SITUATIONAL ANALYSIS OF THE MENTAL HEALTH SYSTEM IN THE WEST REGION OF CAMEROON

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Declaration

I declare that this work is original and has been authored by me. It has not been submitted for an academic award or qualification in any institution of higher learning. Appropriate referencing has been made when citation of other people's work has been done.

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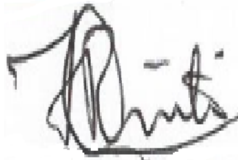
Signature ___  ______________________________

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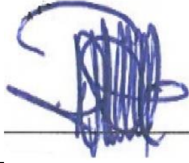

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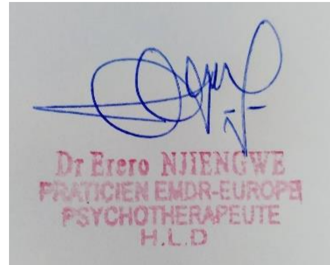

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List of abbreviations

SDG:Sustainable Development Goal

WHO:World Health Organization

WHO-AIMS:World Health Organization Assessment Instrument for Mental Health Systems

UN:United Nations

PHCP:Primary Health Care Provider

MHS:Mental Health System

MH: Mental Health

LMIC: Lower-Middle-Income Country

MoH: Ministry of Health

DALY:Disability-adjusted life year

COVID 19: corona virus disease 19

ICD 10: International Classification of Diseases 10

Operational definitions

Mental health system: all the activities whose primary purpose is to promote, restore or maintain mental health.

WHO AIMS: WHO tool for collecting essential information on the mental health system of a country or region.

Mental hospital: A specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental disorders.

Bed:A bed that is continuously available for use by people with mental disorders for round the clock(dayand night) care.

Community-based facility:A mental health facility outside of a mental hospital.

Community-based psychiatric inpatient unit:A psychiatric unit that provides inpatient care for themanagement of mental disorders within a community-based facility. These units are usually locatedwithingeneral hospitals, they provide care to users with acute problems, and the period of stayis usually short(weeks to months).

Community residential facility:A non-hospital, community-based mental health facility that providesovernight residence for people with mental disorders. Usually these facilities serve users with relativelystable mental disorders not requiring intensive medical interventions.

Community residential facility for children and adolescents only: A facility that meets the definition for community residential facility and exclusively serves children or adolescents.

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Abstract

Cameroon is a lower middle-income country in Central Africa with a population of 25 million people spread over 475,440 km^2. It has a growing burden of mental illnesses with neuropsychiatric disorders representing 6.1% of the burden of all diseases. Also, the resources available for mental illnesses are very insufficient. This is the reason why building a mental health system geared towards efficiency and efficacy is an emergency for the future of mental health in Cameroon. This can only be achieved through a deep understanding of the current state of mental health in Cameroon, what we are intending to do in this study, making use of the WHO assessment instrument for mental health systems (WHO AIMS). We will are first focusing on the west region of the country as a starting point. hope this study will aid as in Ethiopia in making better decisions and contributions to the improvement of the mental health system of Cameroon.

Our aim is to carry out a landscaping and situational analysis of the West region of Cameroon's mental health system keeping WHO AIMS in mind. To achieve this, used the WHO AIMS to interview the key members of the mental health system of the region, collected data on the year 2020. The data collected was grouped and expressed in frequencies, proportions and absolute numbers.

At the end of this study, the main findings are that mental health services are available in 6 departments out of the 20 department of the region. These services are mainly offered by mental health nurses, then neurologist and finally psychologists.

Introduction

Cameroon is a lower-middle-income country (LMIC) in Central Africa with a population of around 25 million. It has two official languages: French and English (The World Bank, 2020). In Cameroon, neuropsychiatric disorders represent 6.1% of the burden of all diseases (Mental health in Cameroon, 2020; Mulango et al., 2018). Between 1990 and 2010, major depressive disorder was number nineteen on the ranking of causes of Disability-adjusted life year (DALY) in the whole country, with a burden that has been increasing during this period(Institute for Health Metrics and Evaluation, 2010). In Douala, in the littoral region, the diagnostic rate of depression by general practitioners by comparison to PHQ-9 is 1.92% (Toguem et al., 2019). In Guidiguis health district in the fare north region, where patients are mainly seen by nurses, 13.33% of them were able to identify 3 symptoms of depression and knew that it can lead to suicide(Keugoung et al., 2013). In the Fako division in South West region, 45.1% of primary health care providers (PHCP) were not aware if there were any psychotropic drugs available in their area and also 49.1% didn't received a formal teaching in mental health (MH)(Mulango et al., 2018). In the west region, we couldn't find any information in regard to mental health.

Cameroon has no mental hospital, and has two mental health departments attached each to a central hospital, Hopital Laquintinie de Douala and Hopital Jamot de Yaoundé which are respectively located in the two capital cities Douala and Yaoundé. These are the only towns where you can find a psychiatrist in Cameroon (Mulango et al., 2018). On average, it was reported 0.03 psychiatrist and 0.15 mental health nurses per 100,000 population with no training program for psychiatrists in the country in 2011. In 2017 this information was not available(WHO, 2011, 2018b). Based on the above, we can say that there is no psychiatrist, no mental psychiatric hospital and no psychiatric department in the west region of Cameroon.

All these systemlevel limitations raise concerns about how do Cameroonian individuals with mental illness in the west regionfind support and care and what sort of mechanisms are in place for thepromotion restoration or maintenance of mental health: mental health system (MHS)(WHO, 2005)? Before we can build a good mental health system, we need to be well informedon the real factsaboutMH in the region but currently, therelevant information about mental health in the region is highly insufficient (Commonwealth, 2020). This is the reason why our aim in this study is to

collect the relevant information in the west region of Cameroon that can be used to make informed decisions geared towards building an efficient MHS for the region.

II. Literature review

WHO-AIMS in LMIC in Africa

African countries with similar income levels as Cameroon; that is LMICs, are at noticeably different stages in terms of how far each of them has gone in their mental health systems. With Senegal and Cameroon where we did not find any publication on their MHS to Cote D'Ivoire who had minimal publication which did not pertain to WHO-AIMS, most of which are hospital-based studies and who spend less than 1% allocation of their health fund on MH. The country doesn't have a mental health policy and the laws for the rights of people with disability ratified, not implemented (Maiga & Eaton, 2014).Analysis were conducted on the MHS in Nigeria, Ethiopia, Kenya, Uganda, Zambia and Ghana using the WHO- AIMS. It was observed that Nigeria, Ethiopia and Uganda were developing a MH legislation with a MH policy already present only in Nigeria. There is insufficient funding of MH in these countries and there is not enough studies supporting the integration of MH in primary health care (Mugisha et al., 2017). In 2011 Ghana had a mental health policy, plan and legislation even though this legislation was outdated. 1.4% of the health budget went to MH with this investment mostly limited to cities, these services been accessible to 2.8% of the mentally sick people(Roberts et al., 2014). In Kenya, in the Makueni County there was no specific government policy nor part of the administration dedicated to MH, this because of the relatively low consideration and low funding (Mutiso et al., 2020). While in Kilifi county, the service is limited to two outpatient psychiatric unit with two psychiatric nurses and inconsistency of the availability of medicines. There is no specific budget for mental health and no process for its integration into primary health care(Bitta et al., 2017).

1. Health and Development Priorities

Cameroon has the strongest economy inCentral Africa, but the poverty level is still rising. From 2007 to 2014, the proportion of poor people has increased by 12%. Following many years of peace, Cameroon is now struggling with Boko Haram in the far-north, the sociopolitical crisis in the two English speaking regions of the country which has led to the internal displacement of more than 500,000 people and more than 600 deaths. There is also the current COVID 19 pandemic which on the 17th June 2020 was at 9,863 diagnosed cases in Cameroon (The World Bank, 2020; WHO, 2020). All this puts more pressure on its health system and its 1.9 doctors per 1000 population which

was still inaccessible to 64% of the population in 2012.(Joseph Nde et al., 2019; The World Bank, 2020).

In order for thesustainable development golds (SDG)for the world that were set by the member states of United Nation (UN) in 2015 to be reach by 2030 some specific targets for mental health were set up base on the evidence of no health without MH(Johnston, 2016; Patel et al., 2018). In other words, to reach these targets for mental health, a diagnosis of the situation needed to be made before any efficient action can be undertaken. This diagnosis of the situation is characterized by the gathering of relevant data to inform decision making. These information has been divided by WHO into six categories:

- Policy and Legislative Framework
- Mental Health Services
- Mental Health in Primary Health Care
- Human Resources
- Public Education and Links with Other Sectors
- Monitoring and Research(WHO, 2005). This is where our work is involved because, with this research, we are going to see how far we have gone in our MHS in Cameroon and what still needs to be done.

So, in this review of literature, we are going to see what is known about each of those items in Cameroon so that we can then go and get the complementary and up to date information.

2. Policy and Legislative Framework

Here, we are concerned about the mental health policy, plan and legislative provisions for mental health. This also includesprovisions for the monitoring and human right's teaching and the financing of MH services.

In Cameroon, a standalone mental health policy or plan was introduced in 2016. This document contains specified indicators or targets which can help in the monitoring of the implementation process. It also includes plan or strategy for children and or adolescent MH. Although there is no reported engagement for human rights, there is an ongoing cooperation between theMH sector and the service users and family or caregiver advocacy groups. Also, in the list of essential medicine, there is a category for psychotropics (Republic of Cameroon Ministry of Public Health, 2017). There is no known standalone provision for MH in the legislation of Cameroon. There is an existing independent organization to assess the respect of MHlegislationencompassing

international human rights even though, it's not functional. Also, there is no known law in line with human rights covenants(WHO, 2018b).Cameroon has signed different conventions to promote justice for its habitants. The African (Banjul) Charter on Human and People's Rightswhich is a document made and published by Amnesty International that defines what is the human right, promotes, and provides mechanisms to protect,evaluate and report in case it is violated(Amnesty International, 2006). The Convention Against Torture and Other Cruel, Inhumane, or Degrading Treatment or Punishment which is a common agreement on what is torture and inhumane treatment and provide the mechanisms to prevent and fight them(Bahrain & Faso, 2018). The Convention on Elimination of All Forms of Discrimination Against Women defines what is discrimination against women, constitute an engagement of the country to eradicate it and provides the mechanisms to achieve this (United Nations, 2009). The Convention on the Rights of the Child which acknowledge that from zero to eighteen years old, people have distinct needs and rights that deserved to be protected(UNICEF, 2017).The International Convention on Elimination of All Forms of Racial Discrimination; the International Covenant Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights and many more(Human Rights MATRIX - POLICY Project/Futures Group, n.d.; Time, 2013). These show that there are some legal provisions for human rights in the Cameroonian lawand some of these provisions could help support individuals with mental illness too.

3. Mental Health Services

One significant area of concern is that Cameroon doesnot have any dedicated psychiatric hospital or mental health facility. It has 2 psychiatric departments, which areeach attached to a Central hospital.One in Hospital Laquintinie de Douala in the economic capital and the other one in Hospital Jamot deYaounde in the political capital(Keugoung et al., 2013; Mulango et al., 2018).

4. Mental Health in Primary Health Care

In Cameroon, the incorporation of MH into the primary health care is still a big issue. In Douala, out of 100 depressed patients received by general practitioners, only 1.92 cases are diagnosed(Toguem et al., 2019). In the Fako area, that is in the south west region of the country, among the PHCPs, that is general practitioners, nurses and so on, 1.8 out of a hundred know a stander tool for the diagnostic of depression. About 66% reported that it isdisagreeable towork with depressed patients. Of these PHCPs, 45.1% was not aware of any psychotropic drugs available atpharmacies within their health area and 15.2% said they have prescribed psychotropic drugs. The participants who reported to have received a formal teaching on MH were 49.1% (Mulango et al.,

2018). In the far north region, in Guidiguis health district where health services are mainly delivered by nurses, 2 out of 15 nurses are able to list 3 or more symptoms of depression and know that depression can lead to suicide (Keugoung et al., 2013).

Figure 1: Map of Cameroon

5. Human Resources

In 2011, it was reported that in Cameroon, there are 0.03 psychiatrist per 100 thousand population, 0.15 nurses per 100 thousand population available; with 0.38 medical doctors being trained. There was no information on any other mental health professionals. Later, in 2017, there was no information about the above in the WHO mental health atlas Cameroon profile(WHO, 2011, 2018b). Still, it can be seen online, several websites for psychologist working in Cameroon(Bénédicte, Psychologue à Yaoundé, Cameroun, n.d.; Psychologie, 2011; Psychologues Cameroun, 2020; NJIENGWE, 2020).We couldn't find any information in regard to the west region.

6. Public Education and Links with Other Sectors

There is no reported public instruction or exchange with other sectors in regard to MH in Cameroon.

7. Monitoring and Research

Some researches about mental health in Cameroon can be seen on google scholar, PubMed and other platforms.But the main issues are that they are still very few and there is no monitoring information available(commonwealth, 2020; WHO, 2011, 2018b). We couldn't find any study done in the west region.

8. Conceptual framework

Figure 2: The optimal mix of services for mental health. (WHO, 2003b)

The above pyramid represents a summary of the conceptual framework in which we are aligning our study. It shows the different levels of care provision in an optimal setting. Based on the above review of literature, we can assume that the long stay facilities, specialist psychiatric services and community mental health services are not available in Cameroon. The psychiatry services in general hospitals and primary care mental health services are insufficient. But, it is only at the end of this study that we will be able to have a clear picture of the present situation.

III. Study justification

In 2009, neuropsychiatric disorders were ranked at the 6th position on the Environmental burden by disease category with 1.8 DALYs/1000 capita, per year, after conditions like diarrhea at 35, and malaria at 20. With its limited resources, this prompted the primary focus of the Cameroonian government towards other priorities (WHO, 2009). Today, mental health inCameroon still has a big delay, with thelack of appropriate information for decision makingas one of the factors

contributing to thiswhich can also lead to an under estimation of their real burden. So, in the next steps, we are going to design an appropriate way to collect some relevant information for the future of MH in Cameroon and specifically in west Cameroon.

On the other hand, this study will be highly facilitated by the fact that the lead researcher is a Cameroonian national studying psychiatry in Kenya, his first language is French, he has conducted a previous study in Cameroon and one of the supervisors, Dr Erero Njiengwe is a senior lecturer at the University of Douala and consultant clinical psychologist at l'Hopital Laquintinie de Douala. Other supervisors are well oriented to research in mental health systems strengthening in Africa.

IV. Study question

What is the current situation of MHS in West Cameroon?

V. Study Objectives

1. Broad objective

To carry out a landscaping and situational analysis of West Cameroon's MHS keeping WHO AIMS in mind.

2. Specific objectives

- Explore the Policy and Legislative Framework of the MHS of West Cameroon
- Describe the MH Services of the MHS of West Cameroon
- Describe MH services in Primary Health Care inWest Cameroon
- Describe the Human Resources implementing MHS of West Cameroon(the structure and investment)
- Describe the Public Education and Links with Other Sectors of the MHS of West Cameroon
- Describe the Monitoring framework and key national and regional Research initiatives of the MHS inWest Cameroon

VI. Methodology

1. Study design

We did an evaluation using a descriptive transversal design, the information was collected using the WHO AIMS questionnaire from primary and secondary sources including key informant interviews.

2. Study area description

The study was conducted in the West region of Cameroon. Cameroon is a LMIC, located in central Africa. It has a population of about 25 million people on a surface area of 475,440 km^2(The World Bank, 2020). It has two national languages, English and French(The World Bank, 2020b).The life expectancy at birth is 65.1 years for women and 61 years for males. The literacy rate is 82.6% for men and 71.6% for women. Cameroon was chosen for this study because neuropsychiatric illnesses represent 6.1% of the burden of illnesses present in the country and to address this issue, we need to be well informed about existing services and infrastructure given that available information is very insufficient(WHO, 2011). The West region of Cameroon has an estimated population of 1 921 590 people in 2015, divided into 20 department. Each department corresponds to one health area(BUCREP, 2015).

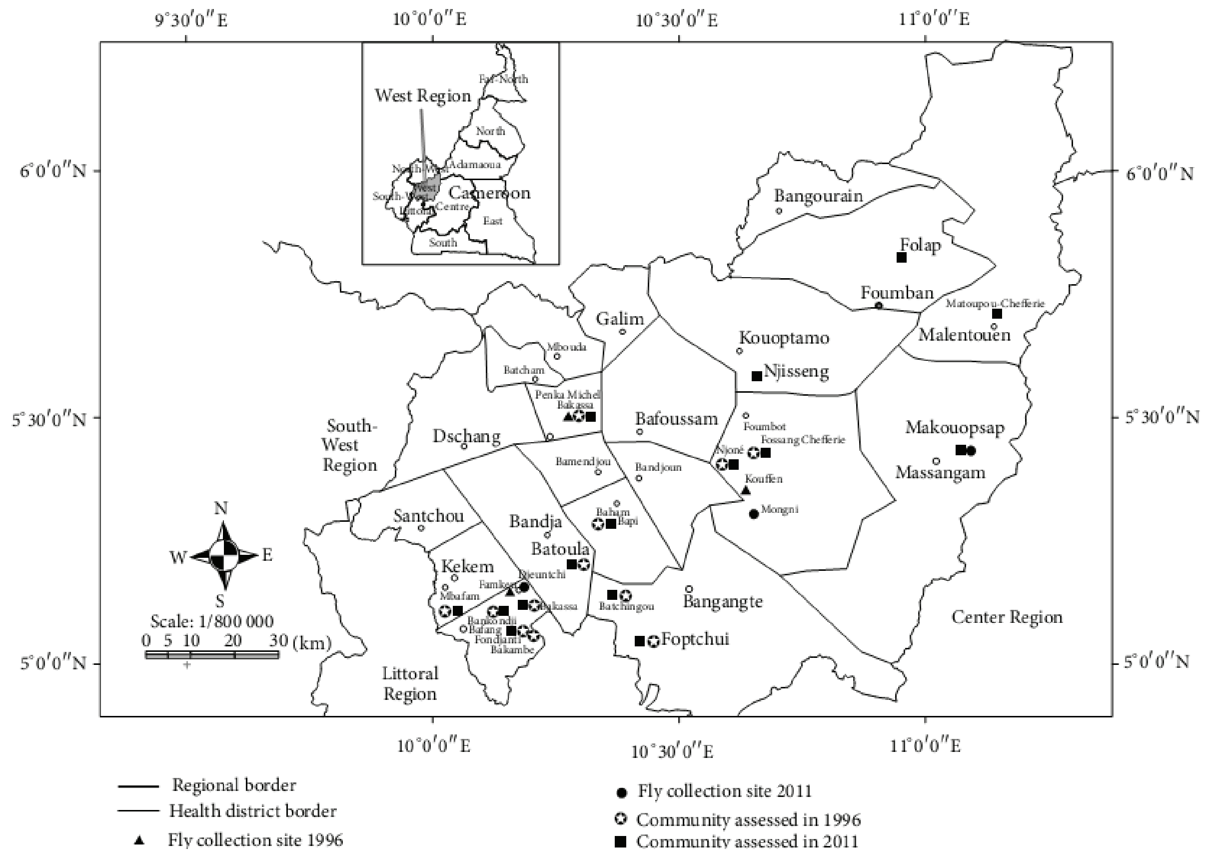

Figure 3: Map of west region Cameroon (study area)(Katabarwa et al., 2013)

The west region of Cameroon has an approximate geographical area of 13,872 square kilometers and a population of 1,982,100. The proportion of population under the age of 15 years is 46.4%, and the proportion of population at and above the age of 60 years is 7.69%.The main language used in the region is French, and the main ethnic group is "Bamileke". Religious groups include Muslim, Animist, Catholics and other Christian confessions. The population is a mixed of rural and urban population. Data was collected in February 2021 and is based on the year 2020.

3. Study population

-Population characteristics

Our objective was to have a mapping of MHS and services of West Cameroon. We collected information about all relevant pieces of this MHS which included personnel, policy, resources investment and policies associated with key institutions. We had 5 principal sources of information: people in psychiatric units of hospitals, community based psychiatric inpatient units, mental health outpatient facilities, community residential facilities and key informants at the MoH. Each of them had a set of questions extracted from the WHO-AIMS specifically designed for them.

-Inclusion

All accountable member of the MHS of the west region ofCameroon able to answer our questions who

- Is above 18 years of age
- Has given informed concern by signing the consent form

Some of our formal sources of information were from the following officials:

- The policy makers in MH, head of unit, MH nurses and other paraprofessionalsemployed in public or private practice.
- Document made available by the government of Cameroon, in regard to MH. Records of the mental health institutions.
- Human resources personnel at the delegation of MoH for the West region of Cameroon.

4. Recruitment and consenting procedures

We started by getting the approval of the ethic committee of UON/KNH, followed by the approval of the ethic committee of the University of Douala. We got the approval of the Delegation of the MoH for West Cameroon, and the approval of the directors of the hospitals where we collected data. To these people from whom we were seeking approval or consent we explained clearly what we were doing and got them sign the consent form that was provided in English and French. The answered questionnaires were kept locked in a safe box and the computer containing this information protected by a password.

5. Attributes of mental health systems of interest (mapped on WHO-AIMS)

Following are some of the indicators:

- Year of the last version of the MH policy document
- Components included in the MH policy
- Categories of psychotropic medicines included on the essential medicines list
- Year of the last version of the MH plan
- Components included in the MH plan(s)
- Strategies in the last MH plan
- Year of the last version of a disaster/emergency preparedness plan for MH in emergencies
- Year of the last version of MH legislation
- Components included in legislation on MH
- Standardized documentation and procedures for implementing MH legislation
- …..

6. Data collection

After the consent form was signed by the participant, the primary investigator was given the records of the year 2020 to extract the needed data and after this, if there were some missing information, the PI further cross-checked the information with the head of the unit or any other accountable person in the hospital. The interview was done in French or English depending in the first language of the interviewee.

WHO-AIMS is a questionnaire built by WHO that serves to collect the relevant information that will help in the future for specific interventions for the improvement of theMHS of a country. So far, Morocco and Ethiopia are reported good examples that made use of this tool to straighten efficiently theirMHS(WHO, 2009).

7. Materials

The interview and data extraction were guided by the WHO-AIMS version 2.2.

VII. Data management

The information collected through the questionnaires were grouped and are found in the present final document.

VIII. Results

1. Policy and legislative framework

Cameroon's mental health policy was last revised in 2016 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) monitoring system, (9) developing community mental health services, and (10) financing. It doesn't include the downsizing of large mental hospital.

The national essential medicines list includes all the categories of psychotropics: (1) antipsychotics, (2) anxiolytics, (3) antidepressants, (4) mood stabilizers, and (5) antiepileptic drugs

The last revision of the mental health plan took place in 2016 and included: (1) human resources, (2) advocacy and promotion, (3) human right protection of users, (4) financing, and (5) monitoring system. This mental health plan doesn't include the development of community mental health services, the downsizing of large mental hospitals, any reforming of the mental health hospitals to provide more comprehensive care, equity of access to mental health services across different groups, quality improvement. Even though users and families are mentioned in this plan, it is not clear which role they are going to play. A timeframe and specific goals are mentioned in the plans, some of which have been reached in the last year but, there is no budget dedicated to mental

health. There is no disaster/emergency preparedness plan for mental health and there is no current mental health legislation even though, there are some consideration in regard to mental health in the penal, civic and family code; example: article 87 of the penal code.

During the year 2020, there wasn't any inspection or training of mental health care workers on human rights.

There is no specific budget for mental health in Cameroon. All the mental health hospitals of the region are privately own and doesn't receive money from the government. There is no social assurance scheme and there is no free access to essential psychotropic medicines. One day treatment of antipsychotic medication is 8.7% and antidepressant medication is 20.4% of the minimum daily wage (these calculations are based on the current minimum monthly wage of 36,270 f. cfa). Worker's insurance benefits exist but the number of people covered is unknown.

2. Mental health services

There is a national mental health authority: vice director of mental health at the ministry of public health. Her and her office (1) provide advice to the government on mental health policy and legislation, (2) they are involved in service, (3) service management but there is no monitoring nor quality assessment of mental health services. In the west region, all community based psychiatric in-patient units are affiliated to a mental health out-patient facility in the same hospital. Both were rand by the same personnel except in the referral hospital of the region. Mental health services are organized in terms of service areas: district. There are 20 districts in the region but only 06 of them have a mental health facility: Batcham, Foumban, Mbouda, Dschang, Mifi, and Bangangte. Those not having any often send their mentally sick patients to the closest mental health service.

In the region, there are 08 outpatient mental health facilities and 02 neuropsychiatric unit that offer outpatient services. The neuropsychiatric unit is a combination of a psychiatric unit and a neurological unit. It is headed by a neurologist who diagnoses and treats psychiatric patients. For the purpose of this research, we are going to consider the neuropsychiatric unit as a psychiatric unit. None of these services is for children and adolescents only. These facilities treated 127 users per 100,000 general population (2,448 users). Of all users treated in mental health outpatient facilities 51% are female and 19% are below 18 years old.

The users treated in outpatient facilities are diagnosed with mental and behavioral disorders due to psychoactive substance (4%); schizophrenia, schizotypal and delusional disorder (14%);

mood disorders (22%); neurotic, stress-related and somatoform disorders (14%); disorder of adult personality and behavior (1%) and other diagnosis (epilepsy, organic mental disorders, mental retardation, behavioral and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development) represented (37%). These other diagnosis were dominated by epilepsy. The total is not adding up to 100% because of missing information in the registers. The average number of contacts per user is 2. Half of outpatient facilities provide follow-up care in the community, while 10% (01) have mental health mobile teams. There is no day treatment facility. In terms of available treatments, 20% of the outpatient facilities offer psychosocial treatments. These psychosocial treatments are delivered by clinical psychologists. 42.9% of mental health outpatient facilities have at last one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility and all of them have them in the facility or in a near-by pharmacy all year round.

There are 07 community-based psychiatric inpatient units (this includes 02 community-based neuropsychiatric inpatient units) available in the region for a total of 0.62 beds per 100,000 population; this doesn't include the beds of neuropsychiatric units. None of the beds in community-based inpatient units are reserved for children and adolescents only. Based on the estimations of mental health nurses, one unit had 20% and another one doesn't have admitted patient aged below 18 years old. One third of community-based psychiatric inpatient units have at least one psychotropic medicine of each therapeutic class (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility. There is no community residential facility in the region.

There are 02 mental hospitals available in the region for a total of 1.6 beds per 100,000 population. All of these facilities are organizationally integrated with mental health outpatient facilities. None of these beds in mental hospitals are reserved for children and adolescents only. Of the users of mental hospitals 40.6% were female. The diagnosis among all users of mental hospitals are as follows: mental and behavioral disorders due to psychoactive substance use (23.8%); schizophrenia, schizotypal and delusional disorders (38.1%); mood disorders (8.8%); neurotic, stress-related and somatoform disorders (5%); disorder of adult personality and behavior (0.6%) and other (6.9%). The number of users of mental hospitals is 8.3 per 100,000 population (160 users). 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. There is no forensic nor residential facility in the region.

The status of voluntary/involuntary admission to mental health institutions is not recorded. Nurses reported that, 19% of patients were restrained or secluded at least once within the last year in community-based psychiatric inpatient units, in comparison to an estimated 30% of patients in mental hospitals.

The ratio of beds located in Bafoussam which is the largest city of the region compare to those available in the whole region is 3. Inequity of access to mental health services for other minority users (e.g., linguistic, ethnic, religious minorities) is a mild issue in the region.

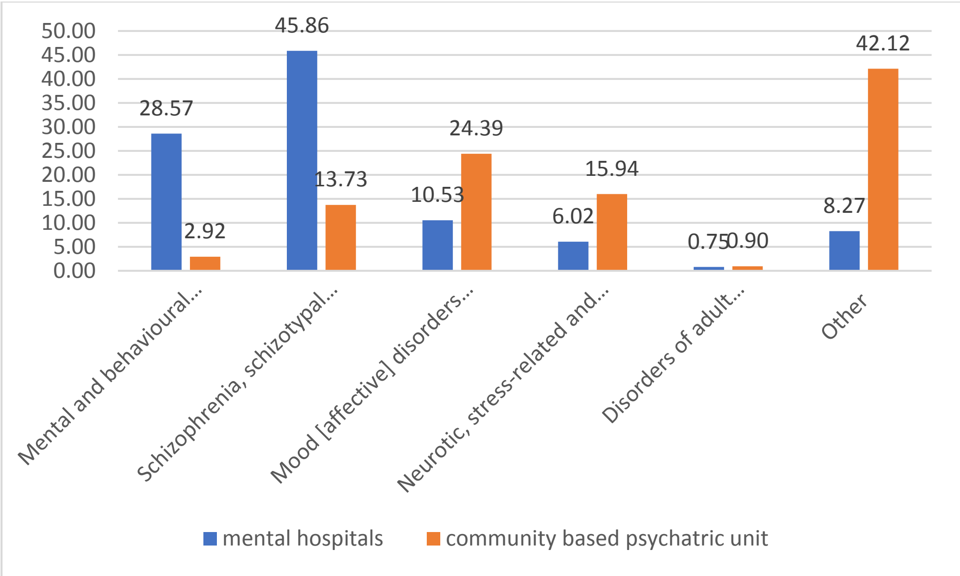

Figure 4: Percentage of patients treated in mental health facilities by diagnosis

The predominant diagnosis category on this diagram is schizophrenia, schizotypal and delusional disorders for mental hospitals and other for community based psychiatric units.

3. Mental health in primary health care

In the training hours for medical doctors 0.9 percent is devoted to mental health, this training is only theoretical. Nurses also receive trainings on mental health but we couldn't get more on this. In terms of refresher training, 02 nurses, belonging to a faith based hospital, have received at least two days of refresher training in mental health, while none of the primary health care doctors received such a training.

In terms of physician-based primary health care clinics offering mental health services, few (14.3%) have assessment and treatment protocols for key mental health conditions available; 50% of full time primary health care doctors make at least one referral per month to a mental health professional; as a follow up on their transferred patients, 29% of the primary health care doctors in these hospitals interact at least once a month with the mental health professional and 14% of these facilities, none of the mental hospitals, interacted with a complementary/ alternative/ traditional practitioner.

Non doctor/non nurse primary health care workers are not allowed to prescribe psychotropic medications in any circumstance. Primary health care doctor and mental health nurses are allowed to prescribe psychotropic medications without restrictions. But on the ground, this is done by psychiatric nurses and neurologists. As for availability of psychotropic medicines, almost all of physician-based PHC clinics have at least one psychotropic medicine of each therapeutic category (anti-psychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic).

4. Human resources

The total number of human resources working in mental health facilities per 100,000 population is 1.87. The breakdown according to profession is as follows: zero psychiatrist, 0.1 neurologist, 0.05 general practitioner, 1.4 nurses, 0.1 psychologists, zero social workers, zero occupational therapists, and 0.2 other health or mental health workers (including auxiliary staff, non-doctor/non-physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counselors). Fifty two percent of psychologists and nurses work only for government administered mental health facilities, 45% only for mental health NGO/ for profit mental health facilities/ private practice, and 3 % work for both. One nurse in 1.4 works in the largest city: Bafoussam

Regarding the workplace, as for other medical doctors (i.e., those not specialized in mental health), 2 (neurologists) work in mental health outpatient facilities and in the community-based psychiatric inpatient units of the same hospitals, 1 (general practitioner) works only in the community-based psychiatric inpatient unit, and none in mental hospitals. There are 17 nurses working in mental health outpatient facilities, 16 in community-based psychiatric inpatient units and 10 in mental hospitals. As for other mental health professionals, there is 02 psychologists working in hospitals that include an outpatient facility and a community-based psychiatric inpatient unit; each of them covers both units. None of

them work in a mental hospitals. Finally, regarding other health or mental health workers, 04 work in mental hospitals, there is none working in community-based psychiatric inpatient units and outpatient facilities because in these facilities, there belong to other units and assist in case they are needed.

In terms of staffing in mental health facilities, there are 1.3 nurses per bed assigned specifically for psychiatric patients in community-based psychiatric inpatient units, in comparison to 0.33 per bed in mental hospitals. Finally, for other mental health care staff (e.g., psychologists, social workers, occupational therapists, other health or mental health workers), there are 0.17 per bed for community-based psychiatric inpatient units, and there is none in mental hospitals. About the distribution of human resources between urban and rural areas, one nurse in 1.4 works in the largest city: Bafoussam.

In the region, there is one school that trains mental health nurse but no gradation so far. There is only one school of medicine and several schools of nursing, these other schools doesn't train mental health professionals. Among the mental health care staff one nurse attended refresher training on the rational use of drugs, none of them attended a refresher training on psychosocial interventions, or child/adolescent mental health issues. There are no consumer or family associations in the region.

5. Public education and links with other sectors

There is a foundation in the region: Fondation Olympia Jujitsu Cameroun (FOJCAM) that oversee public education and awareness campaigns on psychoactive substance use in the whole country. These campaigns have targeted the following groups: general population, adolescents, and women. There haven't been public education and awareness campaigns targeting professional groups.

At the present time, there is no legislative or financial support for employment, provision against: discrimination at work, discrimination in housing for people with mental disorders and for housing. There is no formal collaborative program with other health and non-health agency.

There is no mental hospital providing employment to people with severe mental disorder. Information on mental health and schools is not available but from what was gotten from the mental health workers of the region, none of them work for a school. Only one nurse provides mental health services in one of the prisons of the region and he sees at least one

prisoner per month from the prison of his district. The mental health workers of the region didn't offer any educational activity to police officers, judges, laws. Finally, there is no social welfare benefit for disability in the region.

6. Monitoring and research

A formally defined list of individual data items that ought to be collected by all mental health facilities exists and includes the number of inpatient admissions, number of days spent in hospital, diagnosis, and number of users treated even though none of these facilities collected data on the number of days spent in admission. This information is sent after every trimester to the west regional delegation for the ministry of public health. There is no report produced on mental health services by the government. None of the mental health professionals of the region is involved in research. There hasn't been any publication on mental health in the region in the past five years. In the same time, there are 40 health related publications from the region identified on PubMed.

IX. Discussion

1. Policy and legislative framework

Mental health is one of the priority areas within the Ministry of Health's strategic plan (MoH, 2016a). This might explain why we found some success both from the government and the private sector in regard to mental health services in the West region of Cameroon. These services are been provided in physician based primary health care, in the referral hospital of the region and in two mental hospitals. These mental hospitals are staffed with nurses only. Currently, the service covers 6 of the 20 health districts areas of the region. The commitment of the Cameroonian government towards mental health can also be seen in the efforts they put in place to address the mental health aspect of COVID 19 pandemic (Mviena et al., 2020)..

The last version of the mental health policy and plan were developed in 2016, they were approved by the minister of public health. The mental health policy addresses all the strategic aspect needed except downsizing of mental health hospitals. This might be because currently in Cameroon, the public mental hospitals available are all integrated within general hospitals. Together with the privately own mental hospitals, they are poorly specialized and only offer short term services. So, there is a need to include in the planning the construction of

comprehensive infrastructures for mental health services, including highly specialized, long stay mental hospital, forensic units, and make these services accessible to the populations of the whole country. There should also be community mental health services and a promotion of informal mental health services (WHO, 2003b). The mental health plan failed to take into consideration some key aspects such as equity of access to mental health services, improvement of the package of services, and the development of community mental health services. Some efforts are needed to improve its quality and its impact. These insufficiencies might be due to the failure to include, the patients, their families; representatives from the ministry of finance, ministry of justice, social welfare, and private sector in the development of these documents. Also, it has been reported that the mental health policy is not available in hard copy. As mentioned by some mental health professionals in the country, their quality is questionable. For example, under mental health financing, the amount and the source of money that needs to be allocated are not mentioned; the number of human resources needed is not mentioned. These documents are supported by evidence from some few hospital based studies, which is not enough. And, there are several other quality issues that can be raised (MoH, 2016b, 2016c; WHO, n.d.-b, n.d.-a). Some of these findings are not unique to Cameroon. WHO reports that only half of the lower middle income countries with a mental health policy report an estimation of the financial and/or human resources and, in Africa, 72% of the countries have a standalone mental health policy and/or plan(WHO, 2018a). There is a need for the development of mental health legislation and emergency plan. The mental health legislation is indeed very important because people with mental disorders are highly stigmatized and marginalized in Cameroon (MoH, 2016c). This might thereby help in promoting their rights and improve their management (WHO, 2003a). We also need a mental health emergency plan, particularly because of the current Anglophone crisis in the English speaking regions of the country (O'Grady, 2019).

One day treatment of medication is 8.7% and20.4% of the minimum daily wage. This seems better than the 37% and 7% observed in Uganda, respectively for antipsychotic and antidepressant medication (Kigozi et al., 2010).

2. Mental health services

Currently in Cameroon, there is no monitoring of the mental health services been offered. The mental health department at the MoH might benefit by putting a monitoring system in place. This might help them to have a better understanding of the process been

deployed and build a more efficient approach to address the mental health needs of the population. The most commonly found diagnosis categories in this population was schizophrenia, schizotypal and delusional disorders at 45.86% in mental hospitals and other diagnosis (epilepsy, organic mental disorders, mental retardation, behavioral and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development) at 42.12% in community based psychiatric units. They are several factors which can contribute to this pattern. They were two hospitals with a neuropsychiatric unit, of which one had the highest number of psychiatric patients seen in the year 2020. These neuropsychiatric units are headed by neurologists whom are the ones making diagnosis. These neurologists are likely to attract more of the psychiatric patients with neurological manifestations, and they are likely to attribute a neurological diagnosis to a psychiatric condition thereby; inflating the proportion of patients with neurological diagnosis. The high proportion of patients with schizophrenia, schizotypal and delusional disorder in mental hospitals might be explained by the fact that these are usually very severe and chronic conditions, making it more likely to arrive to the hospital. A similar pattern was observed in Ghana where the predominant diagnosis in outpatient mental health services was other (39%) followed by schizophrenia (25%) and the predominance of schizophrenia (21%) in community based psychiatric in patient unit, other not taken into consideration. Also schizophrenia was the most common diagnosis in mental hospitals: 32% (Roberts et al., 2014). These diagnosis reported in the records present some issues. We observed some diagnosis such as “schizophrenie induite par l’usage de substance psychoactive” (substance induced schizophrenia), “psychose maniaco depressive” (maniaco depressive psychosis), “psychose hallucinatoire chronique” (chronic hallucinatory psychosis) and more which raised some concern about the quality of the diagnosis made because none of these diagnosis exist in the ICD 10 or in the DSM 5(APA, 2013; WHO, 2016). The number of contact of 2 per patient we found is small compare to the 4.99 found in Ghana(Roberts et al., 2014). We couldn’t identify any reason for this loss of follow up. This might be an interesting area of exploration in the future. In community based psychiatric inpatient units nurses estimated that 19% of patients were either secluded or physically restrained. This is higher than the 10% reported in Ghana and lower than the 33% reported on average in LMICs (Roberts et al., 2014; WHO, 2009b).

The psychiatric beds density in the largest city: Bafoussam is 3 times the beds available in the entire region. This ratio is similar to the average 2.9 found in LMIC (WHO, 2009b). It illustrates lower access of rural populations to mental health services.

3. Mental health in primary health care

Less than 1% of the training of medical doctors is devoted to mental health in Cameroon, this is very small compare to the 10% observed in Uganda, and the average 3% in LMICs (Kigozi et al., 2010; WHO, 2009b). Also, this training in Cameroon does not include any practical exposure to mental health. This might explain the less than 2% diagnosis rate of depression by general practitioners of Douala, Cameroon (Toguem et al., 2019). To address this, the ministry of higher education and the ministry of public health should develop a comprehensive program to equip doctors and nurses with skills to address mental health issues. Assessment and treatment protocols were only available in few physician based PHC, which is similar to the findings in Uganda and is the general tendency in LMIC (Kigozi et al., 2010; WHO, 2009b). These protocols should be developed and made available, taking into consideration the recommended drugs and the emergency psychiatric conditions that can be found in Cameroon. There was no interaction with traditional healers, contrary to what was found in Ghana (Roberts et al., 2014). This interaction shall be built because it helps in providing a better care to patients (WHO, 2018a).

4. Human resources

The average number of human resources working in mental health facilities of 1.87 per 100.000 population is way below the 6 per 100.000 population observe in LMICs, and is above the African average of 1.3 per 100.000 population. Of these 1.87 per 100.000 population, there is no psychiatrist. We should acknowledge the fact that by the time we were ending with our data collection, the first psychiatrist of the west region of Cameroon settled in the referral hospital of the region. The school of psychiatric nursing in the region, the post graduate program of psychiatry, and psychology that are in the country might further contribute to fill this gap in the future. The amount of people trained needs to be further aligned with an assessment of the needs of the population in terms of mental health.

5. Public education and links with other sectors

We could only find one mental health promotion program in the region, designed for psychoactive substance use where, 52% of the African countries have less than 2 functional

programs. The public education needs also to be planned and executed by the same team that built the mental health plan. This has also to be expanded to other areas such as suicide prevention, domestic violence, mental health stigma, and more (WHO, 2018a). There is also a need for formal agreement of mental health services with other sectors for the mental health service to be able to reach those in prisons, at school, and all the other area where these services are highly needed.

6. Monitoring and research

As a starting point for an efficient and effective mental health system in West Cameroon, the environment needs to be enable to facilitate research which will serve to build an evidence based mental health service in the region.

X. Conclusion

The current mental health system in west Cameroon still have a lot to improve on. But, some significant effort from the government to fill this gap can be noticed. One mental health nursing school created in the region in the past 2 years, services covering 6 out of the 20 districts, the first psychiatrist in the region arriving during our data collection. This effort need to use an evidence based, and comprehensive approach, with a big focus on quality.

XI. Recommendations

The main recommendations we can make are that the government should:

- Maintain the good things that have been started already
- A more comprehensive approach should be used. That is, including research, systemic planning, training, service delivery, monitoring system
- More studies shall be done to have a good understanding of the need in terms of mental health services in the region and the decisions should reflect on these studies
- The process to address mental health issues should include all the protagonists of mental health. That's: the private sector, the faith organizations, patients and their families, and so on.
- There should be a focus on quality
- A monitoring system should be put in place to assess the evolution of the process and make corrections when needed.

XII. Limitations

The information collected in this study is gotten from key informants and records. The information gotten form key informants may be reflecting their opinion more than the actual fact. The information gotten form records are altered by some missing information and the quality of the information reported. Some indicators such as the number of psychiatric beds available in the community based psychiatric inpatient unit may not really reflect the size of the service offered because most of the time even though they didn't had exclusive beds, they could hospitalize on any bed available in another unit. Some mental health units frequently have student that are there for internships and thereby contribute to the service being offered but were not captured in our study. Some other personnels are trained in HIV programs to offer psychological support to HIV patients but they are not linked with the formal mental health system of the region and were not captured in the study. These data reflect the year 2020 and things seems to be changing on the ground in Cameroon.

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Appendices

Formulaire de consentement éclair

Titre de l'étude : Le système de santé mentale du Cameroun

Investigateur principal: TOGUEM Guy Michaël

Informations sur l'étude

- But de l'étude

Décrire les éléments du system de sante mentale du Cameroun

- Procédure

Après lecture et signature de ce formulaire de consentement, nous vous prions de bien vouloir remplir au mieux le questionnaire qui suit. Les informations ainsi collectées serviront à la cause sus citée

- Confidentialité

Pour assurer une confidentialité stricte, ne mettez pas votre nom sur la fiche, et les données serons traités de façon anonyme. Tout en vous garantissant la plus grande discrétion possible.

- Caractère volontaire de la participation

Nous déclarons que la participation est volontaire et que le refus de participer n'entraîne aucune conséquence.

- Personne à contacter pour répondre aux questions sur la recherche et sur le droit des participants
  - L'investigateur principal: TOGUEM Guy Michaël

Université de Nairobi
+254 7 57 33 47 81
tgmic91@gmail.com

- superviseurs : Dr Frederick Owiti, Dr Manasi Kumar, Dr Erero Njiengwe(Senior lecturer, universite de Douala)

Fait à...le…………………

Signature participant Signature de l'investigateur

Informed Consent Form

Title of the study: The mental health system of Cameroon

Principal investigator: TOGUEM Guy Michaël

Information on the study

- Aim of the study

Describe the features of the mental health system of Cameroon.

- Procedure

After reading and signing this consent form, we kindly ask you to fill out the following questionnaire to the best of your knowledge. The information collected will be used for the above-mentioned purpose

- Confidentiality

To ensure strict confidentiality, do not put your name on the questionnaire, and the data will be treated anonymously. While guaranteeing you the greatest possible discretion.

- Voluntary nature of participation

We declare that participation is voluntary and that the refusal to participate has no consequences.

- Contact person to answer questions about research and the rights of participants
  - The principal investigator: TOGUEM Guy Michaël

    University of Nairobi

    +254 7 57 33 47 81

    tgmic91@gmail.com

- Supervisors: Dr Frederick Owiti, Dr Manasi Kumar, Dr Erero Njiengwe (Senior lecturer, university of Douala)

Done at...the ………………….

Participant's signature   Investigator's signature

Mental health departments' questionnaire

Kindly answer at the best of your knowledge. This is not an evaluation questionnaire but instead we are looking for what we can provide for our mental health system to be of a better quality.

Name of the hospital ______________________________________.

1.4.2- At least one yearly external review/inspection of human rights protection of patients?

Yes ☐ No ☐ UN ☐ NA ☐

1.4.4- At least one-day training, meeting, or other type of working session on human rights protection of patients in the last two years?

Yes ☐ No ☐ UN ☐ NA ☐

2.1.3- Is this hospital integrated with any mental health outpatient facility?

Yes ☐ No ☐ UN ☐ NA ☐

2.6.1- Number of mental health departments in Cameroon?

☐ UN ☐

2.6.2- Number of beds in your mental health department?

☐ UN ☐ NA ☐

2.6.3- Number of beds in your mental health department 5 years ago?

☐ UN ☐ NA ☐

2.6.4- Number of patients treated in your mental health department?

☐ UN ☐ NA ☐

Number of female patients treated in your mental health department?

UN NA

2.6.5- Number of patientstreated in your mental health department last year by ICD-10 diagnosis in each of the following?

1. Mental and behavioural disorders due to psychoactive substance use (F10-F19)
2. Schizophrenia, schizotypal and delusional disorders (F20-F29)
3. Mood [affective] disorders (F30-F39)
4. Neurotic, stress-related and somatoform disorders (F40-F48)
5. Disorders of adult personality and behaviour (F60-F69)
6. Other (e.g., epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development)

2.6.6- Number of admissions to your mental health department?

UN NA

Number of involuntary admissions to your mental health department?

UN NA

2.6.7- Number of patients staying in your mental department on 31 December of the last year?

UN NA

Number of long-stay patients by length of stay on 31 December of the last year in your mental health department?

1. more than 10 years
2. 5-10 years
3. 1-4 years
4. less than 1 year

2.6.8/ 2.6.9- Cumulative number of days spent in your mental health department (total of all patients)

UN NA

2.6.10- Percentage of patients who were physically restrained or secluded at least once in the last year in your mental department?

A = over 20% of patients were restrained or secluded

B = 11-20% of patients were restrained or secluded

C = 6-10% of patients were restrained or secluded

D = 2-5% of patients were restrained or secluded

E = 0-1% of patients were restrained or secluded

2.6.11- Number of patients 17 years of age or younger treated in your mental health department?

☐ UN ☐ NA ☐

2.6.12- Number of beds in your mental health department that are for children and adolescents only?

☐ UN ☐ NA ☐

2.7.2- Number of beds in forensic inpatient units?

☐ UN ☐ NA ☐

2.9.1- Percentage of patients who received one or more psychosocial interventions in your mental health department in the last year?

A = none (0%)

B = a few (1 - 20%)

C = some (21 - 50%)

D = the majority (51 - 80%)

E = all or almost all (81 - 100%)

2.10.1- At least one psychotropic medicine of each therapeutic category(antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) available in your hospital all year long?

Yes ☐ No ☐ UN ☐ NA ☐

2.11.1- Number of psychiatry beds in community-based psychiatric inpatient units in the city?

Number of mental hospital beds in or near the city?

☐ UN ☐ NA ☐

Number of psychiatric beds in community-based psychiatric inpatient units in Cameroon?

☐ UN ☐ NA ☐

Number of mental hospitals (or mental health department) in the entire country?

UN NA

2.11.5- In comparison to their relative population size, ethnic and religious minority groups make up:

A = Substantially larger proportion of admissions to *mental hospitals*

B = Roughly equal proportion of admissions to *mental hospitals*

C = Substantially smaller proportion of admissions to *mental hospitals*

Community based psychiatric inpatient unit's questionnaire

Kindly answer at the best of your knowledge. This is not an evaluation questionnaire but instead we are looking for what we can provide for our mental health system to be of a better quality.

1.4.3- At least one yearly external review/inspection of human rights protection of patients?

Yes No

Number of community-based inpatient psychiatric units and community residential facilities in Cameroon?

UN

1.4.5- At least one-day training, meeting, or other type of working session on human rights protection of patientsin the last two years?

Yes No

2.4.1- Number of community-based psychiatric inpatient units in Cameroon?

UN

2.4.2- Number of beds in community-based psychiatric inpatient units?

UN NA

2.4.3- Number of admissions to your community-based psychiatric inpatient units?

UN NA

Number of female admissions to your community-based psychiatric inpatient units?

UN NA

2.4.4- Number of admissions to community-based psychiatric inpatient units by ICD 10 diagnosis?

1. Mental and behavioural disorders due to psychoactive substance use (F10-F19)
2. Schizophrenia, schizotypal and delusional disorders (F20-F29)

3. Mood [affective] disorders (F30-F39)
4. Neurotic, stress-related and somatoform disorders (F40-F48)
5. Disorders of adult personality and behaviour (F60-F69)
6. Other (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development)

2.4.5- Number of involuntary admissions to your community-based psychiatric inpatient units?

☐ UN ☐ NA ☐

2.4.6- Cumulative number of days that discharged patients spent in your community-based psychiatric inpatient units in the previous year (total across all discharges)?

☐ UN ☐ NA ☐

Number of discharges from community-based psychiatric inpatient units in the previous year?

☐ UN ☐ NA ☐

2.4.8- Number of admissions of patients 17 years of age or younger to your community-based psychiatric inpatient units?

☐ UN ☐ NA ☐

2.4.9- Number of beds in your community-based psychiatric inpatient unit?

☐ UN ☐ NA ☐

Number of beds for children and adolescents only in your community-based psychiatric inpatient?

☐ UN ☐ NA ☐

2.9.2- Percentage of patients who received one or more psychosocial intervention in your community-based psychiatric inpatient unit in the last year?

A = none (0%)

B = a few (1 - 20%)

C = some (21 - 50%)

D = the majority (51 - 80%)

E = all or almost all (81 - 100%)

2.10.2- At least one psychotropic medicine for each therapeutic category(antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) available in your community-based psychiatric inpatient unit?

Yes ☐ No ☐

2.11.1- Number of psychiatry beds in your community-based psychiatric inpatient units?

☐ UN ☐ NA ☐

Number of mental hospital beds in or near the largest city?

☐ UN ☐ NA ☐

Number of psychiatric beds in community-based psychiatric inpatient units and mental hospitals in the entire country?

☐ UN ☐ NA ☐

4.1.1- Number of human resources working for mental health facilities or private practice?

1. Psychiatrists
2. Other medical doctors, not specialized in psychiatry,
3. Nurses
4. Psychologists
5. Social workers
6. Occupational therapists
7. Other health or mental health workers (including auxiliary staff, non-doctor/non- Physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors)

4.1.3- In your institution, number ofpsychologists, social workers, nurses, and occupational therapists working in

1. **only** in or for government-administered mental health facilities
2. **only**in or for mental health NGOs/for-profit mental health facilities /private practice
3. in or for both (a) government-administered mental health facilities and (b) a mental health NGO/for-profit mental health facility/private practice (i.e. this category is for professionals combining work in a government-administered facility and work in one of the other sectors mentioned)

6.1.3- Routinely collect and compile data by type of information

1. Number of beds
2. Number of inpatient admissions
3. Number of days spent in hospital
4. Number of involuntary inpatient admissions
5. Number of patients who are physically restrained or secluded
6. Diagnoses

6.1.5- The government health department received data in the last year from how many

1. Mental hospitals

2. Community-based psychiatric inpatient units

3. Mental health outpatient facilities

Number of mental health facilities (for each type of facility)?

[ ] UN [ ]

Mental health outpatient facilities' questionnaire

Kindly answer at the best of your knowledge. This is not an evaluation questionnaire but instead we are looking for what we can provide for our mental health system to be of a better quality.

2.1.3- Your mental health outpatient facility integrated with a mental hospital?

Yes ☐ No ☐

Number of mental hospitals in Cameroon?

☐ UN ☐

2.2.1- Number of mental health outpatient facilities inCameroon?

☐ UN ☐

2.2.2- Number of users treated throughyour mental health outpatient facility?

☐ UN ☐

2.2.3- Number of female users treated through yourmental health outpatient facility?

☐ UN ☐

2.2.4- Number of users treated throughyour mental health outpatient facilities by ICD-10 diagnosis?

1. Mental and behavioural disorders due to psychoactive substance use (F10-F19)
2. Schizophrenia, schizotypal and delusional disorders (F20-F29)
3. Mood [affective] disorders (F30-F39)
4. Neurotic, stress-related and somatoform disorders (F40-F48)
5. Disorders of adult personality and behaviour (F60-F69)

6. Other (e.g. epilepsy, organic mental disorders, mental retardation, behavioural and emotional disorder with onset usually occurring in childhood and adolescence, disorders of psychological development)

2.2.5- Cumulative number of outpatient contacts provided in the previous year through your mental health outpatient facility (total of all users)?

☐ UN ☐ NA ☐

Number of users treated throughyour mental health outpatient facility in the previous year?

☐ UN ☐ NA ☐

2.2.6- Number of users 17 years of age or younger treated throughyourmental health outpatient facilities?

☐ UN ☐ NA ☐

Number of users treated through yourmental health outpatient facilities?

☐ UN ☐ NA ☐

2.2.7- Number of mental health outpatient facilities for children and adolescents only in Cameroon?

☐ UN ☐ NA ☐

Number of mental health outpatient facilities in Cameroon?

☐ UN ☐ NA ☐

2.2.8- Your mental health outpatient facilities that provides routine follow-up community care?

Yes ☐ No ☐

2.2.9- Your mental health outpatient facilities has mental health mobile clinic teams that provide regular mental health care outside of the mental health facility?

Yes ☐ No ☐

2.9.3- Percentage of users who received one or more psychosocial intervention in mental health outpatient facilities in the last year?

A = none (0%)

B = a few (1 - 20%)

C = some (21 - 50%)

D = the majority (51 - 80%)

E = all or almost all (81 - 100%)

2.10.3- Atleast one psychotropic medicine of each therapeutic category(antipsychotic, antidepressant, mood stabilizer, anxiolytic and antiepileptic medicines) available in the facility or in a nearby pharmacy?

Yes ☐ No ☐

2.11.2- In proportion to their relative population size, rural *users* are:

A = Substantially under-represented in their use of outpatient services
B = Roughly equally represented in their use of outpatient services
C = Substantially over-represented in their use of outpatient services

2.11.3- Percentage of mental health outpatient facilities employing a specific strategy to ensure that linguistic minorities can access mental health services in a language in which they are fluent

A = none (0%)

B = a few (1 - 20%)

C = some (21 - 50%)

D = the majority (51 - 80%)

E = all or almost all (81 - 100%)

2.11.4- In proportion to their relative population size, ethnic and religious minority *users* are:

A = Substantially under-represented in their use of outpatient services
B = Roughly equally represented in their use of outpatient services
C = Substantially over-represented in their use of outpatient services

2.11.6- On average a substantial difference (i.e.. greater than 50%) between governmentadministered and for-profit mental health care facilities on selected indicators of care. Answer by **Yes** or **No**.
On average a substantial difference (i.e.. greater than 50%) on

1. Average duration of the waiting list for an initial non-emergency psychiatric outpatient appointment
2. Average number of minutes of an outpatient consultation with a psychiatrist
3. Average number of beds per nurse in psychiatric inpatient facilities

4.1.1- Number of human resources working for mental health facilities or private practice:

1. Psychiatrists
2. Other medical doctors, not specialized in psychiatry,
3. Nurses
4. Psychologists

5. Social workers
6. Occupational therapists
7. Other health or mental health workers (including auxiliary staff, non-doctor/non- Physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors)

6.1.4- Routinely collect and compile data for

1. Number of users treated
2. Number of user contacts
3. Diagnoses

6.1.5- Transmit data to the government health department in the last year?

Yes ☐ No ☐

Community residential facilities' questionnaire

Kindly answer at the best of your knowledge. This is not an evaluation questionnaire but instead we are looking for what we can provide for our mental health system to be of a better quality.

1.4.3- At least one yearly external review/inspection of human rights protection of patients?

Yes ☐ No ☐

Number of community-based inpatient psychiatric units and community residential facilities in Cameroon?

☐ UN ☐ NA ☐

1.4.5- At least one-day training, meeting, or other type of working session on human rights protection of patients in the last two years?

Yes ☐ No ☐

2.5.1- Number of community residential facilitiesin Cameroon?

☐ UN ☐ NA ☐

2.5.2- Number of beds/places in community residential facilities?

☐ UN ☐ NA ☐

2.5.3- Number of users treated in community residential facilities?

☐ UN ☐ NA ☐

2.5.4- Number of female users treated in community residential facilities?

☐ UN ☐ NA ☐

2.5.5- Cumulative number of days spent in community residential facilities in the previous year (total of all users)?

☐ UN ☐ NA ☐

2.5.6- Number of users 17 years of age or younger treated in community residential facilities?

[ ] UN [ ] NA [ ]

2.5.7- Number of beds/places in community residential facilities for children and adolescents only?

[ ] UN [ ] NA [ ]

4.1.1- Number of human resources working for mental health facilities or private practice:

1. Psychiatrists
2. Other medical doctors, not specialized in psychiatry,
3. Nurses
4. Psychologists
5. Social workers
6. Occupational therapists
7. Other health or mental health workers (including auxiliary staff, non-doctor/non- Physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors)

Mental health day treatment facilities' questionnaire

Kindly answer at the best of your knowledge. This is not an evaluation questionnaire but instead we are looking for what we can provide for our mental health system to be of a better quality.

2.3.1- Number of mental health day treatment facilities in Cameroon?

☐ UN ☐

2.3.2- Number of users treated in mental health day treatment facilities?

☐ UN ☐ NA ☐

2.3.3- Number of female users treated in mental health day treatment facilities?

☐ UN ☐ NA ☐

2.3.4- Cumulative number of days on which users were present in mental health day treatment facilities in the previous year (total of all users)?

☐ UN ☐ NA ☐

2.3.5- Cumber of users 17 years of age or younger treated in mental health day treatment facilities?

☐ UN ☐ NA ☐

2.3.6- Number of mental health day treatment facilities for children and adolescents only?

☐ UN ☐

4.1.1- Number of human resources working for mental health facilities or private practice:

1. Psychiatrists

2. Other medical doctors, not specialized in psychiatry,
3. Nurses
4. Psychologists
5. Social workers
6. Occupational therapists
7. Other health or mental health workers (including auxiliary staff, non-doctor/non- Physician primary health care workers, health assistants, medical assistants, professional and paraprofessional psychosocial counsellors)

Questionnaire pour Hôpitaux psychiatric

Veillez repondre le plus veridiquement possible. Ceci n'est pas un questionnaire d'evalution mais plutot, il servira a apporter au system de sente mentale camerounias ce qu'il lui faut pour etre meilleur.

1.4.2- Y a t il au moins une supervision/inspection annuelle externe de respect des droits de l'homme pour les patients dans votre department?

Oui ☐ Non ☐

Quel est le nombre total de services de psychiatrie dans le pays?

☐ IN ☐

1.4.3- Quel est le nombre d'unités d'hospitalisation psychiatrique et de structures résidentielles communautaires / intégrées dans la cité avec au moins une supervision/inspection externe annuelle du respect des droits de l'homme pour les patients?

☐ IN ☐

Quel est le nombre total d'unités d'hospitalisation psychiatrique et de structures résidentielles communautaires / intégrées dans la Cité.

☐ IN ☐

1.4.4- avez vous eu au moins une journée de formation, une réunion ou autre type de session de travail sur le respect des droits de l'homme pour les patients dans les 2 dernières années dans votre departement de psychiatrie?

☐ IN ☐ NA ☐

2.1.3- Y a t il integre a votre departement de psychiatrie une structure embulatoire de sante mentale?

☐ IN ☐ NA ☐

2.6.1- Quel est le nombre d'hôpitaux psychiatriques au Cameroun?

☐ IN ☐

2.6.2- quel est le nombre de lits dans votre departement de psychiatrie?

[ ] IN [ ]

2.6.3- combien de lits y avait il dans votre departement de psychiatrie il y a 5 ans?

[ ] IN [ ]

2.6.4- Quel est le nombre de patients suivisdans votre department de psychiatrie?

[ ] IN [ ]

Quel est le nombre de femmes suivies dans votre departement de psychiatrie?

[ ] IN [ ]

2.6.5- Quel est le nombre de patients suivis dans votre departement de psychiatrie pour chaque catégorie diagnostique:

1. Troubles mentaux et comportementaux dus à l'utilisation d'une substance psychoactive (F10-F19)
2. Schizophrénie, troubles schizotypiques et autres troubles délirants (F20-F29)
3. Troubles de l'humeur [affectifs] (F30-F39)
4. Troubles névrotiques, liés au stress et somatoformes (F40-F48)
5. Troubles de la personnalité et du comportement chez l'adulte (F60-F69)
6. Autre (ex. épilepsie, troubles mentaux d'origine organique, retard mental, trouble comportemental et émotionnel survenu dans l'enfance et l'adolescence, troubles du développement psychologique)

2.6.6- Quel est le nombre d'admissions **sans consentement/sous contrainte** dans votre department de psychiatrie?

[ ] IN [ ] NA [ ]

Que lest le nombre d'admissions dans votre departement de psychiatrie?

[ ] IN [ ] NA [ ]

2.6.7- Quel est le nombre de patients hospitalisés dans votre departement de psychiatrie au long cours par durée de séjour au31 décembre de l'année précédente:

1. plus de 10 ans
2. 5-10 ans
3. 1-4 ans
4. moins d'un an

Quel est le nombre de patients séjournant dans votre department de psychiatrie au 31décembre de l'année précédente?

[ ] IN [ ] NA [ ]

2.6.8/2.6.9- Quel est le nombre cumulatif de jours passés dans votre departement de psychiatrie (total de tous les patients)?

[ ] IN [ ] NA [ ]

2.6.10- Quel pourcentage d'usagers qui ont été contraints physiquement ou isolés au moins une fois au cours de l'année précédente dans votre departement de psychiatrie?

A= Plus de 20% des patients ont été contraints ou isolés

B= 11-20% des patients ont été contraints ou isolés

C= 6-10% des patients ont été contraints ou isolés

D= 2-5% des patients ont été contraints ou isolés

E= 0-1% des patients ont été contraints ou isolés

2.6.11- Quel est le nombre de patients âgés de moisnde 18 ans suivis dans votre departement de psychiatrie?

[ ] IN [ ] NA [ ]

2.6.12- Quel est le nombre de lits dans votre departement de psychiatrie réservés aux enfants et adolescents?

[ ] IN [ ] NA [ ]

2.7.2- Quel est le nombre de lits dans les unités d'hospitalisations médico-légales par type de structure :

1) Hôpitaux psychiatriques
2) Unités médico-légales dans les hôpitaux psychiatriques
3) Unités médico-légales dans leshôpitaux généraux
4) Structures de soins en santé mentale dans les prisons

2.9.1- quel pourcentage de patients ont bénéficié d'une intervention psychosociale ou plus au cours de l'année précédente dans votre departement de psychiarie?

A = zéro (0%)

B = peu (1 - 20%)

C = quelques uns (21 - 50%)

D = la majorité (51 - 80%)

E = tous ou presque tous (81 - 100%)

2.10.1- y a t il au moins un médicament psychotrope de chaque catégorie thérapeutique disponible dans votre hospital?

Oui ☐ Non ☐

2.11.1- quel est le nombre de lits psychiatriques dans les unités d'hospitalisations psychiatriques **communautaires / intégrées dans la cité** et dans les hôpitaux psychiatriques dans ou à côté de la plus grande ville?

☐ IN ☐ NA ☐

Quel est le nombre de lits psychiatriques dans les unités d'hospitalisations psychiatriques communautaires / intégrées dans la cité et hôpitaux psychiatriques dans tout le pays?

☐ IN ☐ NA ☐

2.11.5- Relativement à la taille de leur population, les groupes de minorités ethniques et religieuses sont:

A = Admis en plus grande proportion dans les hôpitaux psychiatriques
B = Admis en proportion plus ou moins égale dans les hôpitaux psychiatriques
C = Admis en plus petite proportion dans les hôpitaux psychiatriques

4.1.1- Quell est le Nombre de personnes par catégorie professionnelle travaillant dans ou pour les structures de santé mentale ou en cabinet privé:

1. psychiatres
2. autres docteurs en médecine, non spécialisés en psychiatrie
3. infirmièr(e)s
4. psychologues
5. travailleurs sociaux
6. ergothérapeutes
7. autres travailleurs de santé ou de santé mentale (incluant : équipe paramédicale, travailleurs de soins de santé primaire non médecins, assistants de santé, assistants médicaux, conseillers psychosociaux professionnels et para professionnels)

4.1.4- Quel est le nombre de professionnels de santé mentale à temps plein ou à temps partiel travaillant dans ou pour les structures ambulatoires de santé mentale:

1. psychiatres
2. autres docteurs en médecine, non spécialisés en psychiatrie
3. infirmièr(e)s
4. psychologues, travailleurssociaux, et ergothérapeutes

5. autres travailleurs de santé ou de santé mentale

6.1.2- Collectez vous régulièrement les données sur

1. Nombre de lits
2. Nombres de patients hospitalisés
3. Nombre de jour d'hospitalisation
4. Nombre d'hospitalisations sans consentement (sous contrainte)
5. Nombre d'usagers ayant subit une contention physique ou un isolement
6. Diagnostics

6.1.5- avez vous transmis des données au département de santé publique au cours l'année dernière

Oui ☐ Non ☐

Questionnaire pour unité d'hospitalisation psychiatrique, intégrée dans la Cité

Veillez repondre le plus veridiquement possible. Ceci n'est pas un questionnaire d'evalution mais plutot, il servira a apporter au system de sente mentale camerounias ce qu'il lui faut pour etre meilleur.

1.4.3- Avez vous au moins une supervision/inspection externe annuelle du respect des droits de l'homme pour les patients?

Oui ☐ Non ☐

2.4.1- Quel est le nombre total d'unités d'hospitalisation psychiatrique et de structures résidentielles communautaires / intégrées dans la Cité?

1.4.5- avez vous eu au moins une formation d'une journée, une réunion ou autre type de session de travail sur le respect des droits de l'homme pour les patients dans les 2 dernières années?

Oui ☐ Non ☐

2.4.2- Quel est le nombre de lits dans les unités d'hospitalisation psychiatrique communautaires / intégrées dans la cite?

2.4.3- Quel est le nombre total d'admissions dans les unités d'hospitalisation psychiatrique communautaires / intégrées dans la cite?

☐ IN ☐

Quel est le nombre de femmes admises dans les unités d'hospitalisation psychiatrique communautaires / intégrées dans la cite?

☐ IN ☐

2.4.4- Quel est le nombre d'admissions dansles unités d'hospitalisation psychiatrique communautaires / intégrées dans la cité par diagnostic CIM-10?

1. Troubles mentaux et comportementaux dus à l'utilisation d'une substance psychoactive (F10-F19)
2. Schizophrénie, troubles schizotypiques et autres troubles délirants (F20-F29)

3. Troubles de l'humeur [affectifs] (F30-F39)
4. Troubles névrotiques, lies au stress et somatoformes (F40-F48)
5. Troubles de la personnalité et du comportement chez l'adulte (F60-F69)
6. Autre (ex. épilepsie, troubles mentaux d'origine organique, retard mental, trouble comportemental et émotionnel survenu durant l'enfance et l'adolescence, troubles du développement psychologique)

2.4.5- Quel est le nombre d'admissions sans consentement/sous contrainte dans les unités d'hospitalisation psychiatriquecommunautaires / intégrées dans la cite?

[ ] IN [ ]

2.4.6- Quel est le nombre d'hospitalisations dans votreunités d'hospitalisations psychiatriques communautaires / intégrées dans la cite?

Quel est le nombre de jours cumulés d'hospitalisation dans votreunités d'hospitalisations psychiatriquesau cours del'année précédente (total de toutes les hospitalisations)?

[ ] IN [ ]

2.4.7- Quel pourcentage de patients ont été contraints physiquement ou isolés au moins une fois au cours del'année précédente, dans desunités d'hospitalisations psychiatriques communautaires / intégrées dans la cite

A = Plus de 20% des patients ont été contraints ou isolés

B = 11-20% des patients ont été contraints ou isolés

C = 6-10% des patients ont été contraints ou isolés

D = 2-5% des patients ont été contraints ou isolés

E = 0-1% des patients ont été contraints ou isolés

2.4.8- Quel est le nombre d'admissions de patients de moins de 18 ans dans des unités d'hospitalisations psychiatriques communautaires / intégrées dans la cite?

[ ] IN [ ] NA [ ]

2.4.9- Quel est le nombre de lits dans les unités d'hospitalisations psychiatriques communautaires / intégrées dans la cité réservés aux enfants et adolescents?

[ ] IN [ ] NA [ ]

2.9.2- Quel pourcentage de patients ont bénéficié d'une ou plusieurs interventions psychosocialesdans unités d'hospitalisations psychiatriques communautaires / intégrées dans la cité au cours de l'année précédente?

A = zéro (0%)

B = peu (1 - 20%)

C = quelques un (21 - 50%)

D = la majorité (51 - 80%)

E = tous ou presque tous (81 - 100%)

2.10.2- Y a t il au moins un médicament psychotrope pour chaque catégorie thérapeutique (anti-psychotique, antidépresseur, thymorégulateur, anxiolytique et anti-épileptique) de disponible dans votre unités d'hospitalisations psychiatriques communautaires / intégrées dans la cite?

Oui ☐ Non ☐

2.11.1- Quel est le nombre de lits psychiatriques dans les unités d'hospitalisations psychiatriques **communautaires / intégrées dans la cité** et dans les hôpitaux psychiatriques dans ou à côté de la plus grande ville?

☐ IN ☐

Quel est le nombre de lits psychiatriques dans les unités d'hospitalisations psychiatriques communautaires / intégrées dans la cité et hôpitaux psychiatriques dans tout le pays?

☐ IN ☐

4.1.1- Combine de personnes par catégorie professionnelle travaillant dans ou pour les structures de santé mentale ou en cabinet privé

1. psychiatres
2. autres docteurs en médecine, non spécialisés en psychiatrie
3. infirmièr(e)s
4. psychologues
5. travailleurs sociaux
6. ergothérapeutes
7. autres travailleurs de santé ou de santé mentale (incluant : équipe paramédicale, travailleurs de soins de santé primaire non médecins, assistants de santé, assistants médicaux, conseillers psychosociaux professionnels et para professionnels)

4.1.3- Proportion de psychologues, travailleurs sociaux, infirmières, et autres thérapeutes (ergothérapeutes…) travaillant dans différents secteurs de santé mentale

1. nombre de psychologues, travailleurs sociaux, infirmières, et autres thérapeutes (ergothérapeutes…) travaillant **uniquement** dans les structures publiques de santé mentale

2. nombre de psychologues, travailleurs sociaux, infirmières, et autres thérapeutes (ergothérapeutes…) travaillant **uniquement dans** lesONG de santé mentale ou les structures médico-sociales, les cliniques privées, en cabinet privé
3. nombre de psychologues, travailleurssociaux, infirmières, et autres thérapeutes (ergothérapeutes…)travaillant à la fois dans ou pour (a) les structures publiques

6.1.3- Collectez vous et compilez vous régulièrement les données par type d'information sur:

1. Nombre de lits
2. Nombres de patients hospitalisés
3. Nombre de jour d'hospitalisation
4. Nombre d'hospitalisations sans consentement (sous contrainte)
5. Nombre d'usagers ayant subit une contention physique ou un isolement
6. 12.Diagnostics

6.1.5- Combien de structures de santé mentale ont fourni des données au département de santé publique, au cours de l'année écoulée.

1. Hôpitaux psychiatriques
2. Unités d'hospitalisation psychiatrique communautaires / intégrées dans la cité
3. Structures ambulatoires de santé mentale

Questionnaire pour structure de consultation psychiatrique, intégrée dans la Cité

Veillez repondre le plus veridiquement possible. Ceci n'est pas un questionnaire d'evalution mais plutot, il servira a apporter au system de sente mentale camerounias ce qu'il lui faut pour etre meilleur.

2.1.3- Combien y a t il de departement de psychiatrique au cameroun?

☐ IN ☐

Combien y a t il de departement de psychiatries**intégrant dans leur organisation des** structures ambulatoires de santé mentale?

☐ IN ☐

2.2.1- Combine y a t il de structures ambulatoires de santé mentale?

☐ IN ☐

2.2.2- Combien d'usagers sont suivis dans les structures ambulatoires de santé mentale?

☐ IN ☐

2.2.3- Combien de femmes sont suivies dans lesstructures ambulatoires de santé mentale?

☐ IN ☐ NA ☐

2.2.4- combine d'usagers sont suivis dans des structures ambulatoires de santé mentale par diagnostics (CIM-10)

1. Troubles mentaux et comportementaux dus à l'utilisation d'une substance psychoactive (F10-F19)
2. Schizophrénie, troubles schizotypiques et autres troubles délirants (F20-F29)
3. Troubles de l'humeur [affectifs] (F30-F39)
4. Troubles névrotiques, lies au stress et somatoformes (F40-F48)
5. Troubles de la personnalité et du comportement chez l'adulte (F60-F69)
6. Autre (ex. épilepsie, troubles mentaux d'origine organique, retard mental, trouble comportemental et émotionnel survenu dans l'enfance et l'adolescence, troubles du développement psychologique)

2.2.5- Combien de contacts au total ont ete fournis aux usagers par les structures ambulatoires de santé mentales, durant l'année (pour la totalité des usagers)?

IN NA

2.2.6- Combien usagers âgés de moins de 18 ans sont suivis dans des structures ambulatoires de santé mentale?

IN NA

2.2.7- Combine y a t il de structure ambulatoires de santé mentale pour enfants et adolescents uniquement?

IN NA

Combien y a t il destructure ambulatoire de santé mentale?

IN NA

2.2.8- Combien a t il destructures ambulatoires de santé mentale quidispensent un suivi de soins communautaire de routine?

IN NA

2.2.9- Combien y a t il de structures ambulatoires de santé mentale qui ont des équipes mobiles de santé mentale qui dispensent des soins de santé mentale réguliers en dehors des structures de soins?

IN NA

2.9.3 – Quel pourcentage d'usagers ont bénéficie d'une ou plusieurs interventions psychosociales dans les structures ambulatoires de santé mentale **au cours de** l'année précédente.

A = zéro (0%)

B = peu (1 - 20%)

C = quelques (21 - 50%)

D = la majorité (51 - 80%)

E = tous ou presque tous (81 - 100%)

2.10.3- Dans votre structures de santé mentale ambulatoires y at il au moins un médicament psychotrope de chaque catégorie thérapeutique (antipsychotique, anti-dépresseur, thymorégulateur, anxiolytique et anti-épileptique) disponible dans la structure ou dans une pharmacie mitoyenne?

IN NA

2.11.2- Proportion d'utilisation des services ambulatoires de santé mentale par les usagers ruraux proportionnellement à la taille de cette population

En proportion de la taille de cette population, les usagers ruraux sont :
A = Substantiellement sous représentés dans leur usage des services ambulatoires
B = à peu près également représentés dans leur usage des services ambulatoires
C = Substantiellement sur représentés dans leur usage des services ambulatoires

2.11.3- Quel pourcentage de structures de santé mentale ambulatoires emploient une stratégie spécifique afin d'assurer que les minorités linguistiques puissent accéder aux services de santé mentale dans la langue qu'ils parlent couramment.

A = zéro (0%)

B = peu (1 - 20%)

C = quelques(21 - 50%)

D = la majorité (51 - 80%)

E = tous ou presque tous (81 - 100%)

2.11.4- Quel est la proportion d'utilisation des services de santé mentale ambulatoires par des groupes ethniques et par des groupes de minorités religieuses relativement à la taille de leur population?

Relativement à la taille de leur population, les usagers issus de minorités ethniques et religieuses sont:
A = Substantiellement sous représentés dans leur usage des services ambulatoires
B = A peu près également représentés dans leur usage des services ambulatoires
C = Substantiellement sur représentés dans leur usage des services ambulatoires

2.11.6 - En moyenne, existe t il une différence substantielle (ex: plus que 50%) entre les structures administrées par le gouvernement et les cliniques privées selon des indicateurs de santé sélectionnés

1. Durée moyenne de la liste d'attente pour une première consultation psychiatrique en dehors des urgences
2. Nombre moyen de minutes passées entre un psychiatre et un patient enconsultation
3. Nombre moyen de lits par infirmier dans les structures hospitalières psychiatriques

4.1.1- Combien de personnes par catégorie professionnelle travaillent dans ou pour les structures de santé mentale ou en cabinet privé

1. psychiatres

2. autres docteurs en médecine, non spécialisés en psychiatrie
3. infirmièr(e)s
4. psychologues
5. travailleurs sociaux
6. ergothérapeutes
7. autres travailleurs de santé ou de santé mentale (incluant : équipe paramédicale, travailleurs de soins de santé primaire non médecins, assistants de santé, assistants médicaux, conseillers psychosociaux professionnels et para professionnels)

4.1.2- Quel proportion de psychiatres travaille dans les différents secteurs de la santé mentale

1.nombre de psychiatres travaillant uniquement dans ou pour les structures publiques de santé mentale

2.nombre de psychiatres travaillant uniquement dans ou pour une ONG de santé mentale / une clinique privée /, un cabinet privé

3.nombre de psychiatres travaillant à la fois dans ou pour (a) les structures publiques de santé mentale **et** dans ou pour (b) les ONG de santé mentale ou les structures médico-sociales / les cliniques privées / en cabinet privé(ex: cette catégorie regroupe les *psychiatres* travaillant à la fois dans les structures publiques de santé mentale et dans un des autres secteurs mentionnés).

6.1.4- Quel proportion*de structures ambulatoires de santé mentale* collecte et compile régulièrement les données par type d'information

1. Nombre d'usagers traités
2. Nombre d'usagers contactés
3. Diagnostics

6.1.5- Combien de structures de santé mentale ont fourni des données au département de santé publique, au cours de l'année écoulée

1. Hôpitaux psychiatriques
2. Unités d'hospitalisation psychiatrique communautaires / intégrées dans la cité
3. Structures ambulatoires de santé mentale

Combien de structures de santé mentale y a t il au Cameroon?

Questionnaire pour structure résidentielle intégrée dans la Cité

Veillez repondre le plus veridiquement possible. Ceci n'est pas un questionnaire d'evalution mais plutot, il servira a apporter au system de sente mentale camerounias ce qu'il lui faut pour etre meilleur.

1.4.3- Avez vous au moins une supervision/inspection externe annuelle du respect des droits de l'homme pour les patients?

Oui ☐ Non ☐

Combien y a t il au total d'unités d'hospitalisation psychiatrique et de structures résidentielles communautaires / intégrées dans la Cité.?

☐ IN ☐ NA ☐

1.4.5- Avez vous eu au moins une formation d'une journée, une réunion ou autre type de session de travail sur le respect des droits de l'homme pour les patients dans les 2 dernières années?

☐ IN ☐ NA ☐

2.5.1- Combien y a t il de structures résidentielles communautaires / intégrées dans la cite?

☐ IN ☐

2.5.2- Combine y a t il de lits/placesdans des structures résidentielles communautaires / intégrées dans la cite?

☐ IN ☐

2.5.3- Combien d'usagers sont suivis dans des structures résidentielles communautaires / intégrées dans la cite?

IN NA

2.5.4- Combien de femmes sont suivies dans des structures résidentielles communautaires / intégrées dans la cite?

IN NA

2.5.5- Nombre cumulé de jours passés dans des structures résidentielles communautaires / intégrées dans la cité au cours de l'année précédente (total de tous les usagers)?

IN NA

2.5.6- Combien y a t il d'usagers âgés de moins de 18 ans suivis dans des structures communautaires résidentielles?

IN NA

2.5.7- Combine y a t il de lits/places dans les structures communautaires / intégrées dans la cité **réservées aux** enfants et adolescents?

IN NA

4.1.1- Combien y a t il de personnes par catégorie professionnelle travaillant dans ou pour les structures de santé mentale ou en cabinet privé

1. psychiatres
2. autres docteurs en médecine, non spécialisés en psychiatrie
3. infirmièr(e)s
4. psychologues
5. travailleurs sociaux
6. ergothérapeutes
7. autres travailleurs de santé ou de santé mentale (incluant : équipe paramédicale, travailleurs de soins de santé primaire non médecins, assistants de santé, assistants médicaux, conseillers psychosociaux professionnels et para professionnels)

Questionnaire pour structure de soins de jours en santé mentale

Veillez repondre le plus veridiquement possible. Ceci n'est pas un questionnaire d'evalution mais plutot, il servira a apporter au system de sente mentale camerounias ce qu'il lui faut pour etre meilleur.

2.3.1- Combien y a t il de structures de santé mentale de jour?

☐ IN ☐ NA ☐

2.3.2- Combien d'usagers sont suivis dans votre structure de santé mentale de jour?

☐ IN ☐ NA ☐

2.3.3- Combien de femmes sont suivies dans votre structure de santé mentale de jour?

☐ IN ☐ NA ☐

2.3.4- Que lest le nombre cumulé de jours où les usagers ont ete présents dans votre structure de santé mentale de jour au cours de l'année précédente (total de tous les usagers)?

☐ IN ☐ NA ☐

2.3.5- Combien y a t il d'usagers âgés de moins de 18 ans suivis dans votre structures de santé mentale de jour?

☐ IN ☐ NA ☐

2.3.6- Combien y a t il de structures de santé mentale de jour pour enfants et adolescentsuniquement?

☐ IN ☐ NA ☐

4.1.1- Combien y a t il de personnes par catégorie professionnelle travaillant dans ou pour les structures de santé mentale ou en cabinet privé

1. psychiatres
2. autres docteurs en médecine, non spécialisés en psychiatrie
3. infirmièr(e)s
4. psychologues
5. travailleurs sociaux
6. ergothérapeutes
7. autres travailleurs de santé ou de santé mentale (incluant : équipe paramédicale, travailleurs de soins de santé primaire non médecins, assistants de santé, assistants médicaux, conseillers psychosociaux professionnels et para professionnels)

Questionnaire pour structures de soins de santé primaires

Veillez repondre le plus veridiquement possible. Ceci n'est pas un questionnaire d'evalution mais plutot, il servira a apporter au system de sente mentale camerounias ce qu'il lui faut pour etre meilleur.

3.1.1- Combien d'heures de formation (premier grade) consacrée à des sujets de psychiatrie et de santé mentale pour les étudiants en médecine?

☐ IN ☐ NA ☐

Combien d'heures de formation continue au total (premier grade) données à l'université de médecine?

☐ IN ☐ NA ☐

3.1.2- Combien de de médecins en soins de santé primaire ont eu au moins deux jours de stage de mise à niveau en psychiatrie et santé mentale durant l'année précédente?

☐ IN ☐ NA ☐

Combien de médecins au total en soins de santé primaire travaillaient dans les dispensaires de soins de santé primaires durant l'année précédente?

3.1.3- Disponibilité des protocoles de soins et d'évaluation pour les situations clés en santé mentale, dans les dispensaires de soins de santé primaire

Protocoles disponibles dans:

A = Aucun dispensaire / cabinet de soins en santé primaire médicalisés (0%)

B = Très peu de dispensaires / cabinet de en soins de santé primaire médicalisés (1 - 20%)

C = Quelques dispensaires / cabinet de soins en santé primaire médicalisés (21 - 50%)

D = La majorité des dispensaires / cabinet de soins en santé primaire médicalisés (51 - 80%)

E = Tous ou presque tous les dispensaires / cabinet de soins en santé primaire médicalisés (81 - 100%)

3.1.4- Médecin de soins de santé primaire à plein temps qui adresse en moyenne au minimum un patient par mois à un professionnel de santé mentale

A = Zéro (0%)

B = Très peu (1 - 20%)

C = Quelques uns (21 - 50%)

D= La majorité (51 - 80%)

E= Tous ou presque tous (81 - 100%)

3.1.5- Médecins de santé primaire en interaction avec les services de santé mentale au moins une fois par mois durant l'année précédente.

A = Zéro (0%)

B = Très peu (1 - 20%)

C = Quelques uns (21 - 50%)

D = La majorité (51 - 80%)

E = Tous ou presque tous (81 - 100%)

3.1.6- Les réglementations de santé autorisent les médecins de santé primaire à prescrire ou à renouveler la prescription des psychotropes.

A = Non autorisé
B = Les médecins en soins de santé primaire / médecins généralistes sont autorisés à prescrire mais avec certaines restrictions (ex. : ils ne sont pas autorisés à initier les prescriptions mais sont autorisés à renouveler les prescriptions ou ils ne sont autorisés à prescrire que dans des cas d'urgence).
C = Les médecins en soins de santé primaire / médecins généralistes sont autorisés à prescrire sans restriction

3.1.7- Les dispensaires médicalisées de soins de santé primaire ou pharmacies accessibles à la population, dans lesquels au moins un médicament psychotrope de chaque catégorie thérapeutique (médicaments anti-psychotiques, antidépresseurs, thymorégulateurs, anxiolytiques et antiépileptiques) est disponible dans la structure ou la pharmacie la plus proche tout au long de l'année

A = Aucun dispensaire ou pharmacie (0%)
B = Très peu de dispensaires ou pharmacies (1 - 20%)

C = Quelques dispensaires ou pharmacies (21 - 50%)
D = La majorité des dispensaires ou pharmacies (51 - 80%)
E = Tous ou presque tous les dispensaires ou pharmacies (81 - 100%)

3.2.1- Combien d'heures de formation (premier grade) sont consacrées à des sujets de psychiatrie et de santé mentale dans les écoles d'infirmiers?

☐ IN ☐ NA ☐

Quel est le nombre total d'heures de formation (premier degré) délivrées aux étudiants infirmiers dans les écoles d'infirmiers?

☐ IN ☐ NA ☐

3.2.2- Quel est le nombre d'heures de formation consacrées à des sujets de psychiatrie et de santé mentale pour les personnels de santé primaire dans les centres de formation professionnels / écoles?

☐ IN ☐ NA ☐

Quel est le nombre total d'heures de formation pour le personnel de santé primaire dans les centres de formation professionnels / écoles?

☐ IN ☐ NA ☐

3.2.3- Quel est le nombre d'infirmiers de santé primaire avec au moins deux jours de formation continue en psychiatrie/santé mentale durant l'année écoulée.?

☐ IN ☐ NA ☐

Que lest le nombre total d'infirmiers en soins de santé primaire travaillant dans des dispensaires en soins de santé primaire durant l'année écoulée.?

☐ IN ☐ NA ☐

3.2.4- Quel est le nombre total d'infirmiers en soins de santé primaire travaillant dans des dispensaires en soins de santé primaire durant l'année écoulée.?

☐ IN ☐ NA ☐

Quel est le nombre d'infirmiers de santé primaire avec au moins deux jours de formation continue en psychiatrie/santé mentale durant l'année écoulée?

☐ IN ☐ NA ☐

3.2.5- Quel est la disponibilité des outils d' évaluation et des protocoles de traitements pour les situations clés en santé mentale dans les dispensaires non médicalisés de soins de santé primaire / CSI

Protocoles disponibles dans:

A = Aucun dispensaire non médicalisées de soins de santé primaire / CSI (0%)
B = Très peu de dispensaires non médicalisées de soins de santé primaire / CSI (1 - 20%)
C = Quelques dispensaires non médicalisées de soins de santé primaire / CSI (21 - 50%)
D = La majorité des dispensaires non médicalisées de soins de santé primaire / CSI (51 - 80%)
E = Tous ou presque tous les dispensaires non médicalisées de soins de santé primaire / CSI (81 - 100%)

3.2.6- Quel nombre de soignants à temps plein travaillant dans des dispensaires non médicalisés de soins de santé primaire qui adressent en moyenne, au minimum un patient par mois pour des raisons de santé mentale vers un niveau supérieur de prise en charge

A= Zéro (0%)
B= Très peu (1 - 20%)
C= Quelques uns (21 - 50%)
D= La majorité (51 - 80%)
E = Tous ou presque tous (81 - 100%)

3.2.7- Quel n*ombre de dispensaires de soins de santé primaire non-médicalisés* dans lesquels au moins un psychotrope de chaque catégorie thérapeutique (anti-psychotique, antidépresseur, thymorégulateur, anxiolytique et antiépileptique) est disponible dans la structure ou dans une pharmacie mitoyenne tout au long de l'année.

A = Aucun des dispensaires (0%)
B = Très peu de dispensaires (1 - 20%)
C = Quelques dispensaires (21 - 50%)
D = La majorité des dispensaires (51 - 80%)
E = Tous ou presque tous les dispensaires (81 - 100%)

3.2.8- La réglementation de la santé autorise les infirmiers de santé primaire à prescrire ou à renouveler la prescription de médicaments psychotropes

A = Non autorisé
B = Les infirmiers de soins de santé primaire sont autorisés à prescrire mais avec certaines restrictions (ex., ils ne sont pas autorisés à initier les prescriptions mais sont autorisés à

renouveler les prescriptions, ou, ils ne sont autorisés à prescrire que dans des cas d'urgence).
C =Les infirmiers de soins de santé primaire sont autorisés à prescrire sans restriction

3.2.9- Les réglementations de la santé autorisent le personnel de santé primaire non médecin/non-infirmier à prescrire et/ou à renouveler la prescription de psychotropes

A = Non autorisé
B = Les personnels non-médecin / non-infirmier de soins de santé primaire sont autorisés à prescrire mais avec restriction (ils ne sont pas autorisés à initier les prescriptions mais sont autorisés à renouveler les prescriptions ; ils ne sont autorisés à prescrire que dans des cas d'urgence; ils sont autorisés à délivrer des medicaments mais ils leur est formellement interdit de prescrire)
C = Les personnels non-médecin / non-infirmier de soins de santé primaire sont autorisés à prescrire sans restriction

3.3.1- Au moins une interaction au cours de l'année écoulée, entre des dispensaires médicalisées de soins de santé primaire et des praticiens complémentaires / alternatifs / traditionnels

A = Aucun dispensaire (0%)
B = Très peu de dispensaires (1 - 20%)
C = Quelques dispensaires (21 - 50%)
D = Une majorité de dispensaires (51 - 80%)
E = Tous ou presque tous les dispensaires (81 - 100%)

3.3.2- Au moins une interaction au cours de l'année écoulée entre des dispensaires nonmédicalisés de soins de santé primaire et des praticiens complémentaires/alternatifs traditionnels.

A = Aucun dispensaire (0%)

B = Très peu de dispensaires (1 - 20%)

C = Quelques dispensaires (21 - 50%)

D = Une majorité de dispensaires (51 - 80%)

E = Tous ou presque tous les dispensaires (81 - 100%)

3.3.3- Interaction des structures de santé mentale avec les praticiens complémentaires/alternatifs/ traditionnels au moins une fois l'année précédente.

A = Aucune structure (0%)

B = Très peu de structures (1 - 20%)

C = Quelques structures (21 - 50%)

D = Une majorité des structures (51 - 80%)

E = Toutes ou presque toutes les structures (81 - 100%)

Resub P555/10/2020

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Ref: KNH-ERC/RR/842

10th December, 2020

Dr. Toguem Guy Michael
Reg. No. H58/12255/2018
Dept. of Psychiatry
School of Medicine
College of Health Sciences
University of Nairobi

Dear Dr. Michael,

Research Proposal: Situational analysis of mental health system in Cameroon (P555/10/2020)

This is to acknowledge receipt of your research proposal and to inform you that upon review by the KNH- UoN Ethics and Research Committee during the 261st ERC meeting held on 9th December, 2020, the following observations and suggestions were made:

General comments

1. The study title does not answer the question "so what?" Please revise the title appropriately.
2. Title page: Clearly indicate the study title and degree you aim to achieve in the proposal.
3. Supervisor's Declaration (page iii): Take note that Prof. D. Ndetei cannot be a Senior Lecturer and Professor at the same time. Please confirm and correct his qualifications.
4. Research question and Study objectives:
   i. Specific objectives should have corresponding research questions.
   ii. Vary the objectives; all except specific objective one aim at 'describing'.
5. Section on the Research Problem is missing. Please include.

Methodology

6. What is the total number of facilities in your population?
7. Data collection tool: Isn't the study questionnaire too long for the participants?
8. How will the collected data be analyzed?

Recommendation

Revise and resubmit **two (2)** copies of the full proposal inclusive of the Application Form within a period of **four (4)** weeks with effect from the date of this letter. Include a cover letter that summarizes how you have addressed the comments and note the page number(s) where the changes have been made.

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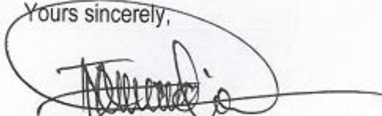
You are also advised to share a soft copy of all the above documents via the ERC email (uonknh_erc@uonbi.ac.ke).

Yours sincerely,



PROF. M.L CHINDIA
SECRETARY, KNH- UoN ERC

c.c. The Principal, College of Health Sciences, UoN
The Senior Director, CS, KNH
The Chair, KNH- UoN ERC
The Dean, School of Medicine, UoN
The Chair, Dept. of Psychiatry, UoN
Supervisors: Dr. Manasi Kumar (Dept. of Psychiatry, UoN),
Dr. Fredrick Owiti (Dept. of Psychiatry, UoN),
Prof. David Ndetei (Dept. of Psychiatry, UoN)

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INSTITUTIONAL ETHICS COMMITTEE FOR RESEARCH ON HUMAN HEALTH

N° 2490 IEC-UD/10/2020/T

Douala, the 28th October 2020

ETHICAL CLEARANCE

The Institutional Ethics Committee for Research on Human Health of the University of Douala **(IEC-UDo)** for the 28th October 2020 evaluation session, has examined the research project entitled **«Situational analysis of mental health system in Cameroon »** submitted by **Dr TOGUEM Guy Michael** for Thesis at the University of Nairobi –Department of Psychiatry.

The present research project has a clear scientific interest and presents no risk for its participants. The objectives and methodology of this research project are clearly described. The principle of data confidentiality is respected. The required expertise for the supervision of the research is present.

From the above mentioned observations, the IEC-UDo approves this version of the project for a period of one year.

However, **Dr TOGUEM Guy Michael** is responsible of the scrupulous respect of the methodology and ethical consideration, and should not amend it without approval of the IEC-UDo. Researchers are expected to collaborate with the IEC-UDo for a follow-up of the ethical aspects of the approved project. A copy of the final report of this research project should be submitted to IEC-UD for archival purposes.

The present ethical clearance is delivered to serve the purpose for which it is presented. It can be cancelled in case of non-respect of the above recommendations.

Copy

- MINPH

The PRESIDENT

Pr Léopold Gustave LEHMAN

NB : Only one copy of an ethical clearance is delivered.

N° 0977/Minsante/SESP/SG/DROS of April 16, 2012
Campus de Logbessou, 3è étage du bloc pédagogique de la FMSP.
Tél. : (237) 680.35.98.35 / 695.39.35.50 / B.P. : 2701 Douala - Cameroun / e-mail : cei@univ-douala.com

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N° 42 /L/MINSANTE/SG/DRSPO/CBF/CA

Bafoussam le, 18 JAN 2021

LE DELEGUE REGIONAL

A

M. TOGUEM Guy Michaël Etudiant En Master de psychiatrie à l'université De Nairobi

Objet : Autorisation d'enquête

J'accuse réception de votre correspondance sollicitant notre accord pour une autorisation de recherche menée conjointement par l'Université de Douala et université de Nairobi dans la région de l'Ouest en vue de l'obtention du diplôme de Master en psychiatrie dont le thème porte sur : **« Analyse situationnelle du système de santé mental du Cameroun ».**

Y faisant, j'ai l'honneur de marquer mon accord de principe pour la mise en œuvre de cette activité pour la période allant du 5 janvier au 5 Mars 2021dans certaines formations sanitaires de la région de l'Ouest.

Vous voudrez bien à cet effet, vous rapprocher des Chefs de district de santé concernés pour les modalités de mise en œuvre.

Ampliations :

- CDS concernés

-Archives/Chrono

LE DELEGUE REGIONAL

Dr CHINMOUN DAOUDA
Médecin de Santé Publique
Délégué Régional de l'Ouest