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ASUGI

INTERNATIONAL CONFERENCE

BRIDGING GAPS IN COMMUNITY MENTAL HEALTHCARE

Towards a Shared Path for Mental Wellbeing in Sudan, Cameroon, Chad and Central African Republic.

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Content

Foreword

This document collects the speeches at the conference "Bridging Gaps in Community Mental Healthcare: Towards a Shared Path for Mental Wellbeing in Sudan, Cameroon, Chad and Central African Republic", realised in the framework of the project "INLAB" funded by the Italian Agency for Development Cooperation and ASUGI Mental Health Departemental Area of Trieste and Gorizia, Italy.

It is an accurate contribution of professionals and operators in the mental healthcare sector who have shared their studies and practical work experiences to create a functional, resilient and highly responsive mental health system in Africa.

Welcome Speeches

LUCA MAESTRIPIERI

DIRECTOR, ITALIAN AGENCY FOR DEVELOPMENT COOPERATION.

Distinguished guests, dear colleagues, and friends,

It is a pleasure to welcome you to the conference: "Bridging Gaps in Community Mental Healthcare: Towards a Shared Path for Mental Wellbeing in Sudan, Cameroon, Chad, and Central African Republic".

Firstly, let me say I really appreciate the joint efforts of the Italian Agency for Development Cooperation in Khartoum and the ASUGI Mental Health Departemental Area of Trieste and Gorizia, for organizing this event.

I am sincerely grateful because it is not every day that we can bring together healthcare professionals, practitioners, anthropologists, advocates, policymakers, and people living with mental health conditions from different areas of the world to share good practices in improving mental health and well-being for all. It is by drawing upon this collective wisdom and know-how that we can achieve our goal: transforming mental health for all.

It is well known that mental health is inextricably linked to health. The pain we do not touch, the pain we do not see, is also the most difficult to heal.

Mental health touches everyone's lives and, to that extent, represents a collective responsibility: it is vital to public health and to move towards universal health coverage.

Despite this, globally, the amount of development assistance dedicated to mental health remains small. The latest figures from WHO highlighted an urgent need to increase mental health investments, and the chronic underfunding in this sector has been exacerbated by the COVID -19 pandemic, which resulted in an increasing demand for mental health services.

The Italian Agency for Development Cooperation is firmly committed to investing in quality, affordable mental health care for all as part of universal health coverage. To achieve this goal, AICS is partnering with civil society, non-governmental organisations, and the private sector, focusing on a person-centred approach. It is only through actively engaging users and families into decision-making practices and arenas that we can implement effective and efficient mental health policies and accountable, inclusive, and respectful services.

Our efforts alone will only partially succeed: this is the reason why this conference also represents a platform to forge synergies between AICS, ASUGI and the national and international organizations, users, and care providers that are here today.

Let me leave you with this food for thought. Turning challenges into opportunities requires new ways of thinking and responding. It's what we call "thinking outside the box," isn't it?

As we look ahead, we must reshape the way we talk about mental health, leaving aside preconceptions, replacing them with curiosity, thus opening the doors to inspire and encourage concrete solutions for the future.

I wish all of you a successful and impactful conference.

MICHELE MORANA

HEAD OF OFFICE, ITALIAN AGENCY FOR DEVELOPMENT IN KHARTOUM.

Presentation

It is a great pleasure for me to have the opportunity to present this publication which collects the interventions of the participants at the Trieste Conference on Mental Health "***Bridging Gaps in Community Mental Healthcare: Towards a Shared Path for Mental Wellbeing in Sudan, Cameroon, Chad & Central African Republic***" jointly organized by the AICS Khartoum office and the ASUGI Mental Health Departemental Area of Trieste and Gorizia.

I want to thank whoever made this event possible: the speakers for their inputs, ideas, thought-provoking talks, and our outstanding rapporteurs who helped us navigate the complex landscape of mental health. I also extend my special thanks to our partners ASUGI Mental Health Departemental Area of Trieste and Gorizia for co-organizing and hosting the event, giving us the unique opportunity to meet in a highly symbolic place, once known for suffering and marginalization, today for being a space for rebirth, innovation, and change. Trieste's outstanding work as one of the global most advanced, community-based mental health care systems is a reason for pride for Italy.

We designed this event as a platform for practitioners, caregivers, and researchers to learn from each other. Listening to different experiences and highlighting cross-country differences and similarities can further enhance collaborative research and help find common strategies in the field of mental health. Great attention has been paid to cross-cultural mental health conceptualizations and how to include them in local and international interventions and programmes. I want to share some key messages we can take from the conference to make sure they live on and impact our daily work.

Firstly, underinvestment in mental health, particularly in community-based mental health services, is a global phenomenon and not just a developing country problem. National and international funders should focus on contextually relevant interventions to protect the fundamental rights of people with mental health conditions.

Throughout the presentations, we heard the critical need to expand the mental health workforce and the central role played by primary healthcare. We have also heard and tangibly experienced the pain of rejection and the stigma people living with a mental health condition face. We have listened to the stories of those fighting to destigmatize mental health through advocacy, education, and peer to peer support.

And last but not least, we have seen the great work mental health practitioners do around the world, on the frontline, with selfless dedication, deep commitment, and courage. The title of this conference mentioned "*A shared path towards mental well-being for all.*" How do we imagine this path? It is a multidimensional process involving empowering individuals, groups, and communities. But it is also much more. It is a long journey to achieve a new paradigm for mental health.

I wish you all a pleasant reading, thank you for being part of this possible change. What is at stake is human dignity. Whenever human rights are violated, we have to take action to protect them.

PIERFRANCO TRINCAS

DIRECTOR DAI DSM - MENTAL HEALTH AREA AZIENDA SANITARIA UNIVERSITARIA GIULIANO ISONTINA (ASU GI).

Let me start by saying that it is a privilege to host the conference "*Bridging gaps in community mental healthcare: Towards a shared path for mental wellbeing in Sudan, Cameroon, Chad & Central African Republic*" in the Park of San Giovanni, a place of rebirth and freedom.

I wish to thank the Italian Agency for Development Cooperation for co-organizing this event which represents an important occasion for discussing and sharing best practices and lessons learnt in the mental health field, and for raising awareness on the need to make mental health a priority for all people.

As you all know, the 1978 Italian Mental Health Law, the result of Basaglia's enlighted and innovative vision, represents a paradigm shift in the cultural and social approach to psychiatry and in the way of providing mental healthcare.

Trieste's mental health system is universally recognized as a pioneering example of deinstitutionalization and community mental health care, inspiring and influencing mental health systems across the globe. The Central premise of the Trieste model is that people experiencing mental health issues should live in the community: the mental institution is replaced by an open-door system where integrated social cooperatives play a crucial role.

When we zoom out to look at other countries and realities, we realize there is still much to do: applying and transmitting Trieste's mental health principles and care model to other countries does not only mean working on the technical components and the environment (rules, access to care eg.), it is also about revolutionizing the relationship between the individual and the society, putting people first.

Several structural factors can obstruct the pathway of this profound transformation: lack of political will, scarce funding, lack of trained staff, and the attitude of the community towards mental health issues.

Building on our experience, we are firmly committed to implementing capacity-building interventions for mental health system strengthening, meeting the infinite diversity of people's needs, under the framework of intercultural sensitivity and respect.

We are proud to share this journey with the Italian Agency for Development Cooperation to foster the social integration of users of mental health services across the world.

Contributions

ALESSANDRA ORETTI

DEPUTY DIRECTOR OF DAI DSM MENTAL HEALTH AREA, (ASU GI).

The Whole Mental Health System: the Process of Deinstitutionalization, Principles and Values in Trieste's Mental Health Organization.

The process that led to the reform of public psychiatric care in Italy started at the end of the 1960s from a theoretical and practical action of criticism and opposition to the asylum, known as deinstitutionalisation. This process has in Franco Basaglia, and his collaborators the main architects for the work carried out at first in the hospital in Gorizia and from 1971 in the one in Trieste.

In Trieste, the hospital's functions ceased in 1977, a year before the promulgation of Law 180, with which psychiatric hospitals were closed, and the transition from a hospital-based care system to a community-based mental health model took place, with the creation of territorial services spread throughout the country.

The work of deinstitutionalisation started from the questioning of the medical-scientific paradigm that supported the asylum (the judgement of incurability-dangerousness attributed to mental illness).

What distinguishes the Trieste experience is the transformation of the hospital, or rather its deconstruction, through a reconversion of resources so as to replace it completely with a network of services in the community capable of taking charge of the demand for mental health services coming from the territory, and of promoting individual and collective paths to health and social emancipation.

This aim at creating treatment alternatives characterises the Italian psychiatric reform and differentiates it from what has happened in the United States and other European countries, where, starting in the 1960s, there had been policies to reduce psychiatric hospitals by discharging patients who were often abandoned to the street and to the social control exercised by other institutions, without providing alternative forms of support.

From a legislative point of view, until 1978, the psychiatric law of 1904 was still in force in Italy, which defined the mentally ill as dangerous to themselves and others and of public scandal, and designed the asylum as the place for their care and custody. The persons were sent to the asylum by order of a magistrate or the police commissioner, admission was carried out by the police, and the director of the psychiatric hospital was criminally and civilly responsible for the discharged patient.

Law 180, the so-called Basaglia Law, later incorporated in the Health Reform 833 of 23 December 1978, establishing the National Health Service, has the following main features:

- Health treatment must be provided on a voluntary basis (similar to the provisions of art. 32 of the Italian constitution for any health act), with compulsory hospitalisation only in cases where: **(1)** a non-deferrable intervention is necessary; **(2)** the patient refuses treatment; **(3)** alternative

treatment in the community is impossible. Compulsory Sanitary Treatment differs from compulsory hospitalisation under the previous legislation in that any reference to dangerousness disappears; it is rather a tool to be implemented with respect for the person's civil and political rights and does not suspend all constitutional rights (obligation of care, without detention or isolation). It has a duration of no more than one week and can be renewed by reasoned request. Seeking consent to voluntary treatment is a clear rule and represents a recognition of the person's negotiating power, which is why non-voluntary treatment is limited in time and must be stopped as soon as the person gives consent. Compulsory admissions are proposed by two doctors, one of whom is a professional of the public health service and must be formally authorised by the mayor as the representative of the public health authority and no longer by the police, which emphasises the prevalence of the health rather than the repressive nature of the measure restricting freedom. The role of the Judiciary is an 'ex post' control of the legitimacy of the act, to protect the patient, in the figure of the Tutelary Judge.

- It is made compulsory to open new wards, 'services' in general hospitals, the Psychiatric Diagnostic and Treatment Services, which cannot exceed 15 beds, where acute mental health conditions can be managed. The limit on the number of beds is explained by the legislator's intention to avoid the reproduction of psychiatric hospitals.

- The gradual but definitive closure of the asylum with the conversion of resources to alternative territorial services and a ban on the construction of new psychiatric hospitals. Prevention, treatment, and rehabilitation interventions related to mental illness have to be implemented by non-hospital psychiatric services and facilities. New community services Mental Health Centres (MHCs) are established to provide mental health care to the population in a given catchment area.

Law 180/78 sanctioned the end of segregation for people with mental disorders and restored their equal dignity and rights with other citizens: the right to vote, the right to live, and the right to work.

There are the Mental Health Departments, as a set of facilities of the health authorities in charge of prevention, treatment, and rehabilitation in the field of mental distress and mental disorder, that must take charge of the enforceability of these rights through links and synergies with other health and social services in the area.

The Department of Mental Health and Addictions, with the Mental Health Area of ASUGI, serves the territories of the cities of Trieste and Gorizia in an area of 370,000 inhabitants. It has now been working without an asylum for 45 years. The asylum has been replaced by a totally open-door system, with Community Mental Health Centres (CMHC) open 24 hours, with 6/8 beds, a supported housing system, a Psychiatric Service in the general hospital, and a residence for the execution of security measures for offender patients.

The values guiding the work in all mental health services are to help the person rather than to treat an illness, to promote recovery and social inclusion, to address practical needs important to the users, to change community attitudes by reducing stigma.

The catchment area of each CMHC is approximately 60,000 inhabitants, and it is a point of reference for all psychiatric needs of the entire catchment area.

The CMHC is not only conceived as a crisis centre. It is in fact polyvalent and multifunctional: it is also a day centre, an outpatient service, a base for community teams.

The organisation and philosophy of the 24-hour CMHC is based on the principles of:

(1) Ease of access, non-selection of demand, and low threshold (i.e. not based on particular diagnoses, severity thresholds, or other exclusion criteria); **(2)** Non-hospitalisation and alternatives to it; **(3)** Flexibility and mobility of the service, proactivity and assertiveness - towards crisis and long-term support; **(4)** Involvement

of multiple global resources, such as a wide range of care arrangements, in the therapeutic and support programmes.

Individual care plans for recovery and social inclusion are developed by the service team through the individualised health budget methodology in projects co-managed with social cooperatives, associations and other regional and municipal agencies. The social cooperatives offer a system of training and work placement opportunities. The Rehabilitation and Residential Service (SAR) coordinates, together with the CMHC, all rehabilitation-type interventions on the axes of living, work, and socialisation.

The Psychiatric Diagnosis and Treatment Service is the unit dedicated to psychiatric emergencies; equipped with 7 beds, it works integrated with all the social-health services in the area and hospital wards. It is characterised by comfortable spaces that are not typical of a hospital ward, by the work with open doors and without the use of mechanical restraint. It represents a crucial junction in the relationship between the hospital and territorial institutions, and works in collaboration with emergency services, law enforcement, and judicial institutions.

The Trieste Residence for the Execution of Security Measures was opened in 2015, following Law 81/2014, which initiated a historic transition with the definitive closure of the six Forensic Psychiatric Hospitals in Italy. The law promotes a new rehabilitation approach oriented towards recovery for people with mental health problems who have committed a crime, but without criminal responsibility and deemed socially dangerous.

In conclusion, the deinstitutionalisation process initiated over the last 50 years in Trieste has led to the implementation of a new paradigm of care by creating services based on the respect for human rights, which take into account people's choices and self-determination. This still represents one of the main achievements of the Italian reform and one of the challenges at a global level, as the UN Convention on the Rights of Persons with Disabilities reminds us. States should implement the quality of policies in favour of mental health, because much must continue to be done to reshape the practices of daily work, update the training of professionals, seek new alliances outside the disciplinary field of psychiatry between stakeholders, policy makers, and the society in general.

There is evidence to affirm that, where new instruments have been "invented", such as strong CMHCs, equipped with community beds, which assume responsibility for the mental health of a defined territory, there has been a decrease in involuntary hospitalisations, less recourse to residential facilities or shorter lengths of stay, less social abandonment, more pathways to wellbeing and emancipation.

The Trieste approach to deinstitutionalisation should not be seen as a model to be exported but as a sustainable experience, an example to look up to and be inspired by in the communities to which it belongs. Because as Basaglia reminds us: *"...It is not so important whether or not there are asylums and clinics closed in the future, it is important that we have now shown that it can be done differently, we now know that there is another way to deal with this problem; even without coercion*."

JUSTINE LAURE MENGUENE

DIRECTOR OF MENTAL HEALTH AT THE MINISTRY OF PUBLIC HEALTH, CAMEROON.

State of play of Mental Health in Cameroon: Achievements and Weaknesses of the System.

General information

Cameroon is a country located in Central Africa with an area of 475,555 km², a population estimated at around 30 million inhabitants, with more than 200 ethnic groups. The official languages are French and English.

Many situations have enabled the Ministry of Public Health to see the extent of the mental health problem in Cameroon. These include:

- The massive influx of refugees from the East and the Far North.
- The war against the terrorist sect Boko-Haram.
- The conflict situation in the regions known as NOSO (North-west and South-West).
- Occurrence of disasters and fatal accidents.

Epidemiological data

Epidemiologically, there is a lack of statistical data. All sections of the Cameroonian population are affected by mental health problems, namely infants, children, adolescents, young people, and the elderly.

The most vulnerable group is young people with the use of psychoactive substances.

Sociocultural representations

Mental illness in Cameroonian society always leads to the stigmatization of patients and the rejection of the latter. It is often considered the disease of shame, a spell cast, a mystical disease. Sometimes, the victims are accused of being responsible for their situation because they broke the pact signed with the devil.

Ignorance and considerations about mental illnesses have limited access to modern medical care. Patients first go to traditional healers or even so-called "revival" churches and exorcist priests to ward off bad luck. This creates a considerable delay in support and case management.

Human resources are insufficient and include:

- 15 Psychiatrists, three in private practice.
- About 200 nurses specialized in mental health.
- 30 clinical psychologists in private practice.
- Many socio-health service providers.
- 3 to 4 psychiatrists per year are trained at the Faculty of Medicine Yaoundé I.
- 50 staff per year in training schools for nurses specializing in mental health.
- Added to this are the lack of initial and continuous training programmes, and the phenomenon of the brain drain.
- Public financial resources are insufficient, with a dependence on external funding (partners).

Achievements of the System

COVID-19 represented a mental health opportunity in Cameroon. Thus, we have a mental health system before COVID-19 and after COVID-19.

Pre COVID-19, at the level of the Ministry of Public Health, we had:

- A Sub-Directorate for Mental Health and a National Committee for the Fight against Drugs.
- A National Mental Health Policy document.
- Mental health indicators in the national health information system (DHIS2).
- Effective mental health care in 10 regions
- Psychological support integrated into the Incident Management System.

New training structures for the care of children with special needs:

At the level of the Ministry of Higher Education:

- The training of psychiatrists at the Faculty of Medicine of Yaoundé I.
- The reopening of schools for nurses specializing in mental health.
- The opening of a specialization in clinical psychology.
- The training of geriatric nurses.
- The training of psychometricians and psycho-educators.

Following the COVID-19 epidemic, Cameroon has:

- Developed a national mental health strategic plan, and national guidelines for the care of children and adolescents.
- Validated a simplified mental health guide and management algorithms.
- Developed a psychological support guide for guidance counselors in schools.
- Set up a national psychological assistance with a toll-free number 1510.
- Seen the involvement of technical and financial partners in mental health support.

A publication in "The Lancet Psychiatry" was made, and Cameroon received WHO Afro congratulations for the involvement of psychological care in response to COVID-19. In addition, training and supervision have been carried out, and many mental health awareness tools have been developed.

The care of PAMME (People with Mental Illness and Wanderers) in Yaoundé was initiated and carried out in collaboration with the Urban Community of Yaoundé; finally, the establishment of a national mental health technical group.

Weaknesses of the System: In terms of weakness, we observe:

- Insufficient data.
- Difficulties in the supply of essential drugs in mental health.
- The illicit sale of drugs (psychotropics).
- Insufficient trained human resources
- Insufficient multidisciplinary collaboration, operational research.
- Inadequate surveillance, monitoring, and evaluation system.
- Stigma and lack of respect for the rights of people with mental illness.
- Legal shortcomings.
- Weakness in coordination.

Conclusion

In conclusion, there is a political will to promote Mental Health in Cameroon, but there is a deficiency in the promotional, preventive, and curative components, at the organizational level, in terms of human resources, infrastructure, training, and the supply of drugs.

A strong plea is made for more technical and financial investment, the sustainability and consolidation of achievements, and the support for research and documentation of "success stories."

KLAKO KARAMEGA

COORDINATOR OF THE NATIONAL MENTAL HEALTH PROGRAMME AT THE MINISTRY OF PUBLIC HEALTH AND NATIONAL SOLIDARITY IN CHAD.

Scaling up Mental Health care in Chad: Barriers and Facilitators.

Introduction

Given its position in the center of Central Africa, Chad has experienced painful situations that jeopardize the positive mental health of its population. In particular, the war in Libya, the inter-community conflict in Sudan, the bloody abuses of Boko Haram in Nigeria, and the crisis in the Central African Republic have affected thousands of people, including returnees, refugees, primarily women, and children.

Additionally, internal displacements caused by natural disasters (such as floods) are factors of stress and trauma to the various target groups on Chadian soil.

More than 919,112 people (UNHCR, Statistics of people under UNHCR protection, December 2020) are displaced, including 483,223 refugees and asylum seekers, 336,123 internally displaced people, 99,765 Chadian returnees (including 30 422 returned to the lake and 69343 returned to the south). In addition to these people, nearly 600,000 people make up the host communities. Nearly 51,000 displaced people who returned to their villages of origin in 2017 are likely to make pendulum movements towards areas of displacement due to insecurity, cropping seasons, and humanitarian assistance.

The long period of French colonization helped pave the way for the introduction of Western techniques and values. The medical field has been included, particularly for what concerns us here, mental health.

It is difficult to talk about mental health in Chad due to the lack of written documents.

However, before colonization, a form of psychiatry was practiced by local populations, commonly called "traditional psychiatry." This, which falls within the domain of traditional healers, has yet to be completely supplanted by new techniques, and at present, one could even say that it is tending to regain ground.

Historical excursus

Despite its emergence since the creation of the World Health Organization (WHO) in 1946, the concept of mental health still struggles today to find its place in the African continent. Unfortunately, mental illness affects both developed and developing countries, especially in Africa. Four hundred fifty million people in the world are affected by these pathologies. However, faced with this scourge, the response provided by African countries in general and Chad is almost non-existent, mainly due to the concentration of means and resources on other diseases (malaria, HIV/AIDS, the diseases of the dirty hands), while mental illness is one of the main causes of morbidity and disability in the world, and its effects manifest themselves in all age groups.

Similarly, the census of mental pathologies remains very limited in Africa due, on the one hand, to patients' fear of being excluded from society and, on the other hand, to the increased role played by traditional medicine. Talking about mental pathologies in most African countries is an absolute taboo.

The causes can be cultural, religious, or even societal. About 7% of the African population suffers from it. The traditional management of mental disorders is still relevant. The patient and his entourage refer to it in combination with a request for care at the hospital.

Indeed, during colonization, Chad, like most African countries, had, as a hospital care device, the shed of the central hospital of Fort-Lamy. Built in 1958, the shed received restless patients destined to solitary confinement. In this context, the organization of care and psychiatric care were done for a long time according to the asylum style.

At the same time, the will of international institutions to promote this subject has been felt since the beginning of the 2000s with, however, a glaring lack of concrete results on the ground. After being excluded from the Millennium Development Goals (MDGs), mental health is now part of the Sustainable Development Goals (SDGs).

On the other hand, the problem here is not the degree of the pathology but the almost total absence of infrastructure and a qualified workforce in sufficient numbers.

National programme on mental health

In order to better coordinate the various psychiatric assistance activities, the creation of a National Mental Health Program within the Ministry of Public Health and National Solidarity was decided in 1998 by Ministerial Decree n°0283/MSP/DG /98 of March 12, 1998.

This Program is responsible for designing and organizing psychiatric assistance and, more generally, the national mental health policy.

However, the National Mental Health Programme is faced with constraints that limit its activities, namely:

- A very small team (with not even a psychiatrist).
- The absence of a specialized care centre.
- Lack of decentralization of care.
- Lack of technical equipment for treatment (EEG and others).
- Difficult access to psychotropic drugs.

Despite enormous efforts, assistance to people suffering from mental disorders still only reaches a small part of the population. The situation of underdevelopment and under-equipped health characterized by the lack of psychiatric institutions and specialized personnel constitutes the major obstacle. Thus, to provide mental health care services to all populations and at a lower cost, it is essential to integrate mental health care into basic health services and create provincial psychiatric institutions.

Mental health service at National Reference University Hospital (CHURN)

The CHU-RN mental health service in Ndjamena is the only psychiatric care unit in the whole country (currently more than 12,000,000 inhabitants). It is a service that operates in an open environment and receives mentally ill people from all the country's provinces. Its capacity is 6 beds, including 3 beds for accompanying persons.

According to the mental health service register, 1885 patients were consulted for a mental disorder in 2019-2021, of which 786 were female, a rate of 41.6%. The most affected age group is between 19 and 30, with 732 cases, or 38.7%. According to the pathologies, the most recurrent disease is schizophrenia, with 547, or 29% of cases, followed by acute psychotic episodes, which is 349, or 18.5%; depression, with 312 or 16.5%; anxious and phobic syndromes, 12.3%; 9.7% manic-depressive psychosis and other 8.6%.

After the death of the head of the department, the psychiatrist Dr. Egip Bolsané, currently, the staff working there is essentially composed of 2 senior mental health technicians, 2 psychologists, and 1 social worker.

Technical working group on mental health and psychosocial support (GTT-SMSPS)

The care of mental disorders poses a real public health problem, while the demand for mental health assistance is becoming increasingly pressing because there is no health without mental health. The needs for psychosocial support and the management of mental and neurological disorders remain enormous in this context. Thus, a Technical Working Group on Mental Health and Psychosocial Support was set up on April 1, 2021, by the Ministry of Public Health and National Solidarity to ensure the coordination and harmonization of the interventions of the various actors.

The Technical Working Group on Mental Health and Psychosocial Support collaborates with UN agencies, national and international NGOs, civil society, and government sectors. It should be chaired by the Ministry of Public Health and National Solidarity.

The primary objective of the MHPSS Working Group is to improve mental health and psychosocial support interventions in Chad. The TWG in MHPSS will coordinate and work with government authorities on the establishment of standards and regulatory frameworks with several work streams, namely:

1. Development of a meeting schedule.
2. Regular meetings of the GTT-SMSPS every last Thursday of the month.
3. Development of a 2021-2022 Work Plan.
4. Establishment of sub-working groups in 04 provinces: Ouaddaï, Biltine, Wadi-Fira, and Lac.
5. Organization of World Suicide Prevention Day.
6. Organization of World Mental Health Day.
7. Development of an Operational Action Plan 2021-2023.

Obstacles

The analysis of the Mental Health and Psychosocial Support situation is currently worrying. Mental Health deserves to be regarded with interest.

There are institutional factors that hinder the effectiveness of care for the mentally ill:

- Lack of qualified personnel.
- Inaccessibility to Mental Health care services.
- Absence of an Autonomous Psychiatric Center with sufficient reception capacity.
- Absence of decentralization of care in Mental Health.
- Unavailability of psychiatric drugs.

Perspectives

In this context, experience shows that the emergency solution is to:

- Train general practitioners, nurses, and social workers in mental health care and psychosocial support: a short and practical training. This number will depend on the size of the Chadian population and the prevalence of psychopathological disorders within the general population. In addition, the involvement of partners is essential for the success of such a training project, which requires the mobilization of human resources who are experts in mental health, resources generally not available at the level of the requesting country.

  Decentralize Mental Health and Psychosocial Support care in each province of the country. This strategy responds perfectly to the concern to integrate mental health care into primary health care in accordance with WHO recommendations.

- Provide Chad with a National Mental Health Policy to promote Mental Health and Psychosocial Support for populations.

Conclusion

The care of the mentally ill in Chad is currently of concern to all actors in the field of mental health. Until recently (1998), psychiatric assistance was not a priority for our country.
The mental health field is one area in which the country does not have enough resources in terms of nurses or, even less, doctors specialized in mental health, nor enough clinical psychologists able to fill the gap caused by such and such a situation.

The role that WHO should play in providing effective and sustained support for measures in favour of mental health and psychosocial support, as well as drug addiction prevention, is almost non-existent. WHO should provide funds for the implementation of the programme.

In this particular context, we launch a vibrant and strong appeal to International Organizations. Chad needs technical and financial support to implement its National Mental Health Policy to promote the population's mental health and psychosocial well-being.

OSAMA ELSHAFIE SIREKHATIM

DIRECTOR GENERAL OF PUBLIC HEALTH INSTITUTE IN SUDAN.

Integration of Mental Health Services Into Primary Healthcare in Sudan.

Situation of mental health services in Sudan

The design of the health care system in Sudan is based on primary health care and the "health area" concept, which is conceived as a decentralized health care system able to integrate at district level the existing vertical programs, including preventive, curative, and promotional activities. At village level, primary health care units represent the first level of contact between the community and the health services. Secondary health care is available in small towns through rural hospitals and urban health centers. Tertiary health care services comprise provincial, regional, university, and specialist hospitals.

There are 72 hospital beds and 19 physicians per 100,000 population in the public sector. In terms of primary care, there are 2031 primary healthcare clinics. These data are available only for the public sector. Health resources are strongly centralized despite the decentralization policy, i.e., 72% of physicians are based in the main city and the surrounding region, both of which congregate 16% of the country's population (2004 Census). The mental health system is hospital-based. For the last 5 years efforts have been made to shift attention to the community, but with limited success. Overall, mental health system resources are scarce and centralized.

Policy and Legislation

Sudan's mental health policy was last revised in 2008 and includes the following components:

(1) developing a mental health component in primary health care, **(2)** human resources, **(3)** involvement of users and families, **(4)** advocacy and promotion, **(5)** human rights protection of users, **(6)** equity and access to mental health services across different groups, **(7)** quality improvement, **(8)** financing, and **(9)** monitoring system. An essential medicines list is available in the country that includes all categories of psychotropic medicines. There is an additional component of reforming mental hospitals to provide more comprehensive care. There is no disaster/emergency preparedness plan for mental health.

The mental health legislation was established in 1998 and is currently under revision. A mental health act has been drafted and is waiting for approval from the parliament. The following components are included in the proposed legislation: access to mental health care, including access to the least restrictive care, rights of mental health services consumers, family and other caregivers, competency, capacity, and guardianship issues for people with mental illness, voluntary and involuntary treatment, law enforcement and other judicial system issues for people with mental illness.

Financing

The percentage of expenditures on mental health in Sudan is unknown. However, available funds are mainly oriented towards mental hospitals. There are no social insurance schemes, and psychotropic medication is available free only in emergency psychiatric care. The cost of the cheapest antipsychotic medication is 27% of the daily minimum wage, and the cost of the cheapest antidepressant medication is 18% of the one-day minimum wage.

Human rights policies

None of the mental health workers receive special training in human rights.

Organization of mental health services

A national mental health authority exists under the umbrella of preventive medicine and primary health care at the federal level. However, it needs strengthening. It provides advice to the government on mental health policies and legislation. It is also involved in service planning, management, and coordination. Mental health services are not available at the primary level or organized in primary health care service packages. The main strategic goal is to introduce care for mental health at the general service level, especially at the primary level. None of the mental hospitals are organizationally integrated with mental health outpatient facilities.

Mental health outpatient facilities

There are 17 outpatient facilities, of which 6% are exclusively for children (Gezira & Khartoum State). These facilities treat 110 users per 100,000 population. Of all the users treated in outpatient mental facilities, 48% are female. The proportion of children and adolescents among users is 8%. The users treated in outpatient facilities are primarily diagnosed with schizophrenia (16%), mood (affective) disorders (47%), and neurotic, stress, and somatoform disorders (10%). None of the outpatient facilities provide follow-up care in the community, nor do any have mental health mobile teams.

There is a lack of information regarding the patient's records in the health facilities. The information available often does not reflect the real situation of the current problems.

Moreover, there is still a great cultural barrier in seeking medical advice - most patients go to traditional healers, especially in rural areas. The average number of contacts per user is 1.47. None of the mental health outpatient facilities provide routine follow-up or community care. There are no mobile clinic teams that provide regular mental health care outside of the mental health facility. All mental health outpatient facilities have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) available in the facility.

Day treatment facilities

There are no day treatment facilities available in the country.

Community–based psychiatric inpatient units:

There are 9 community-based inpatient units available in the country for a total of 0.9 beds per 100,000 population. None of these beds are reserved for children and adolescents; 46% of the admissions to community–based psychiatric inpatient units are female, and 2% are children/adolescents. The primary diagnoses of admissions to the community–based psychiatric inpatient units include schizophrenia (32%), mood disorders (17%), personality and behavior disorders (15%), and neurotic, stress, and somatoform disorder (11%).

On average, patients spend 10 days in community-based psychiatric inpatient units per discharge. The proportion of involuntary admissions to community-based psychiatric inpatient units is 17%, while 11-20% of the patients were restrained or secluded at least once in the past year. Community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facilities or nearby pharmacy.

Community residential facilities

There are 7 community residential facilities available in the country for a total of 1.75 beds/places per 100,000 population. These facilities treat 1.79 patients per 100,000 population. 43% of the patients are female, and 37% are children. No beds are reserved for children and adolescents. On average, patients spend 39 days in community residential facilities.

Mental hospitals

There are two mental hospitals available in the country for a total of 0.86 beds per 100,000 population.
These facilities are integrated with mental health outpatient facilities.

None of these beds in mental hospitals are reserved for children and adolescents only. Thirty percent of patients treated are female, and 13% are children and adolescents. The patients admitted to mental hospitals primarily belong to the following diagnostic group: mental and behavioral disorders due to psychoactive substance use (10%), schizophrenia and related illnesses diagnostic group (15%), mood disorders (22%), neurotic stress-related and somatoform disorders (18%), disorders of adult personality and behavior (11%) and others, such as mental retardation, epilepsy (24%).

24% of the patients were involuntarily admitted, and 11-20% were restrained or secluded.
The occupancy rate of these hospitals is 20%.

The average number of days spent in mental hospitals is 35 days. All patients spend less than one year in mental hospitals. Some (21-50%) patients in mental hospitals received one or more psychosocial interventions in the last year. All mental hospitals have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility. However, such medications are not provided free of charge except in the case of psychiatric emergencies. The number of beds has increased by 62 % in the last five years.

CALEB KETTE

COORDINATOR OF THE NATIONAL PROGRAMME OF MENTAL HEALTH AND SUBSTANCE ABUSE IN CENTRAL AFRICAN REPUBLIC.

Overview of Mental Health and Psychosocial Support in Central African Republic.

General information

The problem of mental health and psychosocial support is a major public health problem in Central African Republic. The main relevant steps for the development of a mental health system have been:

- **2010:** Documentation.
- **2011:** Validation of the National Policy document of Mental Health and Psychosocial Support with a five-year Strategic Plan 2012-2017 (revised in 2019 with a three-year strategic plan 2019-2021).
- **2012:** Creation of the National Mental Health and Drug Addiction Program.

Promoting mental health, preventing, and treating mental, neurological, and psychosocial disorders, and fighting against drug addiction constitute a challenge for the Central African Republic.

National mental health and psychosocial support policy

The National Mental Health Policy outlines strategies for (I) Better mental health of the population; (II) Healthy lifestyles; and (III) Rehabilitation of people who suffer from mental disorders. **These should naturally contribute to improving their quality of life.**

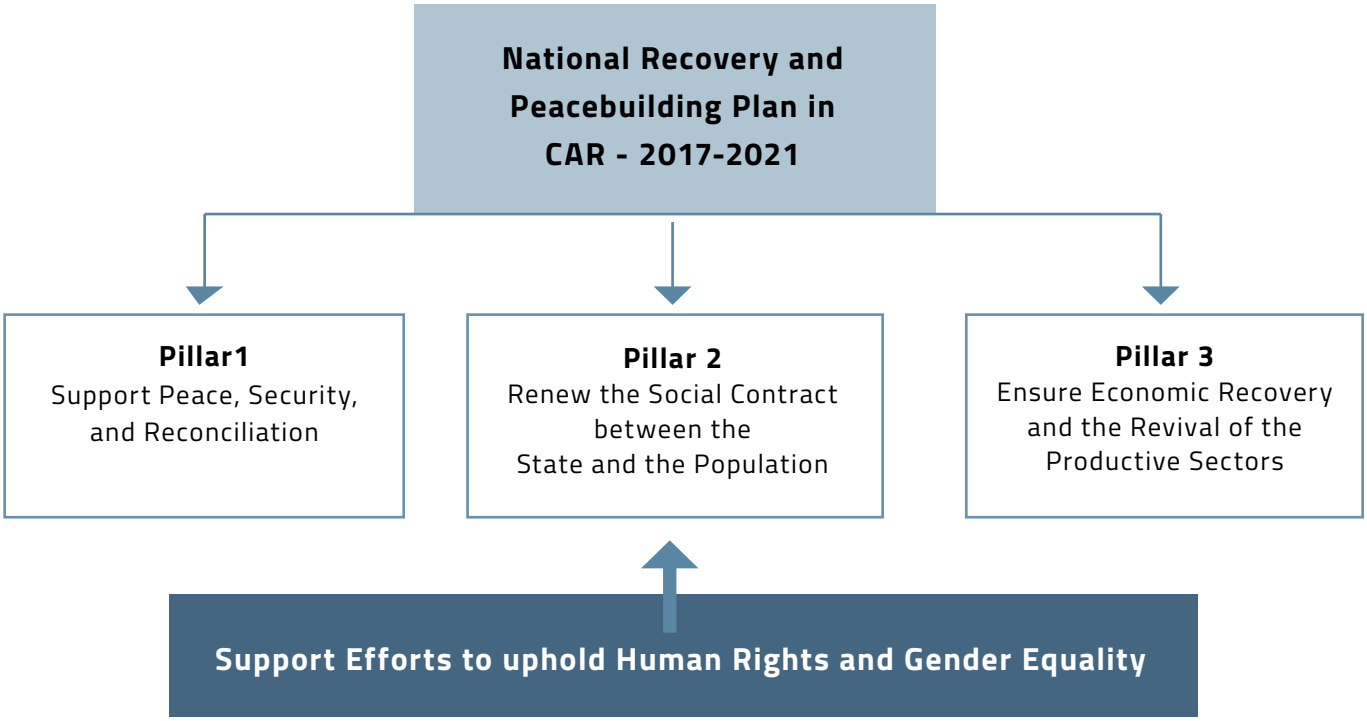
The National Mental Health Policy aims to: (I) Prevent and combat mental, neurological, and psychosocial disorders; (II) Contribute to improving the health of the Central African population by reducing the burden of mental disorders in the Central African Republic.

The main elements are the effective integration of mental health care into general care and the prevention and control of mental, psychological, and substance use disorders.

To implement this, the Central African Republic must integrate mental health into general health care by organizing different health system levels, infrastructures, and conventional or non-conventional human resources.

Background documents

A / National recovery and peacebuilding plan in Central African Republic



B. Sustainable development goal number 3

The CAR government's commitments to Sustainable Development Goal 3 (SDG-3):

Good health and well-being:

Empower people to live healthy lives and promote well-being at all ages.

Organization of mental health and psychosocial support services

Mental health is integrated at the primary healthcare level. The care of mental health disorders is concentrated at the CHNU in Bangui (psychiatric department): the only service for the country, with a capacity of 30 hospital beds. The CHNU has three main areas of activity:

Care – **Training** – Research. It includes the following qualified human resources:

1 psychiatrist, 1 clinical psychologist, 1 specialist nurse.

Elsewhere the service is offered by general practitioners, psychologists, and healthcare professionals who have received training in the care of mental disorders (Guidelines, mhGAP).

Social workers and community relays ensure social mobilization and promote mental health and psychosocial support at peripheral and community levels. The role of traditional healers and the support of NGOs add value.

Human resources

- Community relays
- Social workers
- Psychologists
- Psychiatrists

Key activities

- Raising awareness
- Identification of MHPSS issues
- Individual and family counselling
- Psycho-emotional support
- Primary and emergency care
- Interviewing
- Anamnesis
- Psychological examination
- Therapeutic Project
- Follow-up
- Referral and Counter referral
- Home visit
- Support group
- Information-Education-Communication
- Family psychoeducation
- Community based rehabilitation
- Healthy living

Challenges

The main challenges can be summarized as follows:
Firstly, there is an insufficient capacity for qualified human resources and infrastructure to meet the real need for mental health disorders.
Secondly, the absence of available tools for psychotherapeutic treatment (national guidelines/protocol etc.) and the availability of psychotropic drugs.
The third challenge is represented by local people's beliefs about MHPSS issues. Patients are usually abandoned or brought late to health facilities.
Those who suffer from drug addiction, mental or neurological disorders continue to be victims of discrimination and marginalization.
Even healed, they have integration problems.

Conclusion

The problem of mental health and psychosocial support is a major public health problem in the Central African Republic. The country has a National Policy document with a three-year Strategic Plan 2019-2021 and a National Mental Health and Drug Addiction Program. The government is also committed to Sustainable Development Goal 3 (SDG-3): Ensure good health and well-being for the population. Mental health problems and psychosocial support management must be essentially community-based. Many challenges remain to be met but can be transformed into opportunities.

ARTURO RIPPA

PSYCHOLOGIST, DIRECTOR OF THE RESIDENTIAL AND REHABILITATION SERVICE- EXECUTION OF SECURITY MEASURES, DAI DSM MENTAL HEALTH AREA, ASUGI.

Engagement and Co-production, the Personalized Project and the Role of Stakeholders, Users, Associations and Social Cooperatives.

Taking in Charge Persons with Mental Disorders and Complex Needs Using the Personalized Rehabilitation Therapeutic Project (PRTP) and the Individual Health Budget.

In describing the instrument of the Individual Health Budget and the Personalised Therapeutic Rehabilitation Project, it is necessary to start from the context in which these two tools find their greatest use.

In the work of a Community Mental Health Centre, taking in charge the person plays a central role in the development of his or her care pathway. The Mental Health Services are attended by people with different needs, which must be analysed in order to understand whether they are Simple or Complex.

Simple needs have the following characteristics:

- They are represented by "minor" pathological states, by forms of psychiatric and existential distress that require support, redefinition and/or psychotherapeutic work.
- Intervention: single operator (Nurse, Psychotherapist, Psychiatrist).
- Do not require a case manager.
- Have a limited time horizon.

Are not considered a "high load" for the Service Complex needs have the following characteristics:

- Severe and highly disabling psychiatric pathologies, with serious distress and significant family, social, economic, and legal difficulties.
- They require a customised, multidisciplinary project, which requires the activation and involvement, with varying degrees of intensity, of all resources, including those outside the Services.
- Identification of a case manager.
- The steps of the project are indefinite.
- They are considered as a high or very high load by the Service.

In both cases, priority is given to listening to the person's needs, and subsequently, a customised response is designed (the PRTP) to satisfy the needs and support the person on a pathway to autonomy.

In this paper we will deal with the latter: the complex needs. As it is possible to observe, the characteristics of complex needs make the person particularly fragile and suffering both on a psychiatric level as well as on a relational, work, and living environment level. "Complex needs" are a feature

of users with social disabilities resulting from psychiatric illnesses and socio-environmental marginality with a serious risk of social drift.

In taking in charge these persons, it is necessary to design a project, the PRTP, in which, in addition to their fragilities, the actions and objectives are also designed together by the treating team and the person, who work on the pathway to get out of discomfort and resume a life pathway as autonomous as possible.

The Personalised Therapeutic Rehabilitation Project can be supported/realised through the Individual Health Budget tool. Due to the high complexity of these projects, the support of associations and social cooperatives that collaborate with the Mental Health Departmental Area is needed.

The complex needs can be summarized into three axes corresponding to the main determinants of health:

- Housing.
- Sociality (and affectivity).
- Employment and Vocational Training.

In the Housing Axis, the aim is to promote the care of the individual and the living environment, as well as the development of possibilities and skills for independent living. There are different schemes of independent living which can be used and/or adapted in response to the personal need of the person. For instance, these schemes can provide variable hourly support throughout the day, carried out through close cooperation with the Co-ops, partners, guardians, support administrators, family members, voluntary associations and, through specific agreements, by public and private subjects. These schemes aim at creating effective pathways of emancipation and independence.

In the Social/Affectivity Axis, paths are built to promote and develop social skills and competences, aiming at building friendship, family and social relations and networks. Events and activities are promoted and/or designed in order to enable participation in cultural, expressive, educational, socialising, recreational, and sporting activities, which take place in spaces and times of normal daily life, i.e. in the contexts and places where people live.

In the Employment and Vocational Training Axis, it is necessary to create or recreate a sense of belonging to a social fabric. This means fostering a greater contractual power, access to the productive circuit, the achievement of social integration and independence from the welfare supports, aiming at a generative Welfare. The creation of opportunities and experiences of social and work inclusion in places characterised by real entrepreneurship, outside the psychiatric and mental health circuits is encouraged. The world of commerce and production, and vocational training schools are addressed.

All the projects here described are implemented according to the person's needs and requirements, customised and tailored to the complexity and specificity of their needs.

The actors dealing with the management of complex needs, put in place by ASUGI Mental Health Departmental Area, are various.

In detail, they start from the person, the central subject in the construction of his or her own Personalised Therapeutic Rehabilitation Project, and continue with the Community Mental Health Centre team, the Support Administrator, the Social Cooperatives, the Social Services of the Municipality, the family, the voluntary associations, and other actors when necessary. All actors contribute equally to build the Project and to implement it through the Individual Health Budget.

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CLINICAL PSYCHOLOGIST, PSYCHOTHERAPIST FOR CHILDREN AND ADOLESCENTS VICTIMS OF POST-TRAUMATIC STRESS DISORDER.

A Community Mental Health Service Delivery Model Called “Fracarita”.

Context

For several years, the Central African Republic has experienced recurrent crises of armed conflicts. Recently, in December 2012, a new rebellion arose in the country, once again traumatizing the peaceful population already long bruised. Most of the people affected live in the provinces, left to themselves without any support or psychosocial support.

In 2016, the Congregation of the Brothers of Charity made a firm commitment to accompany all these vulnerable people, the majority of whom are children, women, and elderly people, and set itself the objective of improving the quality of mental healthcare in the CAR, to eliminate stigma, discrimination, and exclusion, to put an end to violations of people’s rights.

Many people believe and think that symptoms due to psychological trauma are the effect of witchcraft. This is why the CEPSSM, through these mobile clinics in the provinces, is committed to raising awareness, training, and supporting the general public on the concepts of mental health and psychological trauma. The planned activities are based on a community-based approach to psychosocial support, which paves the way for the CEPSSM to approach communities that have suffered psychological trauma and provide psychological support in their own environment. In addition, community relays are chosen from among members of the same community.

They are trained on mental health modules, and the MhGAP recommended by the Ministry of Health of the Central African Republic and the WHO. These intermediaries, who enjoy the trust of the local population, in turn, raise awareness by going door to door. Similarly, children participate in recreational activities that build their mental and physical health.

Awareness work on mental health still remains a great field to be exploited. All symptoms related to mental health are considered to be witchcraft or mysticism. Fortunately, through media sensitization, the CAR population gradually understands that psychological trauma disorders can be cured. The training of community and religious leaders supports our efforts to help people who suffer from mental disorders or who develop post-traumatic stress disorder.

Mission of the listening and psychosocial support center « FRACARITA »

The core mission of the Listening and Psychosocial Support Center "Fracarita Brothers of Charity" revolves around nine points:

- Improve mental health services in CAR.
- Focus: children and adolescents suffering from PTSD.
- Promote integrated biopsychosocial care.
- Intensive follow-up and home visits.
- Socio-professional reintegration.
- Training of professional caregivers.
- Guidance and training of local key people.
- Develop partnerships with other partners.
- Restore human dignity.

Clients and Methodology

The Center offers its services:

- For children and adolescents suffering from post-traumatic stress disorder (PTSD).
- For patients with psychiatric problems (children, adolescents, and adults).
- For children, adolescents, and adults with epilepsy.
- For drug addicts.

In order to carry out all the psychotherapeutic, psychosocial, re-educational, and awareness-raising activities and obtain satisfactory results, the Center team uses the following working methods: Awareness, Training and Education, Mobile clinics, External consultations, Home visits, and the possibility of hospitalization (limited).

1. PREVENTION OF MENTAL DISORDERS

1.2 Survey data MSNA, September 2022/REACH

Severe Disorders	Two weeks before the survey June September 2022	People with at least one sign associated with mental health problems (June –September 2021)
Adult (Average) % of people indicated a state of distress that rendered them totally or almost totally inactive.	10% • Bossembélé 30.8% • Bozoum 27% • Bossangoa: 23.6%	7,3 % • Bossembélé 9,66% • Bozoum: 10 % • Bossangoa 10%
Enfant (Average) % children reported behaving strangely or suffering from convulsions/seizures	5.5% • Bossembélé 29.4% • Bozoum 26% • Bossangoa: 20.8%	7,3% • Bossembélé 4% • Bozoum: 4.6% • Bossangoa 5%

2. SEVERE SYMPTOMS

2.1 Survey data MSNA, September 2021/REACH

SEVERE PSYCHOLOGICAL SYMPTOMS	CHILDREN 5 YEARS OR OLDER	ADULTS
Anxiety	2,42%	2,63%
Concentration difficulties	1,91%	4,55%
Unexplained fatigue	8,25%	18,11%
Insomnia / Trouble sleeping	7,71%	17,86%
Chronic headaches	7,00%	15,78%
Sadness	7,80%	9,48%
Eating disorders / Refusing to eat	6,25%	4,38%
Lack of interest in any attivity / Hopelessnes	2,80%	5,92%
Palpitation of the heart	2,84%	9,43%

Between the activities carried out there are:

2.2 Outpatient consultations

Which include also patients coming from different regions of the Central African Republic. The number of consultations is dramatically increasing.

	FROM JANUARY TO DECEMBER 2021		FROM JANUARY TO JUNE 2022	
Sex	**numbers**	**%**	**numbers**	**%**
Women	2.214	39	1.499	43
Men	2.109	38	1.342	38
Girls	607	11	288	8
Boys	674	12	393	11

2.3 Hospitalisation

The number of hospitalized patients – as in 2020 – continues to increase. The need is still immense.
The CEPSSM is saturated by the number of patients hospitalized. The entire local population with mental health problems wishes to be treated and hospitalized at the center.
During 2021, the CEPSSM hospitalized 154 cases, and from January to June 2022: 138 cases.

	HOSPITALIZED IN 2021: **154 CASES**		HOSPITALIZED FROM JANUARY TO JUNE 2022: **138 CASES**	
Cases	numbers	%	numbers	%
New	92	60	68	49
Old	64	40	70	51

2.4 Mobile Clinics

The particularity of the Center lies in its community-based approach. Apart from home visits, door-to-door sensitizations, media sensitizations, and other focus group activities, the medico-psychosocial team organizes monthly mobile clinics during which epileptic children from various villages surrounding the city of Bangui benefit from medico-psychosocial care. Each mobile clinic has awareness on mental health and post-traumatic stress disorder, psychoeducation, and active listening. In addition, detraumatization activities are organized for the children of the village. The center team treated 1,017 cases in 2021 and 2,321 cases from January to June 2021.

FROM JANUARY TO DECEMBER 2021: 1.017			FROM JANUARY TO JUNE 2022: 2.321		
Sex	numbers	%	Sex	number	%
Women	276	27	Women	131	7
Men	240	24	Men	162	7
Girls	262	26	Girls	1.169	50
Boys	239	23	Boys	839	36

2.5 Home Visit

The community-based approach is the workhorse of the Center. Through this activity, the Center makes a difference in supporting its patients. Psychosocial care and medical treatment arrangements are not limited solely to the Centre. It continues in the patient's environment through home visits. The medico-psychosocial team made 541 visits and visited 1,479 households in 2021, and 301 households visited from January to June 2022.

FROM JANUARY TO DECEMBER 2021			FROM JANUARY TO DECEMBER 2022		
Sex	numbers	%	Sex	number	%
Women	429	29	Women	110	37
Men	323	22	Men	88	19
Girls	395	27	Girls	58	29
Boys	332	27	Boys	45	15

2.6 Awareness Raising

The media tool is our sounding board that spreads mental health promotion messages. Although the Center multiplies mass awareness and door-to-door, most clients – especially new cases – do not understand that a mental health problem is not necessarily due to mystical forces. They begin to take care of their case with traditional healers, witch doctors, and/or pastors before consulting the Center. They impose many prohibitions on patients, depriving them of certain foods without them being medical. Indeed, looking at mental illness from this angle comes from the local culture.

The psychosocial team reinforces its awareness in several media (radio, television, written newspapers) to reach a large number of the population, explaining to them the factors contributing to mental health problems. In 2021, awareness messages revolved around mental health promotion; CAR's National Radio and Television have played a significant role in helping to spread our messages throughout the national territory. During 2021, the CEPSSM organized.

FROM JANUARY TO DECEMBER 2021			FROM JANUARY TO JUNE 2022		
- 1 awareness raisign campaign in school - 5 mass awareness - 54 media campaigns			- 1 awareness session - 20 media campaigns		
Sex	**numbers**	**%**	**Sex**	**number**	**%**
Women	207.556	44	**Women**	51.816	45
Men	178.583	38	**Men**	59.646	51
Girls	46.357	10	**Girls**	2.364	2
Boys	40.772	8	**Boys**	2.695	2

2.7 Education

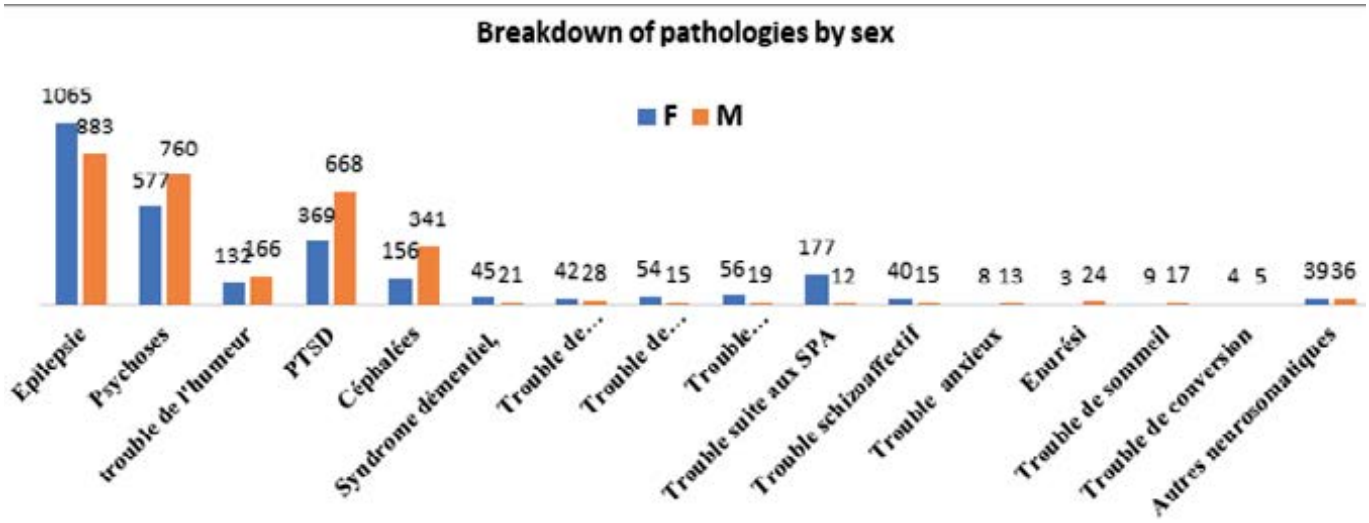
Staff training at the Center continues as provided in the schedule of activities.
The absence of a training school for qualified personnel in mental health in CAR obliges the management team to continue training for its staff (administrative, care providers, psychosocial agents, community workers, hygienists). They participate in training according to the themes and the category of personnel. Administrative staff, community relays, hygienists, and wardens participate in mental health promotion training. Psychosocial agents and care providers focus on medico-psychosocial care. Beyond the training of its staff, the Center also trains different figures.

TARGET GROUPS	TOPICS
- Community Leaders	- Post-Traumatic Stress Disorders
- Traditional Healers	- Mental Health
- Religious leaders	- Traditions and Mental Health in CAR
- Teachers	- Drug Addiction
- Youths	- Community Mental Health
- Youth Movements	- Semiology in Psychiatry
- Fraternities	- MhGAP
- Military, Gendarmes and police	- Generalities about Mental Health and Post-Traumatic Stress Disorders

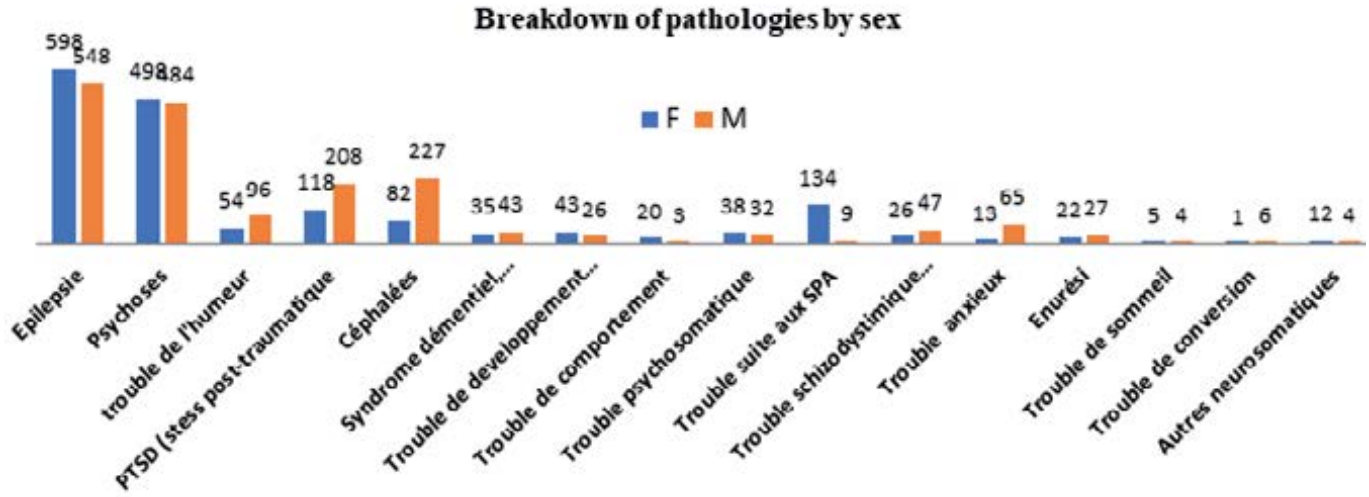
3. DIAGNOSTIC PATHOLOGY

3.1 Survey data MSNA , September 2022/REACH

IN 2021



B. FROM JANUARY TO JUNE 2022



Difficulties encountered

- Very few RCA partner organizations working in mental health
- Problems related to beliefs, cultures, and myths
- The general problem of malnutrition
- Low adherence to treatment: high rate of relapse
- Difficulty in supply of psychotropic drugs
- Difficult accessibility due to the poor road network on the outskirts.

Conclusion

In 2022, people suffering from mental health problems in the Central African Republic are still facing severe problems: (I)Poor state of respect for human rights in the CAR, (II)Massive lack of access to care and treatment, (III) Exclusion, discrimination, and stigmatization, (IV) Massive shortage of mental health professionals, (V) Mental health services are mainly lacking, (VI)The reality of traditional and religious healers, (VII) Weak and ineffective mental health governance structures.

ARSÈNE EYENGA

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Coordination of Mental Health and Psychosocial Support in the far North Region of Cameroon: Meeting the Challenges, Building Bolutions.

Introduction

The Far North region of Cameroon normally enjoys rich trade with Chad and Nigeria, its two bordering countries. Its Sudano-Sahelian climate (intense heat and abundant but short rains), its relief made up of mountain and river plains and desert, and its ethnic diversity constitute a strong potential for tourism, trade, and art (INC, 2000). But for almost a decade, incursions by the jihadist sect Boko Haram, through predation, assassination, attacks on military positions, looting, kidnapping and ransom demands, have created, revealed and/or amplified other risks that have made this region a multidimensional humanitarian crisis zone: insecurity, destruction of infrastructure, refugees and internally displaced persons, intra-community conflict, gender discrimination, drought, low literacy rates, and difficulties in accessing basic resources.

To support the State of Cameroon in assisting the many Nigerian refugees and IDPs, several local and international non-governmental organizations are providing concrete support on several fronts: Health, Protection, Water and Sanitation, Shelter, and more timidly in Mental Health, which remains the poor relation of health. Recently, since March 2021, under the impetus of the International Organization for Migration (IOM) and with the leadership of the Ministry of Public Health (regional delegation), more than 25 state and non-state actors have been able to federate around the creation of the regional technical group for mental health and psycho-social support in the far north. Its goal is to coordinate, consolidate, and improve the multisectoral response of mental health stakeholders, according to the IASC (Inter-Agency standing Committee) in the perspective of the humanitarian-development-peace nexus. With members present in nearly four of the six departments in the region, its objectives include: supporting coordination, mapping actors, sharing data and approaches, assessing needs, building a global strategic orientation, strengthening actors' skills, advocacy, mobilizing resources, etc.

However, despite this commendable effervescence around mental health, the difficulties of coordinating actors, resources and intervention constitute a major challenge to the effectiveness of actions in the field, whose resources are already scarce compared to other types of intervention. These difficulties can be divided into three categories, the first of which is related to cultural representations of mental health and potentially contains the others, including those related to the financing of the intervention, and those related to the practice/intervention/implementation of the activity.

I. Cultural representations of mental health (meaning, significance, value, actions).

1. The strangeness of mental health.

Mental health remains strange because of its intersection between the biological, the psychological, the socio-cultural, and the magical-religious. In fact, because of its history, it is a syncretic precipitate of most of the knowledge in human sciences and exact sciences from which it has benefited during its elaboration: philosophy, sociology, anthropology, mathematics, physics, robotics, conventional medicine, hypnosis and traditional knowledge of all kinds. Moreover, the object of its study, the psychic processes and the mental states at the origin of the behavior, remained since the advent of the Cartesian rationalism (1637) and that of the separation of the Church and the State (1905), something marginal (invisible, impalpable, subjective, irrational, imaginary, uncertain) of mysterious (sacred, celestial, demoniac, dangerous, little comprehensible). In the eyes of the lessor, the political, the administrative, the technical, and the beneficiary, regardless of the culture, the era or the region, mental health is devalued in many ways. Prejudices, discriminating stigmatizing attitudes, both of the corpus, the caregivers, and the sufferers. Mental health equals mental illness, madness, asylum, demonic possession, transgression of the prohibited. And the fate that is reserved for it is exorcism in all its forms. Rejection, ex-communication, eccentricity, putting aside, forgetting, in a word, the repressed. Any cultural tradition that is apparently out of step with the modern psychiatric approach suffers the same fate. There is no real participatory approach that involves the most influential leaders of the community, such as traditional practitioners, traditional leaders, neighborhood chiefs, religious leaders, traditional birth attendants, etc. (ACF 2022). They see their approaches excluded from the health care system, although they are consulted by 80% of the population (Sow, 1978). However, the object of its study (processes, mental states, and behaviors) is at the heart of human and ultimately social activity, it is a transversal activity that can pronounce itself, not on all aspects of life, but on all attitudes and reactions that man proposes to them in terms of adaptive response. How do Man and society mobilize their resources to face the need and the change? Is this way of doing things efficient, healthy, and sustainable in the medium / long term? Is it accessible and available to the majority? If not, how, on the basis of what, from what benchmark, and for what purposes, can it modify its adaptation according to its culture? These are the fundamental questions at the heart of mental health. It is, therefore, urgent and regular to work on deconstructing these harmful cultural mental representations of mental health, by allowing and offering everyone the possibility of directly expressing their perceptions and beliefs, and confronting them with facts, experience, and explanations. Strategic workshops to exchange, share and clarify mental health's meaning, significance and values could facilitate action and participatory engagement of sufficiently informed key players. This process of behavioral change could be monitored, evaluated and adjusted by technicians in the field in order to respond in a concrete way to the problems posed by this initial resistance, which is the foundation of all the ills of the coordination of interventions.

2. Reduction of mental aspects to illness and medication and misunderstanding of the proportion of people concerned with mental health or having problems related to it.

Mental illness, medication, and the asylum are the most well-known and reductive signifiers of the mental health field. This contributes, on the one hand, to creating and maintaining psychiatry in control of decisions related to care; in a tacit conflict with psychologists and psychology in need of recognition and challenging the

abuse of medication. Indeed, psychological or psychotherapeutic foundations remain a minority in university training and supervision, psychiatric intervention, and humanitarian intervention in general, whereas they underlie all psychosocial interventions. On the other hand, all the psychosocial aspects (promotion, stimulation, support, individual and community resilience building) are not well understood as being part of mental health and are not sufficiently supported. However, psychosocial support is the best preventive and curative mass response to distress (malaise, feelings of powerlessness, abandonment, and loneliness), and to the scarcity, difficulties of access, unavailability and instability of the supply circuit of expensive drugs, the rupture of which causes relapses, and many people are lost to follow-up.

Moreover, the claim of the psychosocial concept by the protection cluster ultimately makes it a catch-all, where the tools, the target, the philosophical approaches of intervention, the interventions, and their purposes, need clarification despite a similar vocabulary.

A discussion of clusters and Health and Protection for a clear and consensual definition of psychosocial, its object, its purpose, its actors, and its tools could already give higher visibility to these mental health interventions that do not appear in official state documents, even though they are low cost with beneficial impacts on the long term.
It would also be wise to think about setting up a local laboratory for the manufacture of medication.

II. Insufficient funding/budget for MHPSS interventions and research.

The bulk of the funding for an MHPSS program often resides in staff capacity building (training, supervision), psychosocial activities in the community, and medication. However, the cultural representations mentioned result in a low representation of field workers, of the order of 1%, as opposed to 10% of the needs. Research could easily demonstrate the importance and effects on individual, collective, and socioeconomic well-being. However, a poor understanding of the difficulty of the research process means that a lot of data and field experience remains untapped. A simplified research protocol document and framework for implementation with key stakeholders could allow for more funding to improve the quality of the intervention and the number of stakeholders while increasing the importance and impact of the intervention.

III. Practices

1. Difficulties in understanding, transmitting and operationalizing basic MHPSS concepts and interventions.

The acronym PSS is in vogue, everyone is talking about it and making it their own. But in the field, the specialized nature of the intervention, the complexity of the simplification of the concepts to be conveyed, and the particularity of the biopsychosocial approach, mean that the assimilation, transmission, understanding, integration, and appropriation of the concepts is slow, difficult, and not very effective. This is true both on the side of the "actors" of the accompaniment, of which very few are specialists, and on the side of the beneficiaries, whose concepts and cultural practices are different, devalued and not taken into account in the exchanges. Other direct consequences of the disparity of the concept of PSS, between protection and health, are the absence of centralized and approved documents on the subject, interventions without indicators of change, disharmony and duplication of interventions with different names for similar

content, and finally the ineffectiveness of the interventions in solving in the medium term the mental health problems targeted. It would be useful, within the actors who claim to be part of MHPSS, to harmonize at least the definition of concepts, the choice of research tools, the intervention tools and the monitoring and evaluation.

2. Chronic stress among humanitarian actors.

The pressure to achieve good results on time, without providing staff with the necessary support and accompaniment to carry out the tasks requested, and without considering the permanent and contradictory contingencies, are legion in the humanitarian sector. Between the organization and the employee who mutually reject the responsibility of burnout (Grosjean et al.; 2016), the quantity, the intensity and the pace of the activities come in opposition to the natural rhythm alternated by the body between activity and passivity (Dejours and Gernet, 2012), installs an uneasiness both institutional and individual. But out of nearly 25 NGOs in the region, only one has formalized support for the management of stress and well-being of the workers.

While emergency interventions are quick and brief, they are also superficial and uncoordinated due to a "navigation à vue", too much improvisation to what comes up that gives priority to the operational over coordination. It would be interesting to develop/update/ a "double speed" system and to popularize a two-level work system, one substantial and sustainable; and the other fast, momentary, and superficial, to allow teams to deploy on the field but to think in depth and calmly about interventions. In addition, to break this cycle of emergency intervention, which leads to emergency intervention, formalized support for organizational mental health and psychosocial risk management could be an integral part of safeguarding.

3. Beneficiaries drop out at the end of the project.

On the whole, humanitarian interventions in the Far North remain emergency interventions with no pretension to development. Also, there are almost never any indicators of beneficiary empowerment. Despite the involvement of the state in the continuity of activities at the end of the project, the lack of funding and/or interest in mental health means that beneficiaries are left to fend for themselves. Thinking about developing Community Mental Health to empower the community in basic MHPSS interventions, by training focal points of each intervention, and supervising them along the project, and discussing with the community how these could be integrated into the social economy dynamics, could mitigate the agonies of project termination.

Conclusion and Perspectives

Community mental health is a set of endogenous and/or exogenous practices aimed at promoting, protecting, and strengthening the psychosocial well-being of individuals and community support structures; and at preventing and treating mental disorders in the community by the community.
To do this, it requires:

1. Taking the time to involve all stakeholders in the design, development, implementation, monitoring, evaluation and sustainability of interventions: Donors, political, administrative, technical, and civil society organizations, key community actors, patients, and their families. In a real encounter of knowledge, culture and expectation, where the scientist, under the pretext of modernity and superiority, does not try to subjugate traditional knowledge, to evacuate it or to restrict it to his objectivist ideal (Mbonji, 2017). "Yes to rationalism, provided that it goes to the end of its requirements and takes up the challenge of all phenomena, even what is called paranormal" condition sine qua non to begin a minimum transition towards the intelligibility of black knowledge. (Hebga, 1998). Participatory work that avoids the construction of a victim identity for the beneficiaries and maintains a healthy dynamic tension between tradition and adaptation. (IOM, 2021).

2. To build a mental health policy based on the updated values/background of the traditional African universe, with signifiers that are understandable, accessible, valued by all, and operational in the community (Sow, 1978), reducing the sense of strangeness of interventions, and reinforcing a sense of identity and continuity (IOM, 2021). A policy that directs the scientific and technical towards harmonized, practical, and collective solutions adapted to the contingencies of the environment (Djemo, 2009). A holistic vision that embraces both institutional and organizational mental health, including work-related psychopathology (Dejours and Gernet, 2012) and work-related psychosocial risks (Grojean et al.; 2016); mental health for groups, families, and individuals; and that promotes research and experimentation.

3. To prioritize multidimensional and cultural approaches that link the body, language, social and relational insertion: Psychodrama, sociodrama, body therapy, systemic approach, etc. (Djemo, 2009); and to strengthen the training of community focal points who are custodians of this knowledge and who ensure the transmission, monitoring, evaluation and adjustment in the community of this minimum set of services that will create in each house a general practitioner under supervision.

4. To bring the basic MHPSS concepts and interventions into the daily life of the community in the form of a minimum service package, and this in the sensitive and key sectors for development: Perinatal, Education, Food, Education, Youth, Medicine, Labor, Art, etc.; so as to balance and match the level of knowledge with the level of socio-economic development, favorable to the collective flourishing of all sectors. (Djemo, 2009).

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DIDIER DEMASSOSSO

MENTAL HEALTH ADVOCATE AND CLINICAL PSYCHOLOGIST.

Leveraging Lived Experience: The Case of the Cameroonian Association of People Living with a Mental Health Problem.

Introduction

Mental health development in Cameroon has changed markedly since the past decade. A total mental health revolution is ongoing (Demassosso, 2021). The dynamics of this change have been systematic and consistent. Strong motivation, collaborative and result-based initiatives both from the public and private sector together and separately have been key to this revolution (Demassosso,2021).

In this revolution, private-public collaboration has been instrumental in enabling major milestones in building the elements of a mental health system in Cameroon (e.g., mental health policy, advocacy, and promotion). INGOs and local associations are having growing space to provide for mental health needs of users - e.g., HIFA, MHIN Africa, ACPAP-SM, UNIPSY et Bien-etre, Soins Psy Sans Frontier, RAPHA-PSY, CBHS...-(Demassosso, 2021). Community-based mental health care is gradually emerging in Cameroon (Mvianna et al., 2020).

However, the absence of a mental health legislation is depriving people living with a lived experience of mental illness of their right to mental health in most regards (Ngasa, Demassosso, Chang and Etienne, 2022). Stronger political will for mental health development is growing steadily (Mvianna et al., 2020; Ministry of Economy, Planning and Regional Development, 2020), but concrete actions to prioritize mental health remain largely insufficient. Especially universal coverage for mental health which will enable greater access and availability of mental health care services for all.

Moreover, substantial investment in mental health development is quasi-inexistent. This affects mental health service development, service delivery and mental health service utilization. There is a great need to make mental health a cause for social action. In this line, mental health advocacy is paramount to breaking the hindrances to mental health for all. "Advocacy is the combination of individual and social actions designed to gain political commitment, policy support, social acceptance, and systems support for a particular health goal or programme" (24th IUPHE World Conference on Health Promotion, 2022). Mental health advocacy is "comprised of a range of actions designed to change aspects of attitudes and structures that impede the achievement of positive mental health in populations" (WHO,2003 p.9). Awareness-raising, information, education, training, mutual help, counselling, mediating, defending, and denouncing are advocacy actions (WHO, 2003, p.2).

This current work positions itself in a new perspective of mental health research in Cameroon, which focuses more on describing the processes of the development of the mental health field rather than studying interventions or epidemiology of mental health conditions and mental health promotion activities.

As Touguem et al. (2022) state, this research is in the perspective of a "research-based advocacy". The aim of the study was to describe how mental health advocacy has developed. Specifically, on the one hand, the author wanted to show the evolution of mental health advocacy in Cameroon through the work of the Cameroonian.

Association of People Living with a Mental Health problem (ACPAP-SM). The founder of ACPAP-SM, Blaise Talla, is the first contemporary mental health advocate with a lived experience of mental illness in Cameroon. On the other hand, the online advocacy work of the author and in mainstream media (radio and television). What is the state of mental health advocacy in Cameroon, and how has it evolved? This research question is set to discover the mental health advocacy actors in Cameroon.

Materials and Methods

Descriptive, explanatory, qualitative research, and the historical method. Observation and description of mental health events over a period of 12 years 2010-2022). Reflecting, analyzing, and evaluating as an eyewitness and participant in the events and interviewing two contemporary people with a lived experience of mental health in Cameroon who served as participants to the study were recruited and belong to the oldest and likely only Cameroonian Association of people living with a mental health condition. Then comparing their experience with our own experiences of the shared mental health events. The participants were chosen based on their experience and closeness with the mental health system as mental health users and involved in civil society work. In fact, the events and experiences that make up this study have been lived with greater awareness, consciousness, and intentionality. Photos of the mental health events were taken by the author himself to systematically record the events lived. The author was the photographer in the events he lived and could record what Blaise Talla was doing, using photography (Collier, Jr J., and Collier, M.,1967).

Results

We could identify a list of important mental health events participated by the Cameroonian Association of Persons Living with a Mental Health Problem. The author also participated in these events. These spaces were for both parties spaces to advocate for mental health.

1. International Forum for the promotion of psychological and psychiatric care 2014 in Douala.
2. First Cameroonian days of mental health 2015 in Yaoundé.
3. Second Cameroonian days of mental health 2018 in Yaoundé.
4. First Mental Health and Psychosocial and Disability Policy Forum 3rd December 2021 in Yaoundé.
5. Mental Health Legislators Forum (MELEP) 3rd December 2022, Jamot Hospital, Yaoundé.
6. Meetings of ACPAP-SM in Jamot hospital.

Discussion

There is a paucity of literature specifically on mental health advocacy in Cameroon even though it is mentioned in a few articles we could identify in google scholar after several searches. Nonetheless, the author has embarked in trying to inform, educate, denounce, and raise awareness about mental health issues in Cameroon (Demassosso, 2019; 2021; 2021, 2021; 2022).

The history of mental health advocacy (MHA) in Cameroon is recent. Nonetheless, in just a few years, MHA has played an important role in leveraging mental health at various levels of its actions and framework development (especially online in Community of Practice and online communication over social media like Facebook, WhatsApp, Twitter, and LinkedIn) in Cameroon. Mental health awareness has greatly improved since the past five years. Individuals play an important role in mental health advocacy (24th IUPHE World conference on Health Promotion, 2022).

The role of persons living with a mental health condition in Cameroon's mental health development took a prominent turn in 2006 with the creation of the Cameroonian Association of Persons Living with a Mental Health Problem. Blaise Talla, a 45-year-old married man suffering from bipolar disorder, founded the Cameroonian Association of Persons Living with a Mental Health Problem. Blaise Talla and his association individually and in conjunction have made actions that indicate the importance and need to engage several stakeholders using a socio-ecological model in mental health advocacy (Thompson, J., N. McGee, E., R. and Walker, R., E., 2015).

Unfortunately, there is not yet a common language for all mental health actors on how mental health users should be serviced. This is affecting the direction of the development of the mental health system. What services? For whom? Moreover, how should they be organized and delivered? My work, amongst many other things, has been to advocate for mental health and engage policymakers, populations, health professionals, journalists, educators, and mental health users in prioritizing mental health in Cameroon.

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FIDÈLE NDGUITARA

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Addressing Mental Health and Psychosocial Needs in Humanitarian Crises: The Lake Chad Basin Case Study.

General context of the humanitarian crises in Chad

Chad is facing persistent humanitarian issues related to growing insecurity in certain parts of the territory and neighbouring countries and socio-economic, health, and climatic challenges in a context of political transition. Exposure to the effects of climate change, the extent of violence perpetrated by armed groups in the Lake Chad Basin region, the fragility of the security situation in neighbouring countries, and inter-community conflicts in a context of underdevelopment perpetuate the humanitarian situation in Chad.

Introduction related to the crisis in the Lac Province

The populations of Lake Chad are confronted with a crisis with multiple factors that impact their psychic life and generate mental, psychotic, depressive, or neurotic disorders. If, in this context, the federation of resources and skills is more than ever valued by the place given to speech and the relief of suffering, what is the effective response given to these people?
Since 2015, the attacks and violence orchestrated by the Boko Haram State in the Lake Chad Province have caused a politico-socio-security and humanitarian crisis with long-term negative effects. Lac province continued registering new IDPs following sporadic attacks on villages by non-State armed groups and military counter-offensives.

Figures and people affected

The number of internally displaced persons reached 406,573 people, 29,263 returnees from Niger and Nigeria and 26,937 former internally displaced returnees, which shows an increase of 16% compared to the situation in December 2020. These displaced people occupy 223 localities, including 167 sites and 56 villages in three out of the four departments of the Lac. There are over 6,000 former Boko Haram associates in the communities. Alongside these internally displaced persons, 18,995 Nigerian refugees have been living in the Dar es Salaam site in the Baga-Sola area since 2015.
Population Movement Monitoring Statistics (DTM developed by IOM) show that 29,263 returnees from Nigeria and Niger are in displacement sites in Lac. These people who had left Chad during their childhood, even for generations, have no knowledge of their areas of origin and remain in transit while waiting for the Government to find solutions for their socio-economic integration.

Alongside these returnees, 26,937 former displaced persons have returned to their villages of origin. They face socio-economic reintegration in the face of the absence of social infrastructure and the advanced state of dilapidation of their dwellings.

Insecurity has caused a strong deterioration of the socio-economic fabric of the area, with a loss of production capacity or resistance to shocks.
The ban on fishing, agriculture, and livestock activities

in areas classified as insecure has affected people's livelihoods, reducing their ability to meet their basic needs. These people need support to rebuild their livelihoods and strengthen access to basic social services (schools, health centers, drinking water, market, etc.).

Impacts on people's lives

The exactions caused by Boko Haram and the restrictive measures from the authorities in Lac, the effects of which add to the structural constraints (the islands), have caused massive displacements of people and disruption of families, communities, and social and community services in perpetual deterioration in the province.
These displaced persons are mainly women and children, generally live in often poor host communities, lacking adequate absorptive capacity in terms of livelihood and social services to meet the basic needs of newcomers may therefore lead to repercussions on the lives of members of the host communities and the newcomers in psychological and social terms.

This insecurity is at the origin of the constant movements of people to other sites where the military is present to ensure security. During these movements caused by attacks and the fear of being killed, people on the move are in traumatic situations (hindering their mental health and psychosocial well-being: (theft, physical or psychological violence, exploitation, human trafficking, detention).

These situations have a heavy impact on the well-being of people, both adults and unaccompanied minors, and lead to feelings of sadness, frustration, despair, and fear, with consequences ranging from isolation to death, including the inability to reintegrate, sometimes in new sites.

Activities implemented Partnership

Given the precariousness and the volatile nature of the crisis, it will be better to federate the resources, that is to say, the staff and the premises, in order to sustain the actions to achieve our objectives in these terms:

- Training AFJT staff on the implementation of psychosocial activities and the minimum standards of psychosocial support and mental health.
- Training social and medical workers on the Interagency Steering Committee Guidelines on Mental Health and Psychosocial Support in emergencies to have a synergy of action that can allow assistance at all levels at the Province level Lake.
- Training local, traditional, and religious leaders on Psychological First Aid, experience sharing, and referral mechanisms to serve as an interface between the beneficiary community and the humanitarian actors.
- Training members of women's groups, main actors already trained on basic notions of human rights, psychological first aid, sharing of experiences, and referral mechanism to identify affected people to support them.

Direct action

The composition of the mobile psychosocial team includes psychologists, nurses, social workers, anthropologists, and sociologists:

- Home visit.
- Psychological first aid.
- Recreational and fun activities.
- Speaking group.

Constraints and difficulties for humanitarian action

The current context of the crisis in Lac is characterized by the volatility of recurrent attacks by Boko Haram, and certain areas are very risky to start certain humanitarian activities for all actors. Added to this is the lack of funding.

Recommendations

To follow up on the results presented above, we are formulating recommendations in the form of concrete actions according to the specificity of this crisis in the Lac Province. Due to the precariousness in this region, it is very important to have sustainable and long-term interventions to support the development and establishment of a functional system. The implementation of these recommendations will undoubtedly help to better address psychosocial problems.

For humanitarian actors in the Lac Basin (Lac Province):

- It would be desirable to develop a project that focuses on directly providing social, recreational, and counseling services through different community, psychosocial, artistic, and clinical approaches to serve as a pilot and develop an in-depth psychosocial needs assessment for all the localities of the Province. In terms of services, it is recommended to meet the community and clinical needs of the population through an integrated approach.
- Given that the Lac Province is in perpetual crisis, it is very important to have sustainable and long-term interventions to support the development and establishment of a functional system of assistance in the field.
- It will be necessary to strengthen existing resources and build or strengthen the capacity of local professionals and actors to respond to medium and long-term needs, to guarantee the project's sustainability.

In terms of capacity building, it is recommended to act at three levels:

- Involve and provide technical and financial means to the working group on mental health and psychosocial support in the Lac Province.
- Synergy Include in SMPS programs spaces for listening and talking for psychosocial workers by creating partnership agreements between NGOs to guarantee the sustainability of activities.
- Supports disengaged women and other community members in income-generating activities and socio-economic and community reintegration.

For decision makers and government:

- Strengthen and expand community mental health services through their integration into primary health care, including those located on the outskirts of cities and in rural areas.
- Train primary health care workers to provide integrated care in community health structures and develop the supply of home care.
- Reinforce training psychiatrists, psychologists, specialized nurses, and psychosocial workers to have qualified human resources in the various health facilities, particularly in the areas affected by the crisis when the security situation allows it. Ensure that specialized mental health professionals are assigned to priority locations and that, once in place, they are not reassigned.

Conclusion

Mental health and psychosocial support, it should be remembered, is a state of well-being in which person can fulfill themselves, overcome the tensions of life, perform productive and fruitful work, or contribute to the community's life. It is, therefore, an essential and inseparable element of the life of the entire population. It represents a significant global burden of disease and concerns all sectors of activity and all age groups and therefore deserves special attention. In Chad, in general, the mental health and psychosocial support sector still needs to improve the relation of the health sector on many points, in particular organizational, human resources, care and infrastructure provision, and training.

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Mental Health of Children and Youth with Intellectual Disabilities and the Challenges of their Integration in the Society.

Al-Farouk Center for Rehabilitation of People with Special Needs was founded in June 2014 and recognized by the Ministry of Education Department of Special Education (Elementary School) of Sudan in the same year.

It has become one of the major centres contributing to the well-being of people with disabilities in Sudan. Our mission is to participate in integrating people with mental disabilities into a healthy society in a positive way that affects and is affected by it.

Objectives

1. Providing opportunities to rehabilitate people with special needs skills through vocational training labs such as gardening, handcraft, and providing integrated services that make them self-independent.
2. Providing educational opportunities that suit their abilities and needs.
3. Contributing to raising social awareness and reducing social stigma.
4. Contributing to their social integration and highlighting their effectiveness.
5. Contributing to discovering and showing their creative side and helping them express themselves.
6. Contributing to the training and skills development of some of the main stakeholders in the field (such as the family, Teachers, university students, and those interested in the field).
7. Targeted groups: Children with intellectual disabilities, Families of children with intellectual disabilities, workers and stakeholders related to the field, and the society.

Types of intellectual disabilities in the Center: Down syndrome, Autism, Learning Difficulties, Hyperactivity.

The center works to provide several services designed around the following daily activities:

- Skill development.
- Behavior modification.
- Speech therapy.
- Occupational therapy.
- Family counselling and guidance.
- Academic class.

The Center implements many activities mainly to develop the students' skills and participate in their integration into society.

The main objectives of these activities are:

- Improve students' skills regarding concentration, attention, and movement problems.
- Improve sensory and communication skills.
- Support them in expressing their feelings.
- Support their integration inside the community.
- Develop their skills to include them in the job market.

Challenges:

During all these years working in the field of disability, there were many challenges at all levels.
Challenges facing the persons with disability themselves: Health issues, Accessibility, Stigma, Lack of self-confidence, Bullying, Lack of education and employment.

Challenges facing the families: Stigma, Psychological trauma, and Economic problems.

Challenges facing our center: Lack of support from the government, the small space of the center, Lack of opportunities for the students after graduation, in education, and the labour market. The lack of funding is threatening the future of the center.

Challenges created by the society: Stigma, Physical and psychological bullying, Rejection and non-acceptance in society, rejection of their inclusion inside ordinary schools, Lack of opportunities regarding employment.

The activities:

Handcraft: Hand craft unit includes many activities inside, such as accessories, painting, leather products, kroshi and recycling activities.

Theater and Music: The main goal of these two activities is to develop the student's skills in communication and self-expression.
All the plays focus on behavior-changing activities.
Vocational training activities: gardening, carpentry, cooking and bakery, computer, pottery, tailoring. The main goal of these activities is to provide students with skills allowing them to be included in the working market.

Sport: This activity helps students get good physical fitness. In 2022, we presented professional-level sports champions in different sports such as running, bowling, volleyball, weightlifting, boccia, etc. Our students won several medals in running, weightlifting, volleyball, and bowling.

ISRA ABDELLATIF

CORPORATE COMMUNICATIONS DIRECTOR AT CTC GROUP SUDAN.

Importance of Workforce Wellbeing in the Private Sector.

CTC Group is a privately owned, socially responsible group of companies that has been working on raising awareness around mental health in Sudan.

There is a common misconception that mental health is only a Western concern. That it is only something people in developed countries need to worry about. That it is not an issue for people in emerging markets like Sudan. In fact, stress is universally taxing and can be mentally, physically, and emotionally draining and exhausting. It can make people feel negative about their job and their personal relationships. It can cause them to lose focus on their goals or forget about their responsibilities. Furthermore, all these things lead to feeling unhappy and unproductive at work. In fact, Mental health today is still a taboo subject in Sudanese communities.

CTC Groups Mental Health Program (CAN) focuses on three elements: Collective (collective work), Acceptance (no one is left behind), and Normal (it is ok not to be ok).

The past three years for Sudanese people have been extremely difficult with the revolution, the COVID 19 pandemic, and the current political instability. To add salt to injury, the cost of living has increased by 300% dollar-wise for the first time.

10th October, as Mental Health Awareness day, we organized five sessions on different topics every Monday, including Kids & Parenting Issues; General Mental Health; Relationship Issues; Value Consciousness & Acceptance; How Tradition & Culture Affect Our Mental Health.

These sessions aimed to shed light on our CAN initiative—it is a collective work where everyone is accepted, and no one is left behind; it is perfectly normal and ok not to be ok.


It's OK
not to be ok
You matter
It is Ok not to be Ok


It is Ok not to be Ok
You matter
It is Ok not to be Ok
You matter
It is Ok not to be Ok

TOMMASO BONAVIGO

PSYCHIATRIST AT DAI DSM MENTAL HEALTH AREA, ASUGI

The Quality Rights Programme and the Multisectoral and Multilevel Approach in Mental Health.

Following the 1948 Universal Declaration of Human Rights, the United Nations adopted on 13 December 2006 the Convention on the Rights of Persons with Disabilities, which promotes, protects, and ensures the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and promote respect for their inherent dignity. The Convention shift the paradigm from the previous medical, charity, and social models of disability to the human rights approach.

The World Health Organisation (WHO)'s Quality Rights (QRs) initiative aims to improve the quality of care in mental health and related services and to promote the rights of people with psychosocial, intellectual, and cognitive disabilities in order to face their progressive marginalization disenfranchisement and invisibility within communities.

This program consists of:
(1) training on human rights and recovery; **(2)** support for creating community based and recovery oriented services; **(3)** visiting committees to carry out QRs assessments of mental health and related services; **(4)** improvement plans with reorientation towards a community based model of service provision; **(5)** support for creating and strengthening associations & organizations (advocacy, campaigns, and influence decision-making processes); **(6)** reform of policy and legislation in countries to promote and protect human rights.

The associated QRs e-training is available in 11 languages and covers a range of different aspects, including: taking care of one's own mental health; supporting friends, family and colleagues with their mental health; tackling stigma, discrimination, abuse and coercion in mental health services; and taking action in support of the transformation of mental health services towards a person-centred, rights-based recovery approach. Lessons, videos, gaming, challenges and peer coaching are available on the online platform: https://humanrights-etrain-qualityrights.coorpacademy.com/signup.

As Collaborating Centre of the World Health Organisation, the ASUGI Mental Health Departemental Area of Trieste and Gorizia is supporting the worldwide implementation of the Quality Rights initiative.

Human rights respect is one of the six cross-cutting principles and approaches of the WHO's Comprehensive Mental Health Action Plan 2013-2030.

These are: **(1)** universal health coverage; **(2)** human rights; **(3)** evidence-based practice; **(4)** life-course approach; **(5)** multisectoral approach; **(6)** empowerment of persons with mental disorders and psychosocial disabilities.

Multisectoral approach means that a comprehensive and coordinated response for mental health requires partnership with multiple public sectors such as health,

education, employment, judicial, housing, social, and other relevant sectors as well as the private sector, as appropriate to the country situation. The range of complex needs often expressed by people with mental health conditions requires flexible and personalized strategies of supportive interventions and programs delivered by Mental Health Services (MHS) in partnership with other services and informal actors of the community. Recent papers and publications have described some multilevel models for mental health, which categorise protective and risk factors for mental health as well as the dimensions of intervention at different levels: individual, health system, and community.
The multisectoral & multilevel approach is a strategy to give proper answer to each problem/issue in mental health while taking into account the patients' human rights. Reshaping the determinants of mental health often requires action beyond the health sector, which makes effective promotion and prevention a multi-sectoral venture.

Three examples are discussed during the presentation: **(1)** suicide prevention; **(2)** mental health support during infancy, childhood, and adolescence; **(3)** mental health in the workplace.

Over the last 40 years, the Mental Health Department (MHD) of Gorizia and Trieste MHD has developed a multisectoral and multilevel approach to mental health that comprehend the focus on recovery process, the promotion of users' empowerment, the fight against stigma, and the respect of the human rights of people with mental health conditions (and his/her social network).

The MH staff considers for each person the whole spectrum of needs that contribute to their mental health: family issues, love, social support, housing, education, job, physical health, legal issues, leisure time, interests, etc. In other words, the staff has to explore and understand for each person the individual resources and problems, the potential obstacles as well as the potential allies (among the social network as well as at the community level), to plan the strategies of engagement, and to negotiate with the person a plan of support and intervention.

The multi-professional team of the MHS is composed by psychiatrists, psychologists, nurses, social workers, psychiatric rehabilitation technicians. The MHS works in partnership with the General Practitioners, the Primary Healthcare Services, General Hospital, Addiction Service, Social Services of the Municipality, Police, Court, Jail, Social cooperatives and Associations, among others.

It is essential to connect the MHS with all the actors and resources of the community (i.e., schools, job places, hospitals, primary health care, communities) as well as to have MHSs considering and working in different areas of living (i.e., job, house, training, social activities). An integrated approach to MH requires interventions at different levels:
(1) Legislation & Policies; **(2)** Formal agreements between services; **(3)** Meetings of coordination; **(4)** Building up projects; **(5)** Working on single cases; **(6)** Knowing each other; **(7)** Professional's commitment & curiosity; **(8)** Ask the person.

Some open issues remain:

- how to balance between promotion/prevention of MH vs treatment/rehabilitation;
- how to be open to the community;
- the importance of paying attention to the routine;
- the communication inside/outside of the MHS;
- coordination & levels of responsibility;
- institutional stigma;
- including people with lived experiences/peer support workers, families;
- listening people and giving value to their voice.

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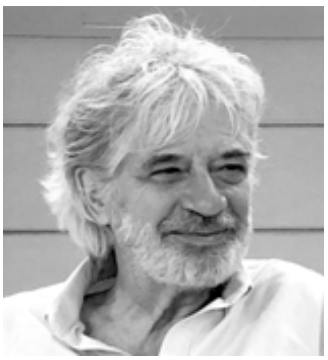

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Primary Mental Health Care Research - Assessment on Access to Primary Health Care in Kassala.

Introduction

The Ministry of Health of Kassala (KMOH), through its Mental Health Directorate, together with the Italian Agency for Development and Cooperation (AICS), performed the P(M)HC Research on the health sector within the capital Kassala City and its peri-urban suburbs, with the specific goal to delve into the health services provided in the State, with special reference to mental health.

The study aims to bring to the attention of policymakers the challenges and opportunities that the health system faces in the country, specifically in the decentralized eastern regions such as the Kassala State. It is now crucial to share results, successful approaches, and models, as well as examples of failures, which are equally important for a boarder learning system. Moving deeper into the study, we tried to identify room for improvement for the primary health care system in the Kassala State with reference to possible future interventions aimed at:

1. Integrating the **family medicine** into PHC ordinary practice.
2. Identifying the main **areas for improvement at service provider level** in order to improve the accessibility of basic health services, such as (but not only) psychosocial and psychiatric services
3. Exploring the **individual factors influencing the health seeking behaviour (HSB)** of people, in order to outline intervention promoting a fairer and more effective access to formal health services.
4. Encouraging periodic reviews of health performance at local level through **monitoring and evaluation practices**, which could guide immediate corrective action, an appropriate allocation of resources and the simultaneous information of policy makers on how to transversally assess, plan, manage and prioritize actions within the health system.

A mixed methodology proved to be the most appropriate solution for this two-fold study. Hence, the quantitative data collection adopted and adapted for a double target, the Service Provider and the Demand, was paired with a supplementary in-depth exploration to support demand side evidence. The qualitative interviews were also aimed at exploring the social representation of mental disorders in Eastern Sudan, since the cultural context influences the creation of concepts in our minds, hence social identities, categorization of people, and prejudices.

The reasons behind the focus on mental health are clearly supported by the WHO's Mental Health Gap Action Programme (mhGAP, 2008), which can be summarised as follows:

- Mental health is a deep-rooted component of health and well-being, thus of PHC.
- Mental health disorders are widely spread among the population and a significant portion of health seekers enter in contact with the primary health care due to symptoms associated with a mental disorder.
- The elevated multi-morbidity of mental disorders and noncommunicable diseases requires mental problems to be managed at primary health care level.
- The majority of mental illnesses begin by the age of 14. Unfortunately, most cases go undetected and untreated (Kessler RC et al., 2007).
- Mental disorders can be treated at primary care level. Simple but adequate training to doctors, nurses and health workers can strengthen the entry points of mental health patients to the formal health care system, reducing the amount of undetected and untreated cases.
- Besides the relatively simple solution, the treatment gap remains enormous due to low detection rates and to the low prioritization given to mental disorders.

Primary health care and mental health care move on the same track. A wiser articulation of PHC services, with adequate training for health professionals and a better resource management, could efficiently detect and insert into formal care paths a wider number of people in need belonging to vulnerable groups.

Conceptual framework

The study's underlying assumption is the close relationship between the structure of the PHC system, the approach pursued in offering health services, and the response to mental health needs. The ability to respond to the needs of people affected by mental disorders in the same way as PHC services respond to any other health disorder depends on multiple variables, first of all on the ability to detect and recognize the need. A need emerges by matching a person's health-seeking behaviour and the service providers' capacity to respond to this behaviour. As for our assumption, a consistent quantitative data collection was adopted for the above-mentioned double-target assessment of access to care.

A supplementary in-depth qualitative exploration was deemed useful to support the quantitative data collected from the demand side and understand the meaning given to mental disorders in Eastern Sudan. The conceptual framework for the design of research tools (both the surveys and the interview outline) is composed of one main theoretical strand, and a research model developed to study health behaviours in developing countries, namely:

- The family medicine approach.
- The PASS-model: a model for guiding health-seeking behaviour and access to care research.

Family medicine approach

Family medicine (or Family Health) is a discipline developed in the 1960s, which has been proposed as a strategy to reorient the health care model by setting up multi-professional teams at Primary Health Care level. Family medicine is defined by WHO as a "*specialty of medicine concerned with providing comprehensive care to individuals and families and integrating biomedical, behavioural, and social sciences; an academic medical discipline that includes comprehensive health care services, education, and research; known as general practice in some countries*".

1. Accessibility care. Family practice addresses the unmet health problems of the whole population.

2. Continuity of care. Family practice ensures ongoing care of individuals such as children, pregnant women and patients suffering from chronic diseases and ensures patients receive specialized and hospital care throughout their lives.

3. Comprehensive care. Family practice provides integrated health promotion, disease prevention, curative care, rehabilitation, and physical, psychological and social support to individuals. Family physicians can provide independent care for 85%–90% of problems encountered in daily practice.

4. Coordinated care. Family practice can deal with many of the health problems suffered by individuals at their first contact with their family physician team, but, whenever necessary, the family physician should ensure appropriate and timely referral of the patient to specialist services.

5. Collaborative care. A family practice team should be prepared to work with other medical, health and social care providers, delegating to them the care of their patients whenever appropriate, with due regard to the competence of other disciplines. Family physicians have traditionally served as the patient's first contact and point of entry into the health care system.

6. Family-oriented care. Family practice addresses the health problems of individuals in the context of their family circumstances, their social and cultural networks and the circumstances in which they live and work.

7. Community-oriented care. The patient's problems should be seen in the context of his or her life in the local community, ensuring community engagement in decision-making about the health and well-being of its members and awareness of the processes of care delivery through a family practice approach.

8. Central patient-doctor relationship. In the early 2000s the authors Mead and Bower made an attempt to review the conceptual and the empirical literature in order to develop a model based on the elements characterizing the doctor-patient relationship within the concept of patient-centred care.

PASS-Model: Model for guiding health seeking behaviour and access to care research

According to the PASS-model for Health Seeking Behaviour (HSB) and access to care research developed by the Belgian Institute of Tropical Medicine of Antwerp, there are four (4) main categories impacting on HSB: i) illness perception and explanatory models, ii) decision-making and social values, iii) access to care and resource seeking, and iv) medical pluralism (Hausmann-Muela et al., 2012). This multi-dimensional model lays on worldviews, social structures and values, and health institutions that participate together in creating social representations of health behaviour and in defining the context for health-seeking processes. Notwithstanding HSB has been widely

explored in the last decades, few studies have explored health seeking behaviour applied to the mental health sector in low-medium income countries, and, especially for Sudan, little literature is available.

Within the P(M)HC Research, an attempt was made to respond to the lack of data concerning both i) the accessibility of PHC services for the population in need, especially for the vulnerable groups, and ii) the consistency of the services provided by health structures, with a specific focus on mental health care. Therefore, the research looks at the PASS-model as a further theoretical foundation to guide its path and adopts a focus on the category "access to care and resource seeking" to assess the consistency of the services available on the ground. To reach its purpose, the research targets both the Service Provider Side (SPS), namely the PHC facilities, and the Demand Side (DS), or rather the patients of the PHC facilities, in order to ascertain the quantity and quality of care supply.

Methodology

The management of the P(M)HC Research activities on the ground followed a pyramidal structure of human resources members of the KMOH and of AICS, whereby the research was ownership of the KMOH, but the Technical Assistance acting as the methodological coordinator of the research was provided by the Italian Cooperation. The teams of enumerators were constantly exchanging feedbacks through a WhatsApp group with the Coordinator, who controlled the data collection of teams from the online platform, and in turn, reported to the Director of the Statistics Department of the KMoH and to the AICS Medical Advisor. Both the latter worked in strict collaboration with the Methodological Coordinator supervising the progress of the entire research. The main workforce deployed in the field was data collectors. Enumerators were paired by putting together one person with strong digital competence and another with a reputable social competence recognised in the health community. The resulting couples, hence, were in general composed of i) a younger profile skilled in using digital devices and ii) a senior profile facilitating the access to PHC facilities thanks to his/her valuable reputation within the intervention communities. Senior profiles were also crucial in resolving logistical issues that emerged due to the lack of fuel and damages in the vehicles selected to drive the enumerators around.

Data collection

The data collection was conducted between February and April 2021, with a supplementary data collection for the Demand Side executed in May 2021, further extending the research. The target of the Service Provider Side survey was a consistent sample of the PHC facilities located in four main areas within the Kassala State: Kassala Rural, Kassala Urban and Telkok, New Halpha, and Girba. The Demand Side surveys targeting patients were conducted in the same facilities targeted by the Service Provider Side survey.

The target areas, and consequently the facilities, were identified within 150 Km from the KMOH headquarters in Kassala city to cover urban, peri-urban, and rural areas without putting the staff at risk and ensuring the actual feasibility of the activities. Data collection was digitally conducted through an application working in online and offline modes. The digitalization of the surveys facilitated the collection of a significant amount of data in a short time, but also ensured the consistency of data reported in the answers, reducing empty answers and calligraphic interpretation. The application was installed on four tablets (one per team), allowing the enumerators to work in parallel in different areas of the State.

The **quantitative methodology**, with information from care service providers and recipients, made it possible to quantify the consistency of the health services offered in the region and their accessibility. Surveys were designed according to a theoretical framework that had been developed in the African context to study malaria, the PASS-model, whose indicators system was replicated to assess care and resource seeking. As for the Demand Side, the WFP's

Coping Strategies Index was used to understand the incidence of poverty on access to health. The information collected came from both the Service Provider and the Demand sides to give an objective and representative picture of the broader aspect of 'access' to healthcare. The study also provides valuable indications extrapolated from collected data, including about access to mental healthcare.

The **qualitative methodology**, instead, aimed at in-depth exploring the pivotal theme of our research, namely mental health. For this methodology, theories from sociology, social psychology, and ethno-psychiatry acted as a guide. Qualitative interviews were conducted by a Sudanese doctor, native to Eastern Sudan, and a social worker who was the focal health professional for people with mental health disorders (PWMHDs).

The team of professionals performed the interviews inside the private houses of the families hosting PWMHDs who enthusiastically welcomed the team's visits. Through this direct interaction with family members and the informal setting, the team explored the representation of mental disorders and how the health system formally catches them.

For **qualitative interviews**, the team exclusively focused on urban Kassala. Tribal clashes, the closure of bridges, and fuel price inflation led the team to take precautionary measures to prevent travel and safety complications. Furthermore, the only health facility offering psychiatric services is the Kassala Hospital in the state's capital. Likewise, the Mental Health Directorate (KMOH) is also based in Kassala city. The tool consists of a grid with guiding questions exploring various aspects contributing to tracing the social representation that the Kassala community shares around mental disorders. The outputs from the interviews were included as quotations in the 'Demand analysis'. They support evidence coming from the data collected through the Demand Side survey targeting a random sample of PWMHD's[1] families facing constraints affecting care. In addition, from the analysis of qualitative interviews, it was possible to outline the current state of the mental health services available specifically in Kassala.

1 People with Mental Health Disabilities.

The open questions aimed at investigating the following:

PART-1 SOCIAL REPRESENTATIONS OF MENTAL HEALTH DISABILITY

Objective:
To explore the representation of the mental disability within the nuclear family and at community level (extended family, neighbourhood, religious community, educational / work environment): causes and long-term impact of the disability.
To explore social values and stigma within the community to which the PWMHD belongs.

PART-2 BUILDING THE ORDINARY DAY LIFE WITHIN THE COMMUNITY

Objective:
To understand social pressure and social support/networks affecting the nuclear family.

PART-3 ACCESS TO HEALTH CARE

Objective: To explore barriers and facilitators to access to primary health care.

Service provider analysis

This service provider analysis relies on the collection of primary data and feedback through the survey submitted to medical and administrative staff working at the target PHC facilities. Where relevant, the findings from the original research where integrated with results from other assessments and studies. The section is structured around six indicators and ten sub-categories of analysis: (i) identification data and distance from health resources; (ii) mobility factors; (iii) general information; (iv) staff; (v) services; (vi) equipment; (vii) finance; (vii) health information system; (ix) facilities for disability; (x) covid-19.

Demand analysis

The demand side analysis relies on collecting primary information and feedback through surveys conducted with individuals receiving medical care at the PHC facilities. Where relevant, findings from the original research were integrated with results from other assessments and studies. This section is structured around the following eight categories of analysis: (i) socio-economic and demographic data; (ii) availability of preventive initiatives; (iii) availability of preventive initiatives; (iv) accessibility - waiting time at the health centre; (v) acceptability; (vi) accommodation; (vii) affordability of health resources; (viii) coping strategies.

Further investigations

The emerging picture is that of a health system having a potential, but lacking i) resources (financial and human) that ensure the quality and sustainability of services, as well as the continuity of health personnel, ii) clear procedures defining the criteria for access to care (health need / entry level), iii) coordination between the different health levels (primary, secondary and tertiary), and, in connection to the previous point, iv) a sound health information system able to monitor financial aspects, services offered to the public and the patients' clinical histories.

Further investigation for each indicator considered has shown as follows:

Care accessibility. PHC services do not always respect their catchment area as established by the FMOH guidelines. Within the study, several PHC centres were found covering single small communities, while wider communities were covered instead by one PHC unit suffering from a large number of people referring to it, the poor availability of services, and the high turnover of the few personnel trying to face everyone's needs. The facilities are reachable with different options, and, if catchment area coverage is respected, people can get to their destination on foot, by animals, or by public transport (when having a job). The waiting time to meet one's medical needs, mostly ranging from 30 minutes to 2 hours for being examined, is not affecting the perceived quality of the services.

Availability of health care. The significant lack of personnel and the poor equipment the facilities have to work with, affect the availability and quality of the services provided. The reproductive health service appears to be the most efficient, while other services such as dental, eye and psychological and rehabilitation services are far from being considered available and consistent. Due to the focus of the study, 0% of the assessed PHC facilities showed any professionals available for responding to the psychosocial needs of the population. It is worth noting that despite many midwives and nurses deployed in the field, 1/3 of the families interviewed to understand the role of mental disorders in the community reported that the PWMHD was a woman and suffering from post-partum depression.

In conclusion, prevention initiatives are promoted by a limited number of facilities, although the importance of these activities is generally recognised and, when implemented, they are promoted in gathering places where a large part of the communities can join them.

Acceptability of health care. The comprehensive evaluation of the quality of services shows a prevalent satisfaction with the services received. The evaluation takes into account the respect perceived by patients for their confidential information and themselves as human beings. The distance facility's personnel-patient seems does not affect the relationship between the service provider and the demand side.

Non-satisfaction, when registered, mainly refers to health personnel behaviour and includes poor explanations of dosage and treatment regimens, rudeness by health personnel, and a blaming-the-victim mentality.

Affordability of health care and sustainability of the services. Both indicators were critical, the first for the patients and the second for the facilities. The two expenditure categories weighing the most on patients are medicines and laboratory services. The services could be covered through direct payment by the patient (OOP) or through public or private health insurance. Curiously, the study has revealed that the number of facilities accepting direct payment falls from 28 to 15, while 27 commonly cover the offered services through the NHIF. However, NHIF is not covering many of the consultancies, treatments, and medicines people need; moreover, not everyone has a health insurance.

This information came up clearly from the interviews with PWMHD's families, who are facing financial challenges in getting medicines for treating the mental condition of their relatives. Considering the sustainability of the services, hence of the facilities, in the State of Kassala, the three main sources of income of a PHC facility are patients (OOP), the NHIF, and the Government in a proportion that varies based on the locality. Due to the little investment by the Government and the little income generation of each facility, many of them closed. In fact, during this study's first steps, the authors asked the KMOH to provide an updated list of the active hospitals, centres, and units in the State. The list, although considered updated, was corrected by deep data cleansing due to the closure of many facilities, mainly for financial reasons.

Inclusion of health care. Kassala Urban and Telkok are the only locations with facilities reporting to have at least a ramp available for people with physical disabilities and / or doors having a width greater than / equal to 90 cm. Physical disability is the only disability taken into consideration since no service is available for people with mental impairments.

A final consideration on mental health should be made separately

Outputs from the fieldwork are full of shadows, and it is still challenging to have a clear picture of the situation in the Kassala State, just as it would be quite hard doing the same for the whole Sudan. Hence, within the conclusions of this study, the authors try to analyse further the concept of mental health and how to support it by relying on the important contribution from WHO, which since the early 2000s has been working to take care of the mental health of the world population, even in resource-poor contexts like Sudan. 'Mental disorders frequently lead individuals and families into poverty. Because of stigmatization and discrimination, persons with mental disorders often have their human rights violated. Many are denied economic, social, and cultural rights, with restrictions on the rights to work and education, reproductive rights, and the right to the highest attainable standard of health. They may also be subject to unhygienic and inhuman living conditions, physical and sexual abuse, neglect, and harmful and degrading treatment practices in health facilities. They are often denied civil and political rights such as the right to marry and found a family, personal liberty, the right to vote and to participate effectively and fully in public life, and the right to exercise their legal capacity on other issues affecting them, including their treatment and care.' (WHO, Mental Health Action Plan 2013-2030).

The P(M)HC Research gave a picture in line with the WHO description above. The Sudanese PWMHDs the team encountered were people with families trying hard to cope with their everyday needs and people whose rights were denied. Their poor education level, little knowledge on mental health, and the stigmatization and discrimination of whatever is considered 'out of normal' isolate mental disorders in a separate and silent bubble within the society. Mental, neurological, and substance use disorders are highly prevalent in Sudan, accounting for a significant burden of disease and disability, even if this need remains hidden. A wide gap remains between available health system capacities and resources, what is urgently needed, and what is available to reduce the burden. Mental disorders could heavily affect children's ability to learn and adults' ability to integrate well into families, at work, and society in general.

Recommendations

1. BOOSTING FAMILY MEDICINE

A first recommendation is to **strengthen the family medicine approach**, whose principles and guidelines help identify physical and psychological symptoms early thanks to the personal and ongoing relationship with general practitioners in possession of each patient's medical and personal history. Family physicians, social workers, community health workers, community nurses, inpatient or outpatient service providers, and outreach care workers (...) become key figures in closing the gap between patients and health services.

Mental disorder is a private and delicate topic. It takes time to be shared with a person outside the family, and when symptoms are evident, the disorder could be in an advanced status, and harder to treat. The available psychiatrists and psychologists are insufficient to serve the whole affected population, from the entrance to the health system, along the follow-up, and until the end of the therapy —when an end is possible. Health specialists need the support of valid and unreplaceable figures having close contacts and ongoing relations with the community.
In order to create a hierarchical structure of access to mental health care, as it would be for standard care, community health professionals should be able to recognize needs and deliver primary interventions as front-line personnel.
To strengthen the family medicine approach, integrated with mental health components, community-based programmes should incorporate the following general principles:

All health care centre staff should receive basic training in family practice, with age-, sex- and culturally sensitive practices that address the required knowledge, attitude, and skills to communicate with their catchment population.

Healthcare centres should provide appropriate education and information on health promotion, disease management, and medications for all groups of patients, particularly vulnerable groups of the community, such as mothers, children, people suffering from communicable and noncommunicable diseases, and the elderly.

Healthcare centres should make every effort to adapt their administrative procedures to the special needs of their catchment population, for example, people with disabilities, chronic patients, elderly people with low educational levels, or with mental conditions.

Healthcare centre systems should be cost-sensitive to facilitate access to needed care by low-income people.

Healthcare centres should adopt systems that support a continuum of care both within the community level and between the community and secondary and tertiary care levels.

Healthcare centres should train volunteers and use them in the follow-up of defaulters, provide simple healthcare services at the community's doorsteps, etc.
All record-keeping systems in health care centres should support care continuity by keeping records on care and facilitating household access through interdisciplinary collaboration.

Individual patients, families, and other groups within the community should be part of participatory decision-making mechanisms regarding the organization of the family practice services.

The physical environment of each healthcare facility should be acceptable and match clients' culture; simple and easily readable signage should be posted throughout the health care centre to locate easily recognized available services.

Key healthcare staff should be easily identifiable by name badges and name boards.

Healthcare centre should be equipped with good lighting, non-slip floor surfaces, stable furniture, and clear walkways.

Healthcare centre facilities, including waiting areas, should be clean and safe environments protecting patients and their caregivers.

These general principles can be adapted to each healthcare centre and provider setting to ensure responsiveness and sensitivity to the community served.

2. TRAINING PROGRAMME IN MENTAL HEALTH

In line with the first recommendation, the second one is to invest in training healthcare providers working in non-specialist settings to deliver interventions as front-line personnel, along with mechanisms to ensure their continued support and follow-up.

The training program aims to teach non-specialist healthcare providers the skills and knowledge needed to assess and manage people with priority mental conditions. The duration of training depends on the local resources and the knowledge and skills that non-specialist healthcare providers already have. Usually, this training process takes several full days and can be conducted face-to-face or via e-learning, depending on feasibility.

The training structure can follow a cascade plan with two levels: a ToT, where a master facilitator trains 'trainers,' and different training for the non-specialist front-line healthcare providers made by the new trainers.

3. PROVISION OF TREATMENT AND CARE

Pharmacological and psychological interventions are recommended to be provided by non-specialised health care providers.

Examples of scalable psychological intervention manuals within the mhGAP that can be accessed on the dedicated website and target the main areas of intervention:

Problem Management; Interpersonal Therap; Maternal Depression; and Parental Skills.

Pharmacological interventions can be used to treat symptoms of mental conditions to shorten the course of many disorders, reduce disability and prevent relapse. Essential medicines are part of the 21st WHO Essential Medicines List (EML). Access to essential medicines is a component of "the right to health".

4. INTEGRATING MENTAL HEALTH IN HEALTH INSURANCE

WHO's determinants of access to essential medicines bring the attention to the financial factor, which is a key aspect in poor countries.

As emerged in the study, the national health insurance has limited coverage of health expenditures. Policymakers should consider a dialogue with the NHIF and private insurance to redefine the converge plans to consider a more comprehensive range of needs, from a broader number of specialized consultancies to a broader number of essential medicines.

As household assets in resource-poor settings were inadequate to cope with the costs of these diseases, there is an urgent need for more collective health services and resource provision to support household treatment and coping strategies.

The disaggregated illness cost data by socioeconomic groups are scarce in the literature and database systems because measuring income or socioeconomic status is immensely difficult. This means that policymakers had limited information about the groups most affected by illness and the economic impact of illness on the poorest. A new financing system should be studied to allow more meaningful comparisons of the economic burden of illness across settings and diseases.

Financial and private institutions are called to design new specific mechanisms to support people in covering medical expenses. First, new products should aim to relieve the burden of low-income families affected by the disease or even promote preventive measures for family members' health. Thus, financing mechanisms should also aim to reduce the individual, local and systemic risk itself, to concretely boost access to credit in rural areas and among less wealthy groups.

Health policy research and debates need to be broadened because even if health services have been improved, they cannot protect households from all illness costs, particularly expenditure on non-medical and indirect costs. (Russel S., 2004).

5. ADVOCACY AND AWARENESS RAISING

Mental health advocacy uses information in deliberate and strategic ways to influence others to create change. It involves the promotion of the needs and rights of people with mental disorders, as well as that of the general population. Advocacy is different from education. Education informs and helps create awareness of an issue. Advocacy, on the other hand, aims to persuade.

A basic principle is that advocacy is only effective when the target audience is asked to do something. Mobilizing people means asking them to become part of the solution.

This is done through requests and calls for specific actions, and involves people at two different levels:

Advocacy actions within the general population: mobilization of PWMHDs and their caregivers, using the media to increase awareness of mental health issues, provide education about mental health issues in public places.

Advocacy actions with health and mental health workers: promoting an understanding of the importance of community care, community participation, and human rights of people affected by mental conditions, providing adequate training and support to mental health and general health workers).

6. NETWORKING AND INTERSECTORAL COLLABORATION

The implementation of programmes aiming at macro changes requires the collaboration of various sectors and stakeholders, such as:

Specialist and non-specialist health services and care-providers: psychologists, community health workers, social workers, inpatient or outpatient service providers, outreach care workers.

Service users: groups or individuals living with the same condition, family members with the same condition, or caring for someone with the same condition (after seeking consent from all those involved).

Family and friends: Identifying the person's prior social activities that, if reinitiated, would have

the potential for providing direct or indirect psychological and social support (e.g., family gatherings, outings with friends, visiting neighbours, social activities at work sites, sports, community activities) and encouraging the person to resume these activities.

Informal community support: spiritual groups, saving groups, recreational groups, women groups, youth support groups, cultural groups, self-help groups, helplines.

Education and employment: schools, education, income generating or vocational training programmes. Specifically, suicide prevention programmes in school settings, including mental health awareness training and skills training, to reduce suicide attempts and suicide deaths among adolescent students.

Non-governmental organizations: legal aid, child protection services, gender-based violence programmes, or psychosocial support programmes.

Government services and benefits: public justice systems, child welfare, pension, disability, transport discounts.

7. DATA COLLECTION AND INFORMATION MONITORING SYSTEM

The last recommendation suggests **designing and implementing an inclusive and coordinated Monitoring and Evaluation programme that should involve planning**, coordinating, collecting, cleaning, analysing, and using federal, State, and local data. Such a system requires the FMOH to invest resources in a dedicated multidisciplinary team to plan and carry out the M&E programme.

Indicators used to monitor should be part of the national health information system and equal in all states and levels, besides adapted to the context. Collecting data using indicators will assist in monitoring health programme, both from a financing and an operational point of view. They will also assist in reporting on national health when interlocution with public and private donors and investors.

The M&E process identifies successes and areas for improvement by currently updating data.

CVCS BURKINA FASO

NGO BASED IN GORIZIA OPERATING IN ITALY AND INTERNATIONALLY IN THE FIELDS OF SOCIAL, ECONOMIC AND ENVIRONMENTAL JUSTICE.

The Renaissance Projects in Burkina Faso.

CVCS, an Italian NGO based in Friuli Venezia Giulia, operating in Italy and internationally in the fields of social, economic, and environmental justice, since 2018 has been promoting cooperation projects in Burkina Faso focusing on mental health, starting with the funding of Regione Friuli-Venezia-Giulia and later through two important initiatives financed by the Italian Agency for Development Cooperation (Agenzia Italiana per la Cooperazione allo Sviluppo – AICS):

Renaissance 1

"Pathways for the social reintegration of people with mental health distress in Burkina Faso"

- **Project activities started:** 15/11/2019
- **Project activities ended:** 14/5/2022
- **Duration:** 24 months + 6-month extension
- **Area of intervention:** Bobo-Dioulasso (Hauts Bassin Region)

The project aimed at developing the model of care for people with psychological distress promoted by the local main partner, the Association Saint Camille de Lellis (ASCL) running the Centre Notre Dame de l'Espérance in Bobo-Dioulasso, the second largest city in the country. This centre, supported by the local diocese, is the only one in the urban and suburban context of Bobo Dioulasso that provides accommodation, treatment, and the possibility of undertaking paths for social reintegration for abandoned and wandering people with psychiatric disorders.

Renaissance 2

"Civil society and institutions work together for the rights, care and social inclusion of people with mental distress in Burkina Faso"

- **Project activities started:** 30/09/2022
- **Duration:** 36 months
- **Area of intervention:** Bobo-Dioulasso (Hauts Bassins Region) and Ouagadougou (Centre Region)

This project aims to continue and strengthen the previous project's strategy and extend it to other areas of the country. In Burkina Faso, people with mental distress suffer from strong social stigmatisation, and their condition is often interpreted as the result of curses or spells, and they are consequently excluded at the family and social levels, often ending up abandoned and wandering. Even at the health level, the issue is neglected due to a lack of specialised personnel and facilities; this contributes to people with psychological distress remaining in a condition of invisibility and social indifference.

The partners

CVCS program on mental health in Burkina Faso is part of an overall strategy that promotes inclusion for vulnerable people in Italy and in the countries of intervention. This programme is made possible by the contribution of different partners actively engaged in Burkina Faso and in Italy.

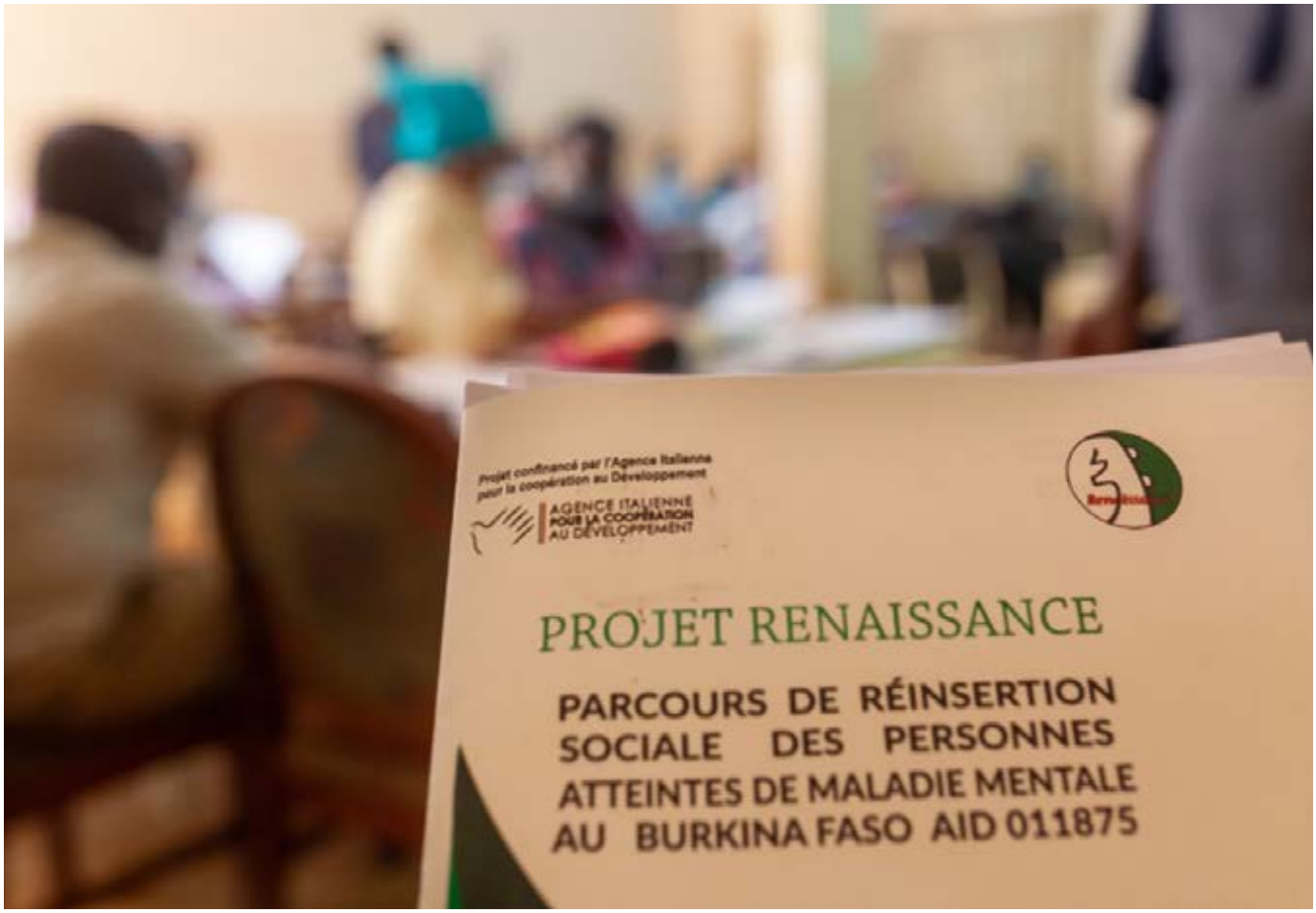
The Association Saint Camille de Lellis (ASCL) is the central partner in this initiative. It has been running the therapeutic centres in Bobo-Dioulasso since 2014 and in Ouagadougou since 2019. It provides shelter, care, and reintegration assistance for people suffering mental distress who wander homeless and do not have any familiar or institutional support.

The aim is to defend and promote the right to care inclusion for those who suffer from exclusion and do not have appropriate assistance and care in order to live their lives with dignity enjoying their rights as society members.

ASCL works in coordination with the local Public Health Ministry Regional Department, health centers, and institutional authorities.

Through mainly voluntary work provided by health professionals, ASCL has built up a centre in Bobo-Dioulasso, the second largest city in Burkina Faso, from where a "patrol unit" formed by social workers identifies people with mental distress living homeless in the streets of the city and offers them the possibility to receive first assistance, care, and medical treatment. Over the years, ASCL developed activities to reintegrate patients into society. Therefore, ASCL works with patients' families to form them in order to adequately reintegrate their beloved with them.

CVCS has started collaborating with ASCL to reinforce the strategy and promote awareness among institutions and population about the reality of mental health and the need to give the right response to tackle the phenomenon.



Important Burkinabé and Italian partners add strength to this program:

- ASUGI Mental Health Departemental Area of Trieste and Gorizia.
  A team of experts of MHD-ASUGI has been actively working since 2019 in collaboration with CVCS to support its strategy concerning mental health in Burkina. This collaboration has led to training and knowledge exchange with Burkinabé mental health professionals on policies, practices, and methods of mental health care and social care. The experience built in Trieste and Gorizia since the 1970s has been presented and analysed by the mixed teams of mental health professionals and caregivers in order to identify paths of social reintegration in Burkina Faso, considering social, cultural, and economic differences. Renaissance 2 project will offer the opportunity to reinforce this collaboration and to extend the fields of mutual exchange through online activities and mutual visits on the field involving other specialized partners as:

- CREtAM University of Turin - Center for Research on Ethnopsychiatry and Anthropology of Migration, who will participate in the training and exchange programme with ASCL and ASUGI. A team of ethnopsychiatrists and psychosocial experts has been working closely with ASUGI to bring specific content concerning mental health and culture in Africa, focusing on multiculturalism and rethinking of psychiatry.

- University Nazi Boni (Bobo-Dioulasso) has been following the process of awareness and promotion of the rights of inclusion of persons with mental distress, and it will conduct research and analysis to support with data and analysis the knowledge and comprehension of the phenomenon at the different level of decision makers in the country.

- University of Trieste/Centre for Migration and International Cooperation on Sustainable Development. It is involved in anthropological research.
- The Minister of Health and its regional departments in Hauts Bassin Region and Centre Region are the institutional partners facilitating coordination with public health centers and staff.
- OCADES (Caritas Burkina Faso) who is involved in sensibilization activities with people in the quarters and villages. Their sound presence in the field allows a wide dissemination and promotion of concepts, values, and practices for a better comprehension of mental diseases and the right to inclusion of the people suffering from this condition.
- AES-CCC, an Italian NGO operating in Burkina Faso in the field of rural development and nutrition is involved in enhancing the agricultural activities that ASCL runs as a therapeutic methodology for persons with mental distress in their way for social and professional reintegration.
- Youth Center JIGI SEME in Bobo-Dioulasso, run by the Congregation of the Sisters of Mary Immaculate, aims to disseminate awareness about mental health through young people in the peripherical areas of the city and through the media and social media and to collaborate in field activities.

Closing

In our onward journey, we reaffirm AICS' commitment to continue working together with ASUGI Mental Health Departemental Area of Trieste and Gorizia, the practitioners that shared their expertise with us during these two days, national and international civil society organizations, and the private sector to ensure mental health services reach all those in need. AICS' appreciation for Trieste's outstanding work has already borne fruit in the ongoing collaboration to support the mental health agenda in various countries and improve mental health access and services for the most vulnerable ones.

We know that creating positive changes also relies on funding, political will, and policies that a caring eye must guide. We want to be part of this caring eye to help define the way forward to guarantee accessible, high-quality mental health services for all. We hope the conference is the first brick to strengthening this partnership as we are inspired by the same principles and values: dignity, respect, inclusion, and freedom.

Inspired by Franco Basaglia, I would like to conclude with this thought:

"Mental illness is a human condition. The problem is that society, to call itself civilized, should accept mental illness, ceasing to consider it as a disease like any other in order to eliminate it, rather than considering it in its complex interaction with the context of life and relationships in which finds its expression and its meaning".

Michele Morana
Head of office, Italian Agency for Development in Khartoum.

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Thanks to all the collaborators who, with their dedication, contributed to the organization of this event. Thanks to ASU GI for the precious support in acting as a technical guide for the conception of these discussion days.

Special gratitude and appreciation go to the esteemed speakers for participating in this international conference, "*Bridging Gaps in Community Mental Healthcare*." Through their thoughtful research and engaging presentations, they shed light on crucial questions about the state of mental health care in Sudan, Cameroon, Chad, and the Central African Republic, helping to stimulate debate and inspiring us all to focus our work and cooperation efforts towards a positive change.

AICS Khartoum.

Working group of the International Conference "Bridging Gaps in Community Mental Healthcare" 14th - 15th December 2022, Trieste Italy.

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