

Knowledge and Pattern of Mental Health Care Practices in Buea Health District

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ABSTRACT

Background: According to the WHO, mental health is “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community”. Healthcare providers especially in primary health care play a major role in the management of individuals who are mentally challenged. This study describes the knowledge and mental health care delivery patterns in the Buea Health District. **Methods:** We conducted a hospital- based cross-sectional study in 15 randomly selected health care facilities in the Buea Health district. Structured questionnaires were administered to healthcare providers (doctors, nurses and counselors/psychologists) in the selected health facilities to assess their level of knowledge and type of mental health care rendered to clients in Buea community of the south west region of Cameroon. **Results:** Out of a total of 300 questionnaires distributed, 292 were returned giving a response rate of 99.3%. Of the 292 participants, 117 (40.1%) health care providers had low knowledge levels of mental health disorders. Similarly, 114 (39.0%) of HCP (Health Care Providers) did not practice mental health care delivery in conformity to acceptable standards. HCP who had attained the Masters level of education and who had 7-10 years of work experience were more likely to have good knowledge on mental health disorders (OR = 1.33, CI = 0.10-6.56, *P*-value = 0.030 and OR = 0.51, CI = 0.19-0.59, *P*-value = 0.001 respectively), compared to less trained professionals. Regarding practice, being a female was a most likely factor for good practice of mental health care (OR = 0.82, CI = 0.49 - 0.38, *P*-value = 0.024) compared to being a male. **Conclusion:** Knowledge levels among practitioners of mental disorders and practiced care in the Buea Health District is below acceptable standards. There is an urgent need to train HCPs in mental health and ideal practice situations for the improvement of mental health care delivery in the district and the region.

Key words: Healthcare Providers, Mental Health, Mental disorder, Practice.

BACKGROUND

The World Health Organization (WHO) defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community [1]. Psychiatric disorders are a major burden of illness worldwide, often treated by health providers who are not specialized in managing mental health illnesses in general health facilities. In these facilities, once patients are seen by non-specialist in mental issues, referral to psychiatrists or other mental health expert is imperceptible [2]. This arises in most circumstances for reasons which are attributed to: greater patient comfort with non-psychiatric workers in general health facilities; the desire to avoid being labeled mentally ill; and a long waiting period for a psychiatric consultation. It is therefore important to acknowledge that non-psychiatric health workers in general health facilities play a pivotal role in the diagnosis and management of patients with mental illnesses [3]. Despite the existence of a mental health policy for children and adolescents, Cameroon still remains one of the countries in Africa whose mental health sector remains underdeveloped. It is worth noting that there are only two recognized state owned psychiatric centres (Hôpital Jamot de Yaoundé and Hôpital La quintinie in Douala) in the country [4]. Each Regional Hospital in the country has a mental health unit headed by one or two psychiatric nurses. However, with regard to the burden of mental health disorders in Cameroon which stands at 6.1%, the number of personnel deployed to the regional level remains appalling and insignificant [5]. The field of mental health and psychiatry is one which has been stigmatized by the lay man and even by some health care providers. The training curricula of medical doctors and nurses is biased towards infectious diseases with very little attention to mental healthcare [6]. This training gap may affect knowledge and practices of mental health in one way or the other in the South West Region of Cameroon.

This study therefore aimed at determining the knowledge of and practices towards mental disorders among hospital staff among health facilities in the Buea Health District (BHD). Findings from the study can be useful in revising training and mental health practice policy for better patient outcomes in the district and at the regional level.

MATERIALS AND METHODS

Study Design and Setting

The Buea Health District (BHD) is one of the largest health districts in the South West region of Cameroon with an estimated population of about 300,000 inhabitants on a surface area of over 870 square kilometers [7]. There are 7 health areas namely Muea, Molyko, Buea Road, Buea Town, Bokwaongo and Tole. There are 38 functional health facilities within the 7 health areas. These health facilities include health centers and hospitals which represent the peripheral and intermediate levels of the Cameroon health system classification. Data on the exact number of health personnel in these health facilities is unavailable. There are two mental health nurses and one clinical psychologist within the BHD with all of them localized at the Regional Hospital Buea.

We conducted an observational cross-sectional study of health care providers in 5 health areas in the BHD who consented voluntarily to participate. Health care providers were selected by a consecutive convenience sampling.

Participants and Sampling

The target population was made up of health care providers (medical doctors, nurses and psychologist/counselors). This study population was deliberately chosen because they are expected to provide primary health care which includes early detection of mental disorders. Nurses and psychologists/counselors were included in this study because they are most likely to receive clients from medical doctors presenting with mental health issues for follow up and management either by way of pharmacotherapy, psychotherapy or counseling. In the health set up, medical doctors also receive cross referrals from the nurses and psychologists/counselors. Eligible participants were HCPs who had at least 3 years of work experience and who provided informed written consent. Those with less than 3 years of work experience were excluded from the study because they were likely no to have experienced or managed a good number of cases. Participants were enrolled at their workstations between January to July 2020. Every eligible participant available was approached by the principal investigator either for the administration of the structured questionnaire or for the In-depth Interviews (IDI).

Participation was voluntary and anonymous questionnaires were administered to participants who gave their consent and were to be returned within a one-week period. Questionnaires were anonymous. The questionnaire was pilot tested prior to the survey proper. A total of 300 health care providers agreed to participate in this study but only 292 returned completely filled questionnaires.

Data Collection, Variables and Measurements

Data was obtained using a structured questionnaire which was self-administered. The questionnaire was divided into three main sections. Section 1; which collected information on the key socio-demographic variables of the PHCPs (age, gender, professional category, religion and years of work experience). Section 2 had 12 questions which assessed the knowledge of health care providers about mental health disorders. Section 3 handled key items as regards their practices of mental health care. Knowledge and practice questions were selected from questions found in other studies [8, 9] and the questions were modified or rephrased for better understanding and adapted to our study.

Data Management and Statistical Analysis

Questionnaires were cross-checked to make sure that they were completely filled by the participants. Questionnaires with a response rate of less than 20% were rejected.

Data from the questionnaires were entered into an Epi Info version 7.2.2.6 (*Epi Info™, Division of Health Informatics & Surveillance (DHIS), Center for Surveillance, Epidemiology & Laboratory Services (CSELS)*) and exported to MS Excel 2016 (*Microsoft Corporation. Microsoft Excel [Internet]. 2018. Available from: <https://office.microsoft.com/excel>*) for cleaning. Finally, it was exported to IBM SPSS software version 25 (*IBM Corp. Released 2017. IBM SPSS Statistics for Windows, Version 25.0. Armonk, NY: IBM Corp*) for analysis. Continuous variables such as age and years of work experience were analyzed using frequencies and proportions. Participants' responses were categorized using relative and absolute frequencies and some key findings were represented on bar charts and pie charts. Logistic regression analysis was used to identify the sociodemographic factors associated with knowledge and practice. What do you mean? To determine the level of knowledge and practice, an average score was set at 50% wherein participants who had a grade of <50% of the questions on the knowledge and practice sections

of the questionnaires were considered to have incorrect knowledge or poor practice of mental health while participants who had a grade of $\geq 50\%$ were considered to have adequate knowledge or good practice on mental health care. The significance level of our results was set at $P < 0.005$ while considering a 95% confidence level.

Ethical considerations

Ethical clearance (2020/1152-03/UB/SG/IRB/FHS) was obtained from the Institutional Review Board of the Faculty of Health Sciences, University of Buea. Approval for this study was gotten from the Regional Delegation of Public Health, South West Region and informed consent was obtained from health care providers who met the inclusion criteria. Participation was voluntary and participants could withdraw at any time from the study.

RESULTS

Out of the 300 questionnaires distributed, 292 were returned for a response rate of 99.3%. The characteristics of the 292 HCPs who participated in the study are summarized in Table 1. Most 193(66.1%) of our participants were female. Half 147(50.3%) of the participants were in the age range of 20-29 years. The mean age of study participants was 28.3 ± 5.2 years. A majority 224(76.7%) of them had worked for at least 3-6 years. The sample distribution was as follows: Nurses, 226 (76.0%). Medical Doctors, 41 or (14.0%), and Psychologist/Counsellors/Mental Health Technicians, 29(9.0%). Nurses include: state registered nurses and assistant nurses. Table 1 below shows the distribution by demographic characteristics.

Table 1: Distribution of the study population according to socio-demographic variables

Variable	Category	N	Percent (%)
Gender	Male	99	33.9
	Female	193	66.1
	Total	292	100
Age range (years)	21-29	147	50.3
	30-39	111	38.0
	40-49	24	8.2
	>50	10	3.4
	Total	292	100
Profession	Medical doctors	41	14.0
	Nurses	226	76.0
	Psychologist/counselors	29	9.0
	Total	292	100
Educational attainment	HND	76	26.7
	Degree	144	49.3
	MD	34	11.6
	Masters	33	11.3
	PhD	03	1.0
	Total	292	100

Work experience (years)	3-6	224	76.7
	7-10	54	18.5
	>10	14	4.8
	Total	292	100
Religion	Christian	282	96.6
	Muslim	10	3.4
	Total	292	100

Knowledge towards the aetiology of mental disorders

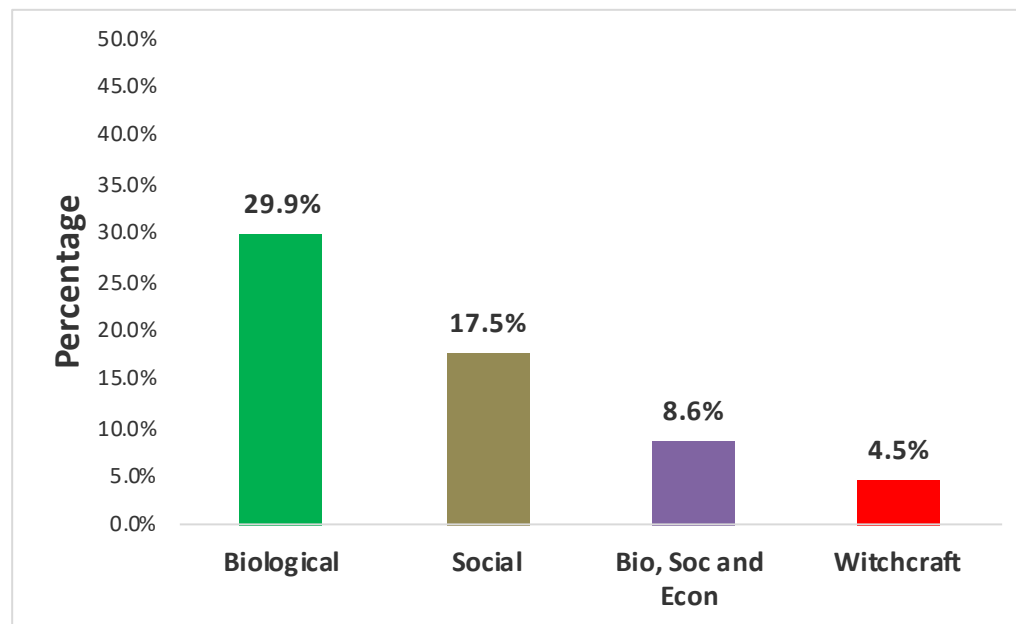


Figure 1: Opinions of health care providers to the cause of mental health disorders

With reference to knowledge and causes of mental disorders, figure 1 shows the opinions of health care providers to the cause of mental health disorders. Eighty-five or (29.9%), [95% CI: 0.24 to 0.35] highlighted the fact that mental disorders were caused by biological factors, 50(17.5%), [95%CI: 0.13 to 0.22] related their cause to social factors, 24(8.6%), [95%CI: 0.05 to 0.12] held the view that they were caused by biological, social, or economic factors and surprisingly, 13(4.5%), [95%CI: 0.02 to 0.07] related the causation of mental disorders to witchcraft.

Knowledge towards the Management of Mental Disorders

More than half of the HCP 189(64.7%), [95%CI: 0.58 to 0.70] did not agree with the notion that mental disorders should be managed in the primary health care settings. Most of the HCP 227 (77.7%), [95%CI: 0.72 to 0.82] confirmed that psychotropic medication and psychotherapy were effective in the management of mental disorders. It was noticed that a majority 177(60.6%), [95%CI: 0.54 to 0.66] did not know the name of any mental disorder. When asked if mentally challenged individuals could make decisions, a greater proportion (58.6%) felt they could not. As to the presenting symptoms of mentally challenged individuals, an overwhelming majority of the HCP 165(56.5%), [95%CI: 0.56 to 0.62] said most of them were violent and

aggressive. Table 2 details the knowledge of health care providers and management views of mental disorders in the Buea health district.

Table 2: Knowledge of health care providers towards mental disorders in the Buea Health district

No	Question	Yes	95% CI
		N (%)	
1	Are mental disorders supposed to be managed in a primary health care setting?	103 (35.3)	0.29 – 0.41
2	In your own opinion, are medication and psychotherapy effective in the management of mental disorders?	227 (77.7)	0.72 – 0.82
3	Are people with mental disorders capable of making decisions?	121 (41.4)	0.35 – 0.47
4	Many mentally challenged persons are neglected and abandoned by family members and even health care providers. Do you agree?	244 (83.6)	0.78 – 0.87
5	Mental disorders are only common in adults. Do you agree?	124 (42.5)	0.36 – 0.48
6	Do you know any medication used for the management of any mental disorder?	173(59.2)	0.53 – 0.64
7	Have you had a specialty in psychiatry?	8(2.7)	0.01 – 0.05
8	Have you had any formal training or attended a seminar in the management of mental health disorders?	87(29.8)	0.24 – 0.35

Practices of Mental Health Care by Health Care Providers in the Buea Health District

When asked if they had consulted or managed a mentally challenged person in their years of experience, majority 176(60.3%), [95%CI: 0.54 to 0.65] responded negatively and 116(39.7%), [95%CI: 0.34 to 0.45] indicated that they had consulted or managed at least one mental disorder (table 3). Upon inquiry about if they use a standard tool (the Patient Health Questionnaire) in the assessment of depression (one of the most common mental illnesses), 26(8.9%), [95%CI: 0.05 to 0.12] of them were ignorant of this tool. A majority of the health care providers 135(46.2%), [95%CI: 0.40 to 0.52] graded the practice of mental health care in their health facilities as poor, 95(32.5%), [95%CI: 0.29 to 0.38] graded it as good while 61(20.9%), [95%CI: 0.16 to 0.26] graded it as very good.

Table 3 represents the practices of HCP in the management of mental health disorders in the BHD.

Table 3: Clinical Management of Mental Health Illnesses by Health Care Providers.

No	Question	Yes	95% CI
		N (%)	
1	Have you consulted or managed a mentally challenged person in your years of experience?	116(39.7)	0.34 – 0.45
2	Do you have sessions in your health facility where you give out mental health education to consulting patients in the waiting area?	15 (1.5)	0.02 – 0.08
3	When an aggressive or violent patient is brought into the health facility, the last thing to do is restraining and sedating the patient.	187 (64.0)	0.58 – 0.69
4	Do you use the Patient Health Questionnaire (PHQ) for the assessment of depression?	26 (8.9)	0.05 – 0.12
5	Are there available guidelines for the management of mental disorders in your health facility?	66(22.6)	0.17 – 0.27
6	Does your health facility refer chronic and complicated cases to the mental health department of the Regional Hospital Buea?	78 (26.7)	0.21 – 0.32
7	Have you been involved in any form of psychotherapy?	170 (58.2)	0.52 – 0.63
8	Does your health facility have basic facilities for the management of mental disorders for example; wards, psychotherapy room?	62(21.3)	0.16 – 0.26

Good and Poor Practices of Mental Health Care

After analysis of the practice section of the questionnaire, it was realized that healthcare providers in the Buea Health District had a below standard practice as regards care of the mentally ill. Only 39.0% of them demonstrated good practice abilities while 65% possessed potentially poor practice skills. Statistical analysis through a chi square test showed a significant difference in practice among the three professional categories (***P-value <0.000***). Further analyses showed that a greater proportion (28.5%) of medical doctors and psychologists/counselors demonstrated good practice compared to nurses (Fig. 2). It was also observed that the proportion of nurses with a poor practice (62.2%) far exceeded those with good practice (37.8%).

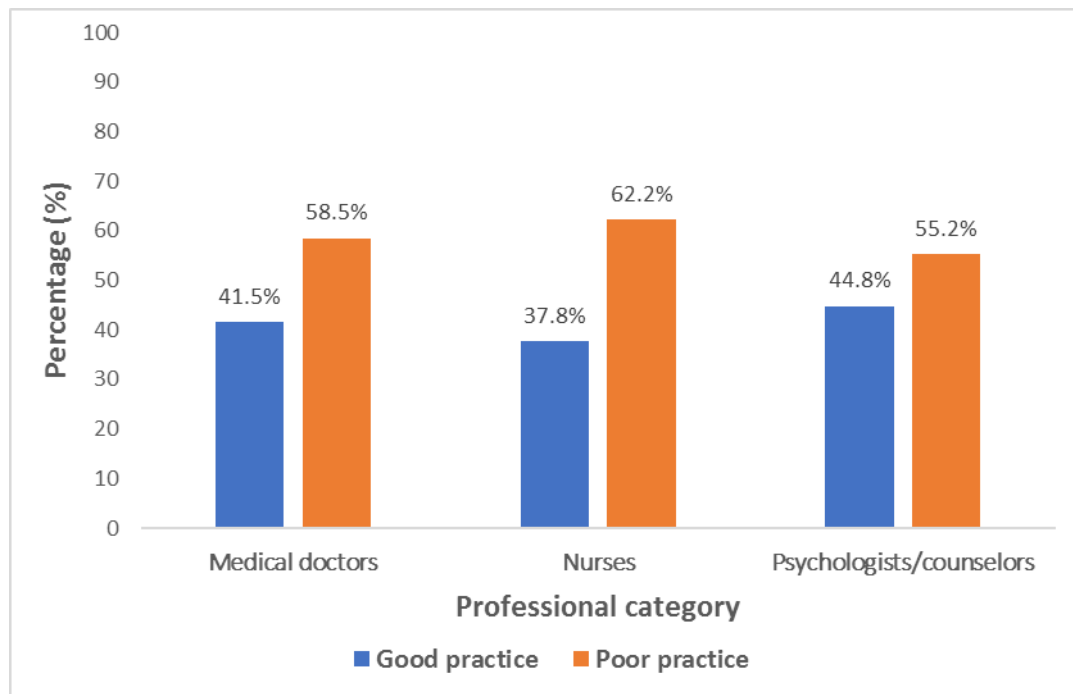


Figure 2: Representation of poor and good practices of mental health care according to professional category

Demographic variables and practice of mental health

In regards to the impact of demographic variables on knowledge of mental health practice, the study did not find any statistically significant differences between knowledge of mental disorders and gender (P -value = 0.933), age group (P = 0.873), professional category (P = 0.786), and religion (P -value = 0.509). However, Logistic regression analysis indicated significant associations between years of work experience and level of education. Health care providers who had 7-10 years of work experience were likely to have adequate knowledge on mental disorders (OR= 0.51, 95% CI [0.19 – 0.59], P -value < 0.001). Again, health care providers who were degree holders were significantly associated with adequate knowledge on mental disorders (OR = 0.70, 95% CI [0.06 - 0.89], P - value = 0.030). Table 4 depicts the relationship between sociodemographic variables and knowledge on mental health care.

Table 4: Relationship Between Sociodemographic Variables and knowledge on Mental Health Care.

Characteristics	Category	Knowledge		OR	95% CI	P-value
		Correct No (%)	Incorrect No (%)			
Gender	Male	40(13.6)	59(20.2)	1		
	Female	77(26.3)	116(39.7)	1.01	0.60-	0.933
	Total	117(39.9)	175(59.9)		1.68	
Age group (years)	21-29	60(20.5)	87(29.7)	0.97	0.13 -	0.466
	30-39	42(14.3)	69(23.6)	0.71	6.95	0.873
	40-49	10(3.4)	14(4.7)	0.60	0.40-	0.457
	>50	05(1.7)	05(1.7)	1	3.79	
	Total	117(39.9)	175(59.9)		0.46-3.77	
Educational attainment	Degree	60(20.5)	84(28.7)	0.70	0.06 -	0.184
	HND	34(11.6)	44(15.0)	0.64	0.89	0.067
	Masters	09(3.0)	24(8.2)	1.33	0.05 -	0.030
	MD	14(4.7)	20(6.8)	0.71	7.43	0.087
	PhD	00(0.0)	03(1.0)	1	0.10 -	
	Total	117(39.9)	175(59.9)		6.56 0.05 - 8.66	
Professional category	Medical doctors	15(5.1)	26(8.9)	2.53	0.41-15.33	0.461
	Nurses	89(30.4)	133(45.5)	1.25		0.786
	Psychologist/Counselors	13(4.4)	16(5.4)	1	0.56 -	
	Total	117(39.9)	175(59.9)		2.82	
Work experience	3-6 years	134(45.8)	90(30.8)	0.40	0.11 -	0.043
	7-10 years	20(6.8)	40(13.6)	0.81	2.47	0.001
	>10 years	07(2.3)	07(2.3)	1	0.19 -	
	Total	117(39.9)	175(59.9)		0.59	
Religion	Christians	114(49.3)	168(57.5)	1.71	0.41 -	0.843
	Muslims	03(1.0)	07(2.3)	1	7.06	0.509
	Total	117(39.9)	175(59.9)			

Table 5 highlights the relationship between sociodemographic variables and the practice of mental health care. From Logistic regression analysis, being female was likely to be a factor for good practice of mental health care among health care providers (**OR = 0.82, 95%CI [0.49 - 0.38], P-value = 0.024**) than being a male.

Table 5: Relationship between sociodemographic variables and practices of mental health care.

Sociodemographic variable	Category	Practices		OR	95% CI	P-value
		Good No (%)	Poor No (%)			
Gender	Male	37(12.6)	62(21.2)	1		
	Female	77(26.3)	116(39.7)	0.82	0.49	- 0.024
	Total	114(38.9)	178(60.9)		0.38	
Age group (years)	21-29	55(18.8)	92(31.5)	0.71	0.09	- 0.781
	30-39	40(13.6)	70(23.9)	1.58	5.18	0.811
	40-49	11(3.7)	13(4.4)	1.59	0.50	- 0.182
	>50	07(2.3)	03(1.0)	1	4.89	
	Total	114(38.9)	178(60.9)		0.55	- 4.59
Educational attainment	Degree	60(20.5)	84(28.7)	1.09	0.05	- 0.424
	HND	27(9.2)	51(17.4)	1.45	21.86	0.889
	Masters	12(4.1)	21(7.1)	1.53	0.07	- 0.712
	MD	13(4.4)	21(7.1)	1.22	29.47	0.722
	PhD	02(0.6)	01(0.3)	1	0.07	-
	Total	114(38.9)	178(60.9)		32.46	- 0.05
Professional category	Medical doctors	17(5.8)	24(8.2)	1.17	0.21	- 0.197
	Nurses	84(28.7)	138(47.2)	1.25	6.34	0.725
	Psychologists/ Counselors	13(4.4)	16(5.4)	1	0.55	-
	Total	114(38.9)	178(60.9)		2.81	
Work experience	3-6 years	87(29.7)	04(1.3)	0.31	0.05	- 0.567
	7-10 years	17(5.8)	37(12.6)	0.52	1.85	0.096
	>10 years	10(3.4)	04(1.3)	1	0.16	-
	Total	114(38.9)	178(60.9)		1.66	
Religion	Christians	110(37.6)	172(58.9)	1.08	0.08	- 0.950
	Muslims	04(1.3)	06(2.0)	1	4.07	
	Total	114(38.9)	178(60.9)			

DISCUSSION

Participants' knowledge and practices on mental health care in the BHD was generally found to be inadequate in this study. Mental health is an important but highly neglected public health aspect in Cameroon. Primary health care providers though deficient in skills to take care of the mentally ill, play a major role in the management of people presenting with mental health problems.

Low knowledge levels observed in our study was also reported by Ndetei *et al.*, in Kenya [10]. However, there was a significant difference in knowledge among the different professional categories with doctors exhibiting the poorest knowledge level. Some of the health care providers attributed the causes of mental disorders to be strictly biological in origin, others attributed them to social factors, others to environmental factors and some to witchcraft. It was however noticed that some of the health care providers associated the causes of mental disorders to emanate from biological, social and environmental factors of which this was a more

holistic approach of visualizing it. Good mental health is put at risk by a range of factors including biological characteristics, social or economic circumstances and the broader environment in which individuals find themselves. Exposure to these risk factors or stressors can lead to a range of mental health problems, especially among more vulnerable population groups like the internally displaced, refugees as documented by WHO [11]. The fact that some of the health care providers had a witchcraft believe as to the cause of mental disorders was an indication that even before becoming health professionals, they had already had their stereotype to these disorders. This was in line with a study by Uys *et al.*, in South Africa [12] and Ewghrudjakpor in Nigeria [13].

More than half of the healthcare providers were against the fact that mental disorders should be managed in the primary healthcare setting. This is contrary to the Mental Health Act, 2017 which stipulates that patients presenting with mental health problems should be admitted in primary health care settings for at least 72 hours and then referred to specialist mental health institutions if more specialized care is needed [14]. Healthcare providers perceived mental health care to be a specialized form of care and with regard to this, they portrayed a poor understanding of primary health care. Providing mental health services in primary healthcare involves diagnosing and treating people with mental disorders; putting in place strategies to prevent mental disorders and ensuring that primary healthcare workers are able to apply key psychosocial and behavioural science skills [15].

According to more than 90% of the respondents, mentally challenged individuals were being abandoned by family members and healthcare providers when in the hospital environment. This finding was in accordance to a study by Dhaar in India who emphasized the stigmatized attitude of health care professions of labeling the mentally ill as mad or as lunatics [16] and contrary to that of Ndeti *et al.*, [10] in Kenya who observed a least stigmatized behaviour by medical doctors and nurses.

Regarding the use of psychotropic medication and psychotherapy, participants had a good knowledge of the fact that mental disorders responded effectively to these especially when considered early into the illness. Healthcare providers who had used a psychotropic medication and had been involved in any form of psychotherapy were aware that these treatment strategies were effective in the management of mental disorders ($P < 0.0001$). This finding was also in line with a study conducted by Mulango *et al.*, [17] in the South West region of Cameroon. Our findings portrayed that healthcare providers were not knowledgeable about the fact that mental disorders are not only common in adults but also in children. This was also in line with a study by Brookman in the United States of America [18]. Common among these mental disorders in Children are Autism Spectrum Disorders and Attention deficit/hyper activity disorders [19].

Our findings with respect to the practices of mental health care indicated that more than half of the health care providers had not consulted or managed a psychiatric patient in their years of experience. This is not an indication that mentally challenged persons are not present in the community or society but it is due to the fear of being stigmatized by the community and sometimes by healthcare providers if they visited the health facilities to seek care. This was a similar phenomenon that was reported by Tawiah *et al.*, in Ghana [20]. Again, nurses in a study by Kapungwa *et al.*, [21] in Ghana reported that many people in need of mental health care avoid

going to a psychiatric hospital for fear of being labeled mentally challenged. For those who acknowledged prescribing at least one psychotropic during their years of experience, Diazepam was the most commonly stated. This is due to the fact that it is the most popular and readily available anxiolytic used to sedate mentally challenged individuals who are violent. Only 8(2.7%) participants accepted to have had a specialty in psychiatry. Mulango *et al.*, [17] in Cameroon recorded even a lower number 2(0.9%) who went for further training on mental health after their undergraduate studies. This is corroborating the findings by Jack-Ide *et al.*, in Nigeria where health care professionals in mental health felt stigmatized by their colleagues [22]. The negative attitude of health care providers to pick up a specialty in mental health influenced their decision to shun this domain of health care.

A high proportion (70.2%) of health care providers highlighted the fact that they had not had any formal training or attended a seminar in the management of mental disorders in their career. This was an indication why the practice of mental health was poor in our study as more time was obviously devoted to the study of infectious diseases than other aspects of health including mental health. Eftu *et al.* [23] in Ethiopia had even a higher proportion of 95.2%. A majority of participants 77.4% denied having guidelines for the management of mental disorders in their health facilities. Eftu *et al.* [23] had contrary results when investigating the knowledge, attitude, and practice towards mental illness service provision and associated factors among health extension professionals in Addis Ababa, Ethiopia. This is likely due to the neglect of mental health in the health system of Cameroon wherein stakeholders hardly dedicate resources be it financial or material (research, innovation, booklets, job aids, flip charts just to name but these) to improve the situation of mental health care in the country.

Few 62 (21.3%) healthcare providers accepted that they had basic facilities in their healthcare facilities like mental health units, restraining areas, psychotherapy room which could improve the management of mentally challenged individuals. This observation was however contrary to what was recorded by Gureje 2016, in Nigeria where in there were 126 outpatient facilities for mental health which were equipped with basic facilities for managing the mentally challenged [24].

CONCLUSION

Primary health care professionals have inadequate knowledge and their practices are below standard in the management of mental disorders in the Buea Health District. This can be ameliorated by making the training in medical schools more holistic and providing refresher courses to health care providers annually on mental health. To add, mental health should be appropriately integrated into primary health care and health facilities should be equipped with basic infrastructure and necessities for the management of the mentally challenged.

References

- [1]. WHO. The World Health Report 2001. Mental Health (2005). New Understanding, New Hope; Geneva Switzerland.
- [2]. Thompson L, Thomas R. Teaching psychiatry to primary care internists. *Gen Hosp Psychiatry* 1985; 7:210-213 2.
- [3]. Jones R, Parlour R. The psychiatric role of the rural primary care practitioner, in *Psychiatric Services for Underserved Rural Populations*. New York, Brunner/Mazel. 1985; pp 92-102.
- [4]. WHO, Mental Health ATLAS 2017. Member State Profile World Health Statistics data visualization dash board. WHO, 2018: World Health Statistics data visualization dashboard; <http://apps.who.int/gho/data/> (Accessed: 29 December 2019).
- [5]. Heiko F., Vitalis N., Fofuleng J. The Challenges of Mental Health Disorder in Cameroon. Master in Peace and Development Work (4FU41E) (2015).
- [6]. Mahlet A. Mental Health Care in Sub-Saharan Africa: Challenges and opportunities (2015).
- [7]. Helders S. Buea". World Gazetter. Archived from the original on 2008-06-13. Retrieved on the 2 hang S, Ong HL,
- [8]. Chang S. Ong H, Seow E. Stigma towards mental illness among medical and nursing students in Singapore a cross sectional study. *BMJ Open*. 2017;7:e018099.doi:10.1136/ bmjopen-2017-0180997th of April 2019.
- [9]. Kapungwe *et al.*, Attitudes of primary health care providers towards people with mental illness: evidence from two districts in Zambia. *Afr J Psychiatry* 2011;14:290-297.
- [10]. Ndetei D, Khasakhala L, Mutiso V, Mbwaiy A. Knowledge, attitude and practice (KAP) of mental illness among staff in general medical facilities in Kenya: practice and policy implications. *Afr J Psychiatry* 2011;14:225-235.
- [11]. WHO. Mental health in primary care: Illusion or Inclusion? Technical series on primary health care. 2019.
- [12]. Uys L, Middleton L. Mental Health Nursing: A South African Perspective. Juta and Company Ltd. Page # 788. 2004. ISBN 978-0-7021-6642-6.
- [13]. Ewhrudjakpor C. Knowledge, beliefs and attitudes of health care providers towards the mentally ill in Delta State, Nigeria. *Ethno Med* 009; 3:19–25.
- [14]. Funk M, Ivbijaro G. Integrating mental health and primary care. *Prim Care*. 2007;34:571-592, vii.doi:10.1016/j.pop.2007.05.007.
- [15]. WHO. Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September, 1978. www.who.int/hpr/NPH/docs/declaration_almaata.pdf (accessed 6 June 2020).
- [16]. Dhaar. Foundations of Community Medicine. Elsevier 2008, Page # 828. ISBN: 978-81-312-1055-0.
- [17]. Mulango *et al.* Knowledge, attitudes and practice regarding depression among primary health care providers in Fako division, Cameroon. *BMC Psychiatry* (2018) 18:66.
- [18]. Richard R. Brookman. Guidance/Committee Opinion/Articles/2017/07/Mental Health Disorders in Adolescents. <https://www.acog.org/en/Clinical/Clinical> (Assessed on: 2020-06-06 09:49:19).
- [19]. Merikangas K, He J, Burstein M, Swanson S, Avenevoli S, Cui L. Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry* 2010;49:980–9.
- [20]. Tawiah P, Adongo P & Akins, M. Mental health related stigma and discrimination in Ghana: Experience of patients and their caregivers. *Ghana Medical Journal*, (2015) 49, 30-36.
- [21]. Kapungwe, A., Cooper, S., Mwanza, J., Mwape, L., Sikwese, A., Kakuma, R., Lund, C., & Flisher, A. J. (2010). Mental illness stigma and discrimination in Zambia. *African Journal of Psychiatry*, 13, 192-203.
- [22]. Jack I, Uys E, Middleton L. Mental healthcare policy environment in Rivers State: Experiences of mental health nurses providing mental health care services in neuro-psychiatric hospital, Port Harcourt, Nigeria. *International Journal of Mental Health Systems*, (2013).

-
- [23]. Eftu *et al.*, Knowledge, attitude, and practice towards mental illness service provision and associated factors among health extension professionals in Addis Ababa, Ethiopia. Int J of Ment Health Sys. 2019 Jan 28. doi: 10.1186/s13033-019-0261-3.
- [24]. Gureje O, Alem A. Mental health policy development in Africa. Bulletin of the World Health Organization, 2000, 78 (4).