-

[61] National Health Insurance Scheme annual report. Accra, Ghana: National Health Insurance Authority; 2010.

[62] 100% of psychiatric hospitals had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility all year long.

As a result, the last procurement order on psychotic medications dates as far back as 2011 in Accra Psychiatric Hospital. The hospital received some drugs in 2013 and since then, the Accra Psychiatric Hospital relied on private donations (such as Direct Relief).

In addition, there are frequent drug shortages of newer medicines (such as Olanzapine) meaning that users would have to continue on medications that they had not been initially prescribed.

In 2016, according the MHA, a budget of GHS3 million (out of the requested GHS20 millions) are given for psychotropic medications.

Affordability

Access to psychotropic medicine is supposed to be free in public facilities according the Mental Health Act of 2012. However, due to a shortage of some psychotropic medicines and the lack of funding, most of patients have to purchase these privately without means of gaining a refund[63].

The needs are met through cash and carry pharmacy system, out of pocket payments of purchases from the open market by patients, donations from philanthropic (such as Direct Relief) or patients just go without medications.

Estimated cost:

Antipsychotic drugs Haloperidol 5mg: 1 month: GHS 30
Artane: GHS 60 /month
Average montly cost of an antipsychotic prescription according to the NGO Mind Fredom: GHS 300

The median cost for antipsychotic medication is therefore about 23% of the average monthly salary.[64]

Human Resources (HR)

Presently, service provision is dominated by nurses with few other professional groups present in any number. The MH specialists (psychiatrists, psychiatrist nurses, occupational therapists, clinical psychologists) are very few in numbers, grossly inadequate.

mental health workforce...

According the Mental Health Authority, there are 16 psychiatrists working **in publics facilities** (the UK has 6,000). A few run also private psychiatric clinics.

In addition, there are 36 CPO (Clinics Psychiatrist officers (physicians assistants with specialization in MH), 1 018 community psychiatrist nurse, 1 clinical psychologist, 21 welfare officers and 4 Occupational therapists employed i**n publics facilities.**

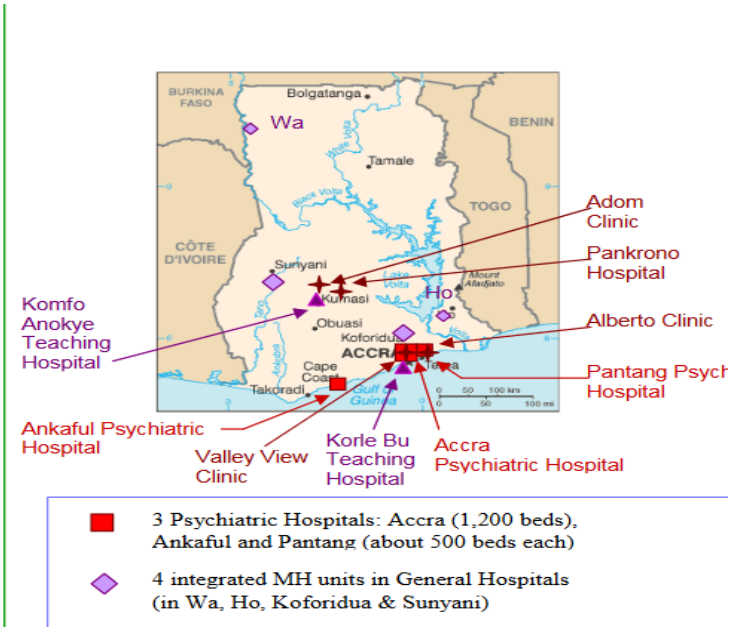
[63] The NHIS do not cover psychiatric care as it is expected to be provided free of charge by government
[64] Average Monthly salary: 1 292, 84 ₵ (https://www.numbeo.com/cost-of living/countryresult.jsp?country=Ghana)

Two new courses have been created at the Kintampo College of Health, training two new types of mental health worker: The Community Mental Health Officer (CMHO) and the Clinical Psychiatric Officer (CPO). The Diploma in Community Mental Health is a one-year.

By 2018, it is expected that there will be at least 2 CMHO and one CPO working in all 275 districts of Ghana.

II. Mental Health and Psychosocial Services

- Most of the MH facilities are located in the capital and in the South.
- Ghana has three large public psychiatric hospitals and five regional hospitals have psychiatric wings, while only 108 of the 230 district hospitals have community psychiatric units[65].



The capacity of each psychiatric hospital is 200, 500, and 250 individuals respectively.

All of the hospitals are organizationally integrated with mental health outpatient facilities.

Kitampo Project

Ghana also has **four private psychiatric hospitals**: two in Kumasi, one in Accra, and one in Tema, all located in the South of Ghana.

The private facilities have an estimated total inpatient capacity of 100 patients, as per their bed capacity. The high cost of care, estimated at about $150 per month per person in such institutions is beyond the reach of most Ghanaians.

- The systems that support delivery of services are currently weak, with poor availability of psychotropic drugs while food, medication and consumable items have been described everywhere by the staff as challenging.

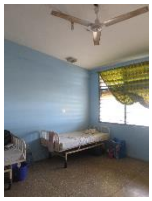
[65] MH strategic Plan 2013-2018

- Psychiatrists in Ghana continue to use Electroconvulsive Therapy (ECT).[66] However, at the time of our visit and with the exception of the Komfo Anokye Teaching Hospital, ECT machines of all three hospitals were broken down.

SERVICES	CAPACITY	COMMENTS	AREA OF PARTNERSHIP
PSYCHIATRIC HOSPITALS			
Pantang Hospital		**ACCRA**	
Case management and hospitalisation of common and severe cases of mental disorders, pharmacological treatment, individual therapy and family support Forensic unit- Drug Rehabilitation Unit- Occupational department; Rehabilitation Unit	270 beds HR : 750 staff including 5 psychiatrists, 16 Clinical Psychiatrists Officers, 1 Occupational therapist, 12 occupational therapist assistants, 340 physicians assistants 1 clinical psychologists plus Support staff	Payable[67] All psychotropic medications are available but on cash and carry basis (paid by client). Occupational ward run by a newly graduated occupational therapist. Lack of basic furniture, tools and equipment.	
Accra Psychiatric Hospital		ACCRA	
Psychiatric hospital - Drug Rehabilitation Unit 	Capacity: 600 beds 3 psychiatrists, 4 physicians assistants, 5 residents in psychiatry, 4 CPO, 3 medical officers	Payable; Overcrowded. Staff shortage Very poorly equipped and maintained. Patients are locked down and seem 'switched off' by the medication.	

[66] A method of treatment which involves passing electricity through one's brain, to treat persons with severe depression. Former UN special rapporteur on torture, Manfred Nowak, has noted that unmodified ECT (without anaesthesia, muscle relaxant, or oxygenation) is an unacceptable medical practice that may constitute torture or ill-treatment.

[67] Estimated costs: Consultation fees: 25/30 GHS Registration : 1600 GHS/month

Ankaful psychiatric hospital		**CAPE COAST**	
Psychiatric hospital - Drug Rehabilitation Unit 	200 beds, 3 psychiatrists, 8 physicians assistants, 3 doctors	Payable Occupational ward was closed during the visit. Conditions (area) seem to be a bit better than in Accra hospital (sheets on the beds, ping pong tables in the wards).	MoU whenever required;
Komfo Anokye Teaching Hospital		**KUMASI**	
Teaching hospital with psychiatric unit (in and outpatient facility)	10 beds, 2 large wards	Payable. Outpatient facility overcrowded. Conditions are poor. Large dormitories. No running water; electricity shortage. Dynamic team of psychiatrists experienced with returnees. ECT.	Consider Research partnership on MH of returnees
Psychiatric Private Clinics		ACCRA	
Brain clinic	1 psychiatrist, 1 Clinical psychologist psychiatric nurse	Payable. Small facility - Decent material conditions- No evidence of other treatment than medication	
Valley Clinic Outpatient and inpatient facility.' Stress Unit'?	3 psychiatrists consultant, 1 part time psychologist, nurses, laboratory	Payable[68]. Decent material conditions- No evidence of other treatment than medication	

Mental health outpatient services

According the MHA, there are 123 mental health outpatient facilities available in the country, of which none are for children and adolescents.

Day treatment facilities

There is no day treatment facilities run by GHS[69]. There were three day-treatments facilities in Ghana run by NGOs or church organisations[70]. The Damien Centre in Takoradi and 2 drop-in facilities for vagrants in Tamale respectively run by Basic Needs and a private practitioner. However, there is no updated information available on these structures.

[68] From 600 to 1500 GHS/Week (VIP)

[69] Ghana Health service

70 Changing Trends in Mental Health Care and Research in Ghana Ofori-Atta, Angela, Ohene, Sammy. The University of Ghana – Medical school. 2014

Community-based psychiatric inpatient facilities

There are 7 community-based psychiatric inpatient units available in the country for a total of 120 beds (2 of which are private facilities with the remaining 5 being connected to regional hospitals.

Community residential facilities

There are 4 community residential facilities available in the country (of which 1 was provided by Ghana Health Service. The remaining 3 were privately managed).

Organisation	Location	Services	Capacity	Comments & Partnership Opportunities
Cheshire Home	Kumasi, Ashanti Region	Rehabilitation programme - 9 to 18 months for adult psychiatric patients, with ages ranging from 18 to 55 years Epileptic patients are not admitted	Maximum bed capacity: 55 Staff: 2 psychologists, 1 cook, 1 psychiatrist, nurses and 6 support staff.	Treatment mainly based on medication. No evidence of occupational therapy, infrastructure in poor conditions, lack of intimacy, no running water.
Kate Centre	Takoradi , Western Region	Shelter for adults with psychiatric disorders.	Maximum bed capacity: 48	*Not visited*
Kitampo Psychosocial Centre	Kitampo, Brong Ahafo Region	Treatment of MH patients and teaching institution. Community Health Workers are trained there.	*Unknown*	*Not visited*
Elmina Rehabilitation Centre	Elmina, Central Region	Treatment of MH patients and teaching students.	*Unknown*	*Not visited*

Consumer associations, family associations and NGO's

There are 10 consumer associations/NGOs in Ghana. These include Mental Health Society of Ghana (MEHSOG), The Ghana Mental Health Association, Mindfreedom, Alcoholics Anonymous, The Epilepsy Association, Basic Needs, World Vision, The Epilepsy Society, Ghana Organisation against Foetal Alcohol Syndrome and Psycho-mental Health International.

Basic Needs, MEHSOG and Mind freedom along others NGOs have been involved in the formulation or implementation of mental health policies, plans, or legislation in the past two years in Ghana and have promoted public education and awareness campaigns in the past five last years.

Organisation	Activities	Capacity	Comments	Areas of partnership
Basic Needs	Training of CPN - Advocacy & capacity building Ensure dally monitoring and follow up of CPO in 97 districts	Support staff	Basic Needs-Ghana is one of the few NGO's involved in mental health care, has partnered with MOH Since 2002 it has actively worked to promote a model for community mental health care and development.	Establish a Referral system (to the CPN) in the area of return
Mental Health Society of Ghana (MESHOG)	Advocacy - Raising awareness in the regions (Ablakuma, Ayawaso, Ashieduketeho Okai Kwei)	Support staff	- Aware of the MH issues on returnees - Partner with the UN funds against torture	To be considered if there is an advocacy work on the issue of MH among returnees or as an implementing partner for community work.
Mind Freedom	Advocacy Peer-to-peer support.	Volunteers	Funding dependant Lack of clear information on current activities	To be included in the list of psychosocial resources

Informal primary health care (Faith-based and traditional practitioners)

Ghana has several hundred prayer camps, which are believed to have emerged in the 1920s, although little is known about their history, numbers, or operations since they are not state-regulated. Across the 10 faith-based facilities, 1253 patients were treated in 2011.

In 2012, Human Rights Watch[71] documented severe cases of physical and verbal abuse of persons with mental disabilities in the family, community, hospitals and prayer camps.

The camps offer prayer and healing services[72] for persons with mental disabilities and are private Christian religious institutions that are usually managed by 'prophets[73]'.

In 2016, the MHA have implemented a program of abolition of chaining and human right abuses in all prayers camps and traditional healing systems through education on human right issues and visits traditional and faith based healing centres aiming at unchaining patients, cessation of human right abuses and better collaboration with referrals to the psychiatrist hospitals. 800 traditional healers and prayer camp managers were trained across the country by Basic Needs on the best practices in managing mental illness.

[71] "Like a Death Sentence" Abuses against Persons with Mental Disabilities in Ghana

[72] Alongside spiritual practices, 56% of faith based healers also administered medications (which they reported buying in pharmacies) and 22% offered herbal remedies.

[73] Many of them self-professed religious leaders claim to be able to cure persons having various conditions, including cancer, infertility and physical or mental disability, through prayer and other non-medical techniques.

Specific recommendations

- Develop a Memorandum of Understanding with the department of psychology and psychiatry in the Teaching hospital in Accra (for care, follow-up and research).
- Develop partnership with the NGOs working with the community psychiatric nurses (BasicNeeds and/or MESHOG).

GAMBIA

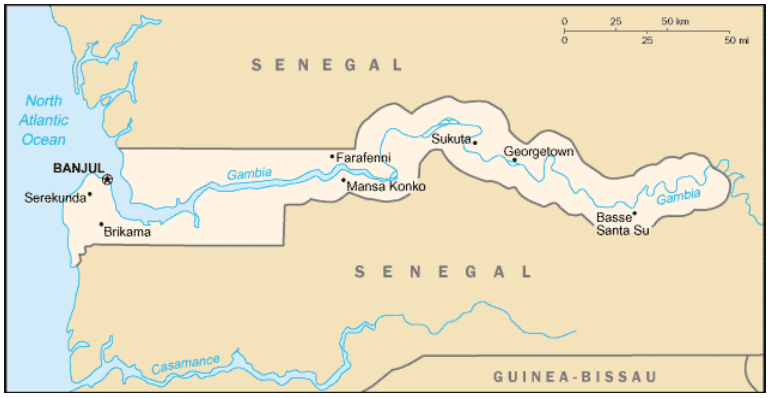
'To leave or to die'

'Death is better than living here'

'Everybody wants to go to Paradise'

Vision -MoH- 2016

'Attainment of equitable, accessible and cost-effective mental health care for people living in Gambia through the provision of quality mental health care integrated into all levels of care, by skilled and motivated personnel, with the involvement of all stakeholders.' [74]



General Information

- With a per capita income of $473, Gambia is one of the world's poorest nations and occupied in 2015 the 173rd spot out of 188 countries ranked at the Human Development Index[75].
- The country has a population of 2 million. Poverty is widespread and has stayed fairly static, worsening slightly to 48.6[76] percent of the population in 2015.
- Health indicators for Gambia are poor. According to the latest WHO data published in 2015 life expectancy in Gambia is 61.1 years.
- In 2011, about 10-11%[77][2] of the Government's budget was allocated to the health sector.

[74] Integration of mental health services into the general health care services in the Gambia- MoH-2016
[75] https://countryeconomy.com/hdi/gambia
[76] http://www.worldbank.org/en/country/gambia/overview
[77] http://www.aho.afro.who.int/profiles_information/index.php/Gambia:Analytical_summary_Health_financing_system?lang=en

About Mental Health

In Gambia, the majority of health facilities and personnel are located in urban areas, resulting in inequitable access to care. There are also disparities among regions, with the Western Region having most of the resources.

According to all stakeholders, mental health services are very limited with significant gaps in capacity, human resources, materials, medication and outreach services, most of which stem from very limited budget allocation.

The specific challenges are:

- The stigma towards mental disorders within all sectors of society. According to the MHLap Gambia coordinator, '*95% of those with mental health problems visit traditional and faith-based healers as a first point of contact and 2/3 of Gambians believed that mental health is caused by evil spirits'* (then seen as demon/witchcraft possession or punishment by supernatural forces)°. Mental health disorders may also be considered to be caused by imbalances of bodily fluids and the belief that mental disorders may arise from an 'infectious agent'.

As also mentioned by the National MH program manager [78] '*many of the Fula people believe in a disorder called 'Dowdi' which they believe arises as a result of a curse imposed by traditional healers, (called Marabout). 'Dowdi' is defined by a collection of somatic, behavioral and cognitive signs and symptoms, which are indistinguishable from, generalized anxiety disorder in ICD 10 (International Classification of Disorders) or DSM (Diagnostic Statistical Manual of Mental Disorders) criteria. Many groups in Gambia believe that contact with the bodily fluid of an individual suffering from epilepsy will result in their contracting the disease themselves.*

- The **limited infrastructure** available for mental health treatment and care. The Tanka-Tanka Psychiatric Unit of Edward Francis Small Teaching Hospital (EFSTH) is the only available inpatient facility for people with mental disorders.

- The Inadequacy **of human resources** for mental health: in 2017, there are no Gambian psychiatrist, no clinical psychologist, no occupational therapist.

Besides these common challenges, it seems that MH Gambia is also characterized by:

- The commitment of youth organisations' volunteers acting in place of the previous Community MH teams. Most of them being psychiatric nurses.

- The lack of coordination between various public and private stakeholders involved in MH and possible overlaps.

[78] Mr Bakary SONKO

I. Mental Health Organisation

Policy, plans, and legislation

- The current mental health legislation was formulated in 1917 and is called the Suspected *Lunatic Act.* It does not have any provisions to protect patients against involuntary admission and treatment or any requirement for consent to admission, treatment and does not address access to care, protection of rights of people with mental disorders, rights of families..

- The Gambian Mental Health Legislation has been reviewed and adopted at the National Council on Health in 2013[79] (but not yet by the parliament) with the support of various stakeholders and make provisions to promote: confidentiality, informed consent, equal access to care, conditions in mental health facilities, appropriate and accessible care in the least restrictive environment in their community, safeguards to protect against abuse, equal opportunities to/for employment and shelter/housing and equal access to justice amongst others.
A strategic plan 2007- 2012 which aims to provide services at the level of primary health care and general hospitals (cf annex) has also been drafted but is not yet adopted.

Financing of mental health services

Over 66% of the total health funding in Gambia comes from international health development partners, raising issues of sustainability and predictability of funding to the sector[80].

There is no separate budget line for mental health. Information regarding the percentage of the overall health budget spent on mental health is not available.

The entire allocated budget is for salaries, allowances and procurement of office materials at National level. Some funds are also provided for the running of the EFSTH polyclinic and Tanka-Tanka Unit and for providing a basic supply of psychotropic medicines.

MH Insurance Scheme

There is a Social Protection regime in Gambia; however, due to their employment status, a significant proportion of the vulnerable population are not covered by these schemes.

Approximately 76% of Gambians work in the rural areas and are mainly involved in small scale subsistence farming. For them and most Gambians operating in the informal sectors in the peri-urban and urban areas, the only social protection available is the informal extended family social security networks.

Human resources

The human resources of the mental health services of Gambia are very poor in all aspects of psychiatric and psychosocial care.

There is no Gambian psychiatrist but 4 Cuban psychiatrists who speak no or little English and none of the local languages. One Gambian physician is presently resident as a psychiatrist in Tanka Tanka hospital. There is no psychiatric curriculum available in Gambia and those who want to specialize have to go abroad.

[79] National policy for mental health services delivery -MoH 2013 -Adopted at the National Council on Health, August 2013.

[80] ww.aho.afro.who.int/profiles_information/index.php/Gambia:Analytical_summary__Health_financing_system

There were 10 psychiatric nurses[81] in 2017 (2 in the Teaching Victoria Hospital, 1 as a program manager, 1 in Who MH Gap and others in Tanka Tanka). Around 15 are presently under training. All of them are based in the Banjul. The training of psychiatric nurses has started 3 years ago and is provided by the American University.

There is one child psychologist[82] trained abroad who is working as a private practitioner and no clinical psychologist nor occupational therapist.

There are presently no MH personnel in the Regional Health Teams, the general hospitals or the major and minor health centres.

Drugs & Medication

The National Essential Drug List was last revised in 2005.

Major issues in relation to psychotropic medications include inconsistent availability of psychotropic medications at the secondary and tertiary care levels and non-availability of some essential psychotropic medications at the primary care level. Medications must also be paid by the patient.

According to Mr Somko[83], prices are as follow:

Haloperidolol	15 Dalasi[84]/pill	a monthly budget between 450 and 900 GMD
Risperidone		From 15 to 50 Dalasi/pill
Artane :		From 5 to 10 Dalasi/pill
Olanzapine :		From 25 to 50 Dalasi/pill
Carbamazepine:		Around 5 Dalasi /pill

An antipsychotic treatment from the first generation will cost an average of 45 DLSI/day meaning 1 350 GMD/month (23€/month).

In today's Gambia where the average salary is D3 000[85], monthly cost of an antipsychotic treatment is therefore unaffordable for most population.

II. Mental Health and Psychosocial Services in Gambia

The country is divided into seven health regions each with a regional health team (RHT), headed by a Regional Health Director (RHD).

2.1 Coordinating body - the Mental Health Unit

The Mental Health Unit was established in 2007 and aims at coordinating mental health services and activities nationally. The mental health programme, led by the National Mental Health Programme

[81] 3 years general training as nurse and 2 years of specialisation
[82] Volunteer in the organisation 'No health without Mental Health'
[83] National MH program manager
[84] 100 Dalasi (GMD): 1, 71 € on the 18/02/2018
[85] http://thepoint.gm/africa/gambia/article/high-cost-of-living-

Manager (NMHPM) coordinates all the mental health activities in the country, including supervision and collaboration with:

- NGOs and related institutions involved in rendering mental health activities/services in the country;
- The Association of Traditional Healers in Mental Health, registered with the Traditional Medicine Programme.
- The 7 Regional Health Teams, 6 Hospitals, Health Centres, Village Health Workers and Community Based Organizations.

Mr Bakery Somko, a psychiatrist nurse is currently the head of the department which hosts also the NGO 'No Health without Mental health' that he founded.

2.2 Current MHPSS services in Gambia

Institution	Capacity	Characteristics	Comments
The Tanka Tanka Psychiatric hospital			
Male and female wing, occupational therapy unit, Conference hall, medication store and records office and recreational facility.	80 patients 3 Cuban psychiatrists, 4 psychiatrist nurses, 3 registered nurses Security and support staff.	This is Gambia's only psychiatric inpatient facility. Admission is free of charge. If patients cannot pay for medications, then, they are not admitted to the hospital. No ECT Free visits at any time for family members.	Care at Tanka-Tanka is mainly custodial with very few human and material resources. Conditions are -poor; dormitories host 6 to 8 persons; there are large ward where patients move freely - Relationships between patients and staff sounds warm - Recreational ward was operational with patients engaged in various activities at the time of our visit.
The Royal Victoria Teaching Hospital in Banjul, the Polyclinic of the EFSTH			
Only Outpatient clinic in Gambia. Services to all outpatients who come for monthly follow-ups.	A unit (two rooms) allocated for outpatient mental health services. 1 Cuban psychiatrist and 1 psychiatrist nurse plus general nurses	First point of contact for almost all patients admitted at the Tanka-Tanka Psychiatric Unit (both new cases and re-admissions).	The Cuban psychiatrist does not speak English (the national language) or any other country's languages.

Psychiatric services integrated into general hospitals

There are 5 other general hospitals in Gambia (Bwiam, Bansang, AFPRC Farafenni and Jammeh foundation) where no inpatient service is available.

Services are limited to psychiatric follow-ups by the general nurses attached to the outpatient departments, with the support of the medical officer in charge who does not have specific mental health training.

Community mental health services

A community mental health service was established in 1993. These services were delivered predominantly by the community mental health team headed by a registered nurse. During 1996-2005, the Community Mental Health Team (CMHT) had the responsibility of outreach to the major health centres.

CMHT used to provide diagnostic assessment, medication treatment intervention, monitoring and follow-ups. In addition to these population-based interventions, health workers of the CMHT were available to go and visit people with mental disorders in their home and community whenever there were claims of mistreatment and/or problems with the family/community.

Due to the lack of funding, this service is no longer available.

Created in 2016 under the umbrella of the MH department, an NGO 'No Health Without Mental Health' (NHWMH) composed of 100 volunteers (doctors, psychiatric nurses, students) propose mobile free clinics and medication (see below).

Informal community care

At the community level, the first point of contact for seeking health care is usually the traditional healer.

- **Traditional healers** are most often the first points of contact for many people with mental disorders.

During the last few years the Ministry of health and Social Welfare have been working in close partnership with traditional healers in a number of districts. Essentially, traditional healers were introduced to medications and supplied with carbamazepine and chlorpromazine 'to deal with epilepsy and acute psychosis' alongside traditional methods. They were provided basic psychoeducation to introduce the use of low dose of oral chlorpromazine, while follow up treatment and support to be provided by the nearest health facility.

To date, a total of 15 traditional healers have been trained by the previously existing Community Mental Health Team and 12 are formally certified and working in collaboration with the Traditional Medicine Program Unit and the Mental Health Program Unit, Ministry of health and Social Welfare.

According to the MH program manager, the programs have been successful with good clinical outcomes. However, this program has stopped a few years ago.

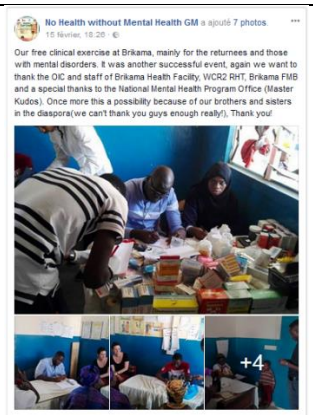
➥ **Faith-based healers**: Spiritual healers' treatment of mental disorders is mainly based on prayers and spiritual rituals whereas traditional healers use concoctions and traditional oral medications.

NGOs

There are no mental health consumers/users or family associations in Gambia.

However, there are a few dynamic and committed youth organisations working alongside in the area of mental health.

ORGANISATION	CAPACITY	ACTIVITIES	AREAS OF PARTNERSHIP
No Health without Mental Health (NGO)	25 volunteers (psychiatric nurses, doctors, Cuban psychiatrists and	Health promotion, community outreach clinics, identification, referrals and follow up;	Present at the community level – Supported by and working in close

	students) registered members -100 volunteers- No institutionalized funding but support from the MoH Around 20 members have followed 1 week training based on the MH Gap Intervention ;	home visits, free medication. Present at the airport and at the transit center. Information sessions proposed to returnees countrywide. Provide people with medication but quality of storage and distributions practises[86] may raise some concern.	collaboration with the Mental health department Staff capacity building
The National Youth Council	20 members from government (2 in each region) and nongovernmental organizations including beneficiaries of psychiatric services.	Involved in the reception of returnees in the airport and at the transit center.	Staff capacity building
YEP	*Unknown*	Empowerment of youth and returnees	*To be investigated*
Head Up Gambia (CBO)	International experts Volunteers in the field of MH and social work. 1 expatriate staff (social worker)	Capacity building in Tanka-Tanka and SAF; Staff training in jail/police department- Raising awareness on drug abuses.	Experienced in capacity building in Gambia.
Supportive Activists Foundation (SAF)	100 young volunteers all over the country	Creating awareness through drama and radio programs - Household support - Provide ad-hoc support to people with mild and severe mental disorders and their family.	Capacity building
MOBEE	Action in a sectorial area of Gambia	*Unmet*	*To be investigated*

Other stakeholders

Mr Bakari Somko is a psychiatric nurse and the head of the MH unit. Strongly committed and involved in the creation and the development of the NGO NHWMH and the community work.

Mh Dawda Samba, the country facilitator for mhLAP[87] and one of the main professional resources in the country. He is a psychiatric nurse, involved in the training of NHWH volunteers. He also has been involved in the training in MH of traditional and faith-based healers (from Islamic council- Christian Council). He runs a training of trainers on the MH Gap.

[86] What we observed during a field visit in Birkhama on feb 10, 2018 was: huge commitment of young and volunteers (psychiatric nurses), no consultation last more than 10 min, no medical records, no confidentiality and poor supervision. There was no psychiatrist nor medical doctor present this day.

[87] Mental Health Leadership and Advocacy Program

According to him, key needs are the followings:

Raising awareness ('the acceptance is still very poor,') capacity building of key stakeholders and institutions (Ministry of health, Tanka-Tanka), advocacy for policy and legislative development by targeting the policy makers, community advocacy programmes and mobilize support among others.

Regarding migrants, needs are: to build capacity of the young counsellors, to improve the reception conditions of the returnees (food, accommodation[88]), develop psychosocial support[89] and follow up of returnees and establishment of a drug rehabilitation program.

Specific Recommendations

Short-term recommendations

- In collaboration with the MHL Gap facilitator, build the capacity of the organisations acting in the Community especially the Supportive Activist Foundation (SAF), the NGO 'No Health without mental Health' (NHWMH) and the National Youth Committee.
- Develop the Mental Health coordination body with the MHPSS stakeholders involved with returnees in the airport and at the transit center.

Mid and long-term recommendations

- Extend the Coordination Body to other stakeholders involved in MH and PSS such as Heads Up Gambia, the SAF, the Ministry of Social affairs and build its capacity.
- Advocate toward the creation of accredited trainings in counselling, psychology and psychiatry.
- Develop a structured capacity building training for the youth organisations of volunteers.
- Investigate opportunities to refer to MH specialists in Senegal.

[88] According to him, promiscuity, poor food among others factors may increase the psychosocial distress of the returnees.

[89] Economic support will fail if you don't bring the psychosocial support here'.

MAIN RECOMMANDATIONS

Short-term recommendations

- Propose psychoeducation (such as leaflets introducing psychosocial difficulties that people can face and present psychosocial available resources in each area).

- Establish or strengthen functional partnerships and referral mechanisms with relevant partners[90] (such as teaching hospitals which have an expertise in the areas of return and do research work).

- Propose each returnee free access to a specialized consultation of their choice in the 6 or 12 months after their return.

- Develop/support the coordination between key psychosocial services providers involved with returnees and referral mechanisms with IOM delegations.

Mid- term recommendations

- To implement a MHPSS assessment among returnees after a certain period of time (such as 3, 6 and 12 months) along with the perception by the communities. This is in order to document the 'grey area' that represents MH among returnees.

- To support the psychosocial interventions run by identified PSS stakeholders at community level.

- To train the IOM staff[91] and other main stakeholders involved in the PSS of returnees (see specific country recommendations) in order to better identify, refer and assist not only those 'who hear voices'.

Long - term recommendations

- Engage in networking, coordination and advocacy with government officials, WHO and other partners at community regional and national level to :
  - Increase or review the application of the MH insurance scheme.
  - Ensuring medication supply in the PHCs levels.
  - Develop professional accredited training in counselling, psychiatry and clinical psychology.

- Along with MH professionals, to support research on MH of returnees.

- To build the capacity of general healthcare staff (through for example, the support of the development of the MH Gap[92]program).

[90] See specific country recommendations

[91] This has been a frequent request from many IOM staff stating that they feel the distress of returnees and not knowing how to address it.

[92] The WHO released the *Mental Health Global Action Program Intervention Guide* (mhGAP) for the management of mental health priority conditions by general healthcare providers in 2011. Aside from being cost-effective,

ANNEXES

Annex 1: List of stakeholders interviewed and contact information

ORGANISATION	NAME	FONCTION	MOB	MAIL
NIGER				
MoH	M. Boureima	MH Coordinator		boureima.abdou@yahoo.fr
OCHA	Naomi Jayne Morris	Officer		morris12@un.org
Psychiatric Unit National hospital Niamey	Pr Professeur Douma Maiga Djibo Dr Oumou Mr Amadou Sidikou Mme Halimatou Sidder Abdoukader	Head of service/Psychiatrist Psychiatrist Psychologist Social worker	93 50 15 15 96 98 46 59	asidikoufr@yahoo.fr
IN REACH (NGO)	Christian Keller	Country focal Point		christian.keller@reach-initiative.org
WHO	Dr Fatima Aboubakar	Non communicable disease		aboubakarf@who.int
COOPI	Jacob Gaouly	Project coordinator - Head of MHPSS unit		cp.coopch@coopi.org
Handicap International	Almadane Tangara	Project coordinator		cpn@hi-burkinaiger.org
BURKINA- FASO				
OUAGADOUGOU				
CBM	Ousséini Badini	Country Director	25 36 28 71 25 36 28 74	ousseini.badini@cbm.org
Handicap International	Clémenta Bagnoa	Project coordinator		csr@hi-burkinaniger.org
MOH	Dr Paulin SOMDA Oumar Sangaromare	Non comunicable disease coordinator MH Coordinator	25 41 41 84 78 04 24 34	k_admos@yahoo.fr sangaromar@yahoo.fr
Psychiatric Hospital	Pr Arouna Ouedraogo	Head of psychiatric hospital, president of the African society of MH	70 23 96 98 25 37 05 60	arouna7ouedraogo@yahoo.fr
OUAHIGOUYA				
Teaching Hospital	Dr Désiré Namena	Responsible for the Burkinabe MH association	70 32 35 30 77 65 18 75	desenanem@yahoo.fr
SAULER	Adama Ouedraogo	Manager	70 71 77 59	sauler2004@yahoo.fr
BOBO-DIOULASSO				
Teaching Hospital	Dr Sié Benoit and psychiatric nurses Pr Sirayan	Psychiatrist Head of unit	70 61 91 85 70 26 95 46	bensieda@hotmail.fr ssiranyan@yahoo.fr

offering services through existing general health care is an accessible, non-stigmatizing way to offer affected populations assistance.

Center ND de l'Espérance	Emmanuel Nabaloum (prêtre)	Manager	70 32 81 33	emnabal@yahoo.fr
TENKODOGO				
Psychiatric Unit Regional Hospital	Mr Paré (*phone interview)*	Psychiatric nurse	63 08 09 26	
GHANA				
ACCRA				
Pantang Hospital	Dr Franck Baning Dr Kwadwo M. Obeng	Hospital managerr Psychiatrist	0202015058 202 936 108	Frank.baning@yahoo.com drkobeng@gmail.com
Accra Hospital	Dr A Pinaman Appau	Hospital manager	576 037 26 3	pinamaapau@gmail.com
Mental Health Authority	Dr Caroline Amisssah Kwaky Brobbey	Deputy Chief Executive Officer Head of Communication	249 379 426 030 396 4879	kbrobbey@yahoo.com
Basic Needs Ghana	Sunday Awaanaba Fred Nantogmah	Project manager Communication Officer	372 023 566 302 781 217	fred.nantogmah@basicneeds.org
Mind Freedom	Dan Taylor Mrs Janet Amegache Nii Lartey Addico	Executive secretary Manager Co director	020 2456 413 020 211 228 055 904 849	janeteamegatcher@yahoo.com office@mindfreedom.org
WHO	Dr Sally Ann Ohene	Head, Disease Prevention and Control dpt	302 763 919 302 763 919	ohenes@who.int
Mental Health Socielty (MESHOG)	Mr. Humphrey Kofie	Director Country Facilitator mhLAP-Ghana		humphrey.kofie@meshog.org
Psychiatric Teaching Hospital	Dr Sammy Ohene Dr Delali Fiagbe Angela Gorri Atta	Head of Department Psychiatrist Head of psychology dpt	302 763919 264 701 764 202 015 050	angela.oforiatta@gmail.com
Valley Clinic	Dr. J.J Lamptey	Psychiatrist	302 764 169	
The Brain Clinic	N/A	Psychiatric Nurse	302 775 249	
CAPE COAST				
Ankaful Hospital	Dr Eugène K Dordoye	Hospital director/psychiatrist	244 658 711	dordoye@gmail.com
KUMASI				
KOMFO Yeaching Hospital	Dr Ruben Owusu antwi Dr Lawabene Kusi Mensah	Psychiatrist Psychiatrist	244 650 245 244 444 268	ruch_2001@yahoo.com
Cheshire Home	Owusu-Adjei Eunice Amina	Chairman Management Committee Psychologist	277 834 634 205 883 254	adjeifeb12@ yahoo.com
NIGERIA				
LAGOS				
Federal Neuro Psychiatrist Hospital	Dr Oluyemi Ogun	Hospital director/Psychiatrist Psychologist	805 787 68 97	

Happy Hospital Family	Dr Charlotte I Nwigwe	Medical director	802 334 91 13	c.nwigwe@happyfamilyhospital.com.ng
Grace Hill Hospital	Mrs Chigozim Otefe Edebi Princess Ukata	Manager Ward manager	802 222 80 91 703 162 66 51	reachigo@gmail.com ibrogiaku@gmail.com
Christ Against Drug Abuse Ministry	Ola Asag Droyune Module Beatrice	Counsellor/peer Manager	103 295 93 70	
Freedom Fundation	Amabelle Nwakanma	Program director Genesis House	808 718 52 02	a.nwakanma@freedomfundation.org
Mental Health Foundation, Lagos	Emmanuel Owoyemi	Manager	803 323 68 14	
Naptik Shelter	Olabode Ogunbiyi Bosede Jimoh Okoye Amaka Rose	Head of unit Counsellors	103 491 61 68	bodebigi@gmail.com
BENIN CITY				
Govenemental House	Mr Solomon Okoduwa	Senior special assistant on human trafficking and illegal migration	703 194 95 79	
Committee for the Support of Dignity of Women (COSUDOW)	Sr Bibiana Emenaya Sr Anthonia Iyade Sr Franciscan Isuwe		803 394 26 52	
Capital Health House	Dr Oseyemwen Ndudu	Psychiatrist	802 344 26 35	dududio2@yahoo;com
IDIA RENAISSANCE Federal Neuro psychiatric Hospital	Roland Nwoha Dr So Olutu Dr Owie Godspower	Project coordinator Medical Director Psychiatrist (and pastor)	808 080 11 67 810 360 41 94 815 566 92 66	idiarenaissance@yahoo.co.uk owiegospy@gmail.com
Department of Psychiatry (teaching hospital)	Dr. Obagaye	Head of the department	802 336 78 39	edosalwadie@yahoo.com
Path Finder Initiative	Bar Dan Uhimwen Evon Idahosa	Laywer Executive director/fonder	817 124 24 44	
SEYP	Jennifer ERO	Executive director	805 165 62 02	jennyvics@yahoo.com
URUOA (EDO STATE)				
Specialist Teaching hospital	Dr Obaguye	Psychiatrist and pastour		kobaguye@gmail.com
GAMBIA				
WHO	Mr Momoudou GASSAMA	National Professional Officer MH Focal Point		mf.gassama@yahoo.co.uk
MoH/Mental Health Department	Dr Bakary SOMKO	National MH and Prevention of Substance Abuse Program Manager	774 95 40	masterbsomko@yahoo.com

Tanka Tanka Hospital	N/A Ora Yaneisys	Administrator, nurse Psychiatrist (Cuban)	 278 80 21	
Heads Up Gambia	Karen Sonko Ousman Saidykhan	Project manager	790 36 73 738 84 14	headsupgambia@outlook.com
MHLap	Mr Dawda Samba	MH Gap Program Coordinator	994 70 43	dawdasamba@yahoo.com
Supportive Activist Foundation (SAF)	Solomon Correa	Manager & founder	303 90 00	solomoncorrea@ yahoo.com
BRIKAMA				
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Annex 3: List of acronyms

CHAG	Christian Health Association of Ghana
CMHO	Community Mental Health Officer
CPN	Community Psychiatric Nurse
CPN	Community Psychiatric Nurse
CPO	Clinical Psychiatric Officer
ECT	Electro Convulsivo therapy
LAMICs	Low- and middle-income countries
MH	Mental Health
MH Gap	Mental Health Gap Action Program
MH LAP	Mental Health Leadership and Advocacy Program
MHA	Mental Health Authority
MoH	Ministry of Health
PHC	Primary Health Care
WHO	World Health Organisation
WHO-AIMS	World Health Organisation Instrument for Mental Health Systems