

Mental Health and Psychosocial Support in Guinea-Conakry

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LIST OF ACRONYMS

CNRS	Centre National de Recherche Scientifique (France)
CVT	Centre for Victims of Torture (United States)
DRC	Democratic Republic of Congo
DTM	Department of Traditional Medicine
ETUS	Ebola Treatment Units
EVD	Ebola Virus Disease
FMG	Fraternité Médicale Guinée
FGM	Female Genital Mutilation
GF	Guinée Forestière
GR	Guéckédou region
HIV	Human Immunodeficiency Virus
IRCRC	International Committee of the Red Cross
IOM	International Organization for Migration
MHPSS	Mental Health and Psychosocial Support
MSF	Médécins Sans Frontières (Doctors without Borders)
NLEM	National List of Essential Medicines
PFA	Psychological First Aid
PPP	Purchasing Power Parity
RUF	Revolutionary United Front (Liberian and Sierra Leone-based)
WHO	World Health Organization
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNMEER	UN Mission for Ebola Emergency Response

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¹ See ethnographic documentation online, CNRS-MNHN Paris (UMR7206) “Santé, maladie, Malheur” in *Canal U : le webtele de l’enseignement supérieur et de la recherche* : <http://www.canal-u.tv> -> Key words « SMM, Ebola, Marburg »

EXECUTIVE SUMMARY

The World Health Organization (WHO) requested a Mental Health and Psychosocial Support (MHPSS) literature review of countries impacted by the Ebola virus, including Sierra Leone, Liberia and Guinea. International Medical Corps expressed an interest in completing the review for Guinea and commissioned a rigorous review of the literature on pre-existing information relevant to mental health and psychosocial support (MHPSS) in Guinea, in the French and English languages. This report presents the findings using an integrated psychological and anthropological framework that is instrumental in understanding MHPSS needs, and how to devise culturally-appropriate MHPSS interventions in Ebola-affected areas.

The report outlines the key findings of the existing academic and grey literature related to Guinean mental health and psychosocial issues and services, with a specific emphasis on the recent Ebola humanitarian crisis. The review was conducted in June-July 2015 and identified relevant academic publications using academic search engines and databases (Google scholar, Medline, Pubmed, PSYCHinfo, APA psycNET, and Anthrosource). The search was extended through manual searches on Google in French and English, and in the journals: *Social Science and Medicine*; *Culture, Medicine, and Psychiatry*, *Transcultural Psychiatry*; and *Medical Anthropology*. Researchers with relevant expert knowledge were also consulted. The overall search identified academic sources, but also relevant reports, policy documents and internet resources.

The report introduces general background information regarding the population of Guinea, its religions, history, politics, economics and health. It subsequently summarizes information on mental health and psychosocial issues including prevalence, local nosologies, help-seeking strategies, formal and informal resources of MHPSS sources of support. There is discussion of the ways in which causes and course of illness and misfortune are intertwined with plural cosmologies and with individuals' relationships with the living, the dead, the spirit world, and nature itself. Finally, the humanitarian crisis of Ebola in Guinea is explored, alongside responses to it, and its social and psychological ramifications for the affected population.

The scholarly and grey literature available on MHPSS specifically in Guinea was limited and thinly spread over many documents. This presented a challenge when writing this report and we acknowledge that there may have been further relevant material to be found in sources that did not focus specifically on MHPSS, but which it was not possible to obtain within the timescale of the review. Nonetheless, we hope the report can provide useful insights for policy-makers, donors, governments and service-providers.

1. INTRODUCTION

Rationale

The largest outbreak of Ebola in the world to date emerged in Guéckédou, South-East Guinea, at the end of 2013 and was officially declared an epidemic by the Guinean Ministry of Health on 22nd March 2014. The overstretched public health system and international NGOs struggled to cope with responding to the epidemic, as political and social divisions and cultural factors contributed to the virus's spread. As of 2nd August 2015, 3327 confirmed and 452 probable cases of Ebola had been identified in Guinea, with 2522 recorded fatalities. The virus has now been brought under control, but the extent of the deaths, damage to the social fabric, economic loss, disruption to normal grieving practices, and stigmatization that it caused still presents considerable challenges to the Guinean population, and to providers of mental health and psychosocial support. It revealed how little institutional capacity existed to deal with crises of this kind and the need to strengthen health systems and provision. It also showed the importance of contextualized information about the MHPSS needs of the population when responding to a humanitarian emergency.

This report aims to assist governments, UN agencies, and local or international NGOs in a holistic understanding of mental health and psychosocial support in Guinea. We outline key anthropological and psychological points to help understand relevant factors related to MHPSS. We focus on how these dimensions shape some of the challenges that are faced during the Ebola crisis. We therefore present information about the socio-cultural context (Populations, History, Politics, Economy, Health), MHPSS (Prevalence, local notions of the self, nosologies of distress, and the healing landscape), and MHPSS issues in the context of the Ebola crisis (Humanitarian context, History and interventions, and Ebola-related beliefs and practices). The report aims to consolidate MHPSS interventions in Guinea by informing policy-makers, donors, and service-providers' understanding of the various dimensions at stake.

Methods

The method implemented was in line with a suggested methodology from the World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR) toolkit for the assessment of mental health and psychosocial needs and resources (Tool 9). The review of the academic and grey literature was conducted in June-July 2015 in the French and English languages. The following terms were entered in both languages: Guinea (Conakry), mental health, mental illness, psychology, psychiatry and psychosocial. We used the following academic search engines and databases (Google scholar, Medline, Pubmed, PSYCHinfo, APA psycNET, Anthrosource). We complemented these searches with manual searches on Google in French and English, and in the journals *Social Science and Medicine*, *Culture, Medicine, and Psychiatry*, *Transcultural Psychiatry* and *Medical Anthropology*, which provided us with additional sources of information (reports, policy documents and internet resources). We used the following key words: Guinée (Conakry), santé mentale, maladie mentale, psychologie, psychiatrie, psychosocial (Boolean operators: AND, OR, NOT). Key professionals familiar with MHPSS issues in Guinea were consulted, making use of the first author's professional networks. Particular thanks are due to Prof. Alain Epelboin, CNRS, who kindly shared with us his bibliography on Ebola, from which we drew on the sources with direct relevance to Guinea (See Appendix 1).

2. SOCIOCULTURAL CONTEXT

2.1 Land and People

2.1.1 Land

Guinea is a coastal country located on the Western side of the African continent (See map below).



(Sourced from <https://commons.wikimedia.org/wiki/File:Un-guinea.png>, Open Source material)

To the west of Guinea lie Guinea-Bissau and the Atlantic Ocean, while it is bordered in the north by Senegal and Mali, to the east by the Ivory Coast, and to the south by Sierra Leone and Liberia. Possessed of a diverse landscape, Guinea boasts four natural regions: Maritime or Lower Guinea (in French, Guinée Maritime), Middle Guinea (Moyenne Guinée), Upper Guinea (Haute Guinée), and Forest Guinea (Guinée Forestière, GF). Lower Guinea is formed of coastal marshes, an alluvial plain, and the foothills that rise towards Middle Guinea. Middle Guinea consists of the Fouta Djallon highlands, formed of cross-cutting plateaus and valleys. Upper Guinea is mainly characterized by savannahs, and GF features rainforest, highland peaks and some rolling plains around Beyla and Nzérékoré. The country encompasses a total area of 245,857 kilometers within which 10,628,972 inhabitants reside, according to the 2014 census. [1, 3]

2.1.2 Population structure

Guinea's population has undergone important demographic, linguistic, and geographical changes in recent years, with the rise of urban-based forms of livelihood and the effects of a shift in national policy away from socialist principles and towards a more capital-friendly, free market regime.

The country's population is predominantly rural, with 71% of people living in rural areas and sustaining themselves through agricultural subsistence. In recent times, large numbers of young people have migrated to urban areas and mining zones. One particularly attractive hub is Guéckédou, the regional capital of GF and a significant commercial center situated near Guinea's borders with Sierra Leone, Liberia and Côte d'Ivoire. Traders come to Guéckédou from across these countries and the rest of Guinea. A number of non-governmental organizations have also been based here to serve the Liberian and Sierra Leonean refugees. [1, 2]

According to figures from 2009, the sex ratio is 102 men for every 100 women. Nearly 50% of Guineans are under 18 years of age, while only 3% of the population is over 60 years of age. Average life expectancy is 51 years of age for men and 54 years for women. An important factor in the high mortality and morbidity is the low level of economic resources available to Guinea. [19, 69]

Literacy rates were reported in 2008 as 67% for men and 51% for women. However, there is considerable variation by area, with literacy rates in rural zones being considerably lower than those in urban zones. [1, 4]

French is Guinea's official language. Around 24 other languages, each roughly corresponding to the ethnic groups represented in Guinea, are present in the country. Prominent among these are Pular, Malinké, Soussou and Kissi, which constitute vehicular expressions allowing communication amongst people having different languages as their principal modes of communication. Other languages not indigenous to Guinea are also spoken, most notably Bambara, Dioula, Wolof, Krio and Arabic. Nearly three quarters of the country is at least bilingual, while a significant number of people are tri-lingual and even quadri-lingual. French prevails amongst the country's vernacular languages, a fact attested by the fact that 86% of the population claims to know and speak it. [1, 16]

2.1.3 Religious and cultural groups

Guinea's society is fractured along religious, ethnic, and gender-based lines. Religious and ethnic groups are often identified with specific geographical areas of the country. This can lead to regional rivalry exacerbating the other aspects of social division, particularly when political power and the allocation of economic resources and infrastructure between regions is in question. [23]

Regarding the country's religious makeup, 85% of the population proclaims its adherence to Islam. Animist traditions are practiced by 5% of the population and Christianity is observed by 4%. Three quarters of Christians follow Catholicism and 1% observe Protestant evangelical beliefs. Islam is generally observed by city-dwellers and those from the country's upper social classes. [4, 25] Amongst the animist traditions, the religion of the Kissi GF dwellers figures prominently. Their religion is based on the cult of ancestors. Their practices incorporate the use of sacred places in rocks, trees, and ponds as cult sites and spaces of initiation. These may be referred to as *Funda tana* or Luando sola in the Kissi language. The Kissi underwent Christianization in tandem with colonization, initially led by Catholic missionaries and later by Protestant churches, a process that produced a number of syncretic practices within which certain taboos are observed. For example, *gboe* and *gbera* are "taboos" indicating that the sacred places

known to harbor deceased persons, djinns or tutelary spirits are forbidden sites, which should only be approached or entered by those “initiated” or “trained” in communicating with such beings. Any others would suffer harm at such places. [20]

Guinea’s ethnic composition is quite varied, with the country’s population generally schematized into 24 distinct groupings. The largest ethnic group is the Peul, represented by 40% of the population, and the other major groups are the Malinké and the Soussou, which respectively constitute 30% and 20% of the population, followed by the “Forestiers” (the communities that make up the country’s forest region). GF residents are often referred to as the common minority populations of the GF region: Kissi (in Kissidougou et Gueckédou), Toma (in Macenta), Guerzé, Kpélé (in N’Zérékoré), Kono, Kopo, Mano (in Yomou), Kônoé (in Lola) Malinké, Konianké (in Beyla). [4, 20]

Gender roles are embedded within a patriarchal familial structure, which implies that the wives of the head of the family technically belong to their own father’s family, even if they live within their husband’s household. The nuclear family has not attained predominance in more traditional parts of Guinean society, wherein most families form part of clan-like structures encompassing the entire extended family, excepting married women, of the male head of the family. [26, 32]

In addition, gender inequality manifests itself in a variety of domains, notwithstanding the affirmation of gender equality and equity in Guinea’s constitution. Women are predominantly married early or forcibly. As of 2005, 37.9% of girls between the ages of 15 and 19 were married, divorced or widowed. 63% of women aged 20-24 had been wedded before the age of 18. While women are legally allowed to divorce, shared assets and the right to custody for children over 7 years of age are generally awarded to their husbands. Customary rural practices exclude women from land ownership and disallow them from obtaining bank loans, even though they are constitutionally guaranteed the same rights to financial services as men. According to ACAPS, at least 92% of women between the ages of 15 and 64 have suffered at least one act of violence perpetrated by a man, a figure that speaks to the significant degree of gender-based violence women experience. [4] The US Department of State notes that a survey in 2005 showed as many as 96% of women in Guinea may have undergone some form of female genital mutilation (FGM); although the practice has long been illegal, only slow progress has been made towards reducing its prevalence. [62] In terms of their mobility in the socioeconomic sphere, only 18 % of women are represented in the non-agricultural labor industry. On the other hand, a majority of women (74%) dispose of their financial resources according to their own will. Finally, there are gender-based disparities in education, where there are only 83 girls for every 100 boys in primary school and 57 girls for every 100 boys in secondary school. [4]

2.2 Political, Historical, Economic aspects

2.2.1 Brief History

From slavery to independence

Slavery and, in its aftermath, colonialism have proven to be major forces in the creation of socio-political dynamics in Guinea. The European-American slave trade assimilated what is now Guinea into its transnational extractive grip beginning in the 15th century. Guinea was officially named as a French colony in 1893, soon followed by French African regiment incursions into the Kissi, and then Toma and Guerzé lands of the area that presently constitutes Guinea. Northern Guinea was progressively conquered and occupied by the French military into the 1920s. Colonial military invasions were not the only invasive force; Christian missionaries initiated their proselytizing and civilizing campaigns in the region at the beginning of the 19th century. Prominent among them figured the Mendé mission headed by former

slaves who had been emancipated from the notorious Amistad ship². [23]

Guinea ushered in its independence in 1958, the first of the France's former colonies in West Africa to do so, by voting in a referendum organized by the French government. Guineans voted for immediate full-fledged independence. In doing so they were unlike all their West African counterparts, who initially chose to remain under France's economic tutelage and not to seek full-fledged independence until 1960. [4]

Post-independence

The country's recent history can be divided up by three major events. The first of these was its achievement of Independence, won in 1958 and officially establishing the First Republic of Guinea. The first republic lasted until 1984, for the most part under the dictatorial regime of Ahmed Sékou Touré, who came to power upon Independence. Implacable nationalist and pan-Africanist, and great grandson of the celebrated Muslim anti-colonial campaigner and war hero, Samory Touré, Sékou Touré embarked on an ambitious programme to modernize Guinea according to socialist principles. Declaring "Our society is achieved by getting rid of the failings inherited from the past: from the fetishist past, from the colonial past, and from the feudal past," he launched campaigns aimed at the elimination of many traditional spiritual beliefs, practices and social hierarchies, leading to the destruction of many venerated magical objects ('fetishes') and the dismantling of local cults [34, 46]. This 'modernizing' legacy stoked tensions between GF, where traditional practices were particularly strong, and central government. [4] Over time, his dictatorship became increasingly repressive. After Touré's death in 1984, a military coup led by Lansana Conté inaugurated a new government, forging the Second Republic Guinea. Conté's reign was characterized by a strong emphasis on pro-market policies, notably in order to attract investors in the mining sector. In 2008, upon Conté's death, the military dictatorship of Moussa Dadis Camara came to power, promising reforms. In 2010, Dadis Camara suffered gunshot wounds to the head in an assassination attempt, was flown to Morocco for treatment, and then exiled to Burkina Faso. A transitional government was appointed pending the holding of viable elections. The Third Republic under Alpha Condé emerged following elections in 2010 and continues today. [4]

2.2.2 Political history

Political landscape

The colonial period lasted from 1893 until 1952 and left a deep imprint upon Guinean history. The country's current political situation is rooted in a colonial and postcolonial context that led to the fragmentation of the sociopolitical sphere along ethnic lines. Its social landscape today is influenced by the population's experience with 'Western' influence and its own complicated inter-ethnic relations. [20]

Colonialism in its formal sense did not begin until 1893, when French Guinea became an official colonial territory after having been an administrative dependency of French Senegal since the 1860s. However, the region's incorporation into an exploitative transnational economy dominated by Europe was first initiated in the 15th century with the exportation of iron and, soon thereafter, the slave trade. Local Manding warlords battled against one another, all while simultaneously exploiting colonial rivalries, for shares of the slave market that extended from the country's interior to its coast. The French African regiment occupied GF in the 19th century, in what became a prolonged military occupation that endured until the 1920s, though the region maintained a vigorous resistance. Christian missionaries also attempted to spread their influence as early as the 19th century, though they were never able to eclipse Islam and Arabic scholarly and medical schemas, which had been salient aspects of regional life for centuries already. [20, 23]

2 This ship was the site of a famous slave revolt in 1839 by Mendé captives enslaved in Sierra Leone.

Some have asserted that the slave trade acted as a major influence on the development of cultural and religious practices, as well as political traditions, in the region. Such schemas include: the fear of anthropophagous, unpredictable spirits (thought to be transposed representations of murderous slave traders) and suspicions of deception by witches who may harm or exploit their communities (figures that likely echo slave-era betrayals or breakdowns in community bonds precipitated by communities' selling of their own members into slavery). Initiation societies born of local political and religious orders may also have been formed partly in reaction to slavery, as local leaders sought to develop alternative political and cultural structures to those of the official colonial government, by developing local cults and regional political federations defined by freedom from slavery, trade monopolies, and military infrastructure. Indeed, political and religious orders became intertwined, beginning with the collusion between Manding (Muslim warlords) and colonial slave-traders, forging a local religious configuration against white Christian (colonial) and Muslim (Manding) groupings. [23] Though Sékou Touré's government strove to suppress these societies, along with many forms of traditional practices in the name of modernizing the state, some have been partially revitalized following Touré's death as government policy became less hostile. [10, 46, 47]

People's contentions with official authority are rooted in colonial history and have partially shaped their resistance to the policies and practices instituted by formal governmental authorities to manage the Ebola crisis. The former sites of labor recruitment under colonialism are now the places where Ebola has taken its greatest toll. This is attributable to the fact that such extractive policies as forced labor were achieved under the colonial regime by placing local political chiefs from powerful families in roles that let them further exploit subordinate families, who themselves were often direct descendants of slaves. From this arrangement emerged two strategies of resistance to official political authority, which are still seen today: 1) bribery and secret societies, offshoots of those undertaken during the slavery era as means of undermining the effective exercise of power by local appointees representing central authority and 2) the organization of political appointments in such a way as to ensure that those designated to hold official positions under the colonial regime held little real sway within local communities. Communities in GF may sometimes prefer the traditional justice system – presided over by village chiefs and elders – to the official one, although there is often considerable movement of cases between the two. [4, 23]

In the aftermath of colonialism, this framework of tensions persisted with the nominally revolutionary politics heralded by Ahmed Sékou Touré's Revolutionary Communist State. Distrust of state actors, and the popular perception that any influence they might try to exercise over local affairs had no real legitimacy, persisted after independence. The country's first post-colonial government engaged in practices that closely resembled those of the formal colonial regime - forced labor taxes with an emphasis on production. Some of these programs were even amplified under his regime, motivating the departure of numerous Guineans to Liberia and Sierra Leone. [23]

Today, internal conflict between ethnic groups associated with specific political parties continues. The presidential elections of 2010 and legislative elections of 2013 provoked massive contestation and were the sites of electoral violence along ethnic lines. Since then, ethno-political tensions have continued. The 2015 presidential election took place as scheduled in October 2015, and was won by the incumbent, Alpha Condé. [4, 14]

Recognizing the social and political challenges that the country faced, in 2011 Guinea became the first country ever to refer itself – as opposed to being referred by the Security Council – to the UN Peacebuilding Commission. This took place in response to violent repression and organized rape against pro-democracy protestors by the military on 28th September 2009 and to the legacy of military dictatorship. The Commission's involvement reinforced work to strengthen civil society and human rights in Guinea, though many challenges remain. [61]

Inter-ethnic tensions

Inter-ethnic tensions often lie at the core of political tensions. The ethnic groups residing in GF, for example, have forged political structures in response to specific colonial experiences. In this region, a fragmented, non-hierarchical and uncentralized structure existed amongst the Kissi ethnic group prior to the arrival of French colonizers. French attempts to impose their political authority thus met with fervent resistance. The Peul, on the other hand, had more hierarchical forms of sociopolitical organization prior to the arrival of French colonizers and were thus more receptive to the political structures that the latter brought with them. This difference is reflected in the relative absence of reticence in the area inhabited by the Peul, namely Fouta Djallon region, to observe the counter-measures of the Ebola response. [4]

Socio-political tensions are marked, as well, in formal politics. In this sphere, two principal ethnic groups, the Peul and the Malinké, compete for power, while forest-dwelling groups have been less represented (save for the brief military government of Captain Moussa Dadis Camara, of Kpéllé origins, in 2008-2009). In the forest region, defiance of central government has persisted, and some inhabitants proclaim their deeper communal and familial ties to inhabitants of Sierra Leone and Liberia, where some of their ancestors fled during the colonial period to escape imperial authorities. Lack of trust in state-based politics and authorities was fuelled in the region by memory of campaigns under Sekou Touré's government to eradicate traditional belief systems. The survival of traditions in the face of persecution has often reinforced a sense of distinctive identity and the deeply held importance of cultural practices. [4, 23, 34]

2.2.3 Economy

Severe poverty, obdurate impediments to accessing fundamental social resources and services, and persistent sociopolitical strife, have had a profoundly negative and systemic impact upon social and economic development programs in the country. Despite being endowed with natural resources and minerals, such as bauxite, iron, gold and diamonds, Guinea is among the region's poorest countries, and is classified as a low-income country according to the World Bank's 2010 criteria. Until the 1990s, and again in recent years, mining has provided more than 20% of the country's GDP. However, a remarkably small proportion of the revenues acquired through the industry have benefited the local population and corrupt contracting and exploitation practices have played a role in stoking ethno-political tensions. In 2011, just after Dadis Camara's departure from power, the Condé administration passed policy measures in an attempt to reduce such corruption, to little or no avail. The implementation of policies favorable to foreign investors and enterprises motivated large mining companies to recommence their activities, which they had halted during the international trade embargos and economic sanctions imposed on Camara's regime. Within the year, mining made up more than 25% of GDP and 95% of exports, while the economy's annual growth has proceeded at a feeble rate of 2.97% and local consumption has continued to decrease. [4]

Over the last decade, the country has undergone a degenerative and unrelenting economic crisis. The majority of the population subsists through agricultural means, though recent modernization has encouraged the flight of younger generations from the countryside into the cities. Common crops in Forest Guinea include rice, cassava, sweet potatoes, plantains and corn, which are farmed for subsistence or for income. In more urban settings, small-scale professions, such as mechanics, wood-working, and craft activities abound, fashioning objects for both local and distant markets. [1, 4, 32]

In terms of class divisions, homes and familial networks range from comparatively affluent to sufficiently resourced, to impoverished. According to the World Bank, Guinea was 179th in the world in equality of income distribution in 2013. Against this backdrop of poverty and minimal state provision, urban and rural households alike rely heavily upon large kin structures for both socioeconomic support and protection against vulnerabilities associated with ill health. [32, 63]

Poverty and social unrest have been aggravated with the institution of a clandestine narcotics trafficking network in Guinea, which over recent years has become a major transit point for drugs being funnelled from Latin America to Europe. The informal narcotics economy was initiated in the 1980s and has recently gained momentum through the constitution of stronger trafficking networks. Young urban dwellers, casualties of the economic crisis, bereft of job opportunities, and suffering from boredom and the hardships that bear unrelentingly upon their daily lives, are particularly vulnerable to these drug trafficking-schemes. Farmers suffering the effects of the economic crisis have also turned to cultivating marijuana, a sack of which can offer proceeds that amount to one year's worth of traditional agricultural crops. [1, 3, 20, 32]

2.3 General health aspects

Maternal and infant mortality

Women and children represent particularly vulnerable groups when it comes to morbidity and mortality outcomes in Guinea. Maternal mortality reaches a figure as high as 724 for every 100,000 live births in 2012 while infant mortality rates might reach 67 per 1000 live births. Such deaths are mostly due to transmissible infectious diseases – malaria, HIV, tuberculosis - for which treatments remain difficult to access. [1]

Mortality and morbidity across the population

Diseases that have posed significant recent threats in Guinea include meningitis, yellow fever, measles, and cholera. During the first trimester of 2014, Southern Guinea became the epicenter of an epidemic of Ebola hemorrhagic fever that struck West Africa in full force, displacing these afflictions as primary public health priorities. [1]

According to a 2001 census, the number of people aged 15 to 49 living with HIV throughout the country was 55,000, which translated to a global prevalence rate among adults of 1.5% in 2000. Studies have suggested that an important factor in this is lack of information regarding modes of transmission, which gives rise to false beliefs and ideas about risks that cause heightened susceptibility to infection. Religious messages have sometimes promoted such false beliefs and ideas. [56]

Chronic diseases, such as diabetes, have also become significant. 3.5% of the adult population suffers from diabetes, with urban-dwellers twice as likely to develop the disease as those living in the country's rural zones. [31]

Health system

The formal health system operates through a pyramidal framework integrated within the government's larger administrative apparatus. The Ministry of Health designs health policies and allocates central funds to regional administrators. They in turn implement policy on a regional level. Below this is the Prefectoral health administration, homologous with the role of the WHO's health district, and operating through village health centers. [4]

Since the 1980s, primary health care has indeed become a focal point for Guinean governmental policy, which has tended to place a great emphasis on prophylactic, therapeutic, and health-maintenance services. The village health centers are reachable by 90% of the population, and assure 75% of the

population's healthcare costs.³ They partake in the prefectoral health system cited above and provide the principal source of care for people outside of the capital. Administrators attempt to compensate for operating expenditures by charging for therapeutic services. NGOs have also taken on a significant role in providing resources for such centers in the form of personnel, infrastructure, or delivery support. Because medicines and treatments have been largely eliminated from public expenditures, non-state, informal markets have emerged in the form of private pharmacies in urban streets and "table-top sellers"⁴, in urban and rural markets who purvey biomedical, as well as non-biomedical medicinal products. These unofficial health workers include Islamic practitioners, herbalists, and local healers venerated by the public for their specific expertise and ability to wield such unorthodox therapies. [31]

Guinea's national policy on traditional and complementary/allied medicine dates from 1994. [64] Formal organizations exist to support, manage and/or regulate traditional healing. A Department of Traditional Medicine (DTM) exists within the Guinean Ministry of Health and has collaborated with traditional healers on primary health care in the country since 1979. [55] However, there are some tensions between the DTM and healers; the latter recently accused the Department of mismanaging funds intended to support their training and activities [54], and researchers have found that few individual healers choose to register with the DTM [17]. Healers may seek to join the national Traditional Health Practitioners' Association or local associations. Public health officials have found working with these associations and healers on training and community education to be an effective strategy in dealing with health crises such as HIV/AIDS and Ebola. [55, 68]

3 There is a gap in the information available regarding the forms of correspondence that occur between prefectoral community health centers and the various health structures. There is, however, a system of correspondence between psychiatrists and neurologists operating in Conakry and N'Zerekore, where the two main mental health facilities are located.

4 The term "table-top sellers" generally refers to merchants selling a mixed collection of formerly discarded medications or medical goods, ordinarily arranged on tables in large collective marketplaces.

3. MHPSS FRAMEWORKS, ISSUES AND SERVICES

3.1 Frameworks for biomedical mental health services

Mental health policy and national plan

The mental health policy and national plan in Guinea was initially formulated in 1995 and further developed in 2000 and in 2013. The tenets set out in the plan were advocacy, promotion, prevention, treatment, and rehabilitation. It was organized around decentralization and integration of mental health services into primary health care. Mental health services and resources were to be transferred from hospitals to community-based facilities, including a provision for children and adolescents with disabilities. However, the Ministry of Health still needs to agree and validate it officially and the plan is not currently operational [49]. The process of agreement and validation has been obstructed by the Ebola epidemic becoming the country's public health top priority. Nonetheless, the crisis has perhaps also provided space for the possibility of integrating mental health within the overall health package within primary and secondary care structures, where it is not currently included, and a revision process of the national mental health policy is in progress in late 2015, with WHO involvement. [1, 59]

A working group on MHPSS was created in February 2015 under the lead of WHO [1], but has since merged with the Ebola survivors group (Capucine de Fouchier, personal communication). This working group recommended the establishment of a coordination structure for all organisations involved in mental health and psychosocial support, in the form of a national consultative committee under the lead of the national coordinator for mental health within the Ministry of Health. However, at the time of this review, concrete steps had not yet been taken to realize it. The child protection working group within the Ministry of Social Affairs, is active [1], but there is little coordination with MHPSS activities focused on adults (Capucine de Fouchier, personal communication).

The WHO is providing several trainings to frontline health professionals. Physicians and nurses in primary health care are receiving training on the management of mental health disorders using the mhGAP Intervention Guide. As of the end of October 2015, 25 national mental health actors and 245 primary health care physicians and nurses had been trained in the Ebola-affected areas and more training is planned (Capucine de Fouchier, personal communication).

Substance abuse policy

A substance abuse policy has existed since 1999 but it is uncertain whether it has been reviewed, and what type of standards on treatment and prevention it is using. Treatment centres specialised in substance abuse or alcohol consumption and harm reduction programs are unavailable nationally, though one psychiatrist based at Donka hospital has specialist training. Consequently, the Donka psychiatric ward serves as the national reference unit for alcohol and substance abuse (Capucine de Fouchier, personal communication). A few NGOs are involved in treatment but the main challenges remain in training and funding. [1, 8, 41]

Mental health legislation

There is no legislation specific to mental health in Guinea. It is instead incorporated within the wider general health legislation with a dedicated chapter that specifies provisions relating to prevention, protection, and treatment (Chapter 11, article 209-221, Public Health Code, Republic of Guinea) enacted in 1997. Measures related to mental health are absent from other existing legislation (e.g. welfare, disability, general health). [18, 41, 66]

National therapeutic drugs policy/Essential list of drugs

A National List of Essential Medicines (NLEM) from the WHO's List of Essential Medicines (2009) is used

in the country. The list⁵ consists of psychotropic medication and anticonvulsants/anti-epileptics. The medicines recommended on this list at secondary health care level are: carbamazepine, phenobarbital, phenytoin sodium, amitriptyline, chlorpromazine, diazepam, fluphenazine, haloperidol, and lithium. From this list however, only phenobarbital, chlorpromazine and diazepam are usually available at primary care level. These medicines are expensive and frequently unavailable, which in turn pushes patients and their families to purchase cheaper unregistered medicines that are available in local markets.

Psychiatrists and generalists can prescribe medicines from the above list, apart from lithium carbonate which only psychiatrists can prescribe. Primary health care doctors and nurses can prescribe and/or continue the prescription of psychotropic medication with certain restrictions. However, the Ministry of Health does not allow primary health care nurses to diagnose independently and treat mental illnesses in primary care settings. [18, 41, 66]

There is limited training available in Guinea for the various professionals involved in the field of mental health. For example, most primary health care nurses and doctors have not received any in-house related training for the past five years, though this is currently being remedied by the WHO mhGAP training mentioned above. Officially approved procedures for referral between tertiary/secondary care and primary care are also lacking. [41, 66] It is not possible to undertake medical specialization in psychiatry within Guinea [2] and the 5 psychiatrists in the country all studied their specialty in Ivory Coast (Capucine de Fouchier, personal communication).

Mental health expenditure

Guinea has limited financial and human resources with which to put into action its national plan to strengthen mental health support services. Overall health expenditure is limited to 5.73% of Gross Domestic Product and \$9 per capita government expenditure on health (PPP [Purchasing Power Parity] \$). Details on the Ministry of Health's expenditure for mental health and for psychiatric hospitals are unknown. A dedicated budget is not allocated to mental health as a whole and the government only budgets for staff's salaries. Guinea does not have provision for mental health disability allowances, which has a direct impact on the accessibility of services. As a result, the patients or their family are the primary funders of mental health-related expenses, when it comes for example to food, medicines and hygienic products during hospital-stays. [1, 41, 66]

Mental health and psychosocial human resources

Human resources in the MHPSS sector are limited in Guinea as Table 1 demonstrates. There is limited training available to train clinicians in mental health to strengthen support services in the country. For example, there is no psychologist training or specialization in psychiatry available. [1] Moreover, the workforce is concentrated in Conakry; all 5 psychiatrists are based at Donka hospital [49]. These figures are below the average for the West African region.

5 See details in the *Public Health Code* produced by the Republic of Guinea in 2012, page 28 and 8-9.

Table 1: MHPSS professionals available in Guinea according to the 2014 census (adapted from Abaakouk, 2015 and Psychology in Africa, 2013) [1, 41]⁶

Mental Health professionals	Number available in Guinea	Number per 100,000 population
Psychiatrists	4	[.038] (WHO, 2011 median rate: 1.27)
Child psychiatrist	1	[.0094]
Trained generalists	13	[.122] 0.122 (WHO, 2011 median rate: 0.34)
Psychologists	10 or 11 ⁷	0.10 (WHO, 2011 median rate: 0.30)
Psychiatric nurses	0	0
Trained nurses	12	[.113] 0.112
Social workers	2 (Based in the ministry of social affairs)	[.019] 0.018 (WHO, 2011 median rate: 0.23)
'Educators'/Youth workers	1	[.0094] 0.009
Neurologists (and neurologist specialists)	9	[.085] 0.04
Neurosurgeon	3	[.028]
Generalists trained in Neurology	4	[.038]
Nurses	6 or 7	.06

3.2 Specific mental health issues

Prevalence in the general population

There is currently a real gap in the availability of epidemiological data on the prevalence of mental health issues in Guinea within the published academic literature, and in policy in the past years. [41, 63] Neuropsychiatric disorders contributed to 6.5% of the global burden of disease in 2008. During the mental health consultations completed throughout the country in 2014, the most frequent descriptions of mental health issues were manic episodes, delusional disorders, confusion, psychosis and epilepsy. Consultations were also sought for psychomotor retardation, depression, and follow-up for difficulties related to HIV and experiences of sexual violence. Information related to the suicide rate is not available. [63] In terms of addictions, the most highly consumed drugs are cocaine, cannabis and alcohol. In Donka hospital, a general public hospital with the only psychiatric ward in the country, 80% of the patients that consulted for psychiatric care between 1984 and 1994 did so for drug addiction. [8, 20, 56]

6 The most recent version of WHO Mental Health Atlas (2014) gives all mental health workforce figures for Guinea as 'Not provided.'

7 This number was calculated retrospectively from the size of the 2014 population census and the number of psychologists for each 100 000 people. [1]

Prevalence in the conflict-affected population

Guinea has also been affected by the armed conflicts and civil unrest that occurred in its neighbouring countries, starting first in Liberia (1989-2004), and spreading across Sierra Leone (1996-2002) and Ivory Coast (2002-2007 and 2010-2011) (See Section 4.1.1). Violence also spread across Guinea in 2000-2001 led by both the Liberian and the Sierra Leone-based Revolutionary United Front (RUF). The communities mainly affected were in the region of GF, Guéckédou in particular. A 2004 study focusing on predictors of psychological and physical distress of these communities, identified the importance of understanding locality, local histories, type of traumatic experiences populations were subjected to, and the ways in which these traumatic events shaped social relations. The authors argued that 65% of the individuals interviewed from these war-affected communities presented with significant psychological distress. Respondents reported the following symptoms: 84% traumatic symptoms, 79% physical anxiety, 74% the presence of three or more somatic symptoms with sadness and guilt, 62% a majority of symptoms of emotional anxiety/fear, and 48% reported two or more symptoms of depression as 'present'. [2] Another study in GF that focused on the marginalized children in this region who were mostly conflict-affected, indicated that 75% had wished to be dead on at least one occasion, 70% of girls and 80% of boys were considered to be at serious risk of suicide, and 30% had already tried to kill themselves. [9]

The suffering of these conflict-affected communities was amplified by a feeling of abandonment from their government and NGOs in assisting them in the reconstruction of their homes, market places, and in making available the necessary public infrastructure. Similar to the refugee population, these communities' struggle for economic survival and their inability to contribute meaningfully to their communities heightened their emotional distress. [2, 15, 53] Their concern also impacted on their ability to participate in social rituals and practices (e.g. *Porro* or *Sande* [men and women's secret societies, respectively], funerals, baptisms, family meetings and other social events) and therefore to access informal social coping mechanisms.

Prevalence in the Ebola-affected population

At the time of writing, no results were identified from available prevalence studies of mental health issues in Ebola-affected areas of Guinea. However, it is widely acknowledged that MHPSS is a significant concern in the wake of the Ebola virus outbreak (see Section 4.3.3).

3.3 Local conceptions and nosologies of distress, loss and trauma

In many parts of Guinea, people draw on a wide variety of frameworks to understand health and illness. Biomedical models are only one among many accounts that may be drawn on to understand the causes and course of illnesses and misfortune. Co-existing frameworks reflect cosmologies in which the individual person is situated within a constellation of relationships with the living, the dead, the spirit world, and nature itself. Thus possible causative factors that might be considered in cases of sickness are the consequences of violations of the natural order the actions of the dead, of non-human spirits (*djinnns*), sorcery, divine punishment, and experiences of violent conflict.

Violations of the natural order

In GF, there is a natural order that should be observed. When actions are committed that do not respect these restrictions, they may bring on *maa*, a disruption of harmony that can lead to such consequences as sickness or economic misfortune. [11] For example, the reproductive cycles of humans, plants and animals are part of this order and Fairhead describes how imperative it is that each respects the proper boundaries of space and time. Hence people should not have sexual relations in the bush (the domain of animals) rather than in the village; mothers should not have sex while breast-feeding a child, as such a lack of self-control would be to start a new cycle before the previous one has completed and it is feared

that the man's semen may enter the breast-milk and sicken the child [36]; pregnant women should not care for the dying, as this is to confuse the cycles of birth and death [22]; menstrual blood should not enter the fields where crops grow; seeds from one year's harvest should not be mixed with the next. To disregard these obligations is to court infertility, drought and / or sicknesses that may afflict the perpetrators, the child, or the crops.

Ancestors

Illness or misfortune may also be brought about by the dead. It is as important that people die 'correctly' as it is to maintain order in the natural world. Examples of infractions that can have serious consequences include: death occurring in the bush rather than the village; debts and credit not being settled correctly before the deceased is ready to leave for the next world; the dying not being given the food and drink they request [22]; the appropriate funerary gathering and farewell not being held. [23] Any of these, whether intended or not, may prevent the deceased from moving on to the afterlife, causing them to remain as a wandering spirit and punish the negligent, as well as other relatives.

Family and social bonds are as important when dealing with dying and death as they are in life. It is important to care appropriately for the dying, to take note of and honour their last words, to settle outstanding debts and other matters, and ideally to transport them back to their home town for funeral and burial arrangements to take place. In GF, consultations may take place with the deceased (or with a substitute made from their clothes, hair and nails) through the intermediary of a diviner, if there are reasons to ask about the cause of death; this may reveal whether sorcery was implicated and whether there is a need to counter it [23]. Many funeral practices are intended to help the soul on the long journey to the afterlife and the deceased may therefore be buried with money or provisions. [13] If procedures are not carried out correctly or adequately, the soul may not be able to depart and may remain to haunt the living as a wandering spirit.

Djinns

Djinns are spirit beings that inhabit areas of the bush. For example, the Baga of the Upper Guinea Coast describe them as the original inhabitants of the land. [46] Also known as *diabes* (devils), they are not necessarily evil as such, but may cause serious harm to people – sometimes in the form of illness – if not treated with respect or if the whim takes them [22, 33]. Past cases in Conakry and Labé where groups of young women experienced possession trance have been attributed to *djinns*. [20] Among other illnesses sometimes attributed to *djinns* in GF are idiocy, madness, paralysis and convulsions. [36]

Sorcery

It is not just *djinns* and the dead who have supernatural powers to harm, but also some of the living. Belief in sorcery is common in Guinea. Sorcerers are distinguished by their selfishness in the pursuit of power or wealth, and suspicions of sorcery sometimes fall on those who appear reclusive or accumulate rather than share what they have, thus failing to fulfill their social obligations. Belief in sorcery thus expresses core values of egalitarianism and community [46], and provides a way of making sense of how some individuals in the modern world seem to enrich themselves very suddenly while most remain poor. Sorcerers may send harm to others through magical means. [23, 31]

Divine punishment

It is sometimes said that all illnesses come from God, as do all cures. Illness may then be a form of punishment for not observing one's obligations to God. [60]

Experiences of violent conflict

The violence suffered by communities in GF as the result of attacks by Sierra Leonean and Liberian forces has been blamed for some forms of ill-being there. In the aftermath of those raids, it was reported

in some towns and villages that 'craziness' had increased among the residents as a result of the trauma of what they went through. Constant fear, inability to think clearly, substance misuse, reluctance to talk to each other, and sadness were highlighted, particularly where there was a sense of abandonment by outside help and where collective community cohesion had not recovered [2]. Experiences of trauma were also reported among residents of the refugee camps that existed in GF, with the condition *haypatensi* ('hypertension') popularly used to label the symptoms that resulted from thinking too much about the fears and suffering resulting from the war. *Haypatensi* is linked to the older condition known in Mendé as 'spoiled heart' and though it is clearly influenced by biomedical notions of 'hypertension,' differs from it in important ways. It is characterized by heart pain and rapid heartbeat and cramps, which stem from the damage that heavy emotional turmoil inflicts on the heart, and may be treated either pharmaceutically or by resting and trying not to dwell so much on one's losses and anxieties. [28]

A study carried out into how epilepsy is understood illustrates the range of interpretations that may exist for a mental health condition. 320 respondents were interviewed and asked to what causes they would attribute epileptic symptoms. The range of answers included: the person's mother failing to observe certain precautions around bathing during pregnancy; sorcery; the action of a night-bird called the *mamadabi*; eating the meat of an animal which had been bitten by a dog; sexual relations between the person's mother and her brother-in-law; the person's parents having sexual relations after a funeral without first bathing; whirlwinds sent by a *djinn*; failure to observe Koranic laws; and transmission through the saliva of another epileptic person. There was a degree of consistency in answers given by members of the same ethnic group, but even here there could be considerable variation. Among the Manding, it was suggested that epilepsy was a sign that the person affected would become a king later in life. However, strong stigmatization of epilepsy was more common. This was not limited to members of the public, as many health professionals also expressed wariness of people who have epilepsy. [50]

3.4 Concepts of the self, person and life course

It is difficult to generalize about concepts of the self, person and the life course, as they may vary significantly among the many different ethnic groups and communities of Guinea. Two historical processes have influenced selfhood in ways that vary between communities: Islamization and the First Republic's modernization campaigns. Both eroded traditional practices and worldviews that centered on local cults or initiation societies. These societies had previously held secret religious, ritual and magical knowledge, and guided the initiation practices that marked individuals' progress through the life course. Islamic reformers from among the Peul, Malinké and Sousou had already started to erode traditional practices and views of the self, which they viewed as heathen, among other ethnicities before independence was gained. Sékou Touré's modernizing 'demystification' campaigns (1958-1984) then further suppressed the initiation societies, burning ritual objects and publicly exposing their secrets. However, the initiation societies were never fully suppressed in GF, as people had cross-border links with Liberia and Sierra Leone where the societies' practices were not forbidden. [10, 23] In other parts of Guinea too, notably on the coast among the Baga, some groups have recovered former 'customs.' However, both on the coast and in GF, some community members strongly condemn traditional practices as un-Islamic or backward, though there are often disagreements about this within communities. [10, 46]

Initiation societies institutionalized a pathway through which young men could gradually achieve the power and respect owing to older men. Though initiation rituals varied from one area to another, they commonly took place for young men at around the age of fifteen. These young men would spend several weeks away from their families in the woods, during which time they symbolically died and were reborn, in order to enter into adulthood and progress over time to a position of seniority [24, 46]. Today, women's societies are in some areas more vital than those of men, perhaps because it was primarily men's societies

that were targeted under Sékou Touré. Women's societies, like men's, structure initiation rituals for their members, though forms of initiation are different and girls have never undergone the long internment in the woods that boys experienced. Other ritual practices of women's societies manage relations with the spirit world (sometimes through possession rituals) and bring about healing and protection against sorcery [10, 23, 46].

Family, social and community bonds and obligations play a very important role in the conceptualization of the self for many Guineans. If one does not – or is perceived by others not to – respect these bonds, one is likely to incur anger and resentment (occasionally even leading to curses) and sometimes lead to suspicions of being a sorcerer. In GF, illness, drought or misfortune for whole villages can result from the infractions of no more than one community member if they disrupt the natural order of things [23], which reinforces the importance of observing collective obligations. This is not of course to say that these norms are always respected, but does suggest why the wider community may feel that they have a stake in the behavior of individuals. Thus the self is commonly seen in relational terms and, while individual success may be valued, strong individualism may be discouraged as selfishness. The extreme example of selfishness is witchcraft. [45]

3.5 Risk and protective factors for mental health issues

In Guinea, the determinants identified for mental health and psychosocial well-being pertain to the degree to which one's community acts as a solid support system during and in the aftermath of crises. An individual's access to familial and parental support structures has been and is critical in assuring positive mental health results in the face of traumatic events. Other social factors include socioeconomic conditions, such as the extent of poverty endured both individually and by one's community. [31]

In the conflict-affected communities of GF, social activities that fostered community ties proved critical in determining positive mental health outcomes in the aftermath of the Sierra Leonean and Liberian wars that spilled over Guinea's borders. Communities that elaborated narratives that promoted healing by explicitly rejecting the violence they had faced, demonstrated greater resistance to mental health problems, both on a collective and individual level. Conversely, narratives that reinforced a sense of powerlessness and defeat when confronted with uncontrollable catastrophes were shown to have an overall negative impact on mental health outcomes. In addition, infrastructural, logistical and financial resources that promoted a sense of security and the ability to endure during and after the wars, were vital elements in the promotion of favorable mental health results. Risk and protective factors with respect to mental illness and disorders were deeply intertwined with the mediating processes between communities and individuals as conduits for psychosocial resources that enable the reconstruction of both community and self in the aftermath of debilitating events. [2]

In a study of the Guéckédou region which was affected by the conflicts in 2000/2001, researchers examined the ways in which a number of the region's villages dealt with the brutalities they were subjected to throughout the war which included executions, rape, destruction of local infrastructure, abduction, forced labor, dehydration, and exhaustion. They demonstrated how the enduring effects of these assaults were processed differently depending on the mechanisms and resources employed by communities to cope with the aftermath. For example, in the villages of Nongoah, Tékulo, and Yendé narrative accounts described how the communities viewed themselves as largely powerless in the face of the violence they had faced and had little hope that the resources and places that had formerly served as supports for community life – public infrastructure, homes, shops, clothes, and goods – could be reconstructed and thus restore the continuity of social life in the aftermath of war events. These communities demonstrated the greatest vulnerability to trauma-related mental illnesses. Economic

deprivation as a result of conflict hindered the preservation of critical social practices that had forged and sustained previous community dynamics, traditions such as funerals, baptisms, family meetings and other social events, leaving community members susceptible to a “loss” of their “social selves”. [1, 2]

In this same study, 65% of respondents irrespective of their home villages, reported experiencing significant distress mainly manifested through physical and trauma-related symptoms, as well as a vulnerability to psychological distress and mental disorders. Social variables figure significantly amongst these influences. For example, the absence of familial support systems represents a major determinant of mental health outcomes. The study reported that 70% of girls and 80% of boys participating in the research who lacked a real parental presence presented with a significant risk for suicide. By contrast, 10% of the girls and 5% of the boys who were supported by parental structures demonstrated suicidal tendencies. [2]

Studies in Guinea have identified other protective factors. These include: strong communal ties; familial and kin networks and parental support structures in the case of children; and community narratives of resistance to the effects of social crises, such as war and persistent socioeconomic deprivation⁸ Non-governmental organizations have also played a major role in furnishing communities and individuals with the economic and logistical means to achieve a level of security. These factors, ensured both by governmental and non-governmental apparatuses, have proven critical in mitigating individuals’ and communities’ vulnerability to events that threaten to break down social ties and communal and moral worlds. Overall, the most significant determinant of well-being resides in resources - financial, political and psychosocial - that allow communities and, by extension, individuals, to maintain the communal and moral universes in which they are embedded, especially in the face of catastrophe, whether it be of a sociopolitical nature, such as war, or a public health crisis, such as the recent Ebola epidemic. [1, 2, 8] Gender, age, socioeconomic status, and related variables are significant dimensions for understanding risk and protective factors at play in MHPSS issues in Guinea. However, these variables do not appear to have been a focus of systematic studies to date.

3.6 The healing landscape

3.6.1 Non-allopathic health system

In addition to the biomedically-trained doctors, pharmacists and allied health professionals in the allopathic health system, Guineans may seek help from a variety of other healing practitioners. Islamic religious healers (*marabouts*), herbalists, traditional healers and diviners, and community elders are commonly consulted to diagnose and treat illness and distress, or for preventive, strength-building measures. [31] They may draw on a variety of practices to address the problem, including prayer, incantations, herbal washes and medicines, the use of protective amulets or ‘fetishes,’ particular foods and cleaning practices, or cleansing rituals and sacrifices. [5, 31] In addition to working with the physical dimension of illness, these techniques often also intervene at the psychological, social and spiritual level. [18]

When the cause of an ailment is unclear, it is common for help-seekers to go to different practitioners in the hope that at least one will prove effective. [31] Thus, it is common to consult non-allopathic healers before, simultaneously with, or soon after resorting to allopathic services. Help-seekers themselves do not necessarily draw clear distinctions between allopathic and non-allopathic treatments as, from their perspective, these forms of healing overlap and they may not make a distinction between scientific and magical procedures. [23]

⁸ The absence of state-based support in the form of financial and infrastructural resources, contribute to create a sense of insecurity and powerlessness for individuals and communities, especially in the context of crisis.

3.6.2 Government and NGOs in mental health care

The main center for mental health care in Guinea is the psychiatric service at Donka, a general hospital with mental health services based in Conakry, which includes inpatient and outpatient services. The inpatient service consists of 62 beds, though often far fewer are available (Capucine de Fouchier, personal communication). In 2014, the service engaged with a total of 1365 patients, admitted 435 in-patients, and carried out 5460 consultations. [1] The health service as a whole is significantly under-funded and state funding only covers the salaries of the mental health service workers. Therefore for individuals who are hospitalized, families must meet the expenses of food, medicine and toiletries [1] and a relative must often accompany and care for the patient for the duration of their hospital stay. Despite the lack of funds the poor hospital conditions that result, psychiatrists at Donka have expressed pride in not relying on physical restraints. [40]

There is also a community mental health service called Boma, at N'Zérékoré. This center was set up to treat residents of the refugee camps in that geographical area. In the past, the World Lutheran Federation – ACT was involved in providing mental health care to refugees, but their involvement ended in 2005. The service now has 18 beds. [1]

Some primary care health centres offer community mental health treatment and interventions. These services are provided by the Ministry of Health in collaboration with Fraternité Médicale Guinée (FMG), an NGO founded in 1994 specializing in mental health care in Hamdallaye. FMG has collaborated with a number of international and national organizations, and works directly to provide interventions at health centres in Conakry, Kindia and Labé. It also works in partnership with health centres at Boma, Yomou, Samoé, Guecké, Pita and Timbi madina. [49]

In Kindia, FMG opened a 'therapeutic complex' for people with mental health disorders in the village of Moriady, located at a distance of 123 km from Conakry. This complex provides a health center staffed by one doctor, two nurses and a laboratory technician, and is closely integrated with the surrounding community in the support it provides for residents. 53% of residents at the complex, who come to Moriady from many different regions of Guinea, have had a diagnosis related to psychosis, 29% have had epilepsy and 18% have had other neuropsychiatric disorders. Pharmaceutical treatments are provided and therapeutic activities include rehabilitation workshops, use of the community bakery and farming work, where residents learn or re-learn practical skills and work towards full community reintegration. The complex is highly distinctive in the Guinean context in this integration of medical and psychosocial interventions. [18, 48, 51]

There are no specialized treatment centers dedicated to drug addiction and consumption, nor any dedicated harm reduction programs, although some NGOs are active in this area [8].

3.6.3 Help-seeking strategies

General health-seeking pathways

In deciding whom to consult about health issues, people make use of their own past experiences, observations, and advice from others. When the nature of the problem is perceived to be clear (e.g., wounds, snakebites, malaria, conjunctivitis), there is usually little hesitation in resorting to treatments viewed as standard for that condition. When the nature of the problem is not so easily identified, or if it fails to respond to initial treatments, people may then resort to a number of different healers to see which one, if any, is effective. [31]

A number of considerations influence how people may view the available treatment options:

- *Cost:* Cost and forms of payment are sometimes significant issues for families. While many pharmacists, market dealers in medicines, marabouts and medical workers charge up-front fees for their products or services, others may allow credit or even payment when the patient gets better. When family finances are running low, as is often the case before harvest, willingness to accept delays in payment may determine who is consulted. [31]
- *Quality:* Certain medicines or cures are thought to be of better quality than others. This often corresponds to the reputation of the individual healer or vendor who provides them. Some ethnic groups in Guinea (e.g., the Baga of the coast [47]) are known for their medical prowess. In GF and possibly elsewhere, the quality of the medicine is believed to be linked to the effects of the sun on the medicines. Although plants that grow in full sunlight in the savanna develop more potency than those that grow in the forest, keeping medicine in sunlight for too long can weaken it and so medicines stored in buildings (pharmacies, health centres) are seen as stronger. [31]
- *Nature of the treatment:* Injections are seen as the strongest treatments, because they enter the bloodstream directly. Treatments designed to be swallowed are perceived as less powerful, and those applied to the skin less powerful still. The mode of delivery can play an important role in what treatments are considered appropriate. In particular, injections may be considered unsuitable for illnesses that affect bodily fluids, such as those that produce swelling or affect the blood. In these cases, injecting further liquids is thought to worsen the condition. [31]
- *Gender:* Health centres have become closely identified with women and infants, perhaps partly as a result of the emphasis placed on maternal and infant health. Because many aspects of the social order in Guinea are differentiated by gender and men feel awkward entering into women's space, men may tend to actively avoid the female- and infant-dominated health centres. Men and boys over 5 tend to prefer to consult pharmacies directly, without attending a health centre. [31]

Mental health pathways

Where mental health service users are admitted to hospital, this is invariably done at the request of a third party rather than through self-referral. [66] However, little is known about referral patterns, as no single data collection system exists across the sector. [1] The creation of such a system is currently under consideration. [41]

Awareness of available mental health services is not always prevalent among the population. For example, a study by the International Organization for Migration (IOM) found that among returning Guineans who had attempted to emigrate irregularly to Europe, less than 30% knew of state or NGO-provided mental health services, despite the heightened psychological risk factors for this group. The study calls for an action plan to enable preventive measures to reach out more effectively to this group. [29]

4. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT BEFORE AND DURING THE EBOLA CRISIS

4.1 MHPSS-related Humanitarian History

The Ebola crisis has overwhelmingly dominated humanitarian efforts in Guinea since early 2014. Before this outbreak, humanitarian efforts largely focused on addressing the needs of Liberian, Sierra Leonean, and Ivorian refugees. There have also been lower levels of humanitarian activity focusing on community-building and addressing gender-based violence.

4.1.1 Summary history of humanitarian crises

Much of the humanitarian work done in Guinea in the last two decades has been in response to the effects of the regional armed conflicts centred in neighbouring countries. Civil wars in Liberia, Sierra Leone and Ivory Coast saw huge flows of refugees into Guinea. In 1999, official UN figures put the number of refugees and asylum-seekers in the country at nearly 502,000, which was the largest concentration within Africa at the time. [58] Large refugee camps were established in GF, though refugees' movements were generally not restricted and some settled outside the camps. Many refugees had experienced or witnessed summary executions, maiming, systematic sexual violence and the destruction of entire communities, giving rise to significant mental health and psychosocial support needs. At times, violence spilled across the border into GF, with, in 2000-2001, attacks by both the Liberian and the Sierra Leone-based Revolutionary United Front (RUF), in retaliation for perceived Guinean government complicity with rebel forces in the camps. The Guinean army repulsed this invasion with the help of sizeable youth militias (the 'Young Volunteers') and the rebel militarisation of the camps was slowly brought under control. However, problems remained, in addition to the direct effects of the violence: the difficulties of demobilising up to 30,000 armed young people (among whom some were 'child soldiers') in a context of high unemployment gave rise to concerns over citizen insecurity, more than 100,000 Guineans were left internally displaced, and there was an upsurge in harassment and abuse of refugees during the conflict [37]. Many people from the affected communities were left with symptoms of 'trauma', while also having to deal with the socioeconomic impacts of the destruction [2]. Refugee numbers have reduced significantly since then, as many have settled or been repatriated, and the regional conflicts fuelling their migration have stabilised to some extent. However, the consequences of this difficult history still exert an influence on communities in the area.

Though Guinea has experienced relative social stability compared with its neighbours, there are nevertheless important tensions (see Section 2.1.2). Inter-ethnic tensions have intensified during and since the 1990s. Often these have been tied to fears of political exclusion. This was the case in 1993, when ethnicity played a role in violent clashes during the presidential election of that year, and again in 2010 during the first democratic presidential elections [30]. During this period, GF has also seen sporadic violent clashes between Guerzés and Koniankés, which took 95 lives in 2013, and the Toma and Tomamania [20, 38].

The organized rape on the 28th September 2009 by Guinean soldiers of more than 100 women and girls during a political demonstration (see Section 2.2.2) highlighted Guinea's high rates of gender-based and sexual violence and the unpreparedness of services to deal with this problem became a focus of interventions [42].

4.1.2 Humanitarian Responses

Among the assistance provided by UN and other agencies to the residents of Kissidougou and N'Zérékoré refugee camps were mental health care and trauma counseling. Of note is the US-based Centre for Victims of Torture's (CVT) 1999-2005 psychosocial program for Liberian and Sierra Leonean survivors. This program employed paraprofessional counselors, supervised by on-site expatriate clinicians, to address trauma symptoms using a relationship-based group counseling model that drew on both Western and indigenous practice. The groups incorporated traditional forms of communication such as stories, music and song, symbols and healing rituals [53].

Following the events in September 2009, some interventions were funded by international partners, including training in medical and psychosocial care for medical teams at mother and child clinics and legal aid for victims of political violence [61]. One noteworthy response was the RESPOND project, led by Guinean agencies and USAID. The project provided medical care and psychosocial support to the affected women and worked to build capacity in dealing with gender-based violence in the health sector and with partner agencies. It particularly identified inconsistency of responses to sexual violence across the health sector and sought to address this problem. [42]

Some efforts were also made to address ethnic and community tensions in the GF region by promoting inter-community conflict prevention and human rights awareness. [61]

4.2 Experiences with the 2014-2015 Ebola crisis

The Ebola virus is transmitted through contact with the body fluids of an infected person and can lead to abrupt-onset fever, headache, joint and muscle pain, weakness, diarrhea, vomiting, rash, impaired organ functioning, internal haemorrhaging, and death [52]. The emergence of the West African Ebola epidemic at the end of 2013 turned into the largest ever outbreak of the disease and posed severe challenges for which overstretched public health systems in the region were unprepared. Guinea, Liberia and Sierra Leone were the countries worst affected, though a handful of cases of the virus have been found in Mali, Nigeria and Senegal, as well as the United States and European countries. GF was the epicentre of the outbreak and the Ministry of Health officially declared an epidemic there on 22nd March 2014. Subsequent events revealed how political, cultural and economic factors played important roles in the course of the virus's spread. This has important lessons for on-going intervention, as well as a broader range of future work.

4.2.1 Prevalence

The start of this outbreak was traced by epidemiologists to the Guéckédou region in GF. [52] Unlike in previous outbreaks in central and eastern Africa, the virus soon spread over a wide area in and beyond Guinea, as a consequence of the high mobility of the general population; cross-border trade, regular visiting among widespread family networks, and the custom of transporting dead bodies to their hometown for burial were all common features of life in GF [35]. As of 2nd August 2015, 3327 confirmed and 452 probable cases of Ebola had been identified in Guinea, with 2522 recorded fatalities [69]. The overall case-fatality rate for this strain of Ebola (the EBOV-Z form) is estimated at 60-90% [52]. At the time of writing, the number of new cases reported by the WHO had greatly decreased and experimental vaccine trials had shown promising results [27], though monitoring of contacts remains on-going.

4.2.2 Political and humanitarian response

Government and Aid Services Provided

Médecins sans Frontières (MSF) and the International Committee of the Red Cross (ICRC) played an important role in providing care for Ebola patients and bringing the epidemic under control, alongside Guinean health care workers. MSF in particular raised concerns at an early stage, but did not meet with a receptive response to foreign interventions and aid. The underfunded Guinean health system, like other health systems in the region, struggled as neither available resources nor expertise on Ebola were adequate to respond rapidly or effectively to the outbreak. MSF provided training for local health teams in self-protection measures, safe care and safe burials. [35, 39]

MSF frontline teams were soon also spread thin. The scarcity of expert knowledge meant that MSF had no option but to send coordinators to Guinea who had received only two days of intensive training on Ebola. The response from multilateral organizations did not take place until the epidemic was well advanced [39], with the World Health Organization declaring the outbreak “a public health emergency of international concern” on 8th August 2014, and the United Nations establishing the first UN health mission in September with the creation of the UN Mission for Ebola Emergency Response (UNMEER) [35]. These steps brought greater input from the international community. MSF played a prominent role in advocating for international assistance and provided training to staff from a number of other international NGOs and organizations. [35]

A number of steps were taken to try to bring the outbreak under control, including:

- Isolation of infected patients and provision of care in Ebola Treatment Units (ETUs)
- Explanation and promotion of safe burial procedures, to minimise the risk of infection when preparing the body
- Awareness raising with communities about the virus’ transmission and counter-measures
- Disease surveillance and disinfection of potential transmission sites
- Tracing the contacts of those who became infected, in order to contain the disease
- Putting in place policies to ensure that health care for other conditions can continue, while controlling the risk of Ebola transmission through health facilities. [19, 35]

Where psychosocial support needs were addressed during the epidemic this was done by NGOs, often with limited coordination of activities. A proposal in May 2014 to train health professionals to provide psychological care alongside their role in fighting the Ebola Virus Disease was not developed. [1, 21] However, as the Ebola response developed, more attention has been paid to capacity building to develop Psychological First Aid (PFA) awareness among health and care staff and community workers. [e.g., 67] A particular focus has been on psychosocial support for children, where UNICEF has helped to develop play and recreational activities, training of community leaders, and the National Strategy for MHPSS for Children and Communities. [59]

Problems in the provision of aid

Unlike previous Ebola outbreaks elsewhere in Africa, many people in GF are very mobile. The virus therefore spread rapidly and presented unprecedented challenges to infection control. [39]

Response efforts encountered considerable non-compliance and sometimes violent resistance. Infected individuals were sometimes concealed from response teams or avoided medical help. Some villages in Guéckédou blocked roads and cut bridges to keep the response teams out. At the height of the outbreak, the ICRC reported that its volunteers were attacked ten times within a month. A number of

deaths occurred as the result of other such assaults, notably at Womey where 8 people died [23]. Reviews of the response have noted mistakes that contributed to these reactions:

- Initially public communication strategies were largely drawn directly from those used in previous outbreaks in the Democratic Republic of Congo (DRC), where people were already familiar with the disease and socio-political conditions were different; they proved ill-suited to Guinea. [3] National and international experts leading the Ebola relief efforts were not familiar with local cultural and social practices. [20]
- Early public communications said that there was no cure for Ebola and spoke of 'isolation centres'. When the messages changed to emphasise the possibility of surviving the disease and used the term 'treatment centres', the public started to become more receptive to the response efforts. [3]
- A slow initial government response and some early broken promises over the supply of equipment fed doubts about the commitment of outsiders to protecting the communities. [3]
- The government response largely bypassed existing local health governance institutions, which led to confusion and made a joined-up response more difficult. [39]
- Control measures were instituted without adequate consultation, explanation, or regard for local customs or sensibilities. There was inadequate recognition of family and community concerns, particularly around funeral practices. Officials appointed were often from outside the area and had little insight into local concerns.
- Local surveillance committees often failed to represent the population properly; different communities are often suspicious of each other and including important figures from some villages does not mean that they will be trusted in others. [5] Particular concerns about representation were expressed over the exclusion of women (whose traditional roles put them more at risk of contracting Ebola and who in some villages led acts of resistance to the response) [5] and young people (among whom disaffection and distrust in the authorities were most marked). Where community participation was more inclusive, populations engaged better with the virus control measures. [3]
- Some politicians attempted to identify themselves with the Ebola control campaign for electoral purposes; this only increased suspicion of the measures implemented. [3, 23]
- After some incidences of violent resistance, soldiers or police often escorted medical response teams to communities, militarizing the campaign in the eyes of the civil population [3].
- The capacity of already over-stretched health workers was pushed to its limit by the epidemic. 195 health workers had contracted the disease as of 5th August 2015, with 99 dying of it [60]. There were concerns that this might further undermine the public's faith in the care provided, if the health workers were seen as unable even to protect themselves [35].

4.3 Ebola-related beliefs and practices

Communities in Guinea affected by Ebola were faced with a virus with which they had no prior experience, a very different situation to that encountered in previous outbreaks in the DRC [12]. Because of GF's long experience of marginalisation, discrimination and repression of customary practices (see Section 2.2.2), unsurprisingly they were not always willing to accept the official information provided about Ebola and explanations of the public health measures being taken to combat it. This distrust partly explains why many Guineans found other explanations for what was happening. Efforts to combat Ebola were soon forced by public non-compliance and active resistance to take account of the political, social and cultural factors that shaped these explanations. It was only when these were better understood that the health campaigns were able to address community concerns more effectively, leading to improved outcomes.

Not all failures to comply with control measures were the result of distrust or lack of acceptance of

the official account. Sometimes very practical issues played a part; for example, people may have been discouraged from seeking help by the difficulties of finding someone to care for their children or farm animals in their absence, or from fear of not being able to obtain the necessary resources to see them through a quarantine period. [23] However, it is clear that deeply-held political sensitivities and cultural values played an important role in much of the difficulty encountered by the response to Ebola. Findings from a survey of 1493 individuals from across 14 prefectures showed that while a majority of respondents said that they did not know the origin of the Ebola virus, 21.1% blamed it on one or more of the government, scientists, politicians, the ICRC, MSF or miners [60]. A number of different explanatory models for Ebola outbreaks were documented as circulating among the population, besides the official biomedical explanations for infection:

- *Overseas Involvement:* Guinea's history as a colony of France, and more recent Western economic policies and projects perceived as neo-colonial, have left a legacy of suspicion of Western motives. Ebola control measures recall past forced and much-resented internments on public health grounds (e.g., sleeping sickness control) in the colonial 1950s [3]. Some suggested that the Ebola virus was a creation of whites to kill blacks, or accused MSF and the ICRC of deliberately spreading the virus [13].
- *Government Involvement:* The inhabitants of GF have long resented their marginalisation from power and many feel discriminated against by government, which has historically been dominated by the Manding and Soussou ethnic groups. When Ebola emerged in that region, this provoked suspicions that the virus was being used to attack the population of the region or as an excuse to enable the governing party to postpone local elections [60].
- *Bushmeat consumption:* Ebola has been attributed by many Guineans to consumption of meat from wild animals living in the bush (e.g., apes). That this is a practice closely associated with the forestiers (i.e., the majority population of GF that includes for example the Toma and the Guerzé ethnicities) has meant that other Guineans at first saw Ebola as a virus only of this ethnic group. Prohibitions placed on eating bushmeat however, made the forestiers themselves feel that their customary practices were once again being persecuted [20], in continuation of the long history of marginalisation that the region and its inhabitants have experienced at the hands of central government.
- *Lack of hygiene:* Some have attributed Ebola infection to poor hygiene practices by the affected, such as not washing their hands after defecation. Like explanations based on bushmeat consumption, this interpretation tends to stigmatise the infected, while giving others the mistaken impression that they are not at risk [60].
- *Sorcery:* Sorcerers are believed to cause death to increase their magical powers or enrich themselves, often through stealing people's organs or blood. They are sometimes suspected of involvement in causing Ebola cases [60].
- *Divine punishment:* Some suggest that the virus is God's punishment for communities not respecting traditional rules and prohibitions [60].
- *Falsity of Ebola:* Some have claimed that there is no Ebola virus. They argued that Ebola was unknown before and that current cases were attributable to other, known viruses. Under this interpretation, stories of Ebola are spread by the government, Western agencies, or sorcerers, for their own ends. Often their aim is said to be to persuade people to seek tests or treatment, at which point they become victims of organ or blood theft. Fears of organ theft by white people or sorcerers are long-standing [60].

It is clear that many of these explanatory models are heavily influenced by historic and contemporary distrust towards outsiders, and often this influenced community reactions to the Ebola response. Where people attributed the virus to divine action or sorcery, this did not necessarily preclude seeking medical care, but often help would be sought first, or instead, from traditional or religious healers. This was made

all the more likely by early public health messages that spread the message that there was no vaccine or cure for Ebola; people may therefore have felt that they were more likely to obtain effective treatment from non-biomedical sources.

Quite apart from the explanatory models that people held about Ebola's emergence, several other factors played a role in dissuading these communities from conforming to medical guidance. When the message imparted by health workers was that no cure existed, it seemed to make as much sense to stay at home, or consult traditional and religious healers, as it did to attend health clinics. Particularly significant was the fear many held of entering the ETUs. Wariness of the quality of treatment provided in the cash-strapped and overburdened Guinean health system was already endemic, with patients' families frequently asked to make unofficial financial contributions for care [3]. Blood transfusions are generally only available if relatives are willing to donate, unless patients are wealthy enough to purchase them, making blood a valuable commodity. Seen in this light, it is understandable why anxieties were widespread that those in the ETUs would be killed so that their blood and organs could be extracted for re-use or sorcery. Such anxieties were fuelled by practices of body disposal designed to minimise the risk of virus transmission. Sealed into hermetic body bags, the dead were shown to few, if any, of their relatives, before being buried. This lack of visibility is in stark contrast to the large gatherings who would view the corpse at a typical funeral, leading to suspicions that the evidence of organ theft was being covered up [20, 60]. Organ theft at the ETUs seemed to some people a risk not worth running when there seemed little prospect of recovery there.

The infection control teams and medical workers who came to communities also inspired fear. Dressed in protective suits and spraying houses and other localities with disinfectant, it has been suggested that their appearance was reminiscent of the masks and costumes worn for traditional cursing rituals [23]. Often spraying activities were suspected of deliberately infecting, rather than disinfecting, the community [3]. This fear played an important part in the attempts by some communities to isolate themselves from the response teams.

4.3.1 Funeral beliefs and practices

Customary funeral practices have been contentious during the Ebola epidemic. Though funerary rituals vary across Guinea, they are commonly a time to bring together relatives, friends and community members, and reinforce social bonds, both among the living and with the dead. Close relatives wash and dress the body, before it is publicly displayed and mourned. It is important to appropriately honour the deceased by bringing people together and clearly showing the sense of loss felt, so that the person's spirit parts without regret. The burial site and positioning of the corpse are serious considerations in both Muslim and autochthonous *forestier* traditions. Where funerary rites are carried out correctly, the deceased person successfully makes the journey to the afterlife and becomes an ancestor. If this does not happen, they may instead become a wandering spirit, and will punish the living who condemned them to this fate by not treating them respectfully [20, 23]. These obligations are treated very seriously, as is shown by the significant expenditure families make on funerals [25]. To fail to live up to their obligations not only runs the risk of offending the deceased, but is viewed very negatively by other community members. Failures to contribute to the funeral, to attend it, or to show appropriate grief are sometimes seen as behaviour characteristic of sorcerers, who do not respect the normal social bonds between people [23].

WHO Ebola guidance advises on 'safe and dignified' burial in accordance with Muslim and Christian traditions, but provides little discussion of animist funeral practices that may exist among some Guinean communities and can vary hugely from place to place. [23, 65] The disjunction between customary practices and Ebola-safe burial procedures led to conflict between health workers and communities on

many occasions. Virus control measures made it impossible to carry out the full washing and dressing rites, and prevented all but close relatives viewing bodies after death. Hermetic body bags and quick disposal of the dead both made people wonder what was being concealed and caused them to fear that the deceased may not reach the afterlife. This is not a fate anyone would wish for their loved ones, but it also may bring dire consequences in the form of misfortune for the community that let it happen.

These fears are exacerbated when Ebola response teams do not take them seriously, but can be assuaged by openness to discussion and cultural sensitivity. Steps that improved the acceptability of burials of victims of the virus without compromising safety included:

- The opportunity for ritual objects and gifts to be included inside the body bags by the burial team: these could be of help to the deceased in making their journey to the afterlife [5], or be carried as gifts for others who have already passed away [43];
- Pictures of the deceased were taken by the response team before placing in body bags, then distributed to family members: this provided a token of the deceased and helped to quell rumours of mutilation and dismemberment [5];
- Greater attention to family desires regarding where the body should be buried [5].

No generic guidance can cover the full diversity of situations that can arise, and so open discussion that takes seriously local concerns is often vital in reaching mutually acceptable agreements [6].

4.3.2 Ebola-related social attitudes and stigma

Even if people recover from the virus, often their problems are not over. In Guinea, social networks are the most essential safety net for life and well-being. The death toll had already reduced social networks, but some Ebola survivors have also found that they were not readily accepted back into their communities. Fear of infection certainly led to ostracism in these cases; the many associations of Ebola with sorcery, Western conspiracies or government malevolence may also have led to survivors being considered suspect. Reintegration can be further complicated where survivors find their homes and belongings burned as an infection prevention measure, potentially leaving them destitute [7].

4.3.3 Psychosocial support needs related to Ebola

The psychosocial impact of the Ebola virus has been significant. There are often particular needs for psychological support:

- At the point of diagnosis and afterwards, for the infected individual and their family members who might have to deal with fear, grief and coping with stigma and marginalization within their communities;
- With the grieving process following bereavement, particularly in the light of the disruption caused by Ebola to customary grieving rituals which might ordinarily have helped adjustment;
- Following recovery from the virus, when stigma and fear of infection may make it difficult to reintegrate into the community;
- And, for Ebola response teams who work with the infected and their families.

Psychosocial interventions at the community level may also be valuable in assisting with the reintegration of Ebola survivors.

Many survivors have found themselves isolated, as a result of the stigma of having had the virus and the disruption of social networks caused by the deaths and disruption to communities. This is often compounded by the economic effects of the epidemic on livelihoods, with lost employment, possessions or position in the community contributing to a decline in economic security and social standing [7, 43]. Some have found new positions working with NGOs to sensitise and educate communities to the risks posed by the epidemic, drawing on their own experiences; this usually provides both remuneration and a valued role. Mutual support groups have also sometimes arisen among Ebola survivors that offer some assistance (e.g., Association des personnes guéries et affectées d’Ebola en Guinée), for the most part with little or no external funding or support [1].

As of 5th August 2015, UNICEF estimated that 5874 children had lost one or both parents to Ebola [60]. UNICEF and its partner NGOs have provided training in child protection and psychological first aid (PFA), organized play sessions, and organized follow-up visits and assisted with family reintegration [59]. These NGOs are *Monde des Enfants (MDE)*, *Enfance du Globe*, *Aide a la Famille Africaine* and *Action d’Intégration Mères et Enfants* [49].

There had been 195 cases of Ebola virus among health workers as of 5th August 2015, of whom 99 had died [60]. These deaths added to the burden and anxieties of their colleagues, who were also dealing with the almost unprecedented experience of seeing well over half their patients die despite their best efforts [35]. Under such circumstances, health workers may be susceptible to traumatising and develop significant psychosocial support needs of their own [1, 67].

The extent of the deaths, damage to the social fabric, economic loss, anxieties, disruption to normal grieving practices, and stigmatisation that the Ebola virus caused presents considerable challenges to mental health and psychosocial support in Guinea.

5. CONCLUSION

Global economic forces, social divisions and inequality, and the effects of violent conflict have meant that the people of Guinea have faced a number of challenges to their psychological, physical, financial and cultural well-being in recent years and decades. Most recently, the Ebola virus outbreak posed an unprecedented challenge to public health and to the existing resources and structures.

Moreover, it highlighted how indispensable it is for the success of interventions, whether in the area of public health or in MHPSS, that they should be grounded in an understanding of the social, political and cultural factors that shape people's perspectives and decision-making. This report has established the significance of situating the particular causes and course of illnesses, and misfortune, that the Guinean population draws from making meaning of their experience. Co-existing frameworks reflect cosmologies in which the individual person is situated within a constellation of relationships with the living, the dead, the spirit world, and nature itself. The causative factors used in cases of sickness in Guinea vary due to the consequences of violations of the natural order, the actions of the dead, of non-human spirits (*djinnns*), sorcery, divine punishment, and experiences of violent conflict.

Because of initial failure to take into account widespread suspicions of those in power or of outside agencies, the intricacies of spiritual and social practices and worldviews, the need for meaningful and representative engagement with a broad cross-section of members of individual communities, and the practical difficulties that recommended control measures often posed to individuals and families, efforts to respond to Ebola faced numerous setbacks and significant levels of reticence or resistance from local populations. It is to be hoped that the learning of these two lessons will lead in the future to more sustained and resourced efforts to build capacity and to strengthen systems in health and in MHPSS, and to redoubled endeavours to ensure more culturally informed interventions and care. At present the research literature applying these lessons to MHPSS is limited, but the high profile resulting from the tragedy of the Ebola outbreak may change that.

Practitioners should be aware that Guineans may draw on a range of perspectives to understand health, suffering and ill-being. Their decisions may be influenced by the bonds they value with family, with wider communities, and with the dead, God and the spirit world, as well as by historical and contemporary experiences of oppression and marginalization. Guinea is culturally diverse and clear generalizations about these issues cannot be made across the population as a whole; however, it is important to recognize that these are issues that are commonly key considerations for clients, although they may take varying forms among different groups and sectors. In their work, MHPSS practitioners must engage with and respect their importance if the outcomes they hope for are to be achieved.

APPENDIX

Appendix 1: Search engines, key words, total hits and number of relevant references for the review process

Name of search engine	Key words	Date(s)	Total hits	Number of relevant references
Google.fr	Guinée (Conakry), santé mentale, maladie mentale, psychologie, psychiatrie, psychosocial	30/05/15 09/07/15	8790	25
	WHO Guinea mental health	09/7/15	34,400 (100 first hits screened)	12
Google scholar	Guinée (Conakry), santé mentale, psychologie, psychiatrie, psychosocial	15/06/15	51	26
Pubmed	Guinea (Conakry), mental health, psychology, psychiatry, psychosocial AND Guinea, mental health	12/06/15	0	0
	Guinée Conakry	12/06/15	99	0
APA psychNET	Guinea	12/06/15	106	2
PSYCHinfo Medline and Ovid	Guinea Conakry	12/06/15	0	0
Anthrosource	Guinea and Africa	3/07/2015	8	1
<i>Social Science and Medicine</i> (Journal search)	Guinea and mental health	3/07/2015	228	3
<i>Culture, Medicine, and Psychiatry</i> (Journal search)	Guinea and Africa	3/07/2015	36	0
<i>Medical Anthropology</i> (Journal search)	Guinea and Africa	3/07/2015	28	0
<i>Transcultural Psychiatry</i> (Journal search)	Guinea and Africa	3/07/2015	85	0

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