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Community and Social Psychiatry in the Gbeke Health Region in Ivory Coast: Preliminary Data 2018 and 2019

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Abstract: Since 2008, WHO has been suggesting to governments that psychiatric care be integrated into primary care based on collaboration with non-conventional care and community actors. The SAMENTACOM Project proposes a locally adapted and integrated model of the WHO mhGAP Programme to contribute to the reform of mental health services in Ivory Coast. This study aims to present the preliminary results of activities within the framework of the Project aimed at bringing primary psychiatric care closer to the community through a mechanism of delegation and supervision of tasks. The results of this study are based on the exploitation of primary data from the mobile clinic activities in the pilot health centres from 22 to 31 October 2018. Then the data from the mobile consultations in 16 prayer camps from 08 March 2019 to 24 March 2019. These mobile and advanced consultation activities enabled the detection and medical management of 62 patients in the mobile consultations in the health centres and 50 patients in the prayer camps in the Gbeke health region. Psychiatric disorders are the most dominant compared to epilepsy. Young adults and those without a profession make up the majority of patients. In their quest for care, patients come from the localities surrounding the consultation sites, which are located within a maximum radius of 15 km, thanks to the important role of community health workers.

Keywords: Community Psychiatry, Mobile Consultations, Primary Health Centre, Prayer Camp, Gbeke

1. Introduction

In Ivory Coast, in the health system, psychiatric care is distilled by the Specialised Hospital Centres (CHS) or Psychiatric Hospitals housed at the second level of the health pyramid in the same way as the Regional Hospital Centres (CHR) and the General Hospitals (HG). However, there are only two (2) Psychiatric Hospitals, namely that of Bingerville in the south of the country and that of Bouaké in the Gbêkê region. These two structures are accompanied by 33 other structures dominated by NGOs and private individuals for a population of over 23,000,000 inhabitants [14]. In addition to being insufficient, this care offer is unevenly distributed, revealing large health deserts that limit the populations' access to quality psychiatric care. Faced with this problem of psychiatric care provision, since 2008 the WHO, through the *mhGAP* programme, has insisted on the need to integrate mental health care into primary care. This is in order to treat

psychiatric disorders at the front line, to make care accessible to a wider population and for a better collaboration and involvement of the community.

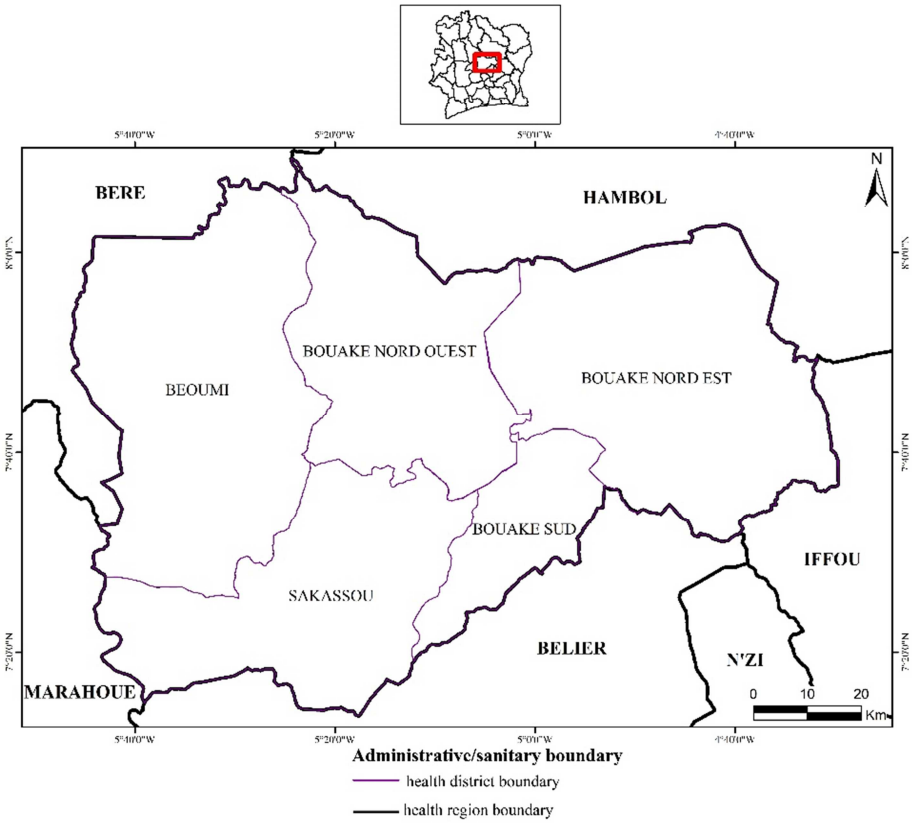
It is with this in mind that the Community Mental Health project (SAMENTACOM) was born in 2018 in the Gbêkê health region. This project contributes to the training of health workers, community health workers and community care actors (prayer camp managers, roqya centre and traditional therapist) in the tools for detecting suspected cases of mental illness and in the primary care of patients.

In the Gbêkê health region, the SAMENTACOM project is present in 4 primary health centres out of the 9 centres that the project has throughout the country. In addition to the health centres, the project collaborates with the prayer camps, which are non-conventional health centres that welcome the mentally ill and their families in their quest for care. This community-based implementation of psychiatric care has enabled the development of advanced strategies to bring care closer to the people, especially in rural areas.

It is therefore important to know what impact the advanced strategies of the SAMENTACOM project are having in the Gbêkê health region. This study aims to analyse the socio-spatial issues of the integration of psychiatric care into primary care and delocalised consultations in the prayer camps of the Gbeke region. It is structured around three parts. The first part presents the mobile consultation activities carried out in the pilot health centres of the Gbêkê health region. The second part reveals the activities of mobile clinics in the prayer camps. The third part presents the spatial and social effects of the advanced strategies of the SAMENTACOM project in the Gbêkê health region.

2. Materials and Methods

The Gbêkê health region is located in central Ivory Coast. It is bordered to the east by the health regions of Iffou and N'Zi. To the south, it borders the Bélier region, to the north with the Hambol and Béré regions and to the west with the Marahoué region. In 2016, the health region is composed of 5 health districts. These are the health districts of Bouaké North-East, Bouaké North-West, Bouaké South, Béoumi and Sakassou as shown on Figure 1.



Source: DPPEIS, 2016 Production: SREU Eric, 2021

Figure 1. *Location of the Gbeke health region in 2016.*

With an area of 8996 km², the Gbêkê health region has a population of 1,036,667 inhabitants in 2016 [6]. Its density is 115.23 inhabitants per km². The Gbêkê region was a martyred area during the 2002 military-political crisis and was strongly affected by the negative effects of the war. The after-effects, although visible in the landscape, are also present in the population. The traumas left by the war have negatively affected the mental health of the population. Since 2002, the number of consultations in the psychiatric care services of the Gbêkê region has increased. However, there are only two psychiatric care services, namely the psychiatric hospital of Bouaké and the confessional hospital Saint

Camille de Bouaké.

As both services are centralised in the city of Bouaké, the urban population, especially those in the city of Bouaké, have easy access to psychiatric care. On the other hand, people living in remote areas of the city of Bouaké and with low financial means have difficult access to psychiatric care. The absence of a first line of mental health care has favoured the proliferation of these unconventional healing centres.

The results of this study are based on the exploitation of primary data from the mobile clinic activities in the pilot health centres of Brobo, Bamoro, Tieplé and Andokekrenou from 22 to 31 October 2018. Then the data from the mobile consultations in 16 prayer camps from 08 March 2019 to 24 March 2019. These 16 prayer camps were selected from the 71 prayer camps in the region [9]. These 16 prayer camps were chosen on the basis of the criterion of the favourable opinion given by the prayer camp leaders as well as their local representativeness.

The data consisted of epidemiological, socio-demographic and geographical information collected from patients using the community consultation forms designed by the SAMENTACOM project. Statistical processing of this data was carried out using Excel and IBM SPSS 20 software. Cartographic processing was carried out using QGIS 2.18 software.

3. Results

3.1. Mental Health Clinics in the Gbeke Health Region

3.1.1. Conduct and Assessment of the Mobile Consultations in the Primary Health Centres Piloting the SAMENTACOM Project

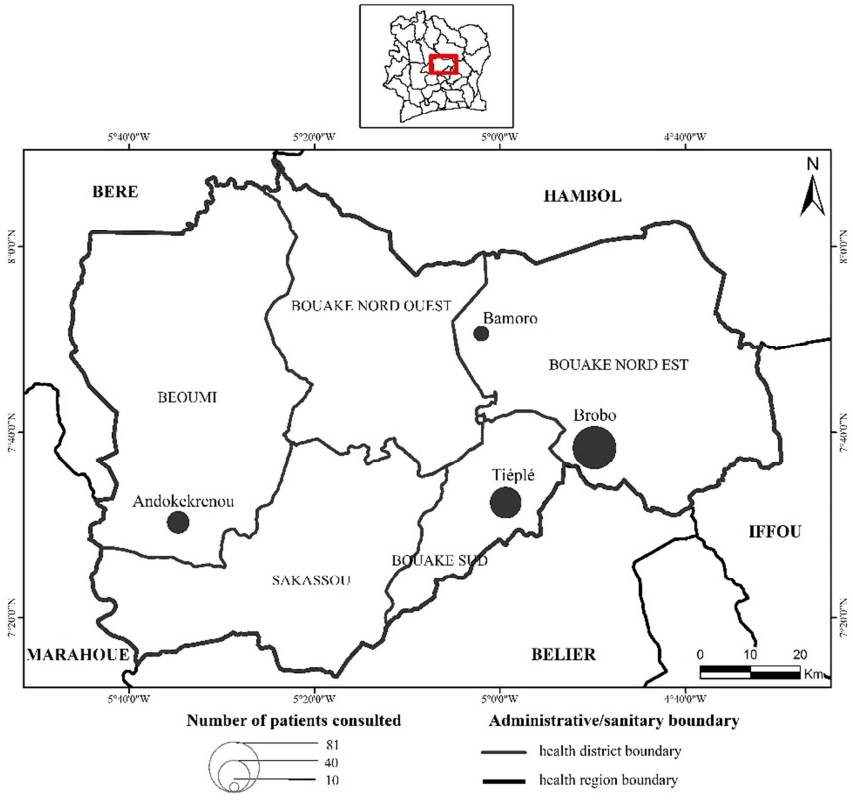
Psychiatric consultations were organised in the various SAMENTACOM pilot health centres in the Gbêkê health region. These activities were held on a daily basis in the different sites as shown in table 1.

Table 1. *Schedule of mobile consultations at the SAMENTACOM pilot sites in the Gbêkê health region in 2018.*

Health Centre	Date	Health District
DR Tieple	22/10/2018	Bouake South
CSR Bamoro	23/10/2018	Bouake North East
CSU Andokekrenou	26/10/2018	Beoumi
CSU Brobo	30/10/2018	Bouake North East

Source: SAMENTACOM, 2018.

They took place from 22 to 30 October 2018 in 4 SAMENTACOM pilot health centres. These were the CSU of Brobo and Ando kekrenou, the CSR of Bamoro and the DR of Tiéplé. In total, 62 people were consulted in all the sites of the Gbêkê health region.

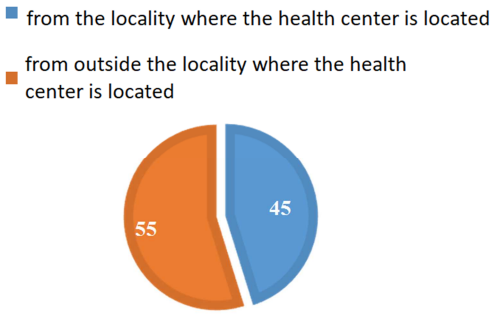


Source: SAMENTACOM, 2018 Production: SREU Eric, August 2019

Figure 2. *Distribution of people attending the mobile clinic in the SAMENTACOM pilot sites in the Gbêkê region in 2018.*

The CSU of Brobo welcomed 30 people who came to the mobile clinic, the largest number in the region. The DR of Tiéplé came second with 16 people, then the one in Ando kekrenou with 10 people and the CSR of Bamoro with only 6 people. Figure 2 shows the distribution of people who came for routine consultations organised by SAMENTACOM.

The majority of consultants come from localities outside the locality where the mobile clinics are located. They represent 55% of the consultants against 45% who come from the localities hosting the mobile clinics, as shown in Figure 3.



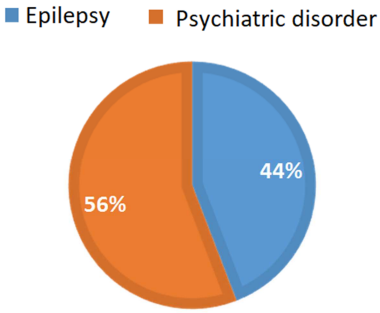
Source: Our surveys, 2018

Figure 3. *Distribution of consultants by place of origin in relation to the locality hosting the mobile clinic in 2018.*

Approximately 94% of the consultants reside in rural areas and only 6% in urban areas. The majority of consultants come from villages in the health area of the health facility hosting the consultations. The flow of people to the consultation posts reveals the areas of influence or attraction of the different sites.

3.1.2. Clinical Aspects of the Mobile Consultations Carried out in the SAMENTACOM Pilot Health Centres in the Gbeke Health Region

People with psychiatric disorders are the most dominant. They represent 56% of the patients against 44% of epilepsy patients as shown in Figure 4.

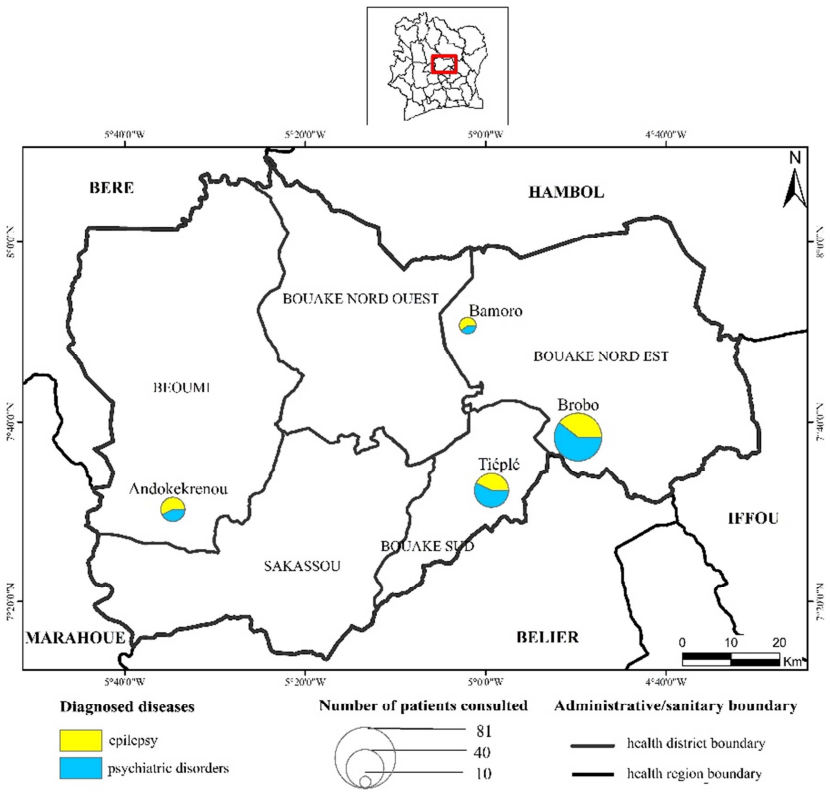


Source: SAMENTACOM, 2018

Figure 4. *Distribution of patients followed in SAMENTACOM pilot health centres according to pathology in 2018.*

However, this dominance varies according to the pilot health centres. In Andokekrenou as in Bamoro, epileptic patients are the most representative to the detriment of cases of psychiatric disorders. Figure 5 shows the distribution of patients followed by health centre according to their pathology.

The sick are dominated by young adults (between 15 and 44 years old) at 45.35%, with 57.35% being male. However, apart from primary health centres, advanced strategies have been deployed in prayer camps, non-conventional care centres which are shelters for the sick and the lost.



Source: SAMENTACOM, 2018 Production: SREU Eric, August 2019

Figure 5. *Distribution of patients followed by health centre according to pathology in 2018.*

3.2. Mobile Clinics Relocated to Prayer Camps in the Gbeke Health Region

3.2.1. Detection of Psychiatric and Epileptic Disorders in the Prayer Camps of the Gbeke Health Region

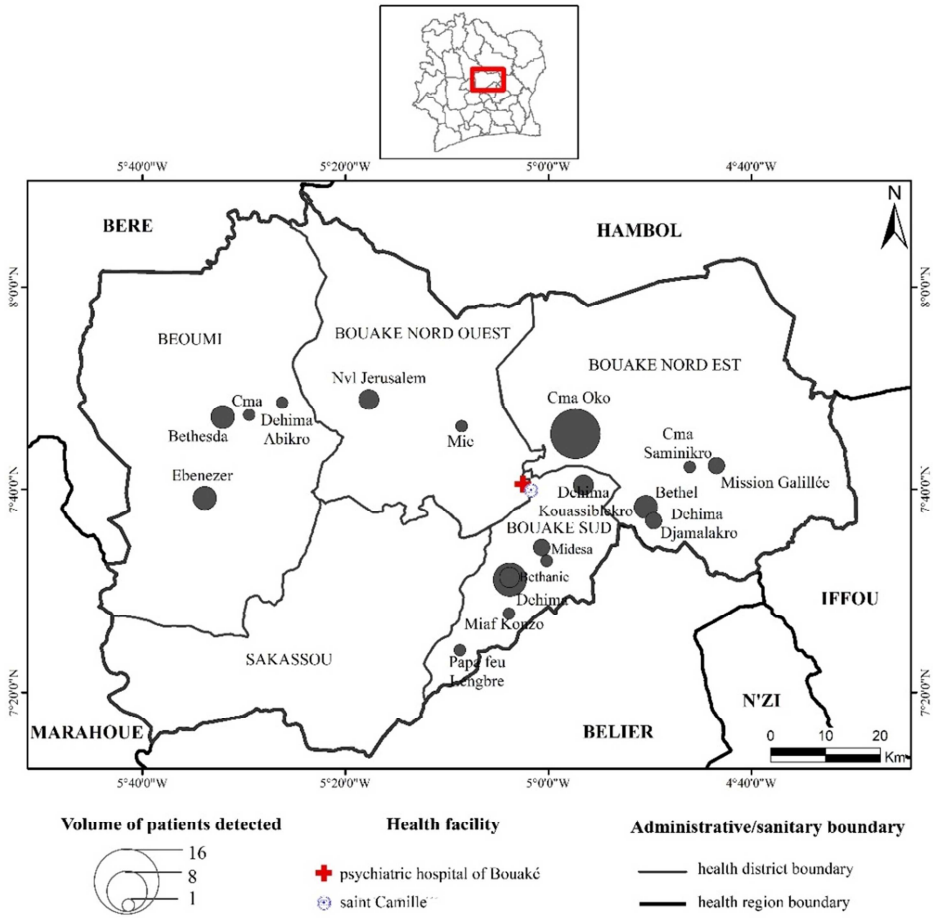
A total of 50 mental and epileptic patients were consulted with the approval of the prayer camp leader. Other patients could not be consulted due to the absence of the camp leader or close relatives. Figure 6 shows a consultation session with a patient.

Shot: SREU Eric, 2019

Figure 6. *Consultation of a patient at the Bethel prayer camp in Brobo in 2019.*

The patients consulted are unevenly distributed in the prayer camps visited. Of the 40 camps visited, consultations were allowed in only 16 prayer camps. The CMA prayer camp in Oko recorded 16 patients, the largest number of patients consulted. Then come the Dehima prayer camps of Brobo in the Bouaké North-East district with 4 patients, Djebonoua in the Bouaké South health district with 8 patients and the Dehima camp of Kouassiblekro with 4 patients. In the other prayer camps, the number of patients consulted was around one and three patients consulted, such as the Bethany, Ebenezer, CMA Fitabro, New Jerusalem, Bethesda and Papa Feu Lengbré camps, as shown on Figure 7.

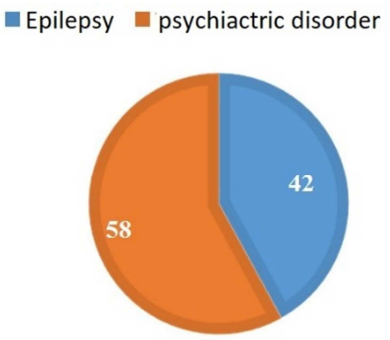
The prayer camps where we were able to detect a good number of patients are characterised by a good collaboration that began when we arrived. In these spaces, the entrance speech, if not the contact, is a key element for the smooth running of the investigations and activities to be carried out with the patients. Once trust has been established, the camp managers call all the patients and explain the importance of medical assistance. If not, the leader refuses or hides the patients.



Source: Our surveys, 2019 Production: SREU Eric, August 2019

Figure 7. *Distribution of patients screened in the prayer camps of the Gbêkê health region in 2019.*

In terms of patients, we note a domination of people with psychiatric disorders to the detriment of epilepsy patients. Epileptics represent 42% of the patients consulted and 58% of the cases of psychiatric disorders, as shown in Figure 8.



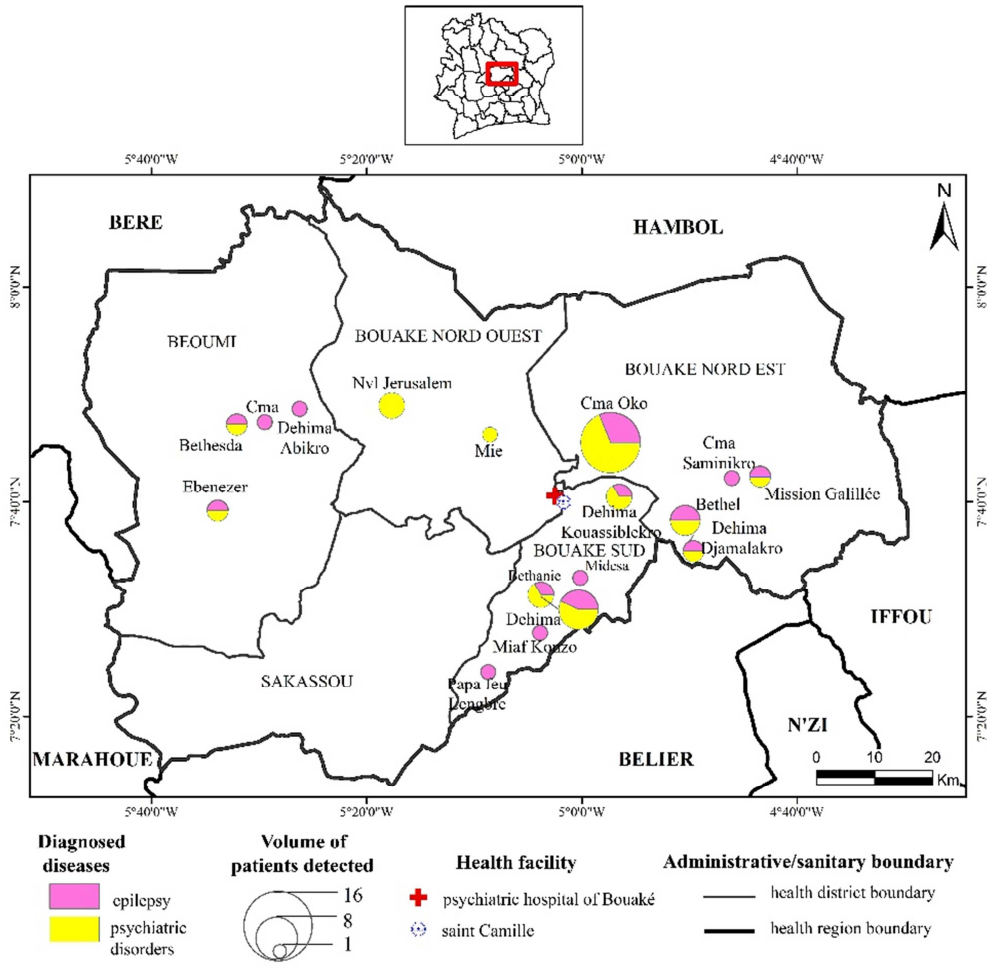
Source: Our surveys, 2019

Figure 8. *Distribution of patients consulted according to pathology mental in 2019.*

As a result, although there are only single cases of epilepsy in the prayer camps, there is a heterogeneity. The CMA Oko camp has the highest number of epileptic patients, i.e. 5 patients, followed by the Dehima camp in Djebonoua with 3 patients and the Bethel camp in Brobo with only 2 patients, as shown on Figure 9.

At the end of these psychiatric consultations in the prayer camps, socio-demographic and clinical aspects of the patients emerged. The patients consulted were able to benefit from free medical care.

A large proportion of the patients consulted in the prayer camps adhered to the medical treatment prescribed by the team doctor with the participation of the team's pharmacist and community health worker.



Source: Our surveys, 2019 Production: SREU Eric, August 2019

Figure 9. *Distribution of patients consulted according to the pathology diagnosed in the prayer camps of the Gbêkê health region in 2019.*

3.2.2. Socio-Demographic Characteristics and Clinical Aspects of Mental Patients Screened in the Prayer Camps of the Gbeke Health Region

Of the 50 patients consulted, the male gender is the most dominant. They represent 56% of the patients consulted, compared to 44% of women. In these prayer camps, the prevalence of mental illness is more marked among young adults. In this respect, patients aged between 20 and 40 years are the most representative. They constitute 54% of the patients. Those under 20 years of age represent 28% of patients and 18% of patients over 40 years of age. In the prayer camps, patients of Baoulé ethnicity are dominant at 86%. This is logical given that the Baoule are the indigenous people of the Gbêkê region. Then follow the Tagbana with 8%, the Djimini 4% and the Agni 2%.

Single or cohabiting people are the most dominant. They represent 95% of the patients against only 5% who are married. Among these patients, there are people with different professions. Unemployed people represent 22% of the patients. Next come pupils or students who represent the largest proportion of the sick in the prayer camps. They represent 30% of the sick, followed by farmers with 20%, housewives with 6%, seamstresses, shopkeepers, restaurant workers and hairdressers with 4% each.

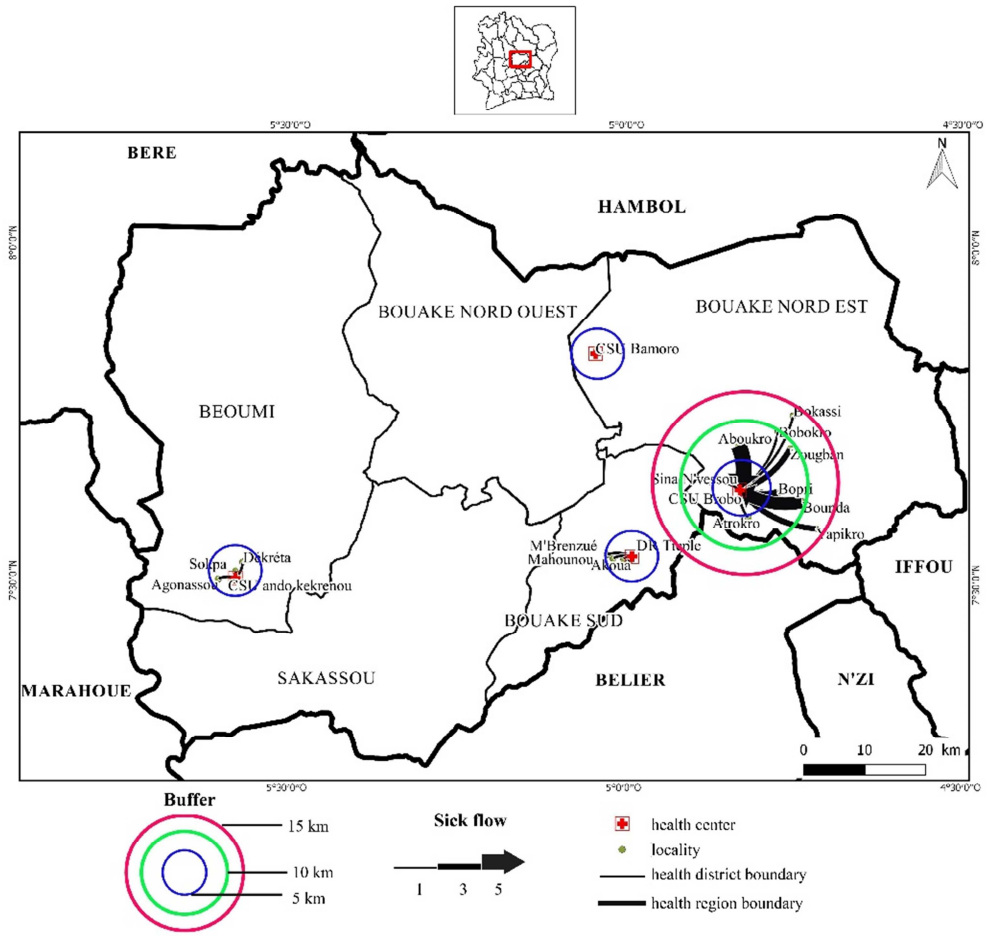
These sick people escape the health system and quality care. They represent a loss of productivity for all sectors of activity. Long stays in prayer camps impact on the professional life of individuals as well as their economic and social development, creating a significant delay in the realisation of their life projects.

3.3. Impacts of Advanced Psychiatric Care Strategies in the Samentacom Pilot Primary Health Centres and in the Prayer Camps of the Gbeke Health Region

3.3.1. Mobile Psychiatric Consultations, a Factor of Attractiveness and Continuity of Care for Patients in Primary Health Centres

At the CSU of Ando kekrenou as well as at the DR of Tiéplé, the flows are low. They are singular movements from neighbouring villages such as Sokpa, Dekreta and Agonanssou for the CSU of Andokerenou. In Tiéplé, the singular flows come from Mahonou, Akoua and M'Brenzué. Thus, their area of influence is between 3.75 and 5 kilometres, while at the level of the CSU of Brobro, the flows are significant. While some villages have a singular flow, this is not the case in certain localities. These are the localities of Bopri (3 consultants), Abouakro (3 consultants), Bounda (4 consultants) and Aboukro (5 consultants), as shown on Figure 10.

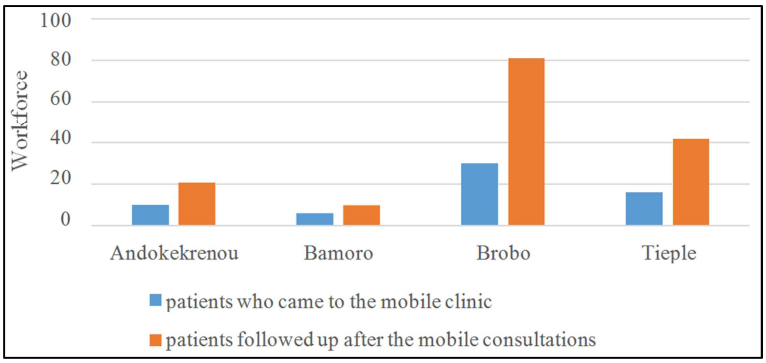
At the Brobo CSU, the outreach area is larger compared to the other consultation sites. Consultants travelled between 4.33 and 15.10 kilometres to reach the Brobo site, for an average distance of 9.7 kilometres. The expansion of the outreach area of the Brobo site is explained by the actions of the community health worker in the area. In fact, in the Brobo area, there is a community health worker in mental health who works in perfect collaboration with the other community health workers and the people of the villages in the area. Information visits to the villages and prayer camps have made it possible to mobilise a large number of consultants. This is different from the other sites, where there is no community health worker and this role is carried out by health workers who do not have the time and resources for their mobility in the community.



Source: SAMENTACOM, 2018 Production: SREU Eric, August 2019

Figure 10. *Outreach areas of consultation sites according to consultant flows in 2018.*

Routine consultations have enabled the development of psychiatric care activities in the health centres. A total of 154 people continue to receive community psychiatric care. Figure 11 shows the distribution of patients followed in the different pilot health centres.



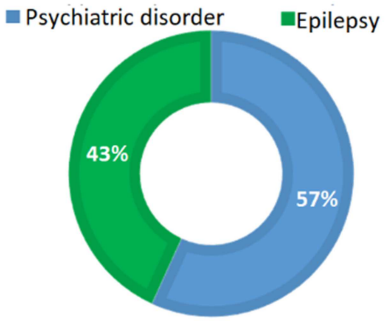
Source: SAMENTACOM, 2018

Figure 11. *Distribution of the number of patients followed in the SAMENTACOM pilot health centres in the Gbêkê region in 2018.*

After the mobile consultations, the number of patients attending the pilot health centres increased. In Ando kekrenou, the number of patients increased from 10 to 21. In Bamoro, there are 10 patients instead of 6 at the beginning. The health centres of Tiéplé and Brobo have the largest numbers. In Tiéplé, 42 patients are being followed up, compared to 16 at the start. In Brobo, 81 patients are being followed up, compared to 30 at the start. In Tiéplé, an association for the mentally ill and epileptics exists. This is due to the detection of isolated or hidden cases in the villages who are then invited by the community health worker to benefit from the treatment available at the health centre. In Brobo, it is the awareness-raising and detection of isolated cases by community health workers that encourage attendance at the health centre. Because of the non-declaration and stigmatising effects of mental illness in the community, the advanced strategies are a solution for access to psychiatric care in the Gbêkê region.

3.3.2. Towards a Collaboration with Non-Conventional Health Care Structures for the Medical Care of Patients in the Gbeke Health Region

In their adherence to treatment, there is a dominance of cases of psychiatric disorders (57%) at the expense of epilepsy (43%) as described in Figure 12.



Source: Our surveys, 2019

Figure 12. *Distribution of patients adhering to treatment by disease in prayer camps in 2019.*

Thus, in the majority of the prayer camps, patients suffering from psychiatric disorders benefited most from the medical treatment offered. This is the case in the CMA Oko prayer camp, Dehima in Kouassiblekro, Béthanie, Dehima Djebonoua, Mie and New Jerusalem camps in Botro. In the other camps, there is a strong adhesion of epileptics, which is due to their unitary presence in these prayer camps.

The treatments prescribed are mostly a combination of two to three molecules, each with a specific role in the treatment of the illness. The combination of Chlorpromazine + Artane + Fluphenazine with Amitriptyline accounted for 31.56% of the treatment of patients with psychiatric disorders adhering to treatment in the prayer camps. This is best illustrated in Table 2.

Table 2. *Distribution of prescribed treatments for people with psychiatric disorders in prayer camps in 2019.*

Molecules	Percentage
Amitriptyline	31,56%
Risperidone + Artane	5,26%
Chlorpromazine + haloperidol + piportil L4	5,26%
Artane + piportil L4 + haloperidol	5,26%
Chlorpromazine + Artane + fluphenazine	31,56%
Chlorpromazine + carbamazepine	5,26%
Haloperidol+ carbamazepine	5,26%
Haloperidol + artane + fluphenazine	5,26%
Haloperidol + chlorpromazine + Artane	5,26%
Total	100,%

Source: Our surveys, 2019

While phenobarbital accounted for 76.44% of the treatment prescribed to epileptic patients adhering to the treatment in the prayer camps as presented in Table 3.

Table 3. *Distribution of treatments prescribed to epilepsy patients in prayer camps in 2019.*

Molecules	Percentage
Phenobarbital	76,44%
Carbamazepine	5,88%
Phenobarbital + carbamazepine	17,64%
Total	100%

Source: Our surveys, 2019

The prescribed treatments lasted two to three months. Thus, in case of satisfaction or improvement of the state of health, the patients have to contact the project team in order to dispatch resource persons to deliver the treatment. This time, treatments are sometimes paid for and very affordable in relation to the price of the molecules in the care services and in the pharmacies or are given free of charge if the patient has no means. The objective is to break the distance barrier for the patient while benefiting from a quality medical treatment that is very affordable.

At the end of these visits to the prayer camps, the prayer camp leaders were satisfied with the well-being of the patients. The majority of the prayer camp leaders agreed to work with SAMENTACOM. The level of cooperation is 94%.

4. Discussion

The lack of primary psychiatric care limits access to quality care for a large part of the population due to the lack of infrastructure and qualified personnel for the treatment of mental illness. In order to promote access to psychiatric care for all, the WHO has been suggesting since 2008 the integration of psychiatric care into primary care through the MHGAP programme [12]. Although since 2001 the WHO has started to produce support tools [7]. Although the implementation of psychiatric care in primary care has been identified as a priority for the national mental health programme [14], the picture is still disappointing. Primary psychiatric care initiatives in Ivory Coast are carried out by faith-based health centres or NGOs instead of primary health centres. This problem of integrating psychiatric care into primary care is explained by the low budget allocated to the field of mental health.

In South Africa, the decentralisation of psychiatric care to community-based services is a difficult task because of the very limited budget allocated to the mental health sector from the general public health budget [5]. Concrete initiatives to integrate psychiatric care into primary care are carried out at local levels. In the Gbêkê health region, activities are carried out in 3 health districts and 4 primary health centres. These integrated activities are characterised by routine consultations in the health centres by health workers (doctors and nurses) and community health workers trained by SAMENTACOM project psychiatrists.

These activities are supported by technical supervisions and mobile consultations to boost the attractiveness of the centre and detect new cases. In 2018, the mobile consultations carried out in the four pilot health centres recorded 62 patients, with psychiatric disorders dominating (56%), compared with 44% for epilepsy. Ninety-four percent of the patients were from rural areas and resided within a maximum radius of 15 km from the pilot health centre. In Ethiopia, in rural areas, nurses and health workers have been trained in community case detection and drug administration [1].

In the Democratic Republic of Congo, according to Mayoyo [10]. In the Democratic Republic of Congo, from 2012 to 2015, a project to integrate psychiatric care into primary care was carried out in the health centres and hospital of the Lubero district. Over this period 3941 patients with mental health problems used the services offered in the health centres with a service utilisation rate of 7 new patients per 1000 inhabitants per year. The follow-ups were ambulatory with 37.2% depressive disorders, 27.9% psychotic disorders and 23.9% due to epilepsy/seizures. However, in developed countries the integration of psychiatric care is more dynamic, thanks in particular to the strong support of public health programmes and the need to widen access to care for the population. Initiatives are integrated in several health centres or clinics as in the United States and England [11]. In addition to frontline health care staff, these integrations of psychiatric care also rely on community actors such as social workers, community health workers, local healers and families. In the SAMENTACOM project, community health workers play an important role in outreach care and awareness raising.

This strategy is similar to the PECADOM which consists of taking care of cases of malaria at home via community health workers. These actions facilitate access to malaria care for populations mainly in rural areas in Ivory Coast [2]. According to Hamilton [8], CHWs are closer to the patients and have a better understanding of their living conditions. They are present in the community and establish the link between the patient, the community and the health services. In addition to the health centres, the SAMENTACOM project collaborates with the leaders of the prayer camps and carries out medical care activities with the collaboration of the leaders. Fifty patients were screened, 39 of whom (85%) adhered to the medical treatment, while 15% refused the treatment in favour of religious care (prayer).

According to Coleman [4], in Ghana, the description of the situational state of prayer camps that host and chain people living with mental illnesses contributed to the development of a law in 2012. This law stipulates active collaboration between prayer camps and mental health specialists for quality medical care.

Prayer camps are remedies for people suffering from mental illness because of the spiritual understanding of mental illness in our African societies [13]. Patients sometimes use several remedies in addition to medical care. This is the case in South Africa where patients use both traditional and medical care which has led to forms of collaboration between traditional healers and frontline health workers in setting up community mental health services [3].

5. Conclusion

This study concludes that the integration of psychiatric care into primary care and collaboration with prayer camps is possible for human rights-based access to quality mental health care for rural and peri-urban populations. It shows the need to rethink the place of the psychiatrist or nurse specialist as a medical coordinator and major actor in the strengthening of mental health services. The sustainability of this approach implies a real commitment from the health authorities and its

integration into the action plans of the health districts and regions. A medico- economic study should be carried out at a later stage to evaluate the financing of the regional or national strategy for the development of community-based mental health services.

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