

Mental health services in the Republic of Niger

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The Republic of Niger is a large, landlocked west African country. Around 80% of its vast land mass (1 300 000 km²) is in the Sahara Desert. Its neighbours are Mali, Algeria, Libya and Chad to the north, and Nigeria, Benin and Burkina Faso to the south. The country came under French rule in the 1890s and gained its independence in 1960, but development has been slowed by political instability, lack of natural resources and drought. In 1999, voters overwhelmingly approved a new constitution, allowing for multi-party elections, which were held later that year. An ongoing rebellion in the north makes access to much of the country difficult.

There is a wide diversity of peoples, including nomadic tribes in the north (the Tuareg and Fulani) and settled groups mainly in the south (the Hausa, Zarma and Songhai as well as many others). The majority of the population are Muslim but animist beliefs and ancestor worship are common.

Niger is one of the world's poorest countries, with a gross national income of US\$280 per capita in 2007 (World Bank, 2007). The population is estimated at 14.2 million, over half of whom are under 15 years of age (UNICEF, 2008). The majority are subsistence farmers and over 60% of people live on less than US\$1 a day. Most of the national export income is derived from uranium mining and cattle-rearing.

Health indicators for Niger are poor. The average life expectancy at birth is 58 years for men and 56 years for women. Niger has the highest fertility rate in the world, with an average of 7.2 births per woman, but infant mortality is also extremely high, and one in four (253/1000) children die before the age of 5 years (UNICEF, 2008). In the year 2000, total health expenditure as a percentage of gross domestic product was 3.7%. Per capita total expenditure on health is US\$22, with the government providing US\$9 of this total.

Mental health services

Traditional medicine is the only option available for the majority of the population when they encounter mental or neurological health problems, as there are few modern services outside of the capital city, Niamey. Widely held beliefs that mental illness has a spiritual cause, low levels of literacy, huge distances and poverty are all factors that compound poor access to orthodox psychiatric services.

There are no specialist psychiatric hospitals in the country, but four of the eight regional hospitals have a psychiatry department (Niamey, Tahoua, Zinder and Maradi). There is no specific government budget for mental health other than what is spent in these general hospitals, but even here the budgets

for mental health are not fixed. Despite its focus on policy and planning, the World Health Organization (WHO) gives some regular funds for the provision of psychotropic drugs.

Community-based mental health services are currently limited to the activities of one large non-governmental project in Niamey (Projet de Réadaptation a base communautaire aux Aveugles et autre personnes Handicapées du Niger, PRAHN). These services mainly consist of occasional outreach 'camps' in remote areas, each requiring several days' travel, rather than a constant presence.

Epilepsy is the most common neuropsychiatric disorder that presents. This reflects the stigma associated with other mental disorders and lack of knowledge about treatability, as well as the positive results of basic treatment for epilepsy.

The availability of psychotropic medication is poor, despite a relatively well organised national medication supply system based on the Bamako initiative (Eaton, 2008). Although in principle this should ensure affordable medication is available, of the basic WHO standard list, only phenobarbital, carbamazepine, chlorpromazine, haloperidol, diazepam, benzhexol and amitriptyline are readily accessible in major hospitals. Beyond these hospitals, only phenobarbital and diazepam are routinely available.

Human resources

There are five psychiatrists in the country, all of whom work in the general hospital in Niamey. There are around 30 psychiatric nurses and a similar number of psychologists, again mainly in Niamey (WHO, 2005). The psychiatry departments in the other three hospitals are run by nurses, and a few district hospitals have a psychiatric nurse. Some training of general nurses and physicians has taken place but there is anecdotal evidence that people who present with neuropsychiatric disorders are neglected in primary healthcare settings (Cohen, 2001). The basic mental health training for primary care staff is not reinforced by ongoing supervision.

Until recently, all training for doctors and nurses took place outside the country – in Morocco, Senegal or Burkina Faso. Psychiatrists now receive specialist training in a programme based in the Republic of Benin and France, and one is about to finish this training. Four psychiatrists have trained in the past 10 years. Unlike in many surrounding countries, they have generally remained in the country, apart from one who now works for the WHO. A psychiatric nursing school opened in Niger in 2003. Typically, seven or eight specialist nurses graduate from here every 2 years, all of whom are employed in government services.

There is no national mental health professional association, though there are service users' and carers' groups supporting people with epilepsy and intellectual disabilities. There is some professional interaction with other Francophone African countries (e.g. through the West African Health Organisation, WAHO) and French universities have some academic collaboration with Nigerien institutions. The division between Francophone and Anglophone traditions is a significant barrier to accessing information, given that the majority of journals and online resources are in English.

Research

There has been little systematic epidemiological data collected, but some ethnographic research was carried out in the 1970s and 1980s (Osouf, 1980). A national survey is currently being undertaken by the Ministry of Health as part of the process of policy development and planning.

National policy and plans

A national mental health policy was formulated in 1993, and a national mental health plan was developed with help from the WHO in 1995, revised in 2000 and 2004 (Ministère de la Santé, 2000). Unfortunately, practical implementation of the plan did not progress beyond some training activities. There has been little long-term impact of the principles of decentralisation of services that formed the core of these policies and plan.

Even with strong advocacy, it is unlikely that there will be adequate funds in the national budget for implementation of a programme unless it is supported by an outside agency. This is in common with other sectors, but the fact that mental health is not specifically mentioned as a Millennium Development Goal makes finding resources more challenging. The integration of mental health as a cross-cutting issue within other areas is one option (Prince *et al*, 2007), but working towards a specific mental health policy is also important (Jenkins, 2003).

A good relationship is emerging between the government, the WHO country office, and the non-governmental sector

(a major healthcare provider in Niger), who are working together to revise the national policy and plan. The ultimate aim of this process is more accessible care, in line with recent international initiatives to scale up services in low- and middle-income countries and to ensure that human rights issues are taken into account (Chisholm *et al*, 2007). The national plan also incorporates participation of service users and other stakeholders in order to ensure that the process has a meaningful impact on their quality of life.

A pilot programme of service delivery following the latest evidence-based guidelines (Thornicroft & Tansella, 2004) is in development; it integrates a modified community-based rehabilitation model (Chatterjee *et al*, 2003) into primary care. This takes into account the importance of the non-governmental sector in a country like Niger. If successful, the pilot will be replicated nationwide.

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COUNTRY PROFILE

Psychiatry in Switzerland

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Switzerland – officially the Swiss Confederation – is a federal republic situated in central Europe. It covers an area of 41 287 km² and has a population of just over 7 600 000. Switzerland consists of 26 federated states, of which 20 are called cantons and 6 are called half-cantons. German, French and Italian are Switzerland's major and official languages.

Switzerland has the second highest per capita level of healthcare spending as a proportion of gross domestic product (11.3%). Although there are no exact data available, based on international comparisons, one may assume that at least 10–12% of total healthcare costs are attributable to mental health problems. A characteristic of Swiss society and therefore of Swiss psychiatry is the federal and liberal tradition. Although