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Scaling up mental health services for internally displaced and vulnerable host populations in the Central African Republic

Using the WHO "Mental Health Gap Action Programme – Humanitarian Intervention Guide (mhGAP-HIG)".

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Master's dissertation / professional work placement report
in Mental Health Policy and Services
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Academic year 2015 – 2017

Content

ACKNOWLEDGEMENTS

This work would not have been possible without a collaborative effort between the Central African Republic Ministry of Health and the World Health Organization, Central African Republic Country Office.

Thank you to the inspiring district health workers in Bangui, Bimbo, Bouar and Sibut, and partners from the Mental Health and Psychosocial Support Working Group.

Thank you to the World Health Organization (WHO) Regional Office for Africa and WHO headquarters, Department of Mental Health and Substance Abuse, for their technical guidance.

Thank you to the Universade Nova De Lisboa, Nova Medical School, Faculdade De Ciencas Medicas, for the guidance and supervision.

Summary

Scaling up mental health services for internally displaced and vulnerable host populations in the Central African Republic.

Using the WHO "Mental Health Gap Action Programme – Humanitarian Intervention Guide (mhGAP-HIG)".

The Central African Republic has been experiencing socio-political conflicts for decades, and political change has mainly come about through violence, leaving millions in immediate need of refuge and humanitarian assistance.

Violence and displacement expose vulnerable groups and the community at large to a number of threats and stressors. In disaster situations, WHO estimates an increase in severe mental disorders from a projected baseline of 2–3% to an estimated 3–4% and an increase in mild or moderate mental disorders from a projected baseline of 10% to an estimated 15–20%.

This programme aims to integrate mental health care in nonspecialized health settings. The Mental Health Gap Action Programme (mhGAP) initiative incorporates evidence-based guidelines on managing mental, neurological and substance use (MNS) disorders in primary care settings by nonspecialist health-care workers. The mhGAP Humanitarian Intervention Guide (mhGAP-HIG), introduced in 2015, is a valuable manual that can be used as a resource in training nonspecialists in providing primary mental health care.

Based on the "Mental Health Gap Action Programme Monitoring and Evaluation Toolkit", as of June 2017:

- 48 nonspecialist health-care providers, including nine medical doctors, 28 certified nurses and 11 other health-care providers have been trained;
- 24 health-care facilities are using mhGAP-HIG to assess and manage persons with MNS disorders (4 hospitals, 20 health centres); and
- 380 people with MNS disorders have been seen in those facilities (184 for acute stress, 55 for post-traumatic stress disorder, 20 for depression, 21 for psychosis, 25 for epilepsy and 75 for harmful use of alcohol and drugs).

Aumentando os serviços de saúde mental para populações internamente deslocadas e vulneráveis na República Centro-Africana.

Usando o programa de ação global da OMS em saúde mental - Guia de Intervenção Humanitária (mhGAP-HIG) ".

A República Centro-Africana vem enfrentando conflitos sócio-políticos há décadas e a mudança política ocorreu principalmente através da violência, deixando milhões em necessidade imediata de refúgio e assistência humanitária.

A violência e o deslocamento dos grupos vulneráveis os expõem a uma série de ameaças e estressores. Em situações de desastre, a OMS estima um aumento na taixa de graves transtornos mentais, 2-3% a uma estimativa de 3-4% e um aumento de leves ou moderados transtornos mentais de 10% a 15-20%.

Este programa integra cuidados de saúde mental em ambientes de saúde não especializadas. A iniciativa do Plano Global de Ação de Saúde Mental (mhGAP) incorpora diretrizes baseadas em evidências sobre o gerenciamento de transtornos mentais, neurológicos e do abuso de substâncias (MNS) nas áreas de atenção primária por profissionais de saúde não especializados. O Guia de Intervenção Humanitária mhGAP (mhGAP-HIG), introduzido em 2015, é um valioso manual que pode ser usado como um recurso na formação de não especialistas em cuidados primários de saúde mental.

Em junho de 2017, usando como base o "Kit de Ferramentas de Monitoramento e Avaliação do Programa de Ação do Gap de Saúde Mental",:

- foram treinados 48 prestadores de cuidados de saúde não especializados, incluindo 9 médicos de clínica geral, 28 enfermeiros gerais e outros 11 prestadores de cuidados de saúde,
- 24 unidades de saúde estão usando mhGAP-HIG para avaliar e gerenciar pessoas com distúrbios MNS (4 Hospitais, 20 Centros de Saúde),
- 380 pessoas com distúrbios MNS foram observadas nessas instalações (184 Estresse agudo, 55 Doenças pós-traumáticas, 20 Depressão, 21 Psicose, 25 Epilepsia, 75 Uso nocivo de Álcool e Drogas).

Ampliación de los servicios de salud mental para las poblaciones internamente desplazadas internamente y vulnerables en la República Centroafricana

Uso del Programa de Acción Mundial de Salud Mental de la OMS - Guía de Intervención Humanitaria (mhGAP-HIG)".

La República Centroafricana han tenido conflictos socio-políticos ha décadas, y el cambio político fue producido a través de la violencia, dejando a millones de personas en necesidad inmediata de refugio y asistencia humanitaria.

La violencia y el desplazamiento exponen los grupos vulnerables y su comunidad a una serie de amenazas y estresores. En situaciones de desastre, la OMS estima un aumento en los graves trastornos mentales del 2-3% a 3-4% y un aumento en las tasas de trastornos mentales leves o moderados del 10% a un estimado 15-20%.

Este programa tiene como objetivo integrar la atención de salud mental en contextos donde no hay salud especializada. La iniciativa del Plan de Acción Global de Salud Mental (mhGAP) incorpora directrices basadas en evidencia de la gestión de trastornos mentales, neurológicos y de abuso de sustancias (MNS) entornos de atención primaria por parte de trabajadores de salud no especializados. La Guía de Intervención Humanitaria mhGAP (mhGAP-HIG), introducida en 2015, es un manual valioso que se puede utilizar como un recurso para formar los “no especialistas” en la atención primaria de la salud mental.

Basado en el "Kit de Herramientas de Monitoreo y Evaluación del Programa de Acción de la Salud Mental", a partir de junio de 2017:

- Se han formado 48 proveedores de atención médica no especializados, incluidos 9 médicos generales, 28 enfermeros generales y otros 11 profesionales de la salud,
- 24 centros de salud están usando mhGAP-HIG para evaluar y manejar personas con trastornos MNS (4 Hospitales, 20 Centros de Salud),
- 380 personas con trastornos MNS se han visto en esas instalaciones (184 Estrés agudo, 55 Trastorno de estrés postraumático, 20 Depresión, 21 Psicosis, 25 Epilepsia, 75 Uso nocivo de alcohol y drogas).

List of acronyms

CAR	Central African Republic
CNHUB	Centra National Hospitalo Universitaire de Bangui (National Central Hospital of Bangui)
DALY	Disability-adjusted life-years
DEP	Severe/moderate depressive disorder
EPI	Epilepsy / Convulsive seizures
FOSA	Formation Sanitaires
GBV	Gender-based violence
GNI	Gross national income
GP	General practitioner
IASC	Inter-Agency Standing Committee
IEHK	Interagency Emergency Health Kit
IDP	Internally displaced people
LMICs	Low- and middle-income countries
LNME	Liste Nationale des Medicaments Essentiels (National List of Essential Medicines)
MoH	Ministry of Health
MNS	Mental, neurological and substance use
mhGAP	Mental Health Gap Action Programme
mhGAP-HIG	mhGAP Humanitarian Intervention Guide
mhGAP-IG	mhGAP Intervention Guide
MHPSS	Mental health and psychosocial support
NGO	Nongovernmental organization
PSY	Psychosis
PTSD	Post-traumatic stress disorder
SGBV	Sexual or gender-based violence
STR	Acute stress
SUB	Harmful alcohol and drug use
ToTS	Training of Trainers and Supervisors
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Introduction

The Central African Republic (CAR) has been experiencing socio-political conflicts for decades, and political change has mainly come about through violence, leaving millions in immediate need of refuge and humanitarian assistance.

In CAR, violence and displacement expose vulnerable groups and the community at large to a number of threats and stressors. In disaster situations, WHO estimates an increase in severe mental disorders from a projected baseline of 2–3% to an estimated 3–4% and an increase in mild or moderate mental disorders from a projected baseline of 10% to an estimated 15–20%.

Before the crisis, mental health had been a highly neglected issue. Mental health is absent from key policy documents. A mental health policy is available (MSHPP, 2011) but not implemented. There are three psychologists and one psychiatrist in the country, and the only mental health service is at the Psychiatry Department of the Central Hospital (CNHUB) in Bangui.

Several nongovernmental organizations (NGOs) are undertaking mental health activities with a limited scope, targeting vulnerable groups and not integrating their activities into the general health system. None of the staff working at public health facilities have been trained on the WHO Mental Health Gap Action Programme (mhGAP) intervention guidelines and they are not aware of the existence of these materials, tools and framework. A transition plan for the health sector 2015–2016 has been developed and integrates for the first time mental health activities.

The CAR Ministry of Health (MoH) and WHO CAR Country Office are implementing a Japanese Government–funded programme, “Providing emergency health-care services to internally displaced and vulnerable host populations in CAR”. The overall programme goal is to reduce excess morbidity and mortality among internally displaced people (IDP) and vulnerable host population in CAR through the provision of quality emergency health services, including mental health care but also trauma and chronic diseases care.

I was deployed as a WHO mental health consultant in CAR to lead the implementation of the mental health component of this programme. The implementation of mental health activities was from 1 August 2016 to 30 June 2017. This programme aims to integrate mental health care in nonspecialized health settings, using the mhGAP Humanitarian Intervention Guide (mhGAP-HIG) (WHO and UNHCR, 2015).

The objective is to enhance coverage and quality of care for people with mental, neurological and substance use (MNS) disorders. It includes three components:

- Development of plans and strategies for care of people with MNS disorders;
- Capacity building of health-care providers; and
- Delivery of care for MNS disorders in non-specialised health settings.

Situation analysis

The goal of this section is to provide a broad understanding of the country's context and the factors that impact health in general as well as MNS disorders. The generic version of the mhGAP Intervention Guide (mhGAP-IG) situation analysis has been used, with the inclusion of humanitarian context as a relevant specific local issue (Vandendyck, 2016).

Political structure, socio-demographic and economic factors

CAR is a landlocked country in the central African region. The country is subdivided into seven regions, 16 prefectures, 71 sub-prefectures, 177 communes, and 8300 villages and neighbourhoods (ACAPS, 2015).

Map: Central African Republic

Source: ACAPS, 2015.

With a population projection estimated at 5 266 960 in 2015 (ACAPS, 2015) based on the General Population Census of 2003 (Ministère de l'économie du plan et de la coopération internationale, 2003), CAR has one of the lowest population densities of the African continent: about seven people per square kilometre, against an average of 38 for sub-Saharan Africa in 2009. The population is not equally distributed, with approximately 70% living on 30% of the land in the western part of the country. About 23% of the population lives in the main seven cities, including the capital, Bangui, with approximately 13% of the total population (World Bank, 2011).

There are more than 80 ethnic groups in CAR: the biggest are Gbaya (33% of the population), Banda (27%) and Mandjia (13%). In terms of religious beliefs, 80% are Christian (51% Protestant, 29% Catholic), 15% Muslim, and 5% practice indigenous beliefs. Christians are found throughout the country, while Muslims live mainly in the northeast. The official languages are Sangho and French, although each ethnic group has its own language. A total of 40.6% of the population is under 15 years old and the literacy rate is 56.6% (ACAPS, 2015).

With a gross national income (GNI) per capita estimated at US$ 450 in 2015, CAR is ranked as a low-income country (World Bank, 2017). With a Human Development Index of 0.315, the country ranks 187 out of 188 considered in the 2015 United Nations Development Programme (UNDP) Human Development Report (UNDP, 2015).

Governance has been weak and strongly centralized since independence (ACAPS, 2015). The current regime is headed by President Faustin-Archange Touadéra, who was elected in 2015. The president is elected for a five-year term and is both head of state and head of government.

Humanitarian context

CAR has been experiencing socio-political conflicts for decades. Political change has mainly come about through violence: five decades have seen coups d'état, army mutinies, interference by foreign armed forces and rebel groups, widespread social unrest, stalled development and progressive impoverishment. The crisis was intensified in December 2013, ultimately turning from a politico-military conflict into an unprecedented intercommunity conflict.

According to the overview of humanitarian needs (OCHA, 2016), 2.3 million people in CAR are still in need of humanitarian assistance, including more than 600 000 in Bangui. The security situation is unstable and unpredictable; violations of human rights and international humanitarian law are observed, including attacks on civilians, killings, looting, sexual violence, recruitment of child soldiers, occupation of schools, and intrusion of armed groups in hospitals; the most basic social services are dysfunctional or nonexistent in many cities. In 2016:

- 467 960 people were refugees;
- 391 433 were internally displaced, including 235 594 in foster families and 155 839 on sites;
- 3077 incidents of gender-based violence (GBV) were reported;
- 13 000 children were associated with armed forces and groups;
- 25% of schools were nonfunctional;
- 40% of the population was in acute food insecurity; and
- only 30% of the rural population had access to protected water points.

Stressors

The constant threat of sectarian violence represents the main stressor and concern among the general population. Communities have been exposed to large numbers of casualties left by the attacks. Many families have lost one or more members or close acquaintances, including women and children. In many cases the families do not have access to the bodies of their loved ones.

The conflict situation led to population displacement, while some members of the population remained in the villages to protect their property. These population movements have led to changes in the functioning of the community and daily activities have been impacted. The stressors for the host community come not only from the current general insecurity but also from a more chronic situation of lack of services (health services, schools, sanitation, hygiene, food and water) and lack of respect for the rights of vulnerable groups (International Medical Corps, 2014).

The loss of work is defined by the separation of reserved seeds, by a decrease in trade (purchase and sale) and by the disappearance of cattle, causing tension and stress within families. Lack of money, lack of professional opportunities, general impoverishment, and destructuring of social services have an impact on the self-esteem of adults, now unable to support their families. Victims find themselves dispossessed of their productive capital and expelled from their social and family environment (Action Contre la Faim, 2013).

Women express concern about how to support their families, particularly in cases where they have lost their husbands or they were separated due to displacement or the need to travel to find a job or to try to recover some of their belongings. An important change is linked to the suspension of the grouping of women in the past, which allowed women to work in the fields next to each other to increase the cultivated area, pool resources and support each other through a structured and organized group. Men regret that in the current situation they cannot fulfil their role as providers and ensure good living conditions for their families. They are worried about the future for themselves and their relatives. Young boys express despair about their own prospects. They regret having lost both their inheritance and the possibility to start or continue their education or any business. Young girls complain about the vulnerable position they have in their families with little autonomy and being exposed to aggressions. They fear of being married at a very early age, and to have to discontinue their education (in cases where they are still attending) while being married off. People with severe mental health conditions are killed during confrontations, reflecting their particular vulnerable position during violent episodes (Croix-Rouge Française, 2016).

The following table summarizes the main stressors reported by the community and service providers.

Table 1: Stressful experiences faced by IDPs

Threats and actual extreme violence	- Organized and spontaneous eruptions of violence - Selective murders - Mutilations and multiple atrocities
Loss and separation	- Relatives killed as a result of violence - Death of family members due to lack of services - Forced family separation and loss of property
Conflict and violence	- Current tribal and religious conflicts - Past experiences of intercommunitarian violence - Torture of children and women; domestic violence
Protection issues	- Orphaned and kidnaped children - Delayed development among children

	- Child labour and early marriage - Health and education infrastructure not functional
Health issues	- Sickness, malaria, diarrhoea, malnutrition, convulsions, spread of sexually transmitted diseases
Environmental issues	- Hygiene and sanitation conditions - Access to water and food insecurity - Coming rainy season, risk of floods and affected planting and harvest
Psychosocial-related concerns	- Cases of GBV and SGBV (sexual and gender-based violence) - Reported problems with the host communities; harassment - Unemployment and poverty

Prevalence of mental, neurological and substance use disorders

Mental health needs have been documented in the reports of the various partners. The psychological consequences of sexual violence related to conflict were taken into account. The statistics and priority conditions for hospitalizations and ambulatory consultations at the CNHUB are available. Pre-existing mental disorders have been documented in the National Mental Health Policy (2011) and in other epidemiological studies. The data are available to identify the priority conditions to be targeted under mhGAP.

There are no nationally representative data on the prevalence of mental disorders. Nevertheless, some data are available:

- Mental disorders account for 5% of the overall health burden in CAR (WHO, 2011). Disability-adjusted life-years (DALY) is 2.659/100 000 and the age-standardized suicide rate is 9.5/100 000 (WHO, 2014).
- A study in 2010 in the prefectures of Lobaye, Ombella M'Poko, Ouham and Bangui, accounting for 52% of the total population of CAR, estimated a prevalence of 55.3% of symptoms of depression and 52.5% of anxiety, and concluded that the exposure to violence and self-reported physical health were statistically associated with those mental health outcomes (Vinck and Pham, 2010).
- The National Mental Health Policy developed in 2011 identifies psychosis as the first cause of hospitalization (57.3%), followed by psychoactive substance abuse disorders (21.6%). The most common cause of consultation reported was anxiety disorders related to violence and sexual violence. The policy also reports that dozens of victims of sexual violence during the military-political events in the country continue to suffer from post-traumatic stress disorder (PTSD) and severe depressive disorders (MSHPP, 2011).

Several partners have documented mental health needs in the context of the humanitarian situation:

- A community-based assessment shows that acute stress reactions and common mental disorders are largely distributed among the population of Bambari, Bria and its axes. In Bouca, Bossangoa and their axes the extreme violence experienced by the population represents a particular concern for suspected cases of mood and anxiety disorders (including PTSD) and psychosomatic complaints which seem recurrent regardless of the condition of IDPs or host communities. Epilepsy was also reported as a problem both in children and

adults, as well as substance abuse (tramadol, drugs and alcohol) (International Medical Corps, 2014).

- In the Bangui and Ouaka region, children's psychological difficulties, including PTSD, are significant and represent a significant burden for children themselves, parents and teachers. Ten percent of children report having been sexually abused; in some places in the study, 64% of children had PTSD (Save the Children, 2015).
- Beyond the direct traumatic impact of the violence that struck CAR in 2013, psychological distress continues in forms other than PTSD, sustained by precarious living conditions, in a climate of tension and anxiety fueled by rumours and propaganda (Croix-Rouge Française, 2016).
- Kémo patients have severe anxiety disorders, symptoms of depression and PTSD. In addition, there appears to be a change in the youth, with a new fascination for the rebels and an increase in particular drug use (Action Contre la Faim, 2013).

General health indicators

Life expectancy at birth is 47.7 years old for males and 51.3 years old for females. Maternal mortality is 890 per 100 000 live births (ACAPS, 2015).

Health System

The health system is organized in three managerial levels:

- Central level: Ministry of Health ("Ministère de la Santé, de l'Hygiène Publique et de la Population").
- Intermediate level: consists of seven Health Regions and coordinated by the Regional Services General Directorate ("Direction Générale des Services Régionaux").
- Peripheral level: consists of 16 "Préfectures Sanitaires" (assimilated to Districts) and the capital Bangui, divided into eight administrative units called "arrondissements" and similar to the Districts.

The health units are grouped into three levels of services:

- First level: Health Posts, Health Centres and District Hospitals (13)
- Second level: Regional Hospitals (5)
- Third level: Central Hospitals (4)

The health system of CAR is plagued by poor overall performance of the system; insufficient and old health infrastructure and equipment; frequent stock-outs of medicines and vaccines; quantitative and qualitative deficiencies of human resources and their misdistribution; insufficient financial resources and their poor management; and an environment not conducive to the health of the people (Ministère de la Santé, Plan National de Dévelopement Sanitaire 2006-2015, 2006).

According to the results of a survey estimating the health needs of populations affected by the crisis in CAR (HeRAMS survey) carried out with the support of WHO in October 2016, 236 (23%) of the 1010 health structures in the country still bear the stigma of the crisis (partial or total destruction),

244 (24%) are partially functional or nonfunctional, and 340 (33%) are supported by humanitarian organizations (OMS, 2016).

Leadership and governance for mental health

There is a Coordinator for the National Mental Health and Drug Abuse Programme and also a Head of the Department of Psychiatry at the Central Hospital (CNHUB).

A coordination mechanism exists through the Working Group on Mental Health and Psychosocial Support, within the Health Cluster, led by the WHO/RCA Office and the Co-lead of the French Red Cross. The group is active and meets every two weeks. It is made up of local associations and NGOs, international NGOs and United Nations (UN) agencies. The 4Ws have been completed and updated. The 4Ws of the Health Cluster also include mental health activities. There is also a child protection sub-cluster within the protection cluster, supported by the United Nation's Children's Fund (UNICEF) and a GBV sub-cluster supported by the United Nations Population Fund (UNFPA). There are no family associations or user groups in CAR.

Policy and legislation for mental health

The response to mental health needs is articulated in several documents:

The National Mental Health System is articulated in a National Mental Health Policy, developed and validated in 2011, and a National Mental Health Plan 2011–2015 that has not been operationalized. There is no specific legislation on mental health, and legal provisions for mental health are not covered in other legislation.

Other health policies and national plans encompass a National Health Policy, 2004, and a National Health Development Plan 2006–2015, including mental health activities. A new National Health Development Plan is under development.

In terms of the humanitarian response, there is a 2016–2017 transition plan between humanitarian response and health system development that has been developed and includes mental health activities. There is an Operational Plan of Response of the Health Sector to the Crisis in the CAR, January–December 2017 (Health Cluster) and there is a Japanese Government Assistance Program, "Providing emergency health-care services to internally displaced and vulnerable host populations in Central African Republic", which includes mental health activities.

Budget and financing for mental health

Per capita health expenditure was US$ 18.28 in 2011, compared to the central African regional average of US$ 94.6 (ACAPS, 2015). Per capita health expenditure was US$ 13 in 2014 (WHO, 2014). The health budget was 7.2% of the total government budget in 2009 and 9.1% in 2010. There is no specific budget allocated to mental health. In 2011, 35.5% of the health sector was financed by external assistance; households financed 90.4% of their health expenses out of pocket (ACAPS, 2015). It must be noted that the budget allocated to the 13 District Hospitals is lower than the one

allocated to each of two of the four Central Hospitals, the "Centre National Hospitalier Universitaire" and the "Hôpital Communautaire".

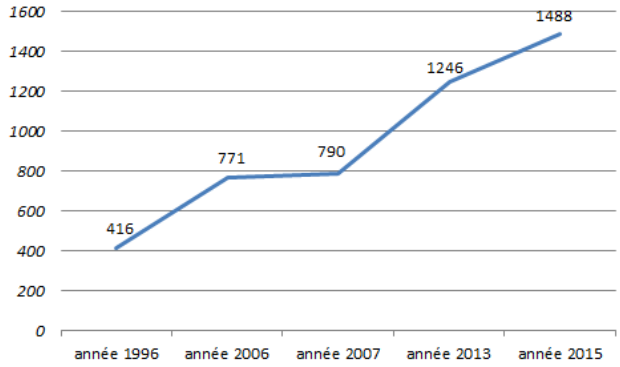
In the framework of humanitarian actions in favour of the populations during the crisis period, free health care has been introduced since 2014 in certain health facilities for a defined package of activities ("*Instruction ministérielle n° 0037 du 14 Janvier 2014, arrêté n°245/MSPP/CAB/SG/CFPS*"). Mental health was not part of this package; cost recovery is therefore practised. The Japanese Government's programme includes the provision of psychotropic drugs for patients in the health facilities implementing mhGAP.

Mental, neurological and substance use disorders service delivery system

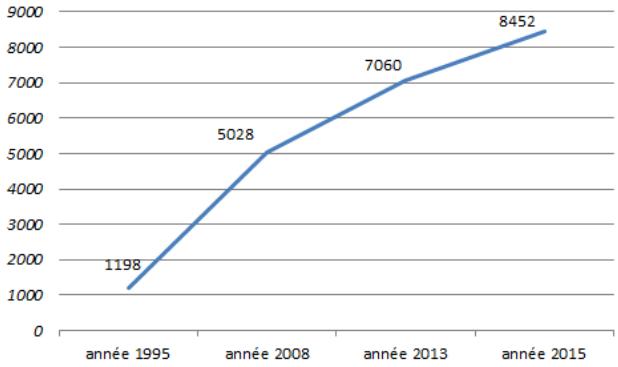
Mental health services

The country's mental health resources are concentrated in the CNHUB in the capital, Bangui, which has seen the number of consultations quadruple over the last 10 years.

The number of consultations has increased by 400% over the last 10 years and the number of new cases has increased from 416 in 1996 to 1488 in 2016 (data as of July 2017).



Graph 1. Nombre annuel de nouveaux cas (Source: Service de Psychiatrie CNHUB)



Graph 2. Nombre annuel de consultation dans les services de psychiatrie (Source: Service de Psychiatrie CNHUB)

In 2015, 27 medical doctors representing 25 health facilities were trained for five days on mental health and psychosocial support, supported by WHO. The availability of services has increased from 1% in 2014 to 17% in 2015. The first and second main causes of unavailability are the lack of training of health personnel and the lack of health personnel (OMS, 2016).

In terms of psychosocial and mental health interventions for survivors of sexual violence related to conflict, national and international partners are integrated into 101 health facilities. Partners recruit and train psychosocial care workers. When available, partners strengthen the role of the psychosocial of the Ministry of Education deployed in the Health Facility. Coverage of the service offered for treating sexual violence in 2015 is estimated at 30%. The first main cause of unavailability is lack of training of health personnel (OMS, 2016).

Prescription regulations authorize primary health care doctors to prescribe and/or to continue prescription of psychotherapeutic medicines. The Department of Health authorizes primary health care nurses to prescribe and/or to continue prescription of psychotherapeutic medicines but with restrictions. The majority of primary health care doctors and nurses have not received official in-service training on mental health within the last five years. Officially approved manuals on the management and treatment of mental disorders are not available in the majority of primary health care clinics. Official referral procedures for referring persons from primary care to secondary/tertiary care do not exist. Referral procedures from tertiary/secondary care to primary care do not exist (WHO, 2011).

There are now 143 health facilities supported by partner organizations for psychosocial support activities, including 101 structures supporting treatment for cases of GBV.

Human Resources

According to the WHO Mental Health Atlas 2014 (WHO, 2014), the total reported human resources for mental health is 12.

Mental health specialists are few and concentrated in the Psychiatriic Department of the CNHUB. Currently, there is a medical doctor with experience in psychiatry, a senior mental health technician and three active psychologists. There are also three neurologists.

They constitute the resources available for the training and supervision of nonspecialized health personnel within the framework of mhGAP, while ensuring the functioning of the Psychiatry Service and their other responsibilities (such as the National Programme and education).

In 2009, there were 3630 health workers, of all the existing cadres, employed at all levels, throughout the country. Of these, 205 were medical doctors, 64 of whom specialized, and 308 were nurses with a state diploma. Sixty percent of patients, especially in the rural areas, are seen by “Infirmiers Secouristes” (aid nurses), trained on the job by various organizations, with different curricula, for different periods of time, without previous qualification (Ministère de la Santé, Profil des ressources humaines pour la santé, 2010).

Medical doctors, in general, are few in number (approximately 200 and not all active at the clinical level), have a significant clinical workload (number of consultations), administrative responsibilities (heads of services) and public health responsibilities in the MoH. Also, there is significant turnover in their assignments (high mobility). The certified nurses are more numerous (approximately 300), are more stable and have fewer responsibilities outside the consultations. The psychosocial agents (under the Ministry of Social Affairs) in place in the health structures play a key role in the follow-up of patients. They are not present in all health facilities and when they are available, some are busy with other tasks.

For medical doctors, knowledge on identification and diagnoses of common and severe mental health disorders was basic but sufficient for patient identification. Their knowledge of differential

diagnoses varied according to their specific background and training. Most of them went through psychiatric rotations during their education but did not have any specialized training or significant practise with psychiatric patients and psychopharmacological treatments. In the case of general health staff, including clinical officers, certified nurses and midwives, the knowledge of typologies and diagnoses was lower than that of doctors but they were able to recognize that there might be a problem in the sphere of mental health in general. From their training and background they have a better understanding of patient care and basic understanding of psychosocial support skills; however, at the same time a gap was observed between their knowledge and the actual practice and application in daily work. When it comes to more specialized techniques for counselling there is a strong need for further training and support to acquire the necessary skills and tools (International Medical Corps, 2014).

The absence of formal training programs in psychiatry is also striking and at the same time the Faculty of Psychology at the University of Bangui was closed in 1990 due to budget cuts. Psychologists are considered more as counsellors and under the new law on public health, psychology is considered a traditional medical practice, which may lead to the possibility of it being perceived as witchcraft, which would be a barrier to scaling up the profession.

Psychotropic drugs

During an emergency it should be expected that agencies make essential medicines and medical supplies available according to the minimum standards of the Interagency Emergency Health Kit (IEHK).

The following psychotropic medicines are included in the IEHK:

- Amitriptyline tablets: 25 mg tablet x 4000
- Biperiden tablets: 2 mg tablet x 400
- Diazepam tablets: 5 mg tablet x 240
- Diazepam injections: 5 mg/ml, 2 ml/ampoule x 200
- Haloperidol tablets: 5 mg tablet x 1300
- Haloperidol injections: 5 mg/ml; 1 ml/ampoule x 20
- Phenobarbital tablets: 50 mg x 1000.

Overall in CAR there is extreme limited availability of medicines and medical supply for treatment of mental health conditions. There is currently no operational national system to ensure availability of drugs in health facilities in the country. Therefore, the availability of psychotropic drugs for the treatment of mental disorders in CAR is extremely limited.

There is a National List of Essential Medicines, « *Liste National des Médicaments Essentiels, 2014* » (LNME), that includes psychotropic drugs:

Category	**Molecule**	**LNME 2014**	**Formulation**	**Dosage**
Anti-depressor	Amitriptyline	Yes	Tablet	25 mg
	Fluoxetine	Yes	Tablet	20 mg

Anxiolytic	Diazepam	Yes	Ampoule	10 mg/ml
Anti-psychotic	Haloperidol	Yes	Ampoule	5 mg
			Tablet	5 mg
	Chlorpromazine	Yes	Ampoule	50 mg
			Tablet	100 mg
	Fluphenazine	Yes	Ampoule	25 mg
Anti-cholinergic	Biperiden	Yes	Tablet	4 mg
Anti epileptic	Phenobarbital	Yes	Ampoule	200 mg – 1 ml
	Sodium valproate	Yes	Tablet	200 mg
	Carbamazepine	Yes	Tablet	200 mg

Besides the need for a reliable drug provision system and adequate drug management, available laboratory services are required to support initiation and monitoring of psychotropic medications. At Bangui there is a national laboratory with limited analyzing capacity due to lack of resources such as materials and instruments. Moreover, there is a Pasteur Institute with full technical capacity. NGOs work closely with the Pasteur institute; however, the referral for laboratory services for analysis of mental disorders is not established. Regional Hospitals have basic laboratory services but they do not have a regular supply of the materials necessary to perform the appropriate tests for follow-up of the use of psychotropic drugs.

State of the art and programming

Mental, neurological and substance use (MNS) conditions are highly prevalent, accounting for 13% of the global burden of disease, yet rarely receiving priority among the many health conditions competing for political will and allocation of funds. In most low- and middle-income countries (LMICs), due to the extreme shortage of a mental health workforce, lack of leadership and other factors, 90% of people living with a severe mental disorder do not have access to mental health services (WHO, 2014).

In disaster situations, van Ommeren et al. (2005) estimates an increase in severe mental disorders from a projected baseline of 2–3% to an estimated 3–4% and an increase in mild or moderate mental disorders from a projected baseline of 10% to an estimated 15–20% (van Ommeren et al., 2005). The Inter-Agency Standing Committee (IASC) Guidelines (2007), *What Should Humanitarian Health Actors Know?* (2010) and the "*Sphere Project*" (2011), provide guidance on actions to be undertaken in emergency settings. They recommend that there be at least one staff member at every health facility who manages diverse, severe mental health problems in adults and children (IASC, 2007).

WHO also recommends ensuring the sustainability of any newly established mental health services (WHO, 2013). It is generally agreed that the best way to scale up service for persons with identified need for mental health care is primary health care integration (Lancet Global Mental Health Group et al., 2007; WHO and Wonca, 2008). Task-shifting has been recognized as a key concept in integrating mental health with primary care provision in resource-poor settings (Petersen et al., 2012). Lack of adequate training for primary care physicians and lack of adequate human resources (number of physicians) are seen as the main barriers to integrating mental health into primary care in LMICs (Saraceno et al., 2007).

Recognizing the treatment gap for MNS care in LMICs, WHO launched mhGAP in 2008. The key objective of mhGAP is to reinforce the commitment of governments, international organizations and other stakeholders to increase the allocation of financial and human resources for care of MNS conditions. Through this objective, mhGAP contributes toward achieving the targets of the Mental Health Action Plan 2013–2020, particularly by directing its capacity building towards nonspecialized health-care providers in an integrated approach to scale up MNS care (WHO, 2017).

Against this background, this project aims to integrate mental health care in nonspecialized health settings. The mhGAP initiative (WHO, 2008) incorporates evidence-based guidelines on managing MNS disorders in the primary care setting by nonspecialist health-care workers (Siriwardhana et al., 2013; Gureje et al., 2015). The Humanitarian Intervention Guide, mhGAP-HIG, introduced in 2015, is a valuable manual that can be used as a resource in training nonspecialists in primary mental health care (WHO and UNHCR, 2015).

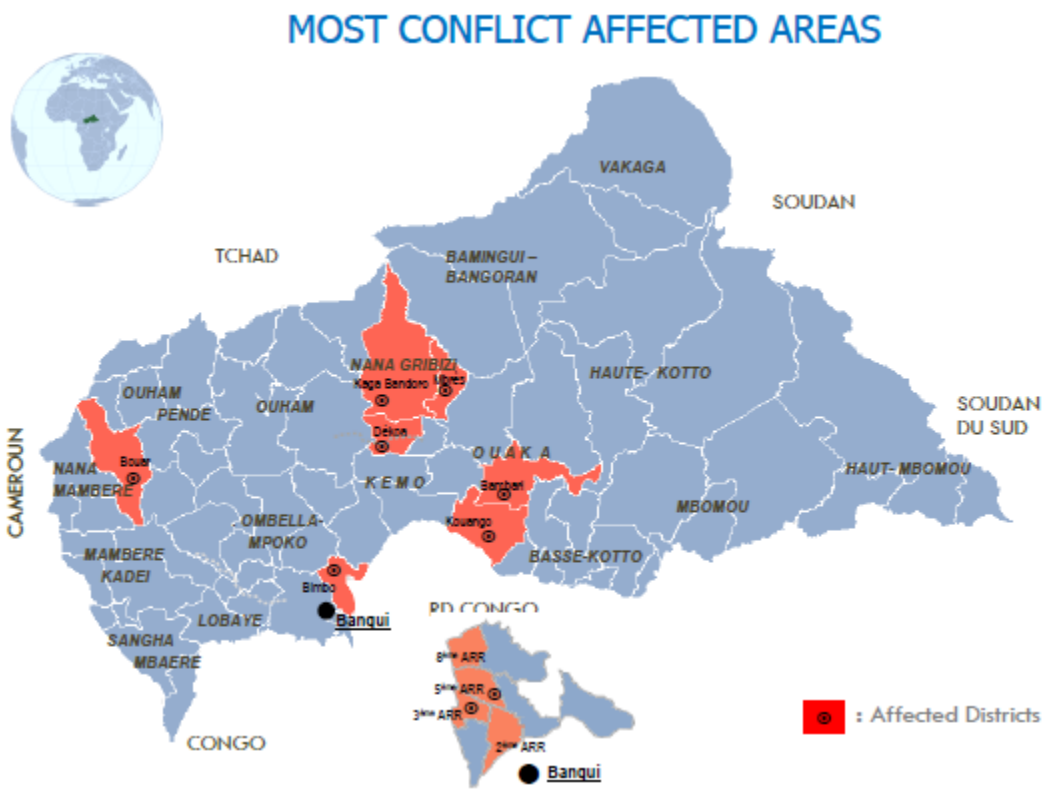
General information

A Japanese Government–funded programme, "*Providing emergency health care services to internally displaced and vulnerable host populations in Central African Republic"*, is being implemented in CAR. The overall programme goal is to reduce excess morbidity and mortality among IDPs and vulnerable host population in CAR through the provision of quality emergency health services, including mental health care but also trauma and chronic diseases care.

Area of intervention

Based on the more conflict-affected areas in CAR, the programme targets eight districts for the support of mental health care services: Bangui (2nd, 3rd, 5th, 8th sub-districts), Bimbo, Kaga-Bandoro, Dekoa, Bambari, Kouango, Mbres and Bouar. These districts were identified as being at high risk of experiencing a deterioration of the security situation with an increased number of displaced people, as well as injured, dead, raped and vulnerable populations in need of emergency assistance.

Map: More conflict-affected districts in Central African Republic



Source: Health Cluster in CAR, August 2016

Start date and duration of the action

The implementation of mental health activities took place from 1 August 2016 to 30 June 2017.

The overall programme duration is 23 months, from February 2016 to December 2017 (the first phase of the programme was between February 2016 and March 2017; the second phase was between April 2017 and December 2017).

Humanitarian organizations in the area

World Health Organization, Central African Republic Country Office.

In addition to its office in Bangui, WHO has set up three sub-offices (in Bouar, Nana-Mambere; Kaga-Bandoro, Nana-Grebizi; Bria, Haute-Kotto; Bambari, Ouaka and Bangassou, Mbomou) to better manage the humanitarian crisis in the health sector. WHO collaborates closely with the Ministry of Health as well as with national and international humanitarian partners in the health field. As the lead agency of the health cluster, WHO coordinates health activities at the national level. WHO also serves as a last resort in filling critical gaps identified (drug supply, epidemic response, support for free health care in some hospitals and displaced sites that do not have the support of partners, etc.).

Terms of reference of the mental health consultant

I was deployed as a WHO mental health consultant in CAR within the Japanese Government–funded project, according to the following Terms of Reference:

1. Revitalize the activities of the Mental Health Cluster with involvement of the Ministry of Health, Public Hygiene and Population.
2. Assess the impact of training and patient care in the area of mental health and psychosocial support in health facilities and displaced sites in Bangui and Bambari.
3. Write the mhGAP training modules adapted to the country context and have them validated.
4. Strengthen the capacities of clinicians in central and regional hospitals and those in the management of mental health and psychosocial support issues through training in mhGAP (targeted reference health facilities as part of humanitarian response – Bangui, Kaga-Bandoro, Dekoa, Bambari, Kouango, Mbrès and Bouar); the 2nd, 3rd, 5th and 8th communes of Bangui will also benefit from this training.
5. Finalize and validate the development of consultation materials, mental health data collection and periodic reports tools.
6. Establish a mechanism for the collection, processing and dissemination of mental health data for all levels of the health system.
7. Organize supervision and evaluation of the activities of trained personnel.
8. Propose a strategy for integrating mental health services into the health system.

Ethical approval

Ethical approval from the Ethics Research Committee NMS|FCM-UNL (CEFCM) was obtained in order to submit this work placement report (Annex 1).

Cross-cutting issues

Mainstreaming (gender-based violence)

Mental health consequences of GBV include nonpathological distress (fear, sadness, anger, self-reproach, shame, or guilt), anxiety-related disorders (including PTSD), depression, medically unexplained somatic pain, alcohol and other substance use disorders, and suicidal ideation and self-harm (Organisation mondiale de la Santé, 2011).

Security and contingency measures

WHO and other UN agencies have set up hubs with appropriate security measures to allow operations in the capital, Bangui, and in the regions by securing compounds through military presence. Security is volatile in Sibut, Kaga-Bandoro, Bria and Bambari. Bouar and Bimbo are in the early recovery phase. Alternative localities identified for the implementation of mhGAP in case of risks are Kouango and Mbrès.

Beneficiaries

In disaster situations, WHO estimates an increase in severe mental disorders from a projected baseline of 2–3% to an estimated 3–4%, and an increase in mild or moderate mental disorders from a projected baseline of 10% to an estimated 15–20% (van Ommeren et al., 2005).

The direct beneficiaries are IDPs, refugees, returnees and the local population.

Direct beneficiary identification mechanisms and criteria

In the health facilities implementing mhGAP, other health personnel and community cadre will receive training in the identification and referral of people with MNS disorders. Health cluster partners will receive information about mental health services available and criteria for referral. Promotion of services will be done through training of local NGO and community members. Medical doctors and certified nurses will use the mhGAP-HIG to evaluate the mental disorders.

As there are no family organizations or user groups in CAR, none could be invited to the National Adaptation and Planning Workshop to represent people with mental disorders.

Total number of direct beneficiaries:

Mild to moderate or severe, chronic mental disorders: 175 664

Severe or chronic mental disorders: 38 424

Mild to moderate mental disorders: 137 240

Table 2: Direct beneficiaries per sector:

Region	**Locality**	**Population / Conflict-affected people *1**	**IDPs and refugees in sites *2**	**IDPs in host family *2**	**Total**	**Number of beneficiaries**	
						Severe or chronic mental disorders: 3–4 %	**Mild to moderate mental disorders: 10–15 %**
Région Sanitaire 7	Bangui (2ème, 3ème, 5ème ,8ème)	400.141	11.139	53.857	465.137	16.279	58.142
Région Sanitaire 1	Préfecture Ombella M'poko, Bimbo						
Région Sanitaire 4	Préfecture Nana-Grébizi: Kaga Bandoro	124.351	11.267	13.067	148.685	5.203	18.585
	Préfecture Kemo: Sibut	50.637	-	-	50.637	1.772	6.329
	Préfecture Ouaka Bambari	149.579	18.755	-	168.334	5.891	21.041
	Préfecture Haute-Kotto Bria	91.110	-	-	91.110	3.188	11.388
Région Sanitaire 2	Préfecture Nana-Mambéré: Bouar	156.792	123	17.132	174.047	6.091	21.755
Total						**38.424**	**137.240**
						175.664	

*Source: *1 Projection sur base du recensement de 2003* (Ministère de l'économie du plan et de la coopération internationale, 2003) **2 Aperçu des besoins humanitaires* (OCHA, 2016)

Other beneficiaries: Health personnel to be included

Nonspecialized health workers will be beneficiaries, through capacity building and being participants in the action. The main participant group will be medical doctors and certified nurses working in government health services in the primary and secondary care institutions listed within the geographical areas mentioned.

Other beneficiary identification mechanisms and criteria

In CAR, there are approximately 205 medical doctors and 600 certified nurses. Medical doctors will have recognized diplomas from the Faculty of Medicine in the country (Faculty des Sciences de Santé) and nurses a diploma from accredited schools for paramedical personnel. They will be registered with the Medical Council. Medical doctors are allowed to independently diagnose and manage mental disorders. There is a restriction for certified nurses in terms of mental health training and supervision.

They will be active as a consultant in one of the priority health facilities identified: hospitals (at Central, except CNHUB, Regional and District level) and health centres. Hospitals, in general, are accessible, functional and staffed with skilled health personnel (medical doctors and certified nurses) present. The health centres of a District will be considered if they are functional and if there is at least one qualified health professional.

With appropriate permission from the MoH, Regional Services General Directorate will be approached. The peripheral level responsible for Districts will select the medical doctors and certified nurses from hospitals and health centres of their respective areas.

Objective, expected results and activities

The overall goal of mhGAP is to reduce disability and mortality due to MNS disorders.

The objective is to enhance coverage and quality of care for people with MNS disorders.

COMPONENT A: Development of plans and strategies for care of people with MNS disorders.

Expected results:

- Situational analysis available to inform planning and implementation.
- Stakeholder involvement.
- Plans developed to expand or scale up the project into other regions/districts.

Activities:

- Conduct a situational analysis.
- Identify and involve relevant stakeholders.
- Develop an action plan and budget.

COMPONENT B: Capacity building of health-care providers.

Expected results:

- mhGAP tools including training materials adapted.
- Improved capacity of nonspecialists to provide mental health care.

- Improved availability and capacity of specialists to supervise/support/train nonspecialists.
- Improved capacity of community-level health workers to be involved in identification and referral of people with MNS disorders.
- Strengthening of Psychiatric Department of the CNHUB.

Activities:

- Adapt mhGAP tools including training packages, Training of Trainers and supervision materials.
- Train nonspecialists in providing mental health care.
- Train specialists in supervision, support and training functions.
- Train other health and community workers' identification and referral of people with MNS disorders.
- Complete the checklist for institutional visits in humanitarian situations.
- Support Psychiatric Department of the CNHUB.

COMPONENT C: Delivery of care for MNS disorders in nonspecialized health settings.

Expected results:

- Adequate and appropriate assessment and management of people with MNS disorders within nonspecialist facilities.
- Functional referral system.
- Adequate and uninterrupted supply of essential medicines for MNS disorders.
- System of support and supervision for nonspecialists.
- Improved recording and monitoring system in the health facilities.
- Improved follow-up of cases with MNS disorders.

Activities:

- Strengthen supply of essential medicines.
- Develop and strengthen referral and back-referral system.
- Develop the system of support and supervision for nonspecialists.
- Provide inputs for better recording of patient information.
- Improve follow-up of cases with MNS disorders in the health facilities.
- Adapt and implement tools for monitoring and evaluation of MNS services.

Variables and data collection methods

A: Improved planning for the care of people with MNS disorders

Measure of Input:

- **Availability of a situational analysis to inform mhGAP planning and implementation.**
  A situation analysis is completed at the beginning of the programme implementation to identify resource availability, needs and barriers to mental health care within the country. Resource availability refers to the identification of existing mental health facilities and providers, including specialists and nonspecialists, and availability and use of drugs and supplies within the country.
  - *Data source*: Situation analysis report

- **Collaboration with relevant stakeholders in the mhGAP planning and implementation process.**
  Relevant stakeholders are identified and consulted for input during the mhGAP planning and implementation process. Examples of stakeholders are the MoH, policy-makers, health-care providers, community members, the private sector, NGOs, service users, families/carers, community advocacy and support groups, faith-based groups and traditional healers.
  - *Data source*: mhGAP focal point, report of planning workshop

- **Development of a mhGAP action plan and budget.**
  An action plan and budget for mhGAP implementation has been developed.
  - *Data source*: mhGAP focal point

Measure of Output:

- **Number of regions/districts with a plan for mhGAP implementation.**
  Number of districts with an action plan to implement mhGAP.
  - *Data source*: mhGAP focal point

B: Improved capacity of nonspecialists to provide mental health care:

Measure of Input:

- **Adaptation of mhGAP materials and tools.**
  Materials to be adapted include: mhGAP-HIG guideline, mhGAP training packages (including slides, facilitator's and participant's guides), Support and Supervision Guide, Monitoring and Evaluation Guide.
  - *Data source*: mhGAP focal point/WHO mental health consultant
  - *Method for data collection*: Specify which documents were adapted.

- **Number of mhGAP "Training of Trainers and Supervisors" workshops held.**
  Number of "Training of Trainers and Supervisors" (ToTS) workshops to train specialists to facilitate future mhGAP Base or Standard course training workshops for nonspecialist health-care providers, and to provide support and supervision to those trained in mhGAP.
  - *Data source*: Training report, Training Evaluation Forms.
  - *Method for data collection*: If ToTS workshop is held separately, also report for that.

- **Number of mhGAP training workshops held for nonspecialist health-care providers.**
  Participants of the mhGAP training workshops are referred to as nonspecialist health-care providers as the training is primarily intended for health workers who do not have formal training in mental health.
  - *Data source*: Training Evaluation Forms
  - *Method for data collection*: Reported per Base course module (for identified priority conditions).

Measure of Output:

- **Number of health-care providers trained in the mhGAP "Training of Trainers and Supervisors" workshop.**
  Total number of health-care providers who have completed training in mhGAP ToTS.
  - *Data source*: Training report
  - *Method for data collection*: Disaggregation by profession. If ToTS workshops are held separately, also report on the trainees for that.

- **Number of nonspecialist health-care providers trained in mhGAP.**
  Total number of nonspecialist health-care providers who have completed training in the Base course module (for identified priority conditions).
  - *Data source*: Training report
  - *Method for data collection*: Disaggregation by profession.

Measure of Outcome:

- **Knowledge among recipients of mhGAP training.**
  Knowledge will be measured using standard test before and after training workshops. Standard test will be adapted based on the international format, taking into account the selected priority conditions for the country.
  - *Data source*: Training pre-post-test forms, training report
  - *Method for data collection*: Participants will use a code to associate pre- and post-test forms. Forms will be scored by the mhGAP trainers based on a corrected pre-post-test available. Data will be entered in an Excel sheet.

C: Improved delivery of care for MNS disorders in nonspecialized settings:

Measure of Input:

- **Number of health facilities with reporting and information system for tracking care inputs and caseloads.**
  Number of health facilities participating in mhGAP routinely collecting, compiling, and reporting information for the purpose of tracking care inputs and caseloads. Care inputs include patient records (for both initial assessments and follow-ups), medical histories, treatment plans, referrals, resource utilization and other relevant information.
  - *Data source*: Supervision forms, facility monthly reports
  - *Method for data collection*: mhGAP focal point/WHO mental health consultant

Measure of Output:

- **Number of health facilities using mhGAP-HIG to assess and manage persons with MNS disorders.**
  Number of health facilities with trained mhGAP provider(s) using mhGAP-HIG to assess and manage persons with MNS disorders.
  - *Data source*: Supervision forms
  - *Method for data collection*: Through supervision.

- **Number of health facilities with an uninterrupted supply of essential psychotropic medicines.**
  Number of health facilities with sustainable access to essential medicines for MNS disorders under mhGAP. Sustainable access refers to a functioning system within the facility that ensures reliable and uninterrupted access to and availability of essential medicines for the treatment of MNS disorders.
  - *Data source*: Facility monthly report
  - *Method for data collection*: Through supervision.

- **Number of support and supervision visits to each health facility implementing mhGAP.**
  Number of support and supervision visits by trained mhGAP supervisor(s) conducted at each health facility with a nonspecialist mhGAP provider.
  - *Data source*: Supervision forms
  - *Method for data collection*: Supervision reports by locality.

Measure of Outcome:

- **Number of people with MNS disorders seen in each health facility implementing mhGAP.**
  Number will be broken down per priority disorder.
  - *Data source*: Facility monthly report
  - *Method for data collection*:
    For each consultation, the personnel trained in mhGAP will record their patient's information in the mental health register and open/update the patient identification form. Registration and patient identification forms are kept in the locked consultation room of the health facility.
    - Data will be collected through the National Information System, but for only one general indicator: mental disorders.
    - Data for the selected priority conditions will be collected during supervision (supervision visits, supervision by phone): from the mental health register; number, age and sex of patients will be compiled in the Facility monthly report.

Process / logic of intervention

The programme has been implemented over 10 months in four selected districts in CAR, using the WHO mhGAP-HIG.

Box: Summary of the process

Adaptation and planning:
Based on a situation analysis, the mhGAP has been adapted to the local context and its implementation at the national level has been planned in collaboration with the partners involved. For the adaptation, priority conditions have been identified based on the needs of the population reflected in the situation analysis. The mhGAP adaptation guide has been completed for each priority condition identified. Based on the adaptation guide and international training materials available,

mhGAP training materials have been developed. The plan for implementation of mhGAP has been developed based on the Districts selected in the Japanese Government programme and actual activities of partners.

Training cascade:
Based on the clinical expertise available in CAR and their active participation in the adaptation and planning process, Master Trainers have been selected for each of the identified priority conditions. Master Trainers received the drafted mhGAP training materials and facilitated their respective module in a national workshop for validation of the training materials. The methodology was presentations, role-plays, videos, case studies and group work. The objective was to validate at the national level the mhGAP training modules and strengthen the capacities of the Master Trainers in the facilitation of their respective module. Two medical doctors were recruited to be mhGAP trainer/supervisor and to support the Psychiatric Department of the CNHUB. Master Trainers and the two general practitioners (GPs) newly recruited who participated in the validation workshop were the mhGAP trainers and supervisors. The mhGAP trainers disseminated the training in the selected Districts. Four trainers were needed for the four days of training (two GPs, two psychologists).

For the diagnosis and clinical management of mhGAP, medical doctors and certified nurses were trained. For each health facility implementing mhGAP it was necessary to train other health and community cadres (health assistants, midwives, psychosocial agents, community health agents, community network, etc.) for the identification and referral of persons suffering from mental disorders.

Support and supervision:
Training was followed by active support and supervision. Support and supervision was not only meant to help trained personnel provide better mental health care (clinical supervision), but also to support them in the work environment associated with the implementation of mhGAP (administrative and programmatic supervision). The methodology was on-site supervision (supervisors visit the facility) and group supervision (a group of trained staff working in the same locality meet with supervisors). Two Supervisors were needed for supervision visits (one GP, one psychologist).

Situation analysis

The goal of the situation analysis was to provide preliminary understanding of the capacity and needs related to services for mental health conditions. A generic tool is part of the mhGAP-HIG toolkit and has been translated into French and adapted to the local context, including the situation of the humanitarian response in CAR.

The available situation analysis compiles useful information about needs and the target group; the availability of policies, plans and legislation; organization of services; partners involved; human resources; psychotropic medications; support and supervision system; monitoring and evaluation system and the current constraints for case management (Annex 2).

The method used to complete this analysis was consultation of key documents (health system and humanitarian response), interview of key mental health actors (MoH and partners) and visits to health facilities in Bangui, where health staff received previous mental health training.

This information was the basis for planning, adaptation and implementation of mhGAP based on available resources and identified needs.

Adaptation and planning at the national level

A two-day workshop for adaptation and planning took place in Bangui on 30 and 31 August 2016. The main objective was to adapt mhGAP to the local context and plan its implementation at the national level in collaboration with the partners involved.

The specific objectives were to:

- Identify the priority conditions to be included in the programme and complete the mhGAP adaptation guide for each condition.
- Plan the implementation of mhGAP at the national level for capacity building of health-care providers and the management of mental disorders in health facilities.

The expected results were:

- Collaboration with relevant actors in the adaptation and planning process for the implementation of mhGAP.
- Adaptation:
    - Priority conditions identified.
    - Consensus on technical issues.
    - Consideration of local terms to improve communication with users and caregivers.
    - Acceptability of the program in the local socio-cultural context.
    - Local ownership of mhGAP.
- Planning:
    - Health regions and target Districts identified.
    - Target health facilities for dissemination identified.
    - Target health personnel for dissemination identified.
    - Resources available and necessary for the supervision identified.
    - Revision of policies and plans necessary for scaling up the program identified.

The methodology used was presentations and group work.

The participants were:

- Health technicians from relevant disciplines: psychiatry, neurology, pediatrics, social work, psychology.
- Policy and Strategy Officer, MoH.
- Representatives of the General Directorate of Public Health.

- Representatives of the General Directorate of Planning and Management of Hospitals.
- Representatives of the Directorate of Management of the Hospital-University Space.
- Representatives of the University (Health Sciences and Psychology).
- Representatives of national and international NGOs involved in the implementation of mhGAP programmes in the country.

Facilitators: Facilitation of the workshop was provided by the Coordinator of the National Mental Health and Addiction Control Program and two psychologist-clinicians from the Psychiatric Department of the CNHUB, supported by WHO.

Results adaptation

During the workshop, several presentations were given by key partners in mental health and psychosocial support. The National Coordinator presented the mhGAP situation analysis done by the consultant. At the end, six conditions were adopted in plenary session:

- Acute stress (STR)
- Post-traumatic stress disorder (PTSD)
- Severe/moderate depressive disorder (DEP)
- Psychosis (PSY)
- Harmful alcohol and drug use (SUB)
- Epilepsy/Convulsive seizures (EPI)

The Adaptation Guide has been completed for each identified priority condition and is available in Annex 3.

Results planning:

In working group, the following questions were discussed:

1. What are the priority health regions and Districts identified? Why?
2. What are the priority target health facilities identified (hospitals, primary health care centres) for dissemination? Why?
3. Who are the target health personnel (medical doctors, certified nurses, midwives, etc.) identified for training? Why?

The answers to the questions reported in plenary sessions were:

Question1: What are the priority health regions and Districts identified?

Health regions 7, 4, 1 and 2 are selected for the implementation of activities.

Why?

Health regions 7, 4: Active conflict with IDPs and host population. Access is difficult due to security constraints.

Health regions 1, 2: Conflict in the recent past; returnees and host population. Access is easier as security situation is stabilized.

Question 2: What are the priority target health facilities identified (hospitals, primary health care centres) for dissemination?

The priority health facilities identified are the hospitals (at Central, except CNHUB, Regional and District level).

Why?

Hospitals, in general, are accessible, functional and staffed with skilled health personnel (medical doctors and certified nurses) present. The health centres of a sub-prefecture will be considered if they are functional and if there is at least one qualified health personnel.

Question 3: Who are the target health personnel (medical doctors, certified nurses, midwives, etc.) identified for training?

For diagnosis and clinical management (mhGAP) the target health personnel identified are medical doctors and certified nurses.

Why? Medical doctors are allowed to independently diagnose and manage mental disorders. There is a restriction for certified nurses in terms of mental health training and supervision.

For the detection and referral of people with mental disorders: other cadres.

Why? For each health facility trained, it will be necessary to train other health and community cadres (assistants, midwives, psychosocial agents, community health agents, community network, etc.) for the identification and referral of persons suffering from mental disorders.

Drafting the training materials

Based on international training material available (mhGAP-IG and mhGAP-HIG, Annex 4) and taking into consideration the recommendations from the adaptation guide, facilitator's guides (including role-plays and exercises) and PowerPoint presentations have been developed in French for each of the six identified priority conditions.

The videos developed by International Medical Corps for the mhGAP-IG have also been selected for DEP, PSY, SUB and EPI.

Selection of Master Trainers

Master trainers have been selected based on the six identified priority conditions through their clinical expertise and active participation in the Adaptation and Planning Workshop. Three Master Trainers were national (EPI, PSY, SUB), three were international (DEP, STR, PTSD).

A recommendation from the planning workshop was taken into account concerning the recruitment of two medical doctors to be included in the process since the beginning and made available to the Psychiatric Department of the CNHUB.

Drafted training materials were provided to the identified Master Trainers for presentation during the validation workshop.

Training materials validation workshop

A three-day workshop took place in Bangui from 13 to 15 September 2016.

The main objective was to validate at the national level the training modules of mhGAP and strengthen the capacities of the Master Trainers in the facilitation of their respective module.

The specific objectives were:

- Provide a training module for each priority condition.
- Collect feedback from specialists and partners through the evaluation form.
- Validate the modules at the national level.

The expected results were:

- Validation: for each priority condition:
    - Additional information collected to make the necessary modifications to the training modules.
    - Facilitator's guide, PowerPoint presentation, videos and role-plays available for each condition.
    - National validation of each training module.

The methodology was presentations and group work.

The participants were:

- Health technicians from relevant disciplines: psychiatry, neurology, pediatrics, social work, psychology.
- Policy and Strategy Officer.
- Representatives of the General Directorate of Public Health.
- Representatives of the General Directorate of Planning and Management of Hospitals.
- Representatives of the Directorate of Management of the Hospital-University Space.
- Representatives of the University Department of Psychology.
- GPs previously trained in mental health.
- Representatives of the Ministry of Social Affairs.
- Representatives of national and international NGOs involved in the implementation of mhGAP programmes in the country.

The content was a trial of the drafted module by the selected Master Trainer.

Facilitators: Facilitation of the workshop was provided by the Coordinator of the National Mental Health Programme and two clinical psychologists from the Psychiatric Department of the CNHUB, supported by WHO.

The detailed list of trainng materials is available in Annex 5.

Six Master Trainers and two medical doctors newly recruited who participated in the Validation Workshop are the mhGAP trainers and supervisors; three Master Trainers (two international and one national) were not available to participate in the dissemination.

There is a pool of five mhGAP Trainers and Facilitators (three GPs, two psychologists); four Trainers are necessary for dissemination (two medical doctors, two psychologists); two Supervisors are needed for supervision visits (one GP, one psychologist).

Dissemination: mhGAP and mini-mhGAP training

The duration of the mhGAP workshop for diagnosis and clinical management was four days. The duration of the mini-mhGAP workshop for the detection and referral of people with mental disorders was one day.

The main objective was to strengthen the capacities of health professionals in the management of the six identified priority conditions during the humanitarian emergency.

The specific objectives were:

- Train medical doctors and certified nurses in the diagnosis and clinical management of the six identified priority conditions during the humanitarian emergency.
- Train other health and community personnel in the identification and referral of people with mental disorders.

The expected results were:

- mhGAP: medical doctors and certified nurses wha are trained state graduate are able to evaluate and propose a basic treatment programme for people suffering from STR, PTSD, DEP, PSY, SUB and EPI.
- Mini-mhGAP: other health and community workers are able to identify and refer a person with a mental, neurological or psychoactive substance disorder.

The methodology was presentations, role-plays, videos, case studies and group work.

The participants were:

- mhGAP (15 participants): medical doctors and certified nurses in the selected health facilities.
- Mini-mhGAP (20 participants): other health and community workers – nurse assistants, midwives, midwife assistants, psychosocial agents, community health workers in the selected health facilities.

Facilitators: Facilitation of the workshop was provided by four mhGAP Trainers (two medical doctors, two psychologists).

The standard agenda for the five days of training is available in Annex 6.

Support and supervision

Health-care workers who attended the mhGAP training workshop were nonspecialized health workers working in health facilities that provide primary or secondary health care. Difficulties in integrating newly acquired mhGAP skills alone can be insurmountable. Trained staff therefore needed to be accompanied and supervised to use what they had learned during training in their clinical practice. This supervision was seen as a continuation of the training required to be able to develop competent mhGAP practitioners.

Support and supervision not only helped trained personnel provide better mental health care (clinical supervision), but also supported in the work environment associated with the implementation of mhGAP (administrative and programmatic supervision).

The supervision took place in the selected Districts. During one supervision visit in one District, health facilities implementing mhGAP were visited, and a one-day case study workshop was held.

The main objectives of support and supervision were:

- Improve the knowledge and skills of trained personnel so that they can assess and manage people with MNS disorders.
- Assist local health institutions in the administrative and programmatic aspects of implementing mhGAP.

The specific objectives were:

- Assist in the transfer of skills and knowledge from mhGAP training in the clinical setting.
- Ensure adequate mental health interventions in accordance with mhGAP and address areas for improvement.
- Identify and help to solve the problems encountered by trained personnel in dealing with complex cases.
- Ensure that the necessary administrative records and procedures (e.g. for referencing/counter-referencing and monitoring of MNS disorders) have been established.
- Ensure that medicines, medical equipment and other support systems for the implementation of mhGAP are operational.
- Set an example and encourage respectful and noncritical behaviour and ethical treatment that promotes and protects the fundamental rights of individuals with MSN disorders.

The methodology was:

- On-site supervision: supervisors visit the facility. Advantages are:
    - Face-to-face interviews provide better communication, improve the quality and type of supervisory activities and help motivate trained staff.
    - The supervisor can directly assess the performance of trained personnel.
    - Trained staff can be actively supervised for complex cases.
    - Administrative procedures, equipment and supplies affecting the treatment of MNS disorders and the implementation of mhGAP may be inspected.

- Group supervision: a group of trained staff working in the same locality meet with supervisors on site. Advantages are:
    - Gives trained personnel an opportunity to exchange experiences and learn from each other.
    - Trained personnel benefit from the experience and solutions provided by other trainees and/or institutions. The supervisor's advice also helps prepare trainees for problems they may encounter in the future.
    - Group participation, peer support and awareness of problems faced by other trainees may help increase motivation.
    - Can help establish a climate of collaboration and encouragement among trained staff.

Two Supervisors were needed for supervision visits (one GP, one psychologist). MhGAP supervisors have the following characteristics:

- Clinical skills and experience in mental health and/or mental health management.
- Skills and experience in the administrative aspects of the management of mental disorders, including record-keeping, tracking and referencing/counter-referencing.
- Good facilitation and problem-solving skills.

The support and supervision tools are available in Annex 7.

Monitoring and evaluation

Evaluations were conducted using the WHO mhGAP monitoring and evaluation toolkit, contextualized for the CAR setting.

The mhGAP Monitoring and Evaluation Toolkit is intended to aid in planning and conducting monitoring and evaluation activities for mhGAP. The overall aim is to enable the use of monitoring and evaluation to support effective implementation of mhGAP. Ministry of Health and WHO CAR Country Office and selected and adapted indicators that are relevant to the particular context and employed the most appropriate methods for measuring these indicators were selected and adpated, reflected in the monitoring and evaluation tools available in Annex 8.

Availability of psychotropic drugs

WHO committed to support with the provision of essential medicines in the current response plan with the following:

Annex II- Psychiatric medicine needed (stock)

N°	Description	Quantity	unity	unit price	total price
1	CHLORPROMAZINE INJECT, ampoule 25 mg -2ml	50	100	9,55	477,50
2	CHLORPROMAZINE, 100 mg tablet	50	1000	15,00	750,00
3	HALOPIRIDOL INJECT, ampoule 1 ml	400	10	3,00	1 200,00
4	HALOPIRIDOL , tablet 5 mg	50	1000	6,00	300,00
5	AMITRIPTILINE, tablet 5 mg	30	1000	6,50	195,00
6	DIAZEPAM, tablet 5 mg	50	1000	11,95	597,50
7	DIAZEPAM INJECT ampoiule	30	100	11,00	330,00
8	CARBAMAZEPINE, tablet 200mg	30	1000	17,00	510,00
9	BIPERIDEN , Inject ampoule 5mg -1ml	400	5	4,00	1 600,00
10	BIPERIDEN, tablet 2 mg	200	50	2,50	500,00
11	PHENOBARBITAL , inject ampoule 200 mg - 1ml	30	100	45,00	1 350,00
12	PHENOBARBITAL, tablet 100 mg	40	100	17,00	680,00
	TOTAL				**8 490,00**

Antipsychotic and anticholinergic drugs have been donated but no health facilities have an uninterrupted supply of essential psychotropic medicines. The content of two mental health kits, for health facilities implementing mhGAP and for the Psychiatric Department of the CNHUB, has been developed.

Strengthening the tertiary level

Human Resources

The human resources available to train and supervise nonspecialist health personnel while operating the Psychiatry Department are limited. The Psychiatry Department also provides care for difficult cases referred by trained nonspecialist health personnel.

In order to strengthen the capacities of the Psychiatric Department of the CNHUB and to accelerate the implementation of mhGAP, two medical doctors were recruited.

Rehabilitation of the Psychiatric Department at the Central Hospital

People with severe mental disorders and other mental and neurological disabilities (including those related to alcohol and other substance use) are at high risk of neglect in humanitarian settings, especially when they live in mental hospitals, social care homes or other institutions.

The checklist for site visits at institutions in humanitarian settings (WHO and UNHCR, 2012) was used to collect information in the Psychiatric Department of the CNHUB in order to protect and provide basic care for the hospitalized patients.

The checklist (Annex 9) suggests recommended actions and indicates a time frame.

Results

From 1 August 2016 to 31 March 2017:

Since August 2016 and in collaboration with relevant stakeholders, an advisory committee for planning and implementation has been established. Based on a situational analysis, an action plan has been developed targeting four Districts (Bangui, Sibut, Bouar, Bimbo) out of the eight mentioned in the Project.

The mhGAP materials and tools for capacity building and implementation of MNS services have been adapted and validated at the national level for the six identified priority conditions: acute stress, post-traumatic stress disorder, depression, psychosis, epilepsy, and harmful use of alcohol and drugs.

A training module for the identification and referral of people with mental disorders, as well as a Support and Supervision Guide, were also developed and validated.

Four mhGAP training workshops were held and 48 nonspecialist health-care providers – including nine medical doctors, 28 certified nurses and 11 other health-care providers – were trained for the clinical management of the six priority conditions; 226 nonspecialist health-care providers were trained for the identification and referral of people with mental disorders.

As of 31 March 2017, 24 health facilities (four hospitals, 20 health centres) are using mhGAP-HIG to assess and manage persons with MNS disorders, and all facilities have a reporting and information system for tracking care inputs and caseloads.

Antipsychotic and anticholinergic drugs have been donated but no health facilities have an uninterrupted supply of essential psychotropic medicines. The content of two mental health kits, for health facilities implementing mhGAP and for the Psychiatric Department of the CNHUB, has been developed.

There have been 29 support and supervision visits to the health facilities implementing mhGAP.

A total of 380 people with MNS disorders have been seen in those facilities (184 for acute stress, 55 PTSD, 20 depression, 21 psychosis, 25 epilepsy, and 75 for harmful use of alcohol and drugs).

In order to ensure implementation of the programme and to ensure the functioning of the Psychiatric Department of the CNHUB, two medical doctors have joined the team.

Based on the WHO checklist for site visits at institutions in humanitarian settings and to ensure care for people hospitalized in the Psychiatric Department, rehabilitation is in process.

The complete Monitoring and Evaluation Form is in Annex 10.

Comments on the programme or administrative component

The mhGAP reference documents, such as the mhGAP Guide and the Main Table, were available and accessible to all trained staff in the health facilities implementing the programme. The staff refer to the Main Table during consultations, as well as to the mhGAP Guide, although this is not yet

systematic. The register of consultations and patient records are available. Reference sheets are available. The announced drug supply arrived partially in the health facility implementing the programme. Only antipsychotic and anticholinergic drugs have been provided as of May 2017.

The referral pathway and associated means is difficult to implement as some Districts are far away from the capital, Bangui. The possibilities of referencing outside the Psychiatric Deopartment of the CNHUB, to partners with mental health and psychosocial expertise, were specified.

The mhGAP initiative meets the expectations and needs of the health zone, but administrative implementation is not fully in place due to lack of availability of psychotropic drugs. Supervision was favourably received and enabled the implementation of the programme.

Comments on the clinical dimension

There was a difficulty in differentiating nonpathological distress (fear, sadness, anger, self-reproach, shame, or guilt) from anxiety-related disorders (acute stress and PTSD). Harmful use of alcohol was detected and drug abuse was detected. It is important to note that people consulted their primary health care clinic for these problems. Depression was understood as a generic term for mental disorders.

Cases of psychosis were correctly diagnosed but only for a small number of cases, as access to care was a challenge. The second analysis did not validate the first analysis during the supervision. For example, a fighter experienced nightmares and had a feeling of being disconnected to his community. His discourse was constructed and coherent, showing no distortion of the patient's reality. At the supervision workshop, professionals realized that it was their own representation of the "abnormal" side of what the combatant experienced that had guided their analysis.

Cases of convulsive seizure were found and epilepsy was correctly diagnosed. The basic management was correctly implemented and anti-epileptic drugs were prescribed. Despite lack of supply, families could access phenobarbital in the community. In other instances, cases of epilepsy were referred to the Psychiatric Department of the CNHUB.

Box: Case study

Since December 2016, the Major of the Traumatology Department of the Community Hospital in Bangui is implementing the WHO mhGAP-HIG with the support of the Japanese Government. This certified nurse, Daniel, has been trained in the clinical management of six priority mental disorders.

Before the training, he explained that in his department, *"there were no cases of mental disorders"*. During the supervision visit, Daniel explained the cases he had recently seen:

- A person from the province was referred to the Traumatology Department after a violent attack in their community. Beyond her serious physical trauma, Daniel noticed that this woman had excessive concern about danger, was feeling shocked and had disturbing emotions. She refused care and could be aggressive. Daniel was able to provide basic psychosocial support by listening carefully, without pressuring her to talk. He asked the

person about her needs and concerns and helped her to address basic needs with the support of the health-care team and caregivers. She now accepts care and feels supported.

- A woman had a seizure while she was cooking alone. She fell into the fire and was severely burned. She arrived in the Traumatology Department, where Daniel was able to treat her leg but also evaluated this person as being epileptic. Daniel educated her and her caregivers about epilepsy, anti-epileptic drugs were initiated and this patient is followed up regularly.
- A man broke his leg during a fall while he was drunk. The fracture being serious, he was hospitalized in the Traumatology Department. This man was very agitated and refused to collaborate. Daniel assessed his drinking and strengthened social support with the presence of the caregivers in the service. As the man became increasingly agitated and confused, life-threatening alcohol withdrawal was assessed and an emergency management plan was developed.

Today, Daniel feels more confident in diagnosing people with a mental disorder, choosing and prescribing the right medication and offering psychosocial care.

The training of health professionals took place over a period of four days, the fifth day being reserved for other health and community cadres. The training materials were developed in French and trainers used Sangho to clarify the concepts. The training therefore required a lot of vocabulary in French, and was not always understood. The amount of information associated with a high degree of "skill shift" on the mental health approach and maintenance techniques is hampering implementation at the clinical level.

During the supervision, it appeared that drugs are understood as the most effective solution for all aspects of mental health. The identification of cases remains difficult and the protocols of care and referencing are difficult to implement, especially concerning transportation on Bangui in cases of referral to the Psychiatric Department. The supervision revealed difficulties in conducting clinical interviews, particularly with children. Trained health professionals leave little room for the expression of the beneficiaries and tend to conclude a little hastily. Emphasis was placed on psychosocial interventions.

The demand for ongoing technical support was clearly expressed. Supervision and workshops with professionals trained in mhGAP have brought to light identification of mental disorders that were not identified prior to the training.

Cultural and contextual perspective

Etymology

Mental illness is known to Central Africans and has its origins in cultural beliefs. Communities have their own understandings about the causes, explanations and care related to mental health and mental disorders. Traditional beliefs related to sorcery and religion constitutes the main frame of reference for dealing with relatives presenting with behavioural troubles. Some Central Africans

believe in “poisoning” and in “reincarnations”. The curse of the “Mamba Muntu” is a most common cause or the explanation for madness. In a trance, the young men will run, called to the river where the siren, Mamba Muntu or Wata, awaits them. Wata is a white woman with long smooth hair. She seduces her “victim” by offering her wealth. However, the man who signs a contract with her will have no right to associate with other women, because she is very jealous. Mami-Wata is supposed to lead him eventually to madness. The borderline between mental illness (fate, poisoning) and congenital disability does not seem clear. A child can be born ill because the father, for example, chased the spirit, or the mother ingested bad food during her pregnancy. It should also be noted that parents may abandon the afflicted child or person because he or she requires too much care and attention (UNICEF, 2010).

A main issue is the problem of substance abuse. The most widely used substances are alcohol and marijuana, but in the last five years there has been an increased consumption of tramadol, which is easily found at public markets and at a very low price accessible to anyone. It has been reported that the drug is used frequently among men, women, and even children. The main reasons for the abuse are either to be able to work harder and longer or to mitigate the fear and distress from exposure to or having witnessed extreme violence. Tramadol has been used by fighters among the multiple groups involved in sectarian, religious and ethnic confrontations. In many cases, extreme violence and atrocities have been executed under the effects of such substances. The parents claim that the Selkas distributed tramadol to child soldiers. They often mix the substance in tea, and are dosed in the jargon “until noon” or “a whole day”.

In the West, depression tends to be expressed emotionally. In CAR, these symptoms tend to be inscribed on the body, expressed by pain. The motifs that arise from consultation are back pain, headache, bleeding nose or abdominal pain, and people seek medical explanations for these pains. Health workers need to be very vigilant in interpreting symptoms. Some of these are the causes. These complaints should not be minimized but taken into consideration – it will validate the patient’s feelings and emotions. Mention of a symptom such as loss of appetite makes the majority of people smile (“never!”). Indeed, they are very hungry and feel they have maintained a good appetite. It is possible to study a loss of appetite more in the context of a sense of hunger, from the fasting imposed by the current situation.

People are not aware that chronic and acute cases of common and severe mental health disorders associated with the exposure to traumatic events can be addressed through modern health care. Main motifs of consultations at health facilities are related to changes in behaviour and aggression, lack of energy and motivation.

Epilepsy is associated with local beliefs related to a mix of religion, magic and superstitions, which keep families from seeking medical assistance and management, with treatment limited to traditional methods. A prospective cross-sectional study conducted in middle school students found that 78.3% of respondents reported they had already seen an epileptic seizure. For 79.7%, epilepsy is a contagious disease; 28.8% believed that epilepsy was due to bad luck and 45.0% believed it to be due to an evil spirit. There remains a need to demystify this disease through awareness (Mbelesso et al., 2009).

Interventions

Families tend to hide family members with mental disorders and avoid consulting health services. They fear the shame such a condition can bring to their families according to their system of values and beliefs. The limited access to care and stigmatization constitutes a serious concern in terms of respect for the human rights of those who are experiencing mental disorders.

Traditional healers recognize that mental disorders are a problem in their communities. These cases are often handled through a traditional response based on a system of beliefs related to religion, magic or superstitions. Traditional healers are perceived as the main resource for such types of cases instead of modern health services. The management of mental disorders takes several forms depending on the manifestations and the gravity of the disorder. Traditional plants are used to calm the person. The product is coated on the body. Traditional techniques of scarification exist. The "nice" or "passive" patients are distinguished from the aggressive patients. They will reject and seek to control the one that is considered dangerous. In fact, it is "common" to attach him/her (UNICEF, 2004).

In Central African society, the social structure is based mainly on family ties instead of societal ties. The crisis of recent months has only reinforced intra-family solidarity and distances with the social environment. Many people have spoken of a decrease in the sharing of acquired goods and rural products. Those who have access to certain commodities hide them so that they do not have to share them with neighbours. Before the crisis, Districts and villages would organize football matches and traditional dances. Music was an important part of everyday life. Now, fearful of being spotted, people no longer sing, and they move discreetly in the bush.

Religion remains – through prayer and meditation – the most frequently used way to relax and regain hope. Rather than turning to community solidarity, people tend to shut themselves up with their own religious beliefs. If faith can be an excellent mechanism of resilience, in a context where religious groups tend to clash and be one of the proponents of the conflict, this community withdrawal can be disquieting.

There is a usual dichotomy. Traditional knowledge and healing are preferred to treat the disease, but medications are used when the situation becomes more severe. The Western solution of medicines seems to have made their way into the minds of the community as viable.

Key drivers, challenges and sustainability

Key drivers

The key drivers that ensured the programme was successfully implemented are:

Prioritization of mental health

Mental health is identified in CAR as a gap by major stakeholders, including the Japanese Government, which funded the programme.

Leadership and governance for mental health

There is a Coordinator for the National Mental Health and Drug Abuse Programme. A coordination mechanism exists through the Working Group on Mental Health and Psychosocial Support within the Health Cluster.

Technical support and capacity building

National and local efforts produce better results when they are supported by regional and global action based on evidence-based intervention.

Supervision

The supervision mechanism allows the trained health-care providers to translate their knowledge into more available services.

Challenges

Limited capacity

The population's need for basic services overwhelms local capacity as the local system has been damaged by the emergency. Resources vary depending on the extent and availability of international humanitarian assistance. Challenges include:

- Heightened urgency to prioritize and allocate scarce resources.
- Limited access to specialists (for training, supervision, mentoring, referrals or consultations).
- Limited time to train health-care providers.

Limited access to psychotropic medications

There is currently no operational system to ensure availability of drugs in health facilities in the country.

Intersectoral coordination

To coordinate action in emergencies, humanitarian organizations are organized into Clusters. In CAR, there is a Health Cluster, with a Mental Health and Psychosocial Support (MHPSS) Working Group, and a Protection Cluster, with Child Protection and Gender-based Violence (GBV) Sub-Clusters. The mental health system is not well connected to other relevant sectors of the health system, nor with other relevant non-health sectors. A comprehensive approach for MHPSS is needed, including the integration of more specialized mental health services at the health facility levels, but also a strong community-based component in order to identify, refer and follow up people in need.

Attitudes, beliefs and practices

A lot of work remains to be done in these areas related to mental health both at the community level as well as at the service provision level; for instance, the associated stigma and the role of traditional healers.

Staff well-being and motivation

These are a concern given the basic conditions of practice, the amount of work and the type of cases they are facing.

Security constraints

The security constraints have an impact on access for training and supervision in the "hot spots", as well as an impact on service delivery as the unstable environment in which activities and services take place can lead to the need for evacuations or force members of the staff to leave on short notice.

Sustainability

Level of sustainability

mhGAP has been developed and implemented under the National Mental Health Programme, with the technical support of WHO. Selected implementing health facilities (functional and staffed) are the MoH facilities, and health personnel trained are MoH cadres. Due to support of the national programme and integration into the general health system, sustainability of the programme is ensured.

Continuum strategy

Humanitarian emergencies are tragedies, but they also provide an enormous opportunity to build a mental health system to support people. Because the rates of a broad range of mental disorders will increase, plans need to be initiated to build long-term, basic, sustainable community mental health services in affected Districts (WHO, 2013).

For the health sector, the most essential activities for the long run are:

- Revise the National Mental Health Policy (2011).
- Initiate the development of the National Mental Health Plan.
- Work to ensure the sustainability of any newly established mental health services.

Networking and exchange of experience among countries:

Exchange between countries with similar religious and cultural norms could strengthen the implementation of the programme through exchange of best practices.

Conclusion

While this humanitarian emergency is a tragedy, it also provides an enormous opportunity to build a mental health system to support people. The present programme has been implemented over 10 months in four selected sub-districts in CAR, using a version of the WHO mhGAP-HIG that has been contextualized for the local setting. The model uses a supervised cascade training model, with Master Trainers providing training for Facilitators, who in turn conduct trainings for front-line health-care workers, followed by active support and supervision.

Before the crisis, mental health had been highly neglected and absent of key policy documents, several NGOs were undertaking mental health activities with a limited scope, targeting vulnerable groups and not integrating their activities into the general health system. The implementation of the project in the four Districts demonstrated that it is feasible to integrate mental health services in nonspecialized settings within the existing system.

It was key to strengthen the capacities of professionals in the tertiary level and of the specialists to be able to implement the programme and continue to ensure the activities at the Psychiatric Department of the CNHUB. Specialists needed support to integrate training and supervision in their daily activities.

Tools are available at the international level, including guidance on how to adapt them to the local conditions, taking into consideration the specific mental health needs, resources available and cultural appropriateness of the intervention.

A community mobilization component to increase case identification at the community level needs to be integrated into the programme. Ongoing individual and group supervision is necessary to ensure appropriate clinical management of people with mental disorders, as well as the continued supply of essential psychotropic drugs.

Revision of the Mental Health Policy and development of the Mental Health National Plan need to be initiated to build long-term, basic, sustainable community mental health services in the affected Districts.

A hand-over plan was developed and transmitted to the Non-Transmissible Diseases Department of the WHO Country Office responsible for the mental health activities.

Annex 1: Ethical approval

Decisão final sobre o projeto "Scaling-up mental health services for internally displaced and vulnerable host populations in Central African Republic; using WHO "mental health Global Action Program - Humanitarian Intervention Guide (mhGAP-HIG)""

A Comissão de Ética da NMS|FCM-UNL (CEFCM) decidiu, por unanimidade, aprovar o projeto intitulado " Scaling-up mental health services for internally displaced and vulnerable host populations in Central African Republic; using WHO "mental health Global Action Program - Humanitarian Intervention Guide (mhGAP-HIG)"" (nº20/2017/CEFCM), submetido pelo Dr. Martin Vandendyck.

Lisboa, 21 de Junho de 2017

O Presidente da Comissão de Ética,

(Prof. Doutor Diogo Pais)

TO WHOM IT MAY CONCERN

The Ethics Research Committee NMS|FCM-UNL (CEFCM) has unanimously approved the Project entitled " Scaling-up mental health services for internally displaced and vulnerable host populations in Central African Republic; using WHO "mental health Global Action Program - Humanitarian Intervention Guide (mhGAP-HIG)"" (nr.20/2017/CEFCM), submitted by Dr. Martin Vandendyck.

Lisbon, June 21th, 2017

The Chairman of the Ethics Research Committee,

(Diogo Pais, MD, PhD)

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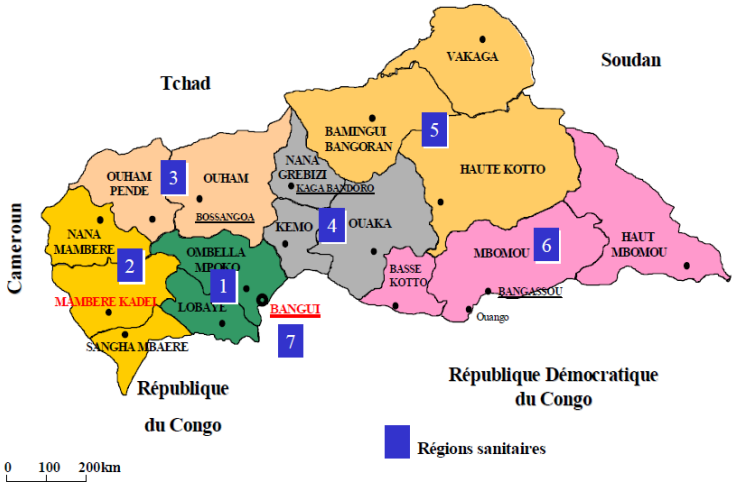
Annex 2: Situation analysis

Nom du Pays: République Centrafricaine				
NIVEAU NATIONAL				
N.1	**STRUCTURE POLITIQUE, SOCIO-DEMOGRAPHIQUE ET FACTEURS ECONOMIQUES**			
	L'objectif de cette section est de fournir une compréhension générale du contexte du pays, des facteurs qui ont un impact sur la santé en général ainsi que la santé mentale.			
N.1.1	**Taille de la Population**	**Total**	**Urbain (%)**	**Rural (%)**
		4.510,000 en 2010 (EIU, 2010). La densité de la population est faible avec 7 personnes au kilomètre carré, pour une moyenne de 38 en Afrique sub-saharienne (World Bank 2011).	38% (RGPH, 2003). 70% de la population vit sur 30% du territoire. 23% de la population vit dans les grandes villes, dont 13% dans la capitale Bangui (MSPP 2006).	62% (RGPH, 2003).
N.1.2	**Age**	**Moins de 14 ans**	**Plus de 65 ans**	
		47% âgés de moins de 18 ans (UNO, 2009).	4% âgés de plus de 60 ans (UNO, 2009).	
N.1.3	**Langues**	Le Sango est la langue nationale. Le Français est la deuxième langue officielle du pays.		
N.1.4	**Ethnicités et religions**	50% de protestants, 29% de catholiques, 10% de musulmans ; les autres religions représentent 20% de la population. La pratique de l'animisme est prédominante (Politique Nationale de Santé Mentale, 2011). Les principaux groupes ethniques sont : Gbaya (28.8%), Banda (22.9%), Mandjia (9.9%), Ngbaka Bantou (7.9%), Ngbandi (5.5%), Zandé Nzakara (3%) (Politique Nationale de santé mentale, 2011).		
N.1.5	**Produit Intérieur Brut**	450 $ (World Bank, 2011). La moyenne dans les pays d'Afrique sub-saharienne est de 1.096 $. Groupe Banque Mondiale: Pays à faible revenu. Avec un index de développent humain de 0.315, le pays se classe 159ème des 169 pays évalués en 2010. 72% de la population rurale et 68.3% de la population urbaine vit en dessous du seuil de pauvreté (MSSP, 2004).		
N.1.6	**Type de Gouvernement**	République parlementaire démocratique.		

Nom du Pays: République Centrafricaine				
NIVEAU NATIONAL				
N.1.7	**Structure Administrative**	Le pays est divisé en 7 Régions (identifiées par des numéros, numéro 7 étant la Région incluant la capitale Bangui), 16 Préfectures, 78 Sous-Préfectures, 177 Communes and approximativement 8.300 Villages.		
N.1.8	**Taux de littérature (%)**	**Total**	**Urbain**	**Rural**
		72% pour les hommes et 56% pour les femmes (UN Statistiques, 2008).	Non disponible.	Non disponible.
	REPONSE HUMANITAIRE			
	Populations affectées	• Il y a actuellement 2,3 millions de personnes en RCA dans le besoin d'aide humanitaire, dont plus de 600.000 à Bangui (OCHA, 2016). • En 2015, 426.000 personnes étaient réfugiées (OMS, 2015). • En Juin 2016, 391.433 étaient déplacées à l'intérieur du pays, 235.594 en famille d'accueil et 155.839 sur sites (Commission Mouvement des Populations, 2016).		
N.2	**STRUCTURE SANITAIRE**			
N.2.1	**Structure sanitaire administrative**			

Nom du Pays: République Centrafricaine		
NIVEAU NATIONAL		
		• **Niveau central ou national** - Cabinet du Ministre de la Santé Publique et de la Population. - Secrétariat Général : 2 Directions Générales (Santé Publique et de la Population, Services d'Appui). - 7 Directions Techniques. - 21 Services Centraux. • **Niveau intermédiaire ou régional :** Constitué de 5 Régions Sanitaires : - Une Région Sanitaire comprend 2 à 4 Préfectures sanitaires dont les limites sont celles des circonscriptions administratives. - Elle est dirigée par un Chef de région sanitaire ayant rang et prérogatives de Directeur et faisant fonction de Service Régional de l'Inspection, assisté d'une équipe composée de trois autres Chefs de services régionaux qui sont : Planification et Programmation ; Coordination des Soins de Santé Primaires, Administration et de la Gestion. • **Niveau périphérique ou préfectoral :** - Le niveau opérationnel du système de santé de la RCA. - Il est dirigé par un Médecin-chef qui est assisté d'une équipe constituée de trois chefs de sections préfectorales représentant les différents services régions : Planification et Programmation ; Soins et Supervision ; Section de Gestion et Administration. Le « Bulletin annuel de Santé » de 2006, publié en 2008, établi le nombre total de structures sanitaires à 746 : 643 publiques et 103 privées. Il y a : • **4 Hôpitaux Centraux à Bangui :** Hôpital Communautaire, Hôpital de l'Amitié, Complexe Pédiatrique, Centre National Hospitalier Universitaire de Bangui –CNHUB. • **Bimbo:** Hôpital de 100 lits. • **5 Hôpitaux Régionaux :** Berberati, Bossangoa, Bambari, Bria, Bangassou. Pour le reste des structures sanitaires: • **11 Hôpitaux Préfectoraux** : M'baïki, Nola, Carnot, Bouar, Bozoum, Paoua, Sibut, Kaga-Bandoro, Ndélé, Birao Mobaye et Obo. • **Centres de Santé :** 301 (Politique Nationale de santé, 2004), 195 (Bulletin MSSP, 2006), 181 (Plan National de Développement Sanitaire 2006-2015) • **Postes de Santé:** 262 (Politique Nationale de Santé, 2004), 427 (Bulletin MSSP, 2006), 330 (Inventaire de Santé, 2006) et 445 (Plan National de Développement Sanitaire 2006-2015).
N.2.2	**Est ce qu'une analyse nationale de la situation de santé mentale, telle qu'OMS-EIMS, est disponible?**	Non. L'Atlas de santé mentale de l'OMS a été complété en 2011 et en 2014 et est disponible.
	REPONSE HUMANITAIRE	
	Enquête rapide sur l'estimation des besoins de santé des populations affectées par la crise. Herasm, 2015.	L'enquête a collecté les données sur 1008 structures de santé (814 structures de santé en 2014) : • 347 structures de santé (34%) ont été partiellement ou totalement détruites (27,7% en 2014 ; 124 Structures de santé partiellement ou totalement détruites inaccessibles en 2014). • 68% structures de santé sont fonctionnelles (235) (52,2% en 2014) au niveau national. • 41% des structures fonctionnelles bénéficient d'un appui.

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	Cluster Santé	Oui.		

	Groupe de Travail de Santé Mentale et Soutien Psychosocial	• Il y a un Groupe de Travail de Santé Mentale et Soutien Psychosocial, au sein du Cluster Santé.
		• Actif et qui se réunit toutes les 2 semaines.
		• Le lead est assuré par le Bureau OMS/RCA et le Co lead par la Croix Rouge française.
		• Il est composé d'associations et d'ONG locales, d'ONG internationales et d'Agences Onusiennes, pour environ 45 membres actifs.
		• Un Plan d'Action Opérationnel (2016) a été développé.
		• Il y a également :
		  ○ Un sous-cluster protection de l'enfance, au sein du cluster protection, soutenu par l'UNICEF.
		  ○ Un sous-cluster GBV, soutenu par UNFPA.		

	Est-ce que les 4 W's sont disponibles ?	Oui, pour le Cluster Santé et pour les Groupe de Travail de Santé Mentale et Soutien Psychosocial.		
N.3	**INDICATEURS DE SANTE GENERAUX ET PREVALENCE DES TROUBLES DE SANTE MENTALE.**			
N.3.1	**Espérance de vie**	**Total**	**Urbain**	**Rural**
		45 ans pour les hommes et 49 ans pour les femmes (World Bank, 2011).	Non connu	Non connu
N.3.2	**Taux de mortalité infantile** (par 1.000 naissances vivantes)	**Total**	**Urbain**	**Rural**
		171/1.000 (2009) Mortalité maternelle 850/100,000 (2008)	Non connu	Non connu
N3.3 a	**Prévalence des troubles mentaux**	Il n'y a pas de données représentatives au niveau national sur la prévalence des troubles mentaux. Cependant, certaines données sont disponibles : • Les troubles mentaux contribuent 5% de la charge globale de santé en RCA (WHO, 2008). • Disability Adjusted Life Years (DALY): 2.659/100.000 (OMS, 2014). • Suicide: 9.5/100.000 (Age-standardized suicide rates) (OMS, 2014). Etudes épidémiologiques: • Vinck & Pham. Association of exposure to violence and potential traumatic events with self-reported physical and mental health status in the Central African Republic. JAMA. 2010 Aug 4; 304(5):544---52. ○ 55.3% de troubles dépressifs chez les personnes exposées à des violences. • Guerchet et al. Prevalence of dementia in elderly living in two cities of Central Africa: the EDAC survey. Dement Geriatr Cogn Disord. 2010; 30 (3):261-8.		

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		La Politique Nationale de Santé mentale (2011) identifie:
		• Hospitalisations :
		  ○ Psychoses (57,3%).
		  ○ Troubles liés à l'abus des substances psychoactives (21,6%).
		  ○ Autres cause d'hospitalisation : les troubles dépressifs, les troubles anxieux.
		• Consultations : la cause la plus commune de consultation sont les troubles anxieux liés aux violences et aux violences sexuelles.
		• A Bossembélé, Damara, Liton et Sibut, des dizaines de victimes (notamment les femmes) de violences sexuelles lors des événements militaro-politiques que le pays a connus continuent de souffrir de stress post traumatique et de troubles dépressifs sévères.
		• Des dizaines de jeunes de 20 à 30 ans de plusieurs villes centrafricaines font un usage répété de substance psychoactives dans le cadre de l'exercice d'emploi informel (conducteurs de taxi motos ou exploitants de diamant ou d'or).

	REPONSE HUMANITAIRE	
	Contexte global dans les situations d'urgences humanitaires	**Contexte Global :** En situation d'urgence, l'OMS estime: • Une augmentation des troubles mentaux sévères d'un taux de base estimé de 2-3% à un taux estimé de 3-4% (par exemple : psychose, dépression sévère, trouble anxieux sévère). Il s'agit d'une estimation basée sur le fait qu'un évènement traumatisant ou la perte d'un relatif peut contribuer à la rechute d'une personne avec un trouble mental stabilisé, et peut causer des formes sévères de troubles anxieux. • Une augmentation des troubles mentaux modérés d'un taux de base estimé de 10 % à un taux estimé de 15-20% (par exemple : dépression et trouble anxieux modéré, incluant le stress post traumatique). Il est établit que les évènements traumatisant ou la perte d'un relatif augmentent le risque de dépression et de troubles anxieux, incluant le stress post-traumatique. **Violence sexuelle liée aux conflits :** Les conséquences psychologiques/pour la santé mentale englobent la détresse non pathologique (peur, tristesse, colère, auto-reproche, honte, ou culpabilité), les troubles liés à l'angoisse (y compris l'état de stress post-traumatique), la dépression, les douleurs somatiques médicalement inexpliquées, les troubles liés à la consommation d'alcool et d'autres substances, ainsi que les idées suicidaires et l'automutilation (IASC, 2011).

	Evaluation des besoins en Santé mentale dans le cadre de la situation humanitaires	Plusieurs partenaires ont documenté les besoins en santé mentale dans le cadre de la situation humanitaires :
		• Rapid mental health situation analysis, IMC, 2014.
		  ○ Troubles mentaux chroniques et sévères associés à l'exposition à des évènements traumatiques.
		  ○ Stress aigu.
		  ○ Epilepsie était rapportée comme un problème tant chez les enfants que chez les adultes.
		  ○ Abus de substance : tramadol, drogues et alcool.
		• Evaluation report on mental health and care practices. Kemo Region, CAR, ACF, 2013.

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		• Evaluation des besoins psychologiques des enfants d'âge scolaire dans les localités de Bangui et de la Ouaka, RCA. Save the children, 2015.
		  ○ Les difficultés psychologiques des enfants, incluant l'état de stress post traumatique sont importantes et représentent un fardeau important pour les enfants eux-mêmes, les parents et les enseignants.
		  ○ 10% des enfants rapportent avoir été victimes de violences sexuelles, dans certains lieux de l'étude, 64% des enfants présentaient un état de stress post traumatique.
		• Rapport final, mission de consultation OMS, Bangui du 15 Avril au 18 juillet et 8 Aout au 7 Novembre 2015, Michel Dzalamou.

N.3.4	**Liste des troubles mentaux les plus fréquents dans le pays.**	Stress aigu, état de stress post-traumatique, psychose, épilepsie, dépression, abus de substance.
N.4	**BUDGET AND FINANCEMENT**	
N.4.1	**Dépenses pour la santé (% du PIB)**	13 $ (OMS, 2014)
N.4.2	**Budget de Santé Mentale en % du budget total de la Santé.**	Non connu. Il n'y a pas un budget spécialement alloué à la santé mentale.
N.4.3	**Budget Neurologie en % du budget total de la Sante.**	Non connu. Il n'y a pas un budget spécialement alloué à la Neurologie.
N.4.4	**S'il y a une assurance sante au niveau national, est-ce que la sante mentale est intégrée ?**	Non, il n'y a pas de système d'assurance santé ou d'autres systèmes de pré payement au niveau national.
N.4.5	**Mécanismes de financement de la sante en général.**	Le budget de la santé était de 7.2% du budget total du Gouvernement en 2009 et de 9.1% en 2010. Le financement du secteur reste fortement dépendant de l'aide extérieure avec 55.8% en 2010 (bailleurs de fond et prêts). Le budget alloué au CNHUB et à l'Hôpital Communautaire consomme une partie importante du budget de la santé. Les patients paient pour les services qu'ils reçoivent dans les structures publiques (recouvrement des couts). Au Service de Psychiatrie du CNHUB, une journée d'hospitalisation coute 1.000 CFA, un mois de consultation ambulatoire (3-4 sessions) coute un forfait de 2.000 CFA et un suivi psychologique à vie coute 15.000 CFA. Un suivi gratuit est disponible pour les personnes nécessiteuses.
N.4.6	**Y a t-il des mécanismes de financement spécifiques ou des programmes d'aide pour les services de santé mentale.**	Non
N.4.7	**Y a t-il des programmes pour les médicaments psychotropes ?**	Il y a une liste nationale des médicaments essentiels, la dernière édition datant de 2015 (voir N.6.3). L'Unité de Cession du Médicament ne peut pas fournir aux structures de santé des médicaments psychotropes de manière régulières.

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	Y a-t-il des mécanismes de financement spécifiques ou des programmes d'aide pour les services de santé mentale.	Un programme d'aide du Gouvernement Japonais nommé « *Providing emergency Health care services to internally displaced and vulnerable host populations in Central African Republic* ", allant du 1er Janvier au 31 Décembre 2016 inclut des activités de santé mentale. Les **structures sanitaires de référence ciblées dans le cadre de réponses humanitaire** sont: 2ème, 3ème, 5ème et 8ème communes de Bangui et dans les localités de Bimbo, Kaga Bandoro, Dekoa, Bambari, Kouango, Mbrès, Bouar.
	Y a-t-il des programmes pour les médicaments psychotropes ?	Le programme d'aide du Gouvernement Japonais inclut une commande de médicaments psychotropes.
N.5	**POLITIQUES ET LEGISLATIONS CONCERNANT LA SANTE MENTALE**	
N.5.1	**Y a t-il une Politique Nationale de Santé mentale et/ou une législation concernant la Santé mentale ?**	• Une Politique Nationale de Santé Mentale a été développée et validée en 2011. • Un Plan National de Santé mentale 2011-2015 a été développé et validé en 2011 mais n'a pas été opérationnalisé. • Il n'existe pas de législation spécifique concernant la santé mentale. Les provisions légales concernant la santé mentale ne sont pas couvertes dans d'autres lois. Autres Politiques et Plans Nationaux: • Il y a une Politique Nationale de Santé, 2004. • Plan National de Développent Sanitaire 2006-2015 incluant des activités de santé mentale.
	REPONSE HUMANITAIRE	
	Plan / Programme	• Plan Opérationnel de Réponse du Secteur Santé à la Crise en république Centrafricaine, Jan – Déc 2016. Cluster Santé. • Plan d'Action Opérationnel du groupe de Travail en Santé Mentale et Soutien Psychosocial, 2016. • Programme d'aide du Gouvernement Japonais nommé « *Providing emergency Health care services to internally displaced and vulnerable host populations in Central African Republic* " • Un plan de transition 2016 – 2017 entre la réponse humanitaire et la relance du système de santé inclut des activités de santé mentale.

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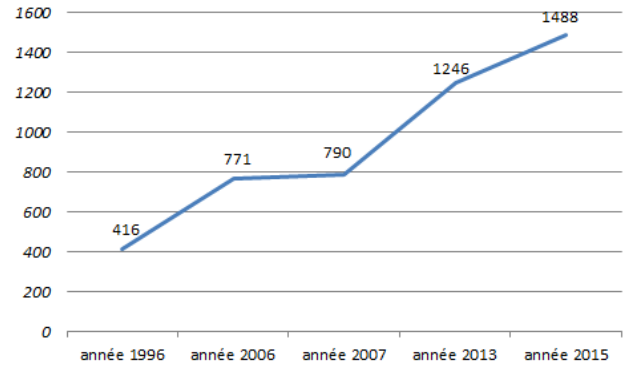
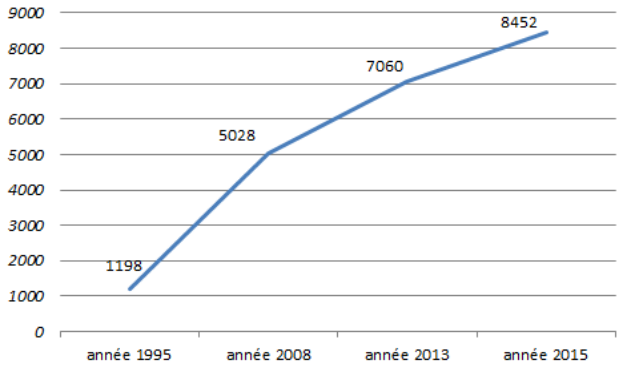
N.6	**ORGANISATION DES SERVICES DE SANTE MENTALE**				
N.6.1	**Services de Santé mentale dans les structures sanitaires**	**Nombre de services ambulatoires**	**Nombre de lits psychiatriques dans les Hôpitaux Généraux**	**Nombre de services résidentiels communautaires**	**Nombre de lits dans les Hôpitaux Psychiatriques**
		1- Service de psychiatrie et d'hygiène mentale situé au Centre National Hospitalier Universitaire de Bangui (CNHUB).	24 Lits Service de psychiatrie et d'hygiène mentale (CNHUB).	0	0
N.6.2	**Nombres de personnes utilisant les services de Santé mentale dans les 12 derniers mois ?**	**Nombre de services ambulatoires**		**Nombre de lits psychiatriques dans les Hôpitaux Généraux**	
		18.42 per 100.000 population (Atlas Santé mentale, 2011). Le nombre de consultations a augmenté de 400% au cours des 10 dernières années et le nombre de nouveaux cas a augmenté de 416 en 1996 à 1.488 en 2016 (données au mois de Juillet)		5.28 per 100.000 populations (Atlas Santé mentale, 2011).	



Graph1. Nombre annuel de nouveaux cas (Source : Service de Psychiatrie CNHUB)



Graph2 : Nombre annuel de consultation dans les services de psychiatrie (Source : Service de Psychiatrie CNHUB)

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	Pyramide d'intervention (IASC) sur base des 4 W's disponible (Cluster Santé et Groupe de Travail Santé Mentale et Soutien Psychosocial).  **Intervention psychosociale et de santé mentale pour les survivants de violence sexuelle liée au conflit.** JUPUDEC, Vitalité Plus, IMC, CRF, MdM-F, MSF-E, MSF-B, MSF-S, CICR, IRC, FAIRMED, UNICEF, UNFPA.
	La réponse en santé mentale et soutien psychosocial dans les **phases aigue** (voir Plan Opérationnel du Cluster Santé), comprenant la capacité à prodiguer les premiers secours psychologiques est assurée majoritairement par les partenaires, à travers le déploiement de spécialistes internationaux, le recrutement et la formation des agents psychosociaux, ou l'activation du réseau de volontaires dans le cadre de la Croix-Rouge. Le **service de psychiatrie du CNHUB** a vu le nombre de ses consultations quadrupler au cours de ces 10 dernières années, sans disposer de plus de ressources. Depuis le départ du Dr Tabo, Psychiatre, en 2011, son adjoint le remplace et fait fonction. Il n'a lui-même pas été remplacé. Bien que faisant fonction de référence nationale pour l'ensemble des partenaires, seul ACF et l'OMS soutiennent le service. Les infrastructures (matelas, sanitaires, commodités) sont dans un état qui ne permet pas un accueil digne et humain des patients. **143 structures sanitaires sont appuyées par les partenaires** pour des activités de soutien psychosocial, à travers le recrutement et la formation des agents psychosociaux, le déploiement de spécialistes internationaux.

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	Concernant les **services de santé mentale prodigués par le système publique**, 27 Médecins Généralistes (Bangui 18, Paoua 3, Bambari 6) et 50 paramédicaux (Bangui 29, Paoua 11, Bambari 10), représentant 25 structures sanitaires ont reçu une formation de 5 jours sur la santé mentale et le soutien psychosocial, supportée par l'OMS (Michel Dzalamou, 2015). Suite à ces formations, **17 cellules d'écoute** ont été mise en place dans les localités suivantes : Bangui (10 : Hôpital de Bimbo, Bekoua et un dans chacun des 8 arrondissements de la ville), Paoua (1), Bambari (1), Baiki (1), Damara (1), Yaloke (1), Bosambèlé (1), Bouali (1), Damara(1). La disponibilité des services est ainsi passée de 1% en 2014 à 17% en 2015. La 1ère et 2ème cause optimale de non disponibilité étant le manque de formation du personnel de santé et le manque de personnel de santé (Herasm, 2015). **Compte-rendu des visites des structures sanitaires dont les agents ont été précédemment formées par l'OMS (2 Hôpitaux et 2 Centres de Santé) :** • Les visites ont mis en avant la motivation des personnels formés ainsi que l'intérêt qu'ils portent à la santé mentale, conscient de leur insuffisance dans ce domaine face aux besoins de la population. • Au vu de la rotation importante des médecins généralistes, certains ont été remplacés et n'étaient plus en poste. Ceux rencontrés avaient une charge de travail clinique importante (nombre de consultations), des responsabilités administratives (Chef de services) et des responsabilités de Santé Publique avec le Ministère. Les infirmiers d'état et les agents-psychosociaux étaient toujours en place et plus disponible. • Les formations précédentes ne se sont pas traduites en plus de diagnostics et de prises en charge des personnes souffrant de troubles mentaux. Les personnels visités invoquent : o Le manque d'outils mis à leur disposition (algorithme, guide, fiche de collecte des données). o Le manque de support et de supervision (et le manque de moyens pour le support et la supervision). o Le manque de médicaments psychotropes mis à leur disposition. o Le manque de sensibilisation d'autres cadres de santé pour l'identification et la référence des cas. • Les cellules d'écoute ne sont pas opérationnelles, pour les mêmes raisons, endéans les médicaments. • Les références vers le Service de Psychiatrie du CNHUB sont en place. **Le programme mhGAP fait partie des programmes de trois partenaires internationaux : IMC, ACF et OMS.** **IMC** a mis en place le mhGAP-IG dans deux Préfectures (Okotoko et Bouka). Après avoir formé les Infirmiers Secouristes dans les Postes et Centres de Santé de Okotoko, IMC souhaite former et déployer ses propres staff à Bouaka afin d'assurer une prise en charge effective de qualité, au vu de la complexité du programme mhGAP et du niveau de base des personnels de santé. La version mhGAP-IG est utilisée, ciblant Dépression, Psychose, Epilepsie et l'Abus de Substance. IMC utilise ses outils de support et de supervision, ainsi que ses outils de suivi et d'évaluation. **ACF** souhaite renforcer les capacités du Ministère de la Santé à travers la formation au mhGAP. Ils souhaiteraient appuyer les Médecins Généralistes et Infirmiers d'Etat à travers la préparation des modules, la formation, le support et la supervision. Un Psychiatre pourrait être déployé rapidement pour une mission courte de 2 mois Concernant **les interventions psychosociales et de santé mentale pour les survivants de violence sexuelle** liée au conflit, les partenaires nationaux et internationaux sont intégrés en appui dans 101 structures sanitaires. Les partenaires recrutent et forment leurs agents de prise en charge psychosociale. Quand disponible, l'agent psychosocial du Ministère est renforcé. La couverture de l'offre de service sur les violences sexuelles en 2015 est estimée à 30 %. La 1ère cause optimale de non disponibilité étant manque de formation du personnel de santé (Herasm, 2015).

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N.6.3	**Médicaments Psychotropes**	**Liste Nationale** Oui, 2015	**Formulation** Comprimé, liquide, injection	**Dosage**	**Niveau de disponibilité**		
					Public	**Privé**	**NGO**
	Chlorpromazine et autres antipsychotiques	Oui	Inj Comp	50 mg 100 / 25 mg	Non	Oui	IMC
	Fluphenazine	Oui	Comp	250 mg	Non	Oui	IMC
	Haloperidol for Psychosis	Oui	Inj / Comp Gouttes	5 mg 2%	Non	Oui	IMC
	Amitriptyline and other TCAs	Oui	Comp Gouttes	50 mg 25 mg	Donation MSF-B	Oui	IMC, MSF-B
	Fluoxetine	Oui	Comp	250 mg	Non	Oui	IMC
	Carbamazepine	Oui	Comp Gouttes	200 mg 400 mg	Non	Oui	IMC
	Lithium carbonate	Non			N/A	Oui	IMC
	Valproic acid	Oui	Comp Gouttes	250 mg 500 mg	Non	Oui	IMC
	Diazepam and other anxiolytics and hypnotics	Oui	Inj Comp	10 mg 5 / 10 mg	Non	Oui	IMC
	Clomipramine	Oui	Comp	25 / 75 mg	Donation MSF-B	Oui	IMC, MSF-B
	Nicotine Replacement Therapy (NRT)	Non			N/A		
	Methadone	Non			N/A		
	Methylphenidate	Non			N/A		
	Haloperidol for Dementia	Non			N/A		

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REPONSE HUMANITAIRE

Médicaments Psychotropes

Le programme d'aide du Gouvernement Japonais inclut une commande de médicaments psychotropes.
Disponible

Annex II- Psychiatric medicine needed (stock)

N°	Description	Quantity	unity	unit price	total price
1	CHLORPROMAZINE INJECT, ampoule 25 mg -2ml	50	100	9,55	477,50
2	CHLORPROMAZINE, 100 mg tablet	50	1000	15,00	750,00
3	HALOPIRIDOL INJECT, ampoule 1 ml	400	10	3,00	1 200,00
4	HALOPIRIDOL , tablet 5 mg	50	1000	6,00	300,00
5	AMITRIPTILINE, tablet 5 mg	30	1000	6,50	195,00
6	DIAZEPAM, tablet 5 mg	50	1000	11,95	597,50
7	DIAZEPAM INJECT ampoiule	30	100	11,00	330,00
8	CARBAMAZEPINE, tablet 200mg	30	1000	17,00	510,00
9	BIPERIDEN , Inject ampoule 5mg -1ml	400	5	4,00	1 600,00
10	BIPERIDEN, tablet 2 mg	200	50	2,50	500,00
11	PHENOBARBITAL , inject ampoule 200 mg - 1ml	30	100	45,00	1 350,00
12	PHENOBARBITAL, tablet 100 mg	40	100	17,00	680,00
	TOTAL				**8 490,00**

IMC assure la disponibilité des médicaments psychotropes pour le mhGAP dans les structures sanitaires supportées avec ses propres ressources.
ACF assure le remboursement des médicaments psychotropes acheté dans les officines privées suite à la prescription reçue au Service de Psychiatrie du CNHUB pour les patients qu'ils réfèrent.

N.6.4 Ressources Humaines pour la Santé mentale

Psychiatre	1, actuellement au Benin depuis Juillet 2011.
Neurologue	3 neurologues, dont 1 Professeur agrégé.
Médecin avec expérience en psychiatrie	1, Chef du service de psychiatrie du CNHUB et Coordonnateur du Programme National.
Technicien supérieur en santé mentale	2, Infirmiers d'Etat avec 2 années de formation en santé mentale (Burkina-Faso et Cameroun) CNHUB.
Psychologue	3 psychologues clinicien (2 CNHUB, 1 Hôpital Communautaire). 4 étudiants en Master et 10 étudiants en Master 1.

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	Autres Personnels de Santé *Profil des Ressources Humaines pour la Santé, Ministère de la Santé Publique, de la Population et de la Lutte contre le SIDA, July 2010*.	
	Médecins (7 années d'Université)	Approximativement 200 ; approximativement 60 actifs au niveau clinique
	Infirmiers d'Etat (3 années d'études)	308
	Techniciens Supérieurs de Santé (Cadre non renouvelé)	104
	Infirmiers Secouristes / Agents de Santé Communautaires (ASC)	1.474
	Sagefemme avec diplôme d'Etat	224
	Matrones Accoucheuses	239
	Agents Psychosociaux	? relevant du Ministère des Affaires sociales présent dans chaque structure sanitaire (2-3 années d'Université, Faculté des sciences de la santé)
	Enquête Herasm, 2016.	Dans les Formations Sanitaires : • 1 Médecins pour 22.013 habitants. • 1 Sage-femme pour 17.440 habitants. • 1 Infirmier d'Etat pour 16.565 habitants. • 1 Agent de Santé communautaire pour 2 014 habitants. Les Agents de Santé Communautaires (ASC) dans les Formations Sanitaires représentent environ 61% de la force de travail du système de santé de la RCA
N.6.5	**Est-ce que les travailleurs de santé dans les soins de santé primaires sont autorisés à diagnostiquer et traiter les troubles mentaux ?**	Médecins Généralistes, diagnostic et traitement (prescription). Infirmiers d'Etat : autorisés à diagnostiquer et à prendre en charge de manière indépendante les troubles mentaux avec restriction : formation en santé mentale et supervision.
N.6.6	**Quels spécialistes sont impliqués dans le traitement des troubles mentaux ?**	Psychiatre, médecin généraliste avec expérience, neurologue, psychologues, infirmier psychiatrique, agents psychosociaux.
N.6.7	**Y a t-il des manuels nationaux disponibles pour la gestion clinique et le traitement des troubles mentaux ?**	Des directives de prise en charge des problèmes de santé mentale et de soutien psychosocial, 2015, sont validées et opérationnelles. Un manuel de formation en Santé mentale et Soutien Psychosocial a été validé en 2015. Un guide de gestion clinique et de traitement des troubles mentaux validé n'existe pas.

Nom du Pays: République Centrafricaine		
NIVEAU NATIONAL		
N.7.1	**Système Général d'Information Sanitaire.**	Il y a un Système National d'Information Sanitaire (SNIS). Le SNIS est caractérisé par le retard dans la collecte des données et la faible capacité des ressources humaines pour l'analyser et prendre des décisions. Le système n'est pas capable de répondre aux besoins en information des programmes de santé.
	REPONSE HUMANITAIRE	
	Les partenaires nationaux et internationaux ont recruté et formé leurs propres staffs de santé mentale et soutien psychosocial, majoritairement constitué d'agents psychosociaux avec différentes qualifications, et déployé des spécialistes internationaux, principalement psychologues. IMC a recruté un psychiatre et ACF est sur le point de recruter un psychiatre. Les **spécialistes en santé mentale** sont peu nombreux et concentrées au Service de psychiatrie du CNHUB. Actuellement, il y a un médecin généraliste avec expérience en psychiatrie, un technicien supérieur en santé mentale et deux psychologues actifs. Ils constituent les ressources disponibles pour la formation et la supervision des personnels de santé non-spécialisés dans le cadre du mhGAP, tout en assurant le fonctionnement du Service de psychiatrie, et leurs autres responsabilités (Programme National, enseignement). Les **médecins généralistes**, d'une manière générale, sont peu nombreux (approximativement 200), ont une charge de travail clinique importante (nombre de consultations), des responsabilités administratives (Chef de services) et des responsabilités de Santé Publique avec le Ministère. Aussi, il y a une rotation importante dans leurs affectations (grande mobilité). Les **infirmiers d'Etat** sont plus nombreux (approximativement 300), sont plus stable et moins de responsabilités en dehors des consultations. Les **agents-psychosociaux** (relevant du Ministère des Affaires sociales) en place dans les structures sanitaire sont également peu nombreux et jouent un rôle clé dans le suivi des patients. Certains sont occupés avec d'autres tâches et ils ne sont pas présents dans toutes les structures sanitaires.	
	Manuels nationaux disponibles pour la gestion clinique et le traitement des troubles mentaux ?	• Le programme mhGAP n'est pas validé au niveau National.
	Support et Supervision **Suivi et évaluation**	• Les partenaires Internationaux assurent le support et la supervision de leurs activités de santé mentale avec leurs propres ressources. • Les données agrégées des activités des partenaires ne sont pas disponible au niveau central. • Un système de support et de supervision des structures sanitaires formées et des Centres d'Ecoute créés n'a pas été mis en place de manière fonctionnelle. • Un système de collecte de donnée concernant la santé mentale et la création des Centres d'Ecoute a été développé et validé en 2015 mais n'est pas opérationnel.

Nom du Pays: République Centrafricaine		
NIVEAU NATIONAL		
N.8	**PROGRAMMES DE PROMOTION DE LA SANTE MENTALE**	
N.8.1	**Y a t-il un programme national de promotion de la Santé mentale ?**	Non. ACA, ONG Nationale, en collaboration avec le Service de Psychiatrie du CNHUB a mené des activités de sensibilisation, comme par exemple lors de la Journée Mondiale de la schizophrénie.
N.9	**ORGANIZATIONS POUR LES PERSONNES ATTEINTES DE TROUBLES MENTAUX ET LEURS FAMILLES**	
N.9.1	**Association de professionnels de Santé mentale.**	Non
N.9.2	**Organisations Non-Gouvernementales fournissant des services au niveau National pour les personnes atteintes de troubles mentaux**	Voir 4W, ONG Nationales.
N.10	**PLAN D'ACTION, PROGRAMME CONCERNANT LA SANTE MENTALE**	
N.10.1	**Détails sur les programmes de Santé mentale en cours.**	Cette analyse de la situation a été développée afin de faciliter l'adaptation et la mise en œuvre du programme mhGAP.

Annex 3: Adaptation Guide

Stress aigu (STR)				
#	**Question à considérer**	**Réponse**	**Adaptation suggérée du matériel mhGAP**	**Commentaire**
Page 13. Evaluation Page 14 Question 2	Le texte stipule *« les individus présentant les symptômes significatifs de stress aigu (STR) peuvent manifester un large éventail de troubles physiques médicalement inexpliqués et psychologiques non spécifiques ».* Quels sont les présentations classiques en RCA ? La liste fournie page 14, question 2, correspond-t-elle à la réalité	- On retrouve les mêmes signes	- Pas d'adaptation spécifique	
Page 13. Evaluation Page 14 Question 2	Le texte stipule «l'individu rencontre d'énormes difficultés à réaliser ses activités quotidiennes à cause des symptômes ». Donnez des exemples d'activités quotidiennes à utiliser dans les formations	- Activités liées aux pratiques religieuses/ culturelles, école, travail (ex : activités champêtre, commerciales, activités domestiques etc. - Le soin aux enfants diminue, et obligations familiales.	- Activités productives, domestiques et socio- culturelles	
PEC Page 15 Point 1.	Renforcer le soutien social. Quelles sont les opportunités de référencement pour le renforcement du soutien social ?	- Les relais communautaires qui travaillent avec les ONG.	- Formation des réseaux communautaires	- *Adapter le matériel de formation en Sangho par exemple*
PEC Page 15 Point 2.	Le personnel de santé est-il formé aux Premiers Secours Psychologiques ?	- Partiellement, a travers les ONG+ Gouvernement	- Former d'avantage	
	Le personnel de santé est-il formé aux techniques de relaxation ?	- Partiellement, Centralise à Bangui	- Sur une grande étendue	
PEC Page 16 Point 3.	Quelle est la compréhension culturelle de l'énurésie en RCA ?	- Les enfants font exprès - Hantés par les esprits	- IEC au niveau des communautés	
PEC Page 16 Point 5.	En cas de symptôme dissociatif le texte stipule « envisager l'utilisation d'interventions spécifiques à la culture locale et inoffensives ». A quoi cela correspond-t-il en RCA ?	- Non, il n'y a pas de dispositif.		

Trouble dépressif modéré à sévère (DEP)				
#	**Question à considérer**	**Réponse**	**Adaptation suggérée du matériel mhGAP**	**Commentaire**
Page 21 encadré	Motifs de consultation typiques : Quelle est la compréhension culturelle de la dépression en RCA ? Quel est le terme utilisé en Sango ? Quels sont les motifs de consultation typiques ?	- J'ai du mal à dormir, je réfléchis, beaucoup, maux de tête, difficulté à se concentrer, asthénies physique sans effort éprouvé, la peur difficulté à se réveiller le matin, insomnie, la colère, irritabilité, nervosité, irritabilité, - Mauvais sort, envoutement (ensorceler), transgressions des lois traditionnelles /coutumier, possession - « kobelatili » - (voir 1)	-	-
Evaluation Page 22 Question 1.	Le texte indique "*consulter un spécialiste*", page 22 Question 1. Que veut dire consulter ? (téléphone? référer?) Qu'est-ce qu'un spécialiste? (une infirmière psy? Un psychiatre?)	- Le membre de la famille va aller voir le spécialiste il lui explique la situation a l'issue de laquelle le spécialiste (tradi praticien) se déplace vers le malade ou le fait appeler. - Urbain téléphone ou référer directement amener au centre de santé, une autre portion commence par le guérisseur / église puis en dernier lieu aller au centre hospitalier - C'est celui qui détient la connaissance nécessaire à guérir le malade mental	-	-
Evaluation Page 22 Question 2.	*Écarter les pathologies physiques concomitantes qui peuvent ressembler à un trouble dépressif. Écarter et prendre en charge l'anémie, la malnutrition, l'hypothyroïdie*, l'AVC ou les effets secondaires médicamenteux (par ex. les changements d'humeur dus aux stéroïdes)*. Compte tenu de ce qui est connu sur l'épidémiologie dans le pays, les maladies	- En face d'une dépression il faut être en mesure d'éliminer les causes somatiques et les traiter, une fois les causes somatiques éliminer la dépression doit être considéré comme telle.	-	-

	données en exemple de maladies doivent-elles être modifiés?			
Evaluation Page 22 Question 2.	Caractéristiques d'un épisode maniaque : Le texte dit : • *diminution des besoins en sommeil* • *humeur euphorique, expansive ou irritable* • *pensées qui défilent, tendance à être facilement distrait* • *augmentation de l'activité, sensation d'énergie accrue ou élocution rapide* • *comportement impulsif ou irresponsable,* *Y a-t-il des termes communs locaux spécifiques pour désigner spécifiquement un épisode maniaque ?*	- Bobollinga /KoblaTili	-	-
PEC Page 23, Point 2.	Renforcer le soutien social. Quelles sont les opportunités de référencement pour le renforcement du soutien social ?	- La famille, voisinage, communauté, entourage, les ONG (cartographie connues), relais communautaires, l'autoréférence, services sociaux existant	-	-
PEC Page 23, Point 3.	Est-ce que le counseling par résolution de problèmes, thérapie interpersonnelle (TIP), thérapie cognitive-comportementale (TCC), activation comportementale sont disponibles / accessibles dès maintenant ou dans les prochaines années?	- Ce qui n'existe pas on les garde et pourront être effectifs dans les prochaines années.	- SI NON, délibérer sur les avantages et les inconvénients de de retirer tout ou une partie du texte	-
PEC Page 24, Point 2.	Le texte précise: "*Choisir un antidépresseur dans le formulaire national ou celui de l'OMS. La fluoxétine [mais pas les autres inhibiteurs sélectifs de la recapture de la sérotonine (ISRS)] et l'amitriptyline [ainsi que d'autres antidépresseurs tricycliques (ATC)] sont des antidépresseurs figurant dans le formulaire de l'OMS et également sur la liste modèle OMS des médicaments essentiels*."	- Se conformer à la liste des antidépresseurs disponibles au niveau de la direction générale de la santé	- Si d'autres ISRS que la fluoxétine est largement disponible/accessible et abordable, alors ceux-ci peuvent être ajoutés pour une utilisation chez les adultes, mais (pas à l'adolescence, où la fluoxétine demeure le seul médicamentpour les adolescents.) - Si d'autres ISRS par exemple sertraline) est ajouté, alors une adaptation devrait également être	-

	Quels médicaments antidépresseurs sont disponibles ou le seront dans les prochaines années seront disponibles / accessibles en soins non spécialisés?		faite pour toutes les informations de dosage. - - Il est suggéré de former sur un seul antidépresseur largement disponible. Modifier le matériel de formation. - SI les ISRSs sont choisis pour la formation, former sur la prescription pour les personnes âgées et les personnes souffrant de maladies cardiovasculaires. - SI ATC est choisi, les personnes âgées et les personnes souffrant de maladies cardiovasculaires devraient être référées à des spécialistes	
PEC Page 24, Point 2.	Le texte *envisage l'emploi de la fluoxétine.* 1) la fluoxétine est-elle disponible en SSP? 2) Faut-il que les enfants adolescents souffrant de dépression soient référés si la première ligne de traitement (psychologique) ne fonctionne pas ou ne devrait-on leur donner la fluoxétine?	- Voir liste officielle des médicaments	- 1) Si la fluoxétine n'est pas disponible, s'il vous plaît noter que la fluoxétine ne peut être changé pour un autre médicament, car c'est le seul médicament recommandé par l'OMS pour la dépression chez les adolescents. 2) Dans les pays avec un bon accès aux soins spécialisés, on peut envisager la référence plutôt que de disposer d'un personnel SSP initier AD en dépression chez les adolescents	-
	Liée au suivi, quelles sont les stratégies possibles localement pour assurer un suivi régulier (par exemple, des visites à domicile, appels téléphoniques, lettres, le contact à travers la famille et les amis?).	- Visites à domiciles, communication avec la famille pour expliquer aux parents comment se comporter par rapport au cas, appels téléphoniques, counselings individuel et avec la famille, les collègues(en milieu scolaire et professionnel),	-	-

Etat de stress post traumatique (ESPT)				
#	**Question à considérer**	**Réponse**	**Adaptation suggérée du matériel mhGAP**	**Commentaire**
Page 27 encadré.	Le texte stipule « *les individus en ESPT peuvent être difficiles à distinguer de ceux souffrant d'autres troubles car ils peuvent initialement présenter des symptômes non spécifiques comme :* • *des troubles du sommeil* • *de l'irritabilité, une humeur dépressive ou anxieuse persistante* • *divers symptômes physiques persistants sans cause physique apparente* ». Ces présentations correspondent-elles au contexte local ?	- Les symptômes restent les mêmes, on retrouve les plaintes somatiques au premier plan	- Rester agitant aux plaintes somatiques dans les motifs de consultation. - Approfondir l'interrogatoire	- S'intéresser aussi à la famille
PEC Page 29, Point 3	Le texte stipule « *une thérapie cognitivo-comportementale post-traumatique ou une thérapie EMDR (désensibilisation et retraitement par les mouvements oculaires)* ». De telles thérapies sont-elles disponibles en RCA ?	- Les approches cognitivo-comportementales sont disponibles, utilisées par les spécialistes uniquement à Bangui.	- Pratiquer le conselling	
PEC Page 29, Point 5	Liée au suivi, quelles sont les stratégies possibles localement pour assurer un suivi régulier (par exemple, des visites à domicile, appels téléphoniques, lettres, le contact à travers la famille et les amis?).	- Oui par les visites à domicile - Rendus difficile avec coûts de transports.	- Mise en place des centres d'écoute dans les communautés + Formation des réseaux communautaires	- *Développer un circuit de référence.*

Psychose (PSY)				
#	**Question à considérer**	**Réponse**	**Adaptation suggérée du matériel mhGAP**	**Commentaire**
Page 21 encadré	Motifs de consultation typiques : Quelle est la compréhension culturelle de la psychose en RCA ? Quel est le terme utilisé en Sango ? Quels sont les motifs de consultation typiques ?	- Voir ci-dessus	-	-
Evaluation Page 32 Question 2.	Le texte dit *« écarter le délire provoqué par des causes physiques (par ex. neuropaludisme, sepsis ou urosepsis), une déshydratation ou des anomalies métaboliques (par ex. hypoglycémie, hyponatrémie)*». Le paludisme cérébral est-il une préoccupation dans le pays?	- Oui le paludisme cérébral est une préoccupation dans le pays	-	-
Evaluation Page 32 Question 2.	*Caractéristiques d'un épisode maniaque :* *Le texte dit*, page 22 Question 2 *:* • *diminution des besoins en sommeil* • *humeur euphorique, expansive ou irritable* • *pensées qui défilent, tendance à être facilement distrait* • *augmentation de l'activité, sensation d'énergie accrue ou élocution rapide* • *comportement impulsif ou irresponsable,* *Y a-t-il des termes communs locaux spécifiques pour désigner spécifiquement un épisode maniaque ?*	- Voir si dessus	- Voir réponse DEP	-
PEC Page 33, Point 1.	Le texte indique "consulter un spécialiste". Que veut dire consulter ? (téléphone? référer?) Qu'est-ce qu'un spécialiste? (une infirmière psy? Un psychiatre?)	- Voir supra	-	-

	Quels antipsychotiques sont disponibles dans les soins de santé non spécialisés?	- Selon l'offre, Les soins de santés non spécialisés ne disposent pas de psychotropes à p	- Former uniquement sur le médicament disponible. La formation de base ne peut concerner que 1 de ces 2 médicaments, en particulier si un seul des deux est régulièrement disponible au niveau de la consultation.	-
	Quels médicaments anticholinergiques sont disponibles dans les soins de santé non spécialisés?	- Selon l'affore, Non les anticholinergiques ne sont pas disponibles	- Enseigner que le médicament disponible. Envisager DE FORMER seulement sur 1 de ces 2 médicaments dans le cours de base. Choisissez le médicament le plus couramment disponibles.	-
PEC Page 34, Point 2.	Faciliter la réadaptation dans la communauté. Y a-t-il de bons exemples locaux sur la façon de faire ce travail dans le pays?	- Prise en charge familiales, le résultat peut être bon ou moins bon,	-	-
	Le texte dit " *poursuivre le traitement au moins 12 mois*. " Le personnel de la santé sait-il comment faire cela?	- Oui dans les structures de prise en charge spécialisées ou dans les soins de santé non spécialisées appuyées par les ONGs qui sont censé être formé.	-	- Donner des conseils et des exemples sur les stratégies d'adhérence lors de la formation
	Liée au suivi, quelles sont les stratégies possibles localement pour assurer un suivi régulier (par exemple, des visites à domicile, appels téléphoniques, lettres, le contact à travers la famille et les amis?).	- Voir ci haut	-	-

Consommation nocive d'alcool et de drogues (SUB)				
#	**Question à considérer**	**Réponse**	**Adaptation suggérée du matériel mhGAP**	**Commentaire**
Page 45 encadré	Le texte dit *« L'usage d'alcool ou de drogues (telles que les opiacés - comme l'héroïne-, le cannabis, les amphétamines, le khat, divers médicaments prescrits comme les benzodiazépines et le tramadol* ».	- OUI+ d'autres structures (solvant peinture, cirage, vernis, gazon, colle etc.	- PEC Toxicomanie + IEC	

	Cela correspond-t-il au contexte local ?			
	Motifs de consultation typiques : Quelle est la compréhension culturelle de l'abus de substance en RCA ? Quel est le terme utilisé en Sango ? Quels sont les motifs de consultation typiques ?	- Fait exprès pour être bien ; - Envoutements, croyances mystique - Ndjo Gbako(soulard) - Bangui (chanvre)	- IEC- S'appuyer sur la législation	
	Est-ce que la drogue la plus répandue est considérée prioritairement ?	- Chanvre et tramadole	- Si le cannabis, par exemple, est la drogue la plus répandue, envisager de réorganiser le texte pour donner plus d'importance au sevrage du tramadol.	- Application des textes de lois.
Evaluation. Page 46, Point 1.	Le texte dit : « Réaliser un rapide examen physique général pour rechercher les signes d'une consommation chronique d'alcool ou de drogues » : • Hémorragie digestive • Maladie du foie • Signes d'infections Les examens sont-ils disponibles et accessibles ?	- Disponible à Bangui et pas dans les provinces.	- Equipement en matériel de laboratoire et en RH dans tout le pays.	
PEC Page 47.	Le texte dit : *« Envisager, si possible, une orientation vers un groupe d'entraide pour les personnes souffrant de dépendance à l'alcool ou à la drogue ».* Les groupes d'entraide sont-ils disponibles ?	- Réseau Centrafricain de prise en charge à Bangui	- Sensibiliser la population sur l'existence de ce réseau	
	Renforcer le soutien social. Quelles sont les opportunités de référencement pour le renforcement du soutien social ?	- Les re-co. ONG	- Formation des réseaux communautaires	
	Le texte stipule que «Assurer le suivi nécessaire, souvent initialement" Qui signifie faire le suivi? A quelle fréquence ?	- Vérifier l'évolution du cas et l'adhérence au traitement hebdomadaire.	Dépend de ressources, mais au moins lors de la visite mensuelle, soit la clinique ou à la maison par quelqu'un de l'équipe	- Difficile à mettre en place

	Y-a-t-il des médicaments recommandés pour la PEC d'abus d'alcool ou de drogues en RCA ?	- Plantes traditionnelles et rituels associés/ lait de porc, vomitif	- Indure les radiothérapeutes aux formations MHGAP	
Encadré SUB 1 Évaluation et prise en charge du sevrage alcoolique à risque vital	Le personnel sait comment reconnaître le délire dû au sevrage alcoolique ?	- Les techniciens formés où	- Former les réseaux communautaires	Delirium Expliquer lors de la formation
	Le texte stipule«*Écarter et prendre en charge les autres causes pouvant expliquer les symptômes, notamment*". Dans quelle mesure le personnel a les moyens et la possibilité d'exclure ces causes?	- Pas de moyens disponibles pour la PEC.	Pour infection, tester pour paludisme et méningite	
	Le texte se réfère la thiamine. Est-il disponible ou qu'il sera disponible d'ici quelques années?	- Non.	- SI NON, délibérer sur les avantages et les inconvénients du maintien ou de retirer tout ou partie du texte pertinent.	- Besoin de faire une étude en RCA pour valider le trama dol.
	Les médicaments utilisés pour traiter les symptômes de sevrage sont-ils disponibles?	- OUI à Bangui mais pas dans les provinces.	- Si non, se concentrer sur les médicaments qui sont disponibles, la clonidine, les opioïdes faibles et d'autres médicaments symptomatiques comme indiqué dans la section sur les symptômes de sevrage.	-

Annex 4: mhGAP materials available and to be adapted

mhGap IG	GB	FR	mhGap HIG	GB	FR		mhGAP HIG RCA	GB	FR
						3.	mhGAP-GIH Guide et	X	X
						4.	Poster mhGAP IG	X	X
Read me first	X	X	FACILITATOR PACKAGE V2 for mhGAP-HIG overview	X		5.	FACILITATOR PACKAGE V2 for mhGAP-HIG overview A traduire et adapter et y inclure cette checklist	X	
Feedback form for field testing easy adaptable for HIG	X	X					-		
mhGAP Manual for Programme Planners lets ignore for now	X	X	Evaluation and feedback forms for mhGAP-HIG	X		4.	Evaluation and feedback forms for mhGAP-HIG		
- suggested Schedule of base course (35h) ignore	X	X				A	Pré et post test: à adapter en fonction des conditions prioritaires		
- pre/post test was updated for HIG	X	X				B	Forme d'évaluation de fin de formation : à adapter en fonction des conditions prioritaires		
- course evaluation was updated for HIG	X	X				C	Forme d'évaluation de chaque module: pour l'atelier de validation ?		
mhGAP Adaptation Guide This is a potential issue	X	X				2.	Recommandations du l'atelier: mhGAP Adaptation Guide	X	X
mhGAP Situation Analysis Toolkit easy adaptable for HIG						1.	mhGAP Situation Analysis Toolkit: traduit, adapté et complété	X	X
- Tool 0. Framework	X						-	-	-
- Tool 1. National	X						-	-	-
- Tool 2. Regional	X						-	-	-
- Tool 3. District	X						-	-	-
- Tool 4. Facility	X						-	-	-
mhGAP Support and Supervision Guide easy adaptable for HIG	X					?	mhGAP Support and Supervision toolkit Guinée à adapter		X
mhGAP Training of Trainers and Supervisors not so easy to adapt for HIG. An important issue							-	-	-
- manual	X						-	-	-
- ppt	X						-	-	-
mhGAP Monitoring and Evaluation	X	X				?	mhGAP suivi et évaluation : à adapter pour GIH		X

Toolkit easy adaptable for HIG									
I. Introduction + GPC – General principles of care *new version prepared by Ken*			Introduction + GPC – General principles of care			M0	Introduction et Principes Généraux de Soins		
- facilitator guide	X	X	Introduction				Guide du faciltateur KEN HIG à traduire et à adapter	X	X
- participant manual	X	X	- facilitator guide	X			PPT/ inclure slides spécifiques HIG de INTRO, COMMU et HUMAN RIGHTS KEN dans Intro et PGS Capucine	X	Part
- ppt	X	X	- ppt	X					
			1. Principles of communication						
			- facilitator guide	X					
			- ppt	X					
			2. Principles of assessment						
			- facilitator guide	X					
			- ppt	X					
			3. Principles of management						
			- facilitator guide	X					
			- ppt	X					
			4. Principles of reducing stress and strengthening social support						
			- facilitator guide						
			- ppt						
			5. Principles of protection of human rights						
			- facilitator guide	X					
			- ppt	X					
			6. Principles of attention of overall well being						
			- facilitator guide	X					
			- ppt	X					
II. Master Chart	X	X	Master Chart						
MODULES									
1. DEP – depression			3. DEP – Moderate-severe depressive disorder			M3	Troubles dépressifs modérés à sévère (DEP)		
- facilitator guide	X	X	- facilitator guide				Guide du facilitateur		
- participant manual	X	X	- ppt				Ppt IG à verifier, inclure slides assessment et management Ken		X

- ppt	X	X							
2. PSY – psychosis			5. PSY – Psychosis						
- facilitator guide	X	X	- facilitator guide						
- participant manual	X	X	- ppt						
- ppt	X	X							
3. BPD – Bipolar disorder									
- facilitator guide									
- participant manual									
- ppt									
4. EPI – epilepsy/seizures			6. EPI – Epilepsy/seizures						
- facilitator guide	X	X	- facilitator guide						
- participant manual	X	X	- ppt						
- ppt	X	X							
CAMH child and adolescent									
- facilitator guide	X	X							
- participant manual	X	X							
- ppt	X	X							
5. DEV – Developmental disorders			7. ID – Intellectual disability						
- facilitator guide		X	- facilitator guide	X					
- participant manual		X	- ppt	X					
- ppt	X	X							
6. BEH – Behavioral disorders									
- facilitator guide	X	X							
- participant manual	X	X							
- ppt	X	X							
7. DEM – Dementia									
- facilitator guide	X	X							
- participant manual	X	X							
- ppt	X	X							
8. ALC – Alcool			8. SUB – Harmful use of alcohol and drugs						
- facilitator guide	X	X	- facilitator guide	X					
- participant manual	X	X	- ppt	X					
- ppt	X	X							

9. DRU – Drug									
- facilitator guide	X	X							
- participant manual	X	X							
- ppt	X	X							
10. SUI – Suicide			9. SUI – Suicide						
- facilitator guide	X	X	- facilitator guide	X					
- participant manual	X	X	- ppt	X					
- ppt	X	X							
11. OTH – Other significant emotional or medically unexplained complaints			10. OTH – Other significant Mental Health Complaints						
- facilitator guide	X	X	- facilitator guide	X					
- participant manual	X	X	- ppt	X					
- ppt	X	X							
Conditions specifically related to stress			1. ACU – Acute Stress			M1	Stress aigu (STR)		
- facilitator guide	X		- facilitator guide				Guide du facilitateur		X
- participant manual	X		- ppt				PPT HIG: à verifier, inclure slides assessment et management Ken		X
							Video		
- ppt	X	X	2. GRI – Grief			M2	Affliction (AFF) Deuil		
			- facilitator guide				Guide du facilitateur		X
			- ppt				PPT HIG: à verifier, inclure slides assessment et management Ken		X
			4. PTSD – Post traumatic stress disorder						
			- facilitator guide	X					
			- ppt	X					

Annex 5: mhGAP tools adapted

« Combler les lacunes en santé mentale (mhGAP-GIH)» Liste de contrôle du matériel

1. **Analyse de la situation -** mhGAP IG Toolkit adapté
2. **Guide d'adaptation -** mhGAP IG Toolkit adapté
3. **Manuels mhGAP**
    - Programme d'action Combler les lacunes en santé mentale
    - Guide d'intervention humanitaire (mhGAP GIH)
    - Tableau Principal - mhGAP IG
4. **Modules de formation**
    - Agenda standard 4 jours
    - **Principe Généraux des Soins**
        - PPT GIH
    - **Stress aigu (STR)**
        - Guide du facilitateur / Jeux de rôle
        - PPT GIH
    - **Etat de Stress Post Traumatique (ESPT)**
        - Guide du facilitateur / Jeux de rôle
        - PPT GIH
        - Video
    - **Troubles dépressifs modérés à sévère (DEP)**
        - Guide du facilitateur
        - PPT GIH
        - Jeux de rôle
        - Vidéo
        - + PPT suicide
    - **Psychose (PSY)**
        - Guide du facilitateur
        - PPT GIH
        - Vidéo OK
        - Jeux de rôle
    - **Epilepsie (EPI)**
        - Guide du facilitateur
        - PPT GIH
        - Vidéo
        - Jeux de rôle
    - **Consommation nocive d'alcool et de drogues (SUB)**
        - Guide du facilitateur / Jeux de rôle
        - PPT GIH
        - Vidéo cannabis
5. **Evaluation**
    - Pré / Post test
    - Corrigé Pré / Post test
    - Evaluation fin de cours
    - Modèle de rapport standard

6. **Support et supervision - suivi et évaluation**
    - Fiche de référencement contre-référence - pour FOSA
    - Fiche d'entretien - dossier du patient - pour FOSA
    - Fiches de supervision - pour superviseur
    - Rapport mensuel mhGAP - pour FOSA
7. **Certificats de formation**
    - Facilitateur mhGAP
    - Participant mhGAP
    - Participant mini mhGAP
8. **Mini mhGAP**
    - Agenda standard 4 jours
    - Guide du facilitateur mhGAP
    - PPT mini mhGAP
    - Manuel PDF
9. **Rapport standard de formation**

Annex 6 : Standard training agenda

Dates et Heures	Intitulé des modules	Responsables
J1		
8H00 - 9H00	Enregistrement des participants	Coordination
9H00 - 9H15	Arrivée et installation des officiels	Protocole
9H15 - 9H45	Cérémonie officielle Mot de Bienvenue Discours d'ouverture Présentation des participants	Protocole
09H45 - 10H00	Retrait des officiels / Pause -Café	
10H00 - 10h15	Présentation des termes de référence de l'atelier	
10H00 - 10h30	Passation du Pré-test	
10h45 - 13h00	Introduction au mhGAP Principes généraux de soins (PGS)	
13H00 - 14H 00	Pause- Déjeuner	
14H00 - 15H00	Stress Aigu (STR)	

Dates et Heures	Intitulé des modules	Responsables
J2		
8H00 - 9H00	Arrivée des participants	Coordination
9H00 - 9H45	Dépression (DEP)	
09H45 - 10H00	Pause -Café	
10H00 - 13h00	Dépression (DEP)	
13H00 - 14H00	Pause- Déjeuner	
14H00 - 15H30	Etat de stress post traumatique (ESTP)	

Dates et Heures	Intitulé des modules	Responsables
J3		
8H00 - 9H00	Arrivée des participants	Coordination
9H00 - 9H45	Epilepsie (EPI)	
09H45 - 10H00	Pause -Café	
10H00 - 13h00	Epilepsie (EPI)	
13H00 - 14H00	Pause- Déjeuner	
14H00 - 15H30	Consommation nocive d'alcool et de drogues (SUB)	

Dates et Heures	Intitulé des modules	Responsables
J4		
8H00 - 9H00	Arrivée des participants	Coordination
9H00 - 9H45	Psychose (PSY)	
09H45 - 10H00	Pause -Café	
10H00 - 13h00	Psychose (PSY)	
13H00 - 14H00	Pause- Déjeuner	
14H00 - 15H00	Suivi et évaluation : feuille de collecte des données	
15H00 - 15H30	Passation du Post test	
15h30	Cérémonie de clôture officielle Lecture du rapport final Remise des attestations aux participants Discours de clôture	Coordination

Dates et Heures	Intitulé des modules	Responsables
J1		
8H00 - 8H45	Arrivée et enregistrement des participants	Coordination
8H45 - 9H45	Introduction	
09H45 - 10H00	Pause -Café	
10H00 - 12h00	Section 1 : Principes Généraux des Soins	
12h00 – 12H30	Section 2 : Détecter les problèmes de santé mentale et les troubles mentaux	
12H30 - 13H00	Section 3 : Références aux prestataires de soins formés au mhGAP.	
13H00 - 14H00	Pause- Déjeuner	
14H00 - 14H30	Section 4 : Suivi et soutien (PPT 62 à 77)	
14H30 - 15H00	Section 5 : Etablissement de liens aux ressources (PPT 77 à 81)	
15H00 – 15H300	Section 6 : Plaidoyer et Section 7 : Auto-soins (PPT 81 à 88) (PPT 88 à 100)	
15h30	Cérémonie de clôture technique	

Annex 7 : Support and supervision tools

Rapport de supervision pour les prestataires de soins de santé
(mhGAP, programme d'action pour combler les lacunes en santé mentale)

Nom du superviseur : _____

Nom du stagiaire mhGAP	Établissement	Date de formation	Date de la supervision	Date de la prochaine supervision	Commentaires/progrès (p. ex. acquisition des compétences, besoin fréquent de soutien et de supervision)

Rapport de l'établissement de santé - mhGAP

Renseignements que l'établissement doit fournir avant les visites de supervision

Mois/Année :_____/_____					**Nom du superviseur : _____**	
Établissement de santé : _____					**District/Région : _____**	
		Oui	Non	NA	Observations de l'établissement	Commentaires du superviseur
1.	Un prestataire de soins de santé formé au mhGAP est sur place (toujours à l'emploi du même établissement et fournissant des soins cliniques). S'il y a plusieurs stagiaires mhGAP dans l'établissement, préciser le nombre.	☐	☐	☐		
2.	Tous les médicaments nécessaires à la prise en charge des personnes souffrant de troubles MNS selon le GI-mhGAP sont disponibles.	☐	☐	☐		
3.	La procédure de consultation ou de référencement des patients est fonctionnelle.	☐	☐	☐		
4.	Le tableau principal du mhGap est affiché dans la salle d'examen.	☐	☐	☐		
5.	Le manuel GI-mhGAP est facilement accessible dans la salle d'examen.	☐	☐	☐		
6.	Le manuel GI-mhGAP est utilisé pour prendre en charge et traiter les troubles MNS.	☐	☐	☐		

7.	La salle d'examen permet de préserver l'intimité.	☐	☐	☐		
8.	Les notes cliniques sont recueillies de façon appropriée.	☐	☐	☐		
9.	Nombre de jours par semaine où les prestataires de soins de santé formés au mhGAP sont disponibles pour le traitement des troubles MNS.	_____ jours				
10.	Pourcentage du temps de travail alloué quotidiennement aux troubles MNS (mhGAP)	_____ %				
11.	**Y a-t-il des problèmes administratifs ou cliniques associés à la mise en oeuvre de mhGAP? Veuillez préciser.**					

Autres commentaires de l'établissement :	Autres commentaires du superviseur :

Formulaire de supervision et de soutien clinique
Ce formulaire doit être rempli par le superviseur le jour de sa visite

Mois/Année : _____/_____ **Nom du superviseur : _____** **Établissement de santé : _____ District/Région : _____**				
<u>PARTIE A</u> : renseignements recueillis au cours d'une entrevue clinique avec le prestataire de soins de santé formé au mhGAP				
	Oui	Non	NA	Remarques
Le prestataire de soins de santé a correctement évalué le patient souffrant de trouble MNS (il a été capable de détecter les signes généraux et de vérifier la présence d'au moins 3 symptômes principaux)	☐	☐	☐	
Le prestataire de soins de santé a correctement diagnostiqué le patient en utilisant le GI-mhGAP.	☐	☐	☐	
Le prestataire de soins de santé a correctement traité le patient ou lui a conseillé un plan de prise en charge.	☐	☐	☐	
Une psychoéducation pertinente et un traitement approprié ont été apportés de pair avec référencement du patient, s'il y a eu lieu, vers d'autres ressources.	☐	☐	☐	
Le prestataire de soins de santé a consigné adéquatement tous les renseignements voulus dans le dossier du patient	☐	☐	☐	
Quelles sont les forces et les faiblesses de l'entrevue clinique menée par le stagiaire? (Indiquez les lacunes dans les habiletés de communication, dans l'évaluation ou la prise en charge psychosociale ou pharmacologique ainsi que dans les conseils d'orientation et de suivi)				
<u>PARTIE B</u> : demandez au stagiaire mhGAP s'il éprouve des difficultés liées à la mise en oeuvre du programme mhGAP (p. ex. processus d'orientation, disponibilité des médicaments, salle d'examen, notes cliniques, horaires de travail, etc.).				

Rapport sur la supervision et formulaire de commentaires

Mois/Année : _____/_____ Nom du superviseur : _____ **Établissement de santé : _____ District/Région : _____**
Commentaires sur le programme ou le volet administratif
Points forts (p. ex. planification, organisation, approvisionnements, logistique) :
Points à améliorer :
Commentaires sur la dimension clinique
Points forts (compétences cliniques) :
Points à améliorer :
Date de la prochaine supervision : _____

FICHE DE RÉFÉRENCEMENT

Date du référencement : ……..

Structure qui réfère : ……..
Nom, fonction et téléphone de la personne qui réfère :
……...

Nom et prénoms de la personne référée :
……..
Sexe : …….. Age : …….. Quartier : ……..

Structure vers laquelle la personne est référée :
…….

Motifs du référencement :
……
……
……

Signature :

FICHE DE CONTRE-RÉFÉRENCEMENT

Date du contre-référencement : …….

Nom et prénoms de la personne référée :
……..
Sexe : …….. Age : …….. Quartier : ……..

Identité, fonction et téléphone de la personne ayant reçue le référé :
……...……..……

Actions mises en œuvre :
……
……
……
……

Si pertinent, autre(s) référencement(s) effectués et pour quelle(s) raison(s):
…….....…….....……
……
……
……

Signature :

Annex 8: Monitoring and evaluation tools

FICHE D'ENTRETIEN

Code Patient(e) Numordre du registre / Initiales / mois et année

Préfecture/District :
Localité :
Consultation : -1ère -Suivi

INSTRUCTIONS	1- Ce formulaire doit être rempli par le personnel assurant des services au/à la survivant(e). 2- Sauf indication contraire, ne crochez toujours qu'un seul camp de réponse pour chaque question.		
Code du Staff	**Date de l'entretien ***	**Date de l'incident:**	**Date de début de manifestation de symptôme :**

Information sur la (le) Patient(e)

Age *	**Sexe *** Féminin ☐ Masculin ☐	**Pays d'origine *** Cameroun ☐ Congo ☐ RCA ☐ RDC ☐ Soudan ☐ Tchad ☐ Autre ☐ (A préciser)…… ……	**Etat Civil/Situation familiale actuel(le)*** Célibataire ☐ Mariée/concubinage ☐ Veuf / Veuve ☐ Divorcée/Séparée ☐

Statut socio-économique (**Profession et source de revenu) :**	**Scolarisation :** Oui / Non
Domiciliation * **N° de téléphone :**	**Statut *** Déplacé : Oui/Non Retourné : Oui/Non Refugié : Oui / Non

Source de référencement *
Equipe des animateurs Institution locale ☐ Institution médicale ☐ Autre (à préciser) ☐

Patient lui-même /auto renvoie ☐ Communauté de base ☐ ONG ☐

Recit de l'entretien

Facteurs décenchants(causes) *

☐ Les problèmes socio – économiques

☐ Les conflits militaro – politiques (rébellions / insécurité)

☐ L'abus de consommation de substances psycho actives (drogues)

☐ Les catastrophes naturelles

☐ Les troubles liés aux affections organiques

☐ Autres(A préciser)

Conditions prioritaires*

☐ État de stress aigu

☐ État de stress post-traumatique (ESPT)

☐ Dépression modérée à sévère

☐ Psychose

☐ Épilepsie/crises épileptiques

☐ Consommation nocive d'alcool et de drogues

☐ Autre :
……

Mesures prises* :

☐ Soutien psychosocial

☐ Prise en charge psychologique

☐ Prise en charge Psychiatrique

☐ Prise en charge médicale

☐ Référence/contre-référence à ONG

☐ Référence/contre-référence à une FOSA

☐ Référence à la Psychiatrie

Prise en charge*

☐ Individuelle

☐ Familiale

☐ Groupe

Consultant (nom, prénom) :……
Signature :

Rapport mensuel: Récapitulatif des consultations associées aux troubles mentaux, neurologiques et à l'utilisation de substances psychoactives (MNS)[1]

Mois/année : _____/_____ **Établissement de santé : _____** **District/Région :_____**

Nombre total de personnes vues au cours de la période (y compris les conditions physiques générales et les troubles MNS) : _____

	Nombre total de cas	Nouveaux cas	Cas suivis	Cas référés	Sexe		Âge	
					Masculin	Féminin	< 18 ans	≥ 18 ans
État de stress aigu	**Nb :**	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :
État de stress post-traumatique (ESPT)	**Nb :**	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :
Dépression modérée à sévère	**Nb :**	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :
Psychose	**Nb :**	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :
Épilepsie/crises épileptiques	**Nb :**	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :
Consommation nocive d'alcool et de drogues	**Nb :**	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :
TOTAL	**Nb :**	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :	Nb :

[1] Critères pour le diagnostic et la classification des troubles mentaux, neurologiques et liés à l'utilisation de substances psychoactives selon le guide d'intervention mhGAP (GI-mhGAP)

Annex 9: Checklist for site visits at institutions in humanitarian settings

<table>
<tr><th colspan="4">Informations générales</th></tr>
<tr><td>Nom de l'établissement :</td><td>Service de psychiatrie et d'hygiène mentale situé au Centre National Hospitalier Universitaire de Bangui (CNHUB)</td><td rowspan="5">Activités pendant la visite :</td><td rowspan="5">• Visite d'inspection
• Entretien avec le personnel
• Entretien avec les patients
• Entretien avec les accompagnants</td></tr>
<tr><td>Situation géographique :</td><td>Bangui, 1er arrondissement</td></tr>
<tr><td>Enquêteur :</td><td>Martin Vandendyck
Consultant santé mentale OMS</td></tr>
<tr><td>Date et heure de la visite :</td><td>17/08/2016, 10h00</td></tr>
<tr><td>Durée de la visite :</td><td>3h00</td></tr>
<tr><td colspan="4">Brève description de l'établissement (nombre de lits, état général) :
• Il y a 24 Lits répartit dans 2 bâtiments principaux (hommes et femmes).
  
• Une partie des lits a été réquisitionnée par le service ORL / Stomatologie.
• Il y a également deux autres blocs pour les salles de consultation et bureaux.
• Il y a un hangar au niveau central utilisé pour les activités de groupe et un autre dans le troisième bâtiment. Ces deux hangars sont les seuls abris du service en dehors des deux bâtiments principaux et sont utilisés par les patients et les accompagnants pour toutes activités (groupe de paroles, détente, abri pour les accompagnants, …). Le hangar sert également de salle d'attente pour les consultations ambulatoires du lundi au vendredi.</td></tr>
</table>

- L'état général structurel des bâtiments en place est satisfaisant.
- Les patients reçoivent les soins appropriés.
- Il n'y a pas de médicaments psychotropes.
- Il manque un espace pour cuisiner et de la place pour que les accompagnants dorment.
- L'état général de l'accès à l'eau, des sanitaires, des lits, de l'hygiène ne permet pas un accueil digne et humain des résidents.

1. Personnel et résidents

1.1 Nombre d'employés ayant survécu à la catastrophe / au conflit (crise)	**Psychiatres :**	0
	Médecins avec expérience en Psychiatrie:	1, Coordonnateur du Programme National de Santé Mentale et de Lutte contre les Toxicomanies, Médecin-Chef de service de Psychiatrie et d'Hygiène Mentale du CNHUB, Assistant à la FAC.S.S (Université de Bangui)
	Technicien supérieur en santé mentale :	2
	Infirmiers :	6
	Psychologues :	2
	Travailleurs sociaux :	2
1.2 Nombre d'employés décédés suite à la crise		0
1.3 Nombre d'employés (toujours) blessés suite à la crise		0

1.4 Nombre d'employés ne s'étant pas présentés au travail la semaine précédente suite à la crise (par exemple, pour des raisons familiales/personnelles)	**Total**	Lors des derniers évènements datant du 26/09/2015, le personnel ne s'est pas présenté au service pendant 2 semaines suite au risque. Les malades étaient livrés à eux-mêmes.
1.5 Nombre de résidents ayant survécu à la crise		N/A
1.6 Nombre de résidents décédés suite à la crise **1.8 Nombre de résidents ayant quitté l'établissement suite à la crise (par exemple, ils peuvent avoir pris la fuite ou avoir tout à coup été autorisés à sortir)**		Lors des derniers évènements datant du 26/09/2015, les malades livrés à eux-mêmes ont quitté le service et erré dans la rue. 6 sont décédés en étant impliqué dans des violences.
1.7 Nombre de résidents (toujours) blessés suite à la crise		0
1.9 Nombre de résidents présentant un handicap physique		0
1.10 Nombre de résidents présentant une déficience intellectuelle		0

2. Besoins physiques de base

2.1 Les installations d'assainissement et d'approvisionnement en eau sont-elles adaptées ? (Y a-t-il, par exemple, un accès à l'eau potable, des points d'eau et du savon ?)

Opinions des résidents / autres commentaires :

<u>Accès à l'eau potable, points d'eau</u>

- Il y a seul point d'eau dans le service qui se trouve à l'écart des deux bâtiments principaux.
- L'eau est potable selon les standards de la Sodeco (Société Nationale de distribution d'eau).
- Le robinet est défectueux (faible débit).

- Les résidents déclarent s'approvisionner en eau au service voisin de maintenance du CNHUB.

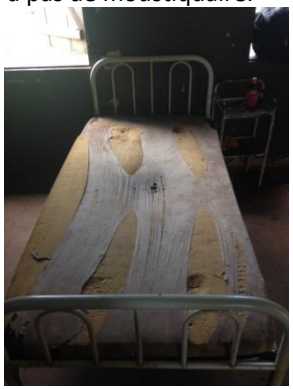
<u>Savon :</u>

- Il n'y a pas de savon disponible dans le service.

<table>
<tr><td></td><td>Action requise : Oui X Non ☐ Sans objet / Ne sait pas ☐
➢ Réparer le robinet défectueux.
➢ Installer un point d'eau supplémentaire entre les deux bâtiments principaux.
➢ Fournir un savon par patient hospitalisé.</td></tr>
<tr><td rowspan="2">2.2 L'hygiène et les soins du corps sont-ils adaptés (y compris les installations d'hygiène et l'accès à des articles de toilette) ?</td><td>Opinions des résidents/autres commentaires :
<u>Installations d'hygiène :</u>
• Il y a 6 latrines dans le service, dont 2 réservées au personnel.
• Seul 2 sont fonctionnelles, utilisées par tous pour se soulager et se laver.
• Il n'y pas de produit disponible pour les entretenir.
• Les résidents déclarent ne pas les utiliser et se « débrouillent ».
   </td></tr>
<tr><td>Action requise : Oui X Non ☐ Sans objet / Ne sait pas ☐

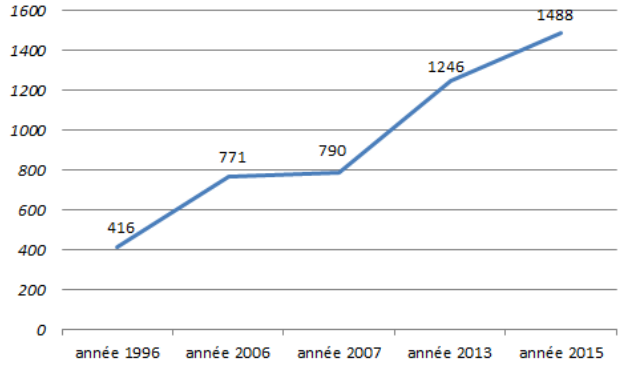
Pour le service, rendre disponible 2 latrine hommes, 2 latrines femme, 2 douches homme, 2 douches femme.
➢ Remplacer le bloc de 2 latrines par un nouveau bloc de 4 (2 douche, 2 latrines).
➢ Réhabiliter les 2 latrines non fonctionnelles dans le bloc de 4 (2 douche, 2 latrines).
➢ Fournir du papier hygiénique.
➢ Mettre à disposition des produits et matériels d'entretien.</td></tr>
</table>

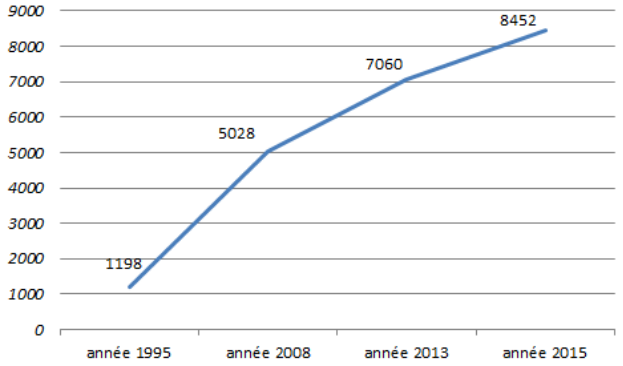
2.3 L'alimentation et la nutrition sont-elles adaptées ? (Par exemple, les résidents reçoivent-ils chaque jour 2 à 3 repas ayant une valeur nutritionnelle adaptée ?)	**Opinions des résidents/autres commentaires** : • Les résidents reçoivent chaque jour 1 repas ayant une valeur nutritionnelle adaptée. • Ils complètent leur alimentation avec leurs propres ressources, les accompagnants préparent la nourriture. • Il n'y a pas d'espace cuisine dédié. 
	Action requise : Oui **X** Non ☐ Sans objet / Ne sait pas ☐ ➢ Réhabilitation de l'ancien cabanon pour l'isolement en cuisine. 

2.4 Les pièces de séjour et de repos des résidents sont-elles adaptées ? (Par exemple, y a-t-il assez de matelas, de couvertures, de protections adaptées contre les intempéries (chaleur/froid, pluie, vent) et ces pièces sont-elles suffisamment propres ?)	**Opinions des résidents/autres commentaires** : <u>Matelas et couvertures</u> • L'ensemble des matelas est dans un état de dégradation avancé. • Il n'y a pas de drap ou de couverture. • Il n'y a pas de moustiquaire.    <u>Propreté des pièces de séjour</u> • Les pièces de séjour ne sont pas entretenues avec des produits d'entretien. • Les patients alités se soulagent à même le sol. <u>Abri pour les accompagnants</u> • Il n'y a pas de place à l'intérieur pour que les accompagnants puissent dormir. Ils dorment sous le hangar à l'extérieur.
	Action requise : Oui **X** Non ☐ Sans objet / Ne sait pas ☐ <u>Matelas et couvertures</u> ➢ Remplacer l'ensemble des matelas du service. ➢ Fournir un drap et une moustiquaire pour chaque patient hospitalisé. <u>Propreté des pièces de séjour</u> ➢ Fournir des pots de chambre aux malades alités. ➢ Fournir des produits et matériels d'entretien. <u>Abri pour les accompagnants</u> ➢ Construire un nouveau hangar afin que les accompagnants puissent dormir et qui pourra être utilisé pour d'autres activités. ➢ Installer une télévision pour le divertissement.

2.5 Les maladies physiques sont-elles prises en charge ? (La santé physique est-elle contrôlée et un accès aux soins médicaux et aux vaccins est-il assuré ?)	**Opinions des résidents/autres commentaires** : • La prise en charge des maladies physique est assurée.
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
2.6 Les handicaps physiques sont-ils pris en charge ? (Par exemple, les installations sont-elles accessibles aux personnes handicapées, des services sociaux adaptés leur sont-ils fournis et le personnel leur offre-t-il aide et soutien lorsque cela est nécessaire, notamment pour utiliser les installations sanitaires ?)	**Opinions des résidents/autres commentaires** : • Les patients faibles, alités ou avec un handicap physique ne peuvent pas se déplacer dans le service ou sein de l'hôpital en cas de référence vers un autre service.
	Action requise : Oui **X** Non ☐ Sans objet / Ne sait pas ☐ ➢ Fournir 2 chaises roulantes.
3. Soins de santé mentale	
3.1 L'état de santé mentale de chaque résident est-il régulièrement contrôlé?	**Opinions des résidents/autres commentaires** : L'état de santé mentale de chaque résident est régulièrement contrôlé.
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
3.2 Des psychotropes essentiels sont-ils disponibles ?	**Opinions des résidents/autres commentaires** : Le programme d'aide du Gouvernement Japonais inclut une commande de médicaments psychotropes.
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
3.3 Des pratiques non pharmacologiques (réadaptation psychosociale, ergothérapie, etc.) sont-elles utilisées lors des soins ?	**Opinions des résidents/autres commentaires** : • Les interventions psychologiques sont disponibles. • Il n'y a pas de salle d'écoute appropriée disponible.

<table>
<tr><td></td><td> 

Action requise : Oui X Non ☐ Sans objet / Ne sait pas ☐
➢ Aménager une salle d'écoute.</td></tr>
<tr><td>3.4 Quel est le ratio personnel / résidents du service ?</td><td>Opinions des résidents/autres commentaires :
• 13 personnels pour 24 lits d'hospitalisation et les consultations ambulatoires.
• Depuis le départ du Dr Tabo, Psychiatre, en 2011, son adjoint le remplace et fait fonction. Il n'a lui-même pas été remplacé.
• Le nombre des consultations a quadruplé au cours de ces 10 dernières années.
• Les personnels du service constituent les ressources disponibles pour la formation et la supervision des personnels de santé non-spécialistes dans le cadre du mhGAP.
 

Graph1. Nombre annuel de nouveaux cas (Source : Service de Psychiatrie CNHUB)
 

Graph2 : Nombre annuel de consultation dans les services de psychiatrie (Source : Service de Psychiatrie CNHUB)</td></tr>
</table>

	Action requise : Oui **X** Non ☐ Sans objet / Ne sait pas ☐ ➢ Mettre à disposition un Médecin Généraliste. ➢ Réhabiliter une pièce pour le repos des soignants.
3.5 Y a-t-il des dossiers individuels pour chaque résident ? (Par exemple, des dossiers médicaux qui sont tenus confidentiels ?)	**Opinions des résidents/autres commentaires** : • Il y a un dossier individuel pour chaque résident.
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
4. Questions de protection	
4.1 Les enfants sont-ils pris en charge et protégés ? (Par exemple, bénéficient-ils de conditions de vie adaptées (lieux sûrs pour dormir et jouer, nutrition, stimulation et éducation) ?)	**Opinions des résidents/autres commentaires** : • Les activités des services incluent la pédopsychiatrie. • Les enfants bénéficient des mêmes conditions que les adultes.
	Action requise : Oui **X** Non ☐ Sans objet / Ne sait pas ☐ ➢ Mis aux normes d'un service de pédopsychiatrie.
4.2 Les hommes et les femmes sont-ils logés séparément ? (Par exemple, dorment-ils dans des pièces séparées et disposent-ils d'installations sanitaires distinctes ?)	**Opinions des résidents/autres commentaires** : • Les hommes et les femmes sont logés séparément.
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
4.3 Est-il fait état ou avez-vous été témoin de formes de maltraitance physique comme des coups ?	**Opinions des résidents/autres commentaires** : • Non
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
4.4 Est-il fait état d'abus sexuels ?	**Opinions des résidents/autres commentaires** : • Non
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
4.5 Est-il fait état ou avez-vous été témoin de formes de violence verbale ?	**Opinions des résidents/autres commentaires** : • Non
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
4.6 Certains résidents sont-ils placés sous contention physique ?	**Opinions des résidents/autres commentaires** : • Non
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
4.7 Certains résidents sont-ils enfermés ?	**Opinions des résidents/autres commentaires** : • Non ; Le cabanon a été clos (voir ci_dessus).
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐

4.8 Les résidents sont-ils négligés ?	**Opinions des résidents/autres commentaires** : • Non
	Action requise : Oui ☐ Non **X** Sans objet / Ne sait pas ☐
5. Évacuation	**N/A**
5.1 Existe-t-il des plans d'évacuation ?	Opinions des résidents/autres commentaires :
	Action requise : Oui ☐ Non ☐ Sans objet / Ne sait pas ☐
5.2 Le personnel est-il formé au respect des plans d'évacuation ?	Opinions des résidents/autres commentaires :
	Action requise : Oui ☐ Non ☐ Sans objet / Ne sait pas ☐

6. Impact de la crise

Observations sur l'impact de la crise :
La crise a augmenté la prévalence de troubles mentaux en Centrafrique et le seul service de psychiatrie a vu le nombre d'hospitalisations et de consultations augmenter. Les partenaires nationaux et internationaux détectent plus de cas dans le cadre de leurs activités de soutien psychosocial et le nombre de références a augmenté.
Les personnels du service constituent les ressources disponibles pour la formation et la supervision des personnels de santé non-spécialistes dans le cadre du mhGAP.
Les ressources et les capacités du service n'ont pas été adaptées, ni même augmentée.

7. Actions recommandées			**Par date :**	**Par qui :**
Matériel	**Réhabilitation**	**Ressources Humaines**		
2.1 Eau et assainissement				
➢ Fournir un savon par patient hospitalisé.			Septembre 2016	OMS
	➢ Réparer le robinet défectueux.		Octobre 2016	OMS
	➢ Installer un point d'eau supplémentaire.		Octobre 2016	OMS
2.2 Installations d'hygiène				
➢ Fournir du papier hygiénique.			Septembre 2016	OMS
➢ Mettre à disposition des produits et matériels			Septembre 2016	OMS

d'entretien.				
	➢ Remplacer le bloc de 2 latrines par un nouveau bloc de 4.		Octobre 2016	OMS
	➢ Réhabiliter les 2 latrines non fonctionnelles.		Octobre 2016	OMS
2.3 L'alimentation et la nutrition				
	➢ Réhabilitation du cabanon en cuisine.		Octobre 2016	OMS
2.4 Les pièces de séjour				
➢ Remplacer l'ensemble des matelas du service.			Septembre 2016	OMS
➢ Fournir un drap et une moustiquaire pour chaque patient hospitalisé.			Septembre 2016	OMS
➢ Fournir des pots de chambre aux malades alités.			Septembre 2016	OMS
➢ Fournir des produits et matériels d'entretien.			Septembre 2016	OMS
	➢ Construire un nouveau hangar.		2017	?
2.6 Handicaps physiques				
➢ Fournir 2 chaises roulantes.				OMS
3.3 Pratiques non pharmacologiques				
➢ Aménager une salle d'écoute.				OMS
3.4 Ratio personnel / résidents				
➢ Aménager une pièce pour le repos des soignants.				?
		➢ Mettre à disposition un Médecin Généraliste.		MSSP
4.1 Protection des enfants				
➢ Mis aux normes d'un service de pédopsychiatrie.			2017	?

Annex 10: mhGAP Monitoring and Evaluation Recording Form

This is a master form for the mhGAP monitoring and evaluation coordinator to fill in. The form covers all the indicators.

Some of the indicators were not included in the action plan (in red).

Recording period : 1st of August 2016 to 31st March of 2017		
COMPONENT A: **Development of Policy, Plans and Strategies for Care of People with MNS Disorders**	***Data***	***Remarks/source of data***
A1. Establishment of an advisory committee for mhGAP planning and implementation	X Yes ☐No	MHPSS Sub-Cluster
A2. Availability of a situational analysis to inform mhGAP planning and implementation	X Yes ☐No	Situation Analysis available
A3. Collaboration with relevant stakeholders in the mhGAP planning and implementation process *(include details about who was involved in collaboration, how their input was recorded and used, and the frequency of collaboration)*	X Yes ☐No	Report of Adaptation and Planning Workshop for the implementation of the mhGAP-HIG (30, 31 August 2016) Adaptation guide available
A4. Development of an mhGAP action plan and budget	X Yes ☐No	Report of Adaptation and Planning Workshop for the implementation of the mhGAP-HIG (30, 31 August 2016) Action Plan available
A5. Mental health policy up-to-date / recently updated (specify date last updated)	☐Yes X No	Indicator not selected in the action plan
A6. Mental health legislation up-to-date / recently updated (specify date last updated)	☐Yes X No	Indicator not selected in the action plan
A7. Number of regions/districts with a plan for mhGAP implementation	**4**	Bangui, Sibut (Dekoa), Bouar, Bimbo
A7a). Number of regions/districts in country	**8**	8 Districts targeted in the Japanese project

A7b). Proportion of regions/districts with a plan for mhGAP implementation(=A7/A7a)	**50 %**	
COMPONENT B: **Capacity Building of Health Care Providers**	***Data***	***Remarks/source of data***
B1. Adaptation of mhGAP materials and tools for capacity building and implementation of MNS services:		
B1a). mhGAP-IG	X Yes ☐No	mhGAP-HIG used
B1b). mhGAP training packages	X Yes ☐No	Availability of a training module for each identified priority condition: 6: Acute Stress, Post Traumatic Stress Disorder, Depression, Psychosis, Epilepsy, Harmful use of Alcohol and Drugs. Availability of a training module for the identification and referral of people with mental disorders (mini-mhGAP).
B1c). Training of Trainers	☐Yes X No	Indicateur non-sélectionné dans le PAO
B1d). Support and Supervision Guide	X Yes ☐No	Guide adapted to the local context through the selection of the relevant tools: - Rapport mensuel - Rapport de supervision pour les prestataires de soins de santé - Rapport de l'établissement de santé - Rapport sur la supervision et formulaire de commentaire - Rapport sur les cas difficiles - Rapport de Formulaire de supervision et de soutien clinique
B1e). Other resource materials (Specify)	☐Yes ☐No	Indicator not selected in the action plan

B2. Number of mhGAP training workshops held for non-specialist health care providers	**4**	Bangui: September 2016 Sibut : October 2016 Bouar : January 2017 Bimbo: February 2017
Example only (adapt as required): identified priority condition: 6: Acute Stress, Post Traumatic Stress Disorder, Depression, Psychosis, Epilepsy, Harmful use of Alcohol and Drugs		
Base Course	____	
Standard Course: Depression module	____	
Standard Course: Psychosis module	____	
B3 Number of mhGAP 'Training of Trainers and Supervisors' workshops held	**1**	The modules were adopted at national level at a validation workshop of the training modules.
B4. Number of non-specialist health care providers trained in mhGAP *Example only (adapt as required):* identified priority condition: 6: Acute Stress, Post Traumatic Stress Disorder, Depression, Psychosis, Epilepsy, Harmful use of Alcohol and Drugs mhGAP HIG Total	**48**	
General Practitioners	9	
General Nurses	28	
Others (specify: Technicien supérieur en santé, assistant de santé)	11	
Number of non-specialist health care providers trained in mini-mhGAP for the identification and referral of people with mental disorders Mini- mhGAP Total	**226**	
General Practitioners	0	
General Nurses	2	
Others (specify: préciser Infirmiers Assistants, Agents Psychosociaux, Agents de Santé Communautaire, Réseau Communautaire, ONG *)*	78	
Faculté des Sciences de la Santé de l'Université de Bangui : Internes de 5ème année de médecine et Elèves Infirmiers Diplômés d'Etat de 3eme année	107	
Partenaires du Cluster Santé	39	

B5. Number of health care providers trained in mhGAP 'Supervisors' workshop Total	**0**	Activity not realized: Specialists trained "on the job". District Supervisors: to be implemented with incentive payments. Guinea 2015 Training Module available.
Example only (adapt as required): *Psychiatrists*		
Psychiatric Nurses		
Psychologists		
Others (specify:)		
Others (specify:)		
B6. Number of medical education programmes that have incorporated mhGAP-IG into the course curriculum	____	Indicator not selected in the action plan. However, mini-mhGAP implemented at the Faculty of Health Sciences of the University of Bangui.
B6a). Number of medical education programmes in country	____	
B6b). Proportion of medical education programmes that have incorporated mhGAP-IG into course curriculum(=B6/B6a)	____%	
B7. Knowledge, attitudes and practices among recipients of mhGAP training		
T1 Baseline (Before the mhGAP training)	**54 %**	Result pre-test
T2 After the training	**68 %**	Result post-test
T3 Follow up (6 months after the training)	____	
Change T2 - T1	**14 %**	
Change T3 - T1	____	
COMPONENT C: **Delivery of Care for MNS Disorders in Non-Specialized Health Settings**	***Data***	***Remarks/source of data***
C1. Number of health facilities using mhGAP-IG to assess and manage person with MNS disorders	**24**	**4 Hospitals, 20 Health Centers:** - Bangui: 1 Hospital, 2 Health Centers - Sibut: 1 Hospital, 1 Health Center - Bouar: 1 Hospitals, 11 Health Centers - Bimbo: 1 Hospital, 6 Health Centers

C1a). Number of health facilities in the country	N/A	According to the results of the HeRAMS survey carried out with the support of WHO in October 2016, 236 (23%) of the 1010 health structures in the country still bear the stigma of the crisis (partial or total destruction), 244 (24%) are partially or non-functional and 340 are supported by humanitarian organizations.
C1b). Proportion of health facilities using mhGAP-IG to assess and manage person with MNS disorders (=C1/C1a)	N/A	
C2. Number of health facilities with reporting and information system for tracking care inputs and caseloads	**24**	- Register, individual patient record, reference sheet, monthly report available in each FOSA implementing the program - Collection of data through the supervision of specialists. - Indicator on "Mental Disorders" in the Early Warning Fact Sheet (Surveillance). - Indicator on "Mental Disorders" in National Health Information System.
C2a). Proportion of facilities implementing mhGAP with reporting and information system(=C2/C1)	100%	
C3. Number of health facilities with an uninterrupted supply of essential psychotropic medicines[2]	0	Order of psychotropic drugs approved on May 19, 2016.
C3a). Proportion of health facilities implementing mhGAP with access to an uninterrupted supply of essential psychotropic medicines (=C3/C1)	0 %	Antipsychotic and anticholinergic drugs have been donated
C4. Number of support and supervision visits to each health facility implementing mhGAP	***17 Health Facilities in Bangui, Sibut and Bouar**	
C4a). Total number of support and supervision visits to the health facilities implementing mhGAP	**29**	**Analyze**
C4b). Average number of support and supervision visits to the health facilities implementing mhGAP (=C4a/C1)	1,2	- Difficulty in differentiating non-pathological distress (fear, sadness, anger, self-reproach, shame, or guilt) from anxiety-related disorders (Acute Stress and Post-
C5. Number of people with MNS disorders seen in each health facility implementing mhGAP		

[2] Information regarding availability may also be recorded per type of psychotropic medication

C5a). Total number of people seen at the health facilities implementing mhGAP with any condition (physical or MNS disorders)	____	Traumatic Stress Disorder). - Depression not detected - Behavior disorder or nightmares = Psychosis - Epilepsy not referred from the community - Alcohol detected, drug detected
C5b). Total number of MNS disorders seen in those facilities	**380**	
C5c). Number of MNS disorders seen as a proportion of the total number of persons seen at the health facilities implementing mhGAP (=C5b/C5a)	____%	
C5d). Average number of MNS disorders seen at the health facilities implementing mhGAP (=C5b/C1)	22*	

	Stress aigu					**Etat de Stress Post Traumatique**					**Depression**					**Psychose**					**Epilepsie**					**Consommation nocive alcool drogues**					**Tot.**
	Nov	**Déc**	**Jan**	**Fév**	**Mar**	**Nov**	**Déc**	**Jan**	**Fév**	**Mar**	**Nov**	**Déc**	**Jan**	**Fév**	**Mar**	**Nov**	**Déc**	**Jan**	**Fév**	**Mar**	**Nov**	**Déc**	**Jan**	**Fév**	**Mar**	**Nov**	**Déc**	**Jan**	**Fév**	**Mar**	
Bangui																														
Hôp Com Traumatologie	17	12	28	4	8	2	1	1	0	1	0	0	0	1	0	0	0	1	0	0	0	0	0	1	0	3	2	4	2	4	92
Hôp Com Urgence	0	74	2	6	3	2	1	0	0	0	0	1	0	0	2	0	1	0	1	0	0	1	0	0	1	2	1	0	3	2	103
Hôp Com Médecine Interne	2	2	0	0	0	0	1	0	0	0	0	0	0	3	2	0	1	0	0	0	0	1	0	0	0	0	1	0	1	2	16
CS Mamadou-Baïki	0	0	1	3	2	3	0	2	0	1	0	0	0	0	1	0	0	2	0	1	0	1	0	3	2	2	5	3	4	6	42
CS Castors	0	0	0	2	4	1	0	1	0	0	1	0	0	2	1	0	0	0	1	0	0	1	0	2	1	0	5	2	2	4	30
Sibut																														
Hôpital Préfectoral de Sibut		0	0	2	1		2	1	0	1		2	0	1	0		1	3	0	0		1	2	0	1		3	0	2	1	24
CS Dekoa		0	0	4	6		14	12	3	5		1	0	1	0		3	2	0	1		0	0	1	2		0	0	1	4	60
Bouar																														
Hôpital Préfectoral Bouar					0					0					0					1					2					1	4
CS Herman					0					0					0					0					0					0	0

Infirmerie Garnison					0					0					0					1					1					2	4
CS Cantonnier					0					0					0					0					0					1	1
CS Wantiguera					0					0					0					0					0					0	0
CS Haoussa					1					0					1					1					1					0	4
CS St Joseph					0					0					0					0					0					0	0
CS SOS					0					0					0					0					0					0	0
CS Maïgaro					0					0					0					0					0					0	0
CS St Michel					0					0					0					0					0					0	0
CS Haba (Baboua)					0					0					0					0					0					0	0
CS Baboua (Baboua)					0					0					0					0					0					0	0
Total	19	88	31	21	25	8	19	17	3	8	1	4	0	8	7	0	6	8	2	5	0	5	2	7	11	7	17	9	15	27	380
					184					55					20					21					25					75	

C6. Number of people with MNS disorders on follow-up in each health facility implementing mhGAP	**?**	Data not available during supervision visits.
C6a). Total number of people followed-up at the health facilities implementing mhGAP with any condition (physical or MNS disorders)	____	
C6b). Total number of MNS disorders followed-up in those facilities	____	
C6c). Number of MNS disorders followed-up as a proportion of the total number of persons followed-up at the health facilities implementing mhGAP (=C5b/C5a)	____ %	
C6d). Average number of MNS disorders followed-up at the health facilities implementing mhGAP (=C5b/C1)	____ %	
C7. Number of referrals to specialist care made for people with MNS disorders in each health facility implementing mhGAP	**4**	Management at CNHUB Psychiatry Department.
C7a). Total number of referrals to specialist care made for people with MNS disorders per in each health facility implementing mhGAP		

C7b). Average number of referrals to specialist care made for people with MNS disorders per in each health facility implementing mhGAP(=C7a/C1)		
Strengthening the CNHUB Psychiatry Department		
Rehabilitation project developed on the basis of a checklist for institutional visits in humanitarian situations.	**X** Oui ☐Non	
General practitioner available and motivated to support the service and implementation of mhGAP.	**X** Oui ☐Non	

COMPONENT D: **Raising Awareness and Understanding of MNS Disorders in the Community**	***Data***	***Remarks/source of data***
D1. Development of public education and promotional materials for different target audiences *(Include details about the number and type of materials)*	☐Yes ☐No	Activity planned for Mai / June 2017.
D2. Number of awareness raising programmes/ activities (*Include details about the type and level of implementation*)	____	Activity will start after the development of the material.
D3. Number of service users and carer groups		Indicator not selected in the action plan
D3a). Number of service users groups	____	
D3b). Number of carer groups	____	
D3c). Number of members in the service users groups	____	
D3d). Number of members in the carer groups	____	
D4. Perceptions, knowledge and attitudes about MNS disorders in the general community		Indicator not selected in the action plan
D4a). T1 Baseline (Before the mhGAP implementation)	____	
D4b). T2 One-year After the implementation	____	
D4c). Change T2 – T1	____	

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