

# Mental Health Management during the COVID-19 Pandemic in Senegal: Lessons Learned

Jean Augustin Diégane Tine<sup>1,2</sup> 

<sup>1</sup>Mental Health Division, Ministry of Health and Social Action (MSAS), Dakar, Senegal

<sup>2</sup>Institute for Research and Teaching in Psychopathology (IREP), Cheikh Anta Diop University of Dakar (UCAD), Dakar, Senegal  
Email: jeanaugustindiegane.tine@ucad.edu.sn

**How to cite this paper:** Tine, J.A.D. (2025) Mental Health Management during the COVID-19 Pandemic in Senegal: Lessons Learned. *Health*, 17, 1068-1080.  
<https://doi.org/10.4236/health.2025.179069>

**Received:** April 6, 2025

**Accepted:** September 15, 2025

**Published:** September 18, 2025

Copyright © 2025 by author(s) and Scientific Research Publishing Inc.  
This work is licensed under the Creative Commons Attribution International License (CC BY 4.0).  
<http://creativecommons.org/licenses/by/4.0/>



Open Access

---

## Abstract

**Introduction:** This work stems from practical experience during the unexpected context of the COVID-19 pandemic. As the person responsible for mental health policy in Senegal, it was necessary to demonstrate creativity and adaptability to respond to the health challenges posed by the pandemic. A few years later, it seemed important to conduct a reflexive analysis in order to better understand the scope of the actions undertaken and propose a conceptual framework based on the lessons learned. **Methods:** This scientific contribution is a reflexive analysis—an intentional intellectual process in which individuals explore or examine a specific situation, problem, or issue based on past experiences in order to develop new insights that can inform future actions. It focuses on mental health interventions led by Senegal’s Ministry of Health and Social Action (MSAS) during the first year of the COVID-19 pandemic. **Results:** A structural and functional reorganization enabled a rapid response to new types of needs that emerged with COVID-19, including: 1) the establishment of a multidisciplinary remote psychosocial care unit for Senegalese citizens abroad and for confirmed/contact cases within the country; 2) psychological support for healthcare workers in various care settings; 3) psychiatric teleconsultations in mental health services; 4) the decentralization of psychosocial care to regional and departmental levels; 5) strengthening of community-level responses through training and the provision of equipment. However, the implementation of these interventions lacked sustainability due to reduced stakeholder motivation, discontinuity in funding, and the absence of a formalized psychosocial care framework. **Conclusion:** Senegal’s experience during the COVID-19 pandemic demonstrates that a mental health response can be rapid, innovative, and adapted across multiple levels of intervention. However, the sustainability of these actions depends on the quality of intersectoral coordination, the effective integration of community actors, and the consolidation of innovations introduced, particularly in areas such as teleconsultation

---

and the decentralization of services. Mental health must now be recognized as a strategic pillar of public health systems, on par with epidemiological response and social support. As a lever for both individual and collective resilience, it serves as a key component for post-crisis recovery and for strengthening the adaptive capacities of communities in the face of current and future health shocks.

## Keywords

Mental Health, Psychosocial Support, COVID-19, Pandemic, Senegal

---

## 1. Introduction

Reflexivity, as defined by Haggerty, resembles an intellectual performance that engages the author in a dynamic relationship with the field and is fully realized in the act of writing itself [1]. It aligns with the epistemology of positionality [2], where knowledge production is situated, embodied, and contextual. However, reflexivity should not fall into excessive introspection centered on the self, as this risks drifting toward hermeneutic narcissism detached from analytical relevance. Such an approach would compromise reflexivity's essential role: contributing to critical and potentially transformative knowledge [3].

From this perspective, reflexive analysis is not about justifying or retrospectively rationalizing unconscious biases or motivations. Rather, it must be rooted in rigorous professional practice, allowing for a clear distinction between subjective considerations and those related to the professional domain. The reflexive author must adopt an ethical stance—recognizing the limits of their involvement while valuing their position as an engaged actor [4].

This paper emerges from that same spirit, grounded in a unique field experience: the management of mental health policies in Senegal during the critical and unforeseen context of the COVID-19 pandemic. That period required the mobilization of creativity, adaptability, and decision-making under pressure. Five years after the initial impact of the crisis, it is timely to conduct a reflexive analysis to better understand the scope of actions undertaken and to extract useful lessons. This process aims to contribute to a more structured conceptualization of crisis response practices and to enrich public policy through the lens of learned experiences.

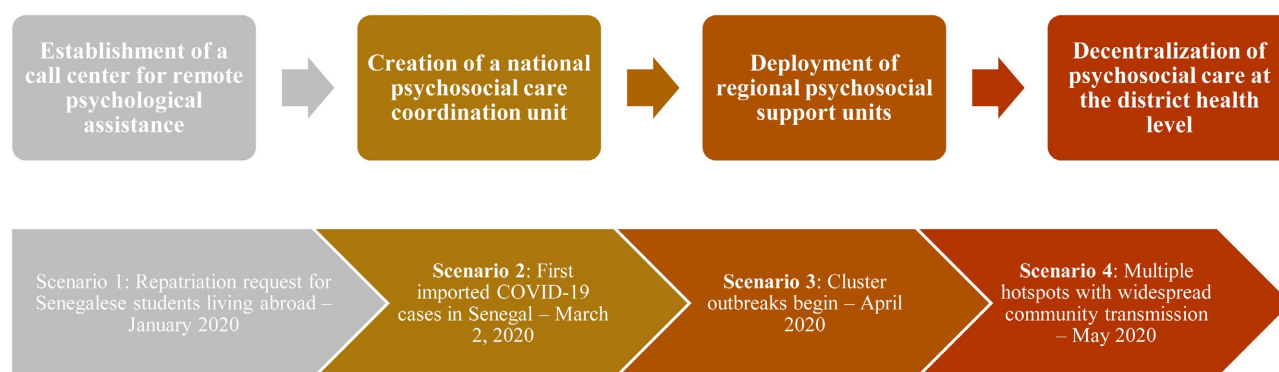
## 2. Study Context

On January 30, 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a Public Health Emergency of International Concern, following the second meeting of the Emergency Committee under the International Health Regulations, convened to address the outbreak [5]. In response to the first reported COVID-19 cases in Europe, Senegal held an emergency meeting of its National Epidemic Management Committee (CNGE), which decided on January 22, 2020,

to activate a preparedness plan. During that meeting, the concerns of Senegalese families whose children were studying in Wuhan were raised. The parents requested the repatriation of their children. As the government declined this proposal, the Mental Health Division of the Ministry of Health and Social Action (MSAS) implemented a remote psychological support strategy. A psychological support call center was established within the Directorate General of Public Health (DGSP). Senegal recorded its first confirmed COVID-19 case on March 2, 2020 [6]. The government quickly adopted several measures to care for patients and to enhance epidemiological surveillance: the Health Emergency Operations Center (COUS) was activated; public gatherings, interregional travel, and mass events were banned; air, land, and sea borders were closed, along with schools and places of worship. Mask-wearing became mandatory in public spaces. A state of emergency was declared, followed by the imposition of a curfew [7]. In parallel with these restrictions on movement and contact, additional measures were introduced to strengthen surveillance and improve healthcare delivery nationwide, requiring health facilities to implement institutional protocols to reduce contamination in medical settings [8].

The COVID-19 pandemic led to psychosocial risks and had significant repercussions on mental health and well-being across different groups—primary victims (confirmed cases), secondary (contacts), tertiary (health workers), and even quaternary (decision-makers and the general population) [9]. Given this context, psychosocial care gained substantial importance in both the response to and prevention of mental health problems.

**Figure 1** illustrates the strategic progression of Senegal's national psychosocial care system in response to the COVID-19 pandemic. It presents a dual vertical and horizontal view of both the evolution of psychosocial response mechanisms (top) and the different epidemiological scenarios (bottom) encountered between January and May 2020. The process began in January 2020 (Scenario 1) with the repatriation requests concerning Senegalese students living abroad. In response, a remote psychological assistance call center was launched—marking the start of a reactive, distance-based intervention. With the detection of the first imported cases in March (Scenario 2), a national psychosocial care unit was established. This unit coordinated actions, conducted training for responders, and supervised early care responses. In April, faced with the emergence of localized clusters (Scenario 3), an operational decentralization process began through the creation of regional response units, enabling quicker and more contextually adapted interventions. Finally, by May (Scenario 4), with the rise of widespread community transmission, the system was further decentralized to health districts, thereby reinforcing the local anchoring of the psychosocial response. This figure reflects the progressive adaptation of Senegal's mental health system, transitioning from a centralized and reactive response to a territorial, coordinated, and preventive approach. It also illustrates the growing competencies of institutional and community actors in the face of an evolving crisis.



**Figure 1.** Evolution of the psychosocial response strategy during the COVID-19 pandemic in Senegal.

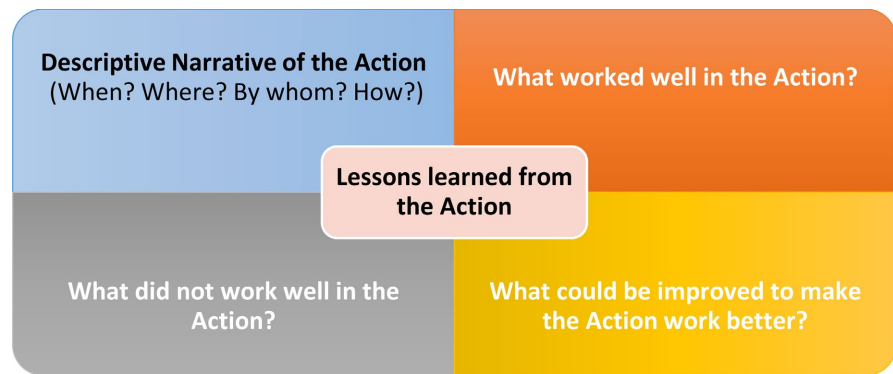
### 3. Methodology

This scientific contribution adopts a reflexive analytical approach, understood as an intentional intellectual activity aimed at critically revisiting a situation, problem, or intervention based on the lived experiences of the actors involved. The objective is to generate new understandings capable of informing and guiding future actions [10]. This study focuses specifically on mental health interventions implemented by Senegal's Ministry of Health and Social Action (MSAS) during the first year of the COVID-19 pandemic. It offers a retrospective analysis of the strategies adopted, the institutional dynamics at play, and the concrete situations encountered in the field. The reflection draws on multiple empirical sources: interviews conducted with key stakeholders, analysis of activity reports, and an examination of the mechanisms used for coordinating and implementing the actions.

The reflexive analysis employed here is grounded in a position of strategic distance, enabling a deeper inquiry into how the intervention was designed, structured, and executed, as well as the methods and strategies used to achieve the intended outcomes. It also interrogates the gaps between initial intentions and observed effects, with a view toward institutional learning.

The analysis is structured around a detailed description of key actions, followed by a critical examination designed to extract cross-cutting lessons. This process aims to identify what worked well, the challenges encountered, and areas for potential improvement. In doing so, it transforms experience into operational knowledge that can inform the planning and enhancement of future interventions. Reflexive analysis, in this sense, becomes a valuable tool for strengthening stakeholder capacity and promoting more coherent, adaptive, and resilient mental health policy management [10] [11].

A structured reflexive analysis framework was developed based on four complementary dimensions, centered around a core objective: the formulation of lessons learned from a given intervention. This methodological tool enables a critical and constructive review, incorporating descriptive, evaluative, and forward-looking elements (see **Figure 2**).



**Figure 2.** Analytical framework of actions implemented during COVID-19 management.

### 1) Descriptive narrative of the action

This first component sets the factual foundation of the analysis: when, where, by whom, and how the action was implemented. It helps contextualize the intervention by identifying the actors involved, the initial objectives, implementation modalities, and the resources mobilized. This step is essential for situating the analysis within a precise spatiotemporal and institutional framework.

### 2) What worked well in the action

This section highlights the successes or strengths of the intervention. It draws attention to the factors that contributed to achieving the goals, whether through effective methods, collaborative dynamics, stakeholder engagement, or tangible outcomes. It forms a basis for knowledge capitalization and potential replication.

### 3) What did not work well in the action

This component seeks to identify weaknesses, obstacles, or dysfunctions encountered during the intervention. These may include planning limitations, field constraints, resistance, or methodological shortcomings. Such critical analysis is essential for a nuanced and honest understanding of the experience.

### 4) What could be improved to enhance the intervention

This final dimension directs the analysis toward future improvement. It involves formulating concrete, realistic, and context-sensitive recommendations to optimize future actions. This forward-looking perspective reinforces the transformational intent of reflexive analysis.

5) At the center of the framework is the section titled “**Lessons Learned from the Action**”, which synthesizes the reflections developed across the four dimensions. These lessons are not merely observations—they represent actionable knowledge that can guide future practice, inform decision-making, and enhance the effectiveness of subsequent interventions.

## 4. Results

### 4.1. Coordination of Mental Health and Psychosocial Support

#### 4.1.1. Description of the Action

In response to the growing psychological needs related to the COVID-19 pandemic—particularly among healthcare workers and affected patients—the Minis-

try of Health and Social Action (MSAS) of Senegal launched a national psychosocial support mechanism during the first year of the crisis, under the supervision of the Mental Health Division.

This centralized mechanism was based on a multidisciplinary national task force that included psychiatrists, psychologists, sociologists, social workers, religious leaders, and community leaders. Its mandate involved coordinating psychosocial strategies, training stakeholders at the national and regional levels, and directly supporting patients, healthcare personnel, and recovered individuals upon discharge from Epidemiological Treatment Centers (CTEs).

To ensure broader coverage, regional cells were established, supported by focal points in health districts. The strategy was structured around three key intervention areas: 1) Psychological support; 2) Social assistance to individuals and households; 3) Social communication to strengthen community engagement.

Innovative strategies were deployed, including remote psychological support through phone calls and training for healthcare and community actors in psychosocial care. Various channels were used for case referrals: toll-free numbers (COUS, SNEIPS, SAMU), CTE coordination teams, epidemiological surveillance services (BRISE), and users themselves. At the same time, psychiatric facilities were provided with protective equipment to maintain the continuity of mental health services.

#### **4.1.2. What Worked Well**

The multidisciplinary nature of the teams and their deployment based on profiles, experience, and geographic proximity enabled a rapid and structured response. Phone-based interventions preserved the safety of responders while maintaining contact with affected populations. The training provided for responders helped standardize practices and increase responsiveness. The progressive decentralization enhanced response capacity as community transmission intensified, bringing services closer to local realities.

#### **4.1.3. What Did Not Work Well**

Dysfunctions were observed in coordination with institutional actors, particularly with epidemiological surveillance and social service departments. The coexistence of parallel systems undermined the unity of the response. The gradual disengagement of responders was fueled by limited financial resources, irregular supply of materials (phone credits, supervision funds), and growing demotivation due to unequal treatment compared to CTE teams. In addition, the lack of official validation of procedure manuals and the abrupt end of activities following the drop in cases in July disrupted the continuity of the response mechanism.

#### **4.1.4. What Could Have Been Improved**

Better intersectoral coordination involving all stakeholders from the outset would have enhanced the coherence of the response. Dedicated funding for psychosocial support and a sustainable incentive system for responders could have helped maintain team engagement. Greater involvement from the private sector would also have

been a valuable lever, as would early anticipation of the post-crisis phase to avoid the premature dismantling of the mechanism.

## **4.2. Involvement of Community Actors in Mental Health and Psychosocial Support**

### **4.2.1. Description of the Action**

The community-level mental health response to the COVID-19 pandemic in Senegal was built on an existing network of more than forty organizations active in the field. Some associations gradually specialized, such as *And Taxawu Gnu Weredi*, dedicated to the rehabilitation of homeless individuals with mental illness, and others working on drug prevention among youth.

To improve coordination, these associations were brought together in 2019 under the umbrella of the Network of Organizations for the Promotion of Mental Health in Senegal (REPOSAMS). This network played a key role in the psychosocial support strategy during the pandemic, organizing outreach interventions in neighborhoods and households.

During curfews, associations such as *Clean Mind*, in collaboration with local authorities, distributed food kits to homeless people with mental disorders—who were highly vulnerable during confinement.

Due to the irregularity of mobile outreach interventions, the idea emerged to establish fixed reception facilities. One such facility, named *Delossi*, was created in Rufisque with support from local administrative authorities. It aims to offer psychosocial rehabilitation for homeless individuals with mental illness and relies on the voluntary commitment of local actors.

### **4.2.2. What Worked Well**

The community system was significantly strengthened during the pandemic. Targeted training was provided to community actors, known as peer listeners, enabling them to support people with mental illness more effectively. The creation of a reception center for homeless individuals with mental disorders marked a major step forward—providing temporary shelter, nutritional support, and basic care. These initiatives helped reduce vulnerability during lockdowns and reinforced the role of volunteerism in mental health.

Community mental health actors made a significant contribution to combating the stigma associated with individuals infected with SARS-CoV-2 and countering misinformation. They played a key role in promoting the acceptance of testing strategies and supporting the COVID-19 vaccination campaign.

### **4.2.3. What Did Not Work Well**

The lack of regular follow-up by local authorities weakened the sustainability of some initiatives. No dedicated funding was allocated for community assistance, undermining the operational capacity of the network. Furthermore, community mental health activities lacked proper medical and legal supervision, which may have limited their impact or raised ethical and accountability concerns. In the long

term, the absence of moral and material support diminished volunteer engagement—a key driver of these actions.

#### **4.2.4. What Could Have Been Improved**

Greater involvement from health, departmental, and local authorities would have improved coordination and recognition of community-based initiatives. The creation of a dedicated fund for community psychosocial support, particularly for managing reception centers, appears essential. Lastly, formalizing practices through the development of community-based intervention protocols would have standardized approaches and ensured the quality of actions undertaken.

### **4.3. Adaptation of Psychiatric Facilities to Mental Health Care during COVID-19**

#### **4.3.1. Description of the Action**

The onset of the COVID-19 pandemic severely disrupted psychiatric services in Senegal, leading to a marked decline in outpatient visits and hospitalizations due to the high risk of nosocomial transmission. Faced with this unprecedented context, psychiatric facilities had to adapt their service delivery to maintain access to care while minimizing health risks.

Remote consultation strategies (e-consultations) were introduced, including phone and video consultations via WhatsApp when clinical observation was necessary. This approach maintained direct interaction with patients and allowed caregivers to participate in treatment follow-up, including prescription renewals. In-person consultations were still available when clinically justified.

Given the specific vulnerabilities of people with mental disorders (comorbidities, cognitive difficulties, social isolation, stigma), a dedicated epidemiological treatment center was established at the Thiaroye Psychiatric Hospital to provide care for unstable psychiatric patients who tested positive for SARS-CoV-2.

Following the lifting of interregional travel restrictions, psychiatric services observed a gradual return of regular patients, those who had dropped out of care, and new patients impacted by the psychological repercussions of the epidemic.

#### **4.3.2. What Worked Well**

Remote consultations reduced physical attendance at psychiatric facilities, thus limiting the risk of infection while ensuring continued patient monitoring. This strategy also brought care closer to families, facilitating psychosocial support in domestic settings. It helped reduce patient transportation costs and freed up time for psychiatric personnel involved in the national response. These adaptations ensured the continuity of care despite regional border closures.

#### **4.3.3. What Did Not Work Well**

Despite these efforts, coverage remained incomplete due to network issues, social isolation, or lack of family support, making some patients unreachable. In addition, the limited and under-equipped teleconsultation tools sometimes led to a decline in the quality of psychological care, as the absence of direct contact compromised

clinical assessments in psychiatry.

#### **4.3.4. What Could Have Been Improved**

Systematizing well-equipped teleconsultation services across all psychiatric facilities, supported by coordinated national regulation, would have enhanced their effectiveness. Moreover, interconnecting psychiatric services with the Ministry's epidemiological surveillance systems (particularly the Directorate of Prevention) would have enabled better identification, referral, and management of individuals in psychological distress or relapse.

#### **4.4. Lessons Learned**

Before the pandemic, mental health care in Senegal relied on thirteen formal psychiatric facilities, supported by a few centers for youth with intellectual disabilities and a still limited private sector. Access to care was often costly (between 5000 and 25,000 XOF), psychotropic and antiepileptic medications were frequently out of stock, and community-based psychological support remained marginal. The outbreak of COVID-19 exposed these vulnerabilities while simultaneously stimulating the establishment of a structured psychosocial support mechanism, mobilizing both central and community-based resources. Although initially characterized by a degree of improvisation, this response led to significant institutional learning dynamics. Several key lessons can be drawn:

- The establishment of integrated multidisciplinary units enabled the rapid deployment of remote psychosocial support, serving both Senegalese citizens abroad and positive or contact cases within the country.
- The integration of psychological support into occupational health services—especially for healthcare workers—proved essential in reinforcing resilience and maintaining the quality of care under intense pressure.
- The development of psychiatric teleconsultation, via phone calls or video conferencing, ensured continuity of care while reducing contamination risks in specialized facilities.
- The deconcentration of psychosocial response, through the creation of regional and local response cells, improved reactivity to surging case numbers. This approach facilitated the rapid mobilization of human and financial resources at the local level.
- Community-level decentralization, through the direct involvement of associations, local leaders, and volunteers, contributed to the social care of individuals with mental illness through concrete actions such as food kit distribution, family reintegration, and the establishment of care centers.

In summary, the crisis acted as a catalyst, revealing the adaptability of Senegal's mental health system. It demonstrated that the effectiveness of interventions depends not only on institutional responses but also on the functional integration of different levels of action—from national to community—and the active inclusion of grassroots stakeholders. These achievements now deserve to be consolidated and institutionalized to better address future health and social emergencies.

Based on the lessons learned, we propose six major recommendations to improve the management of mental health in the face of future national or international public health emergencies in Senegal, as presented in **Table 1**.

**Table 1.** Major recommendations to improve the management of mental health in the face of future national or international public health emergencies in Senegal.

Recommendations	Actions
1) Institutionalization of Mental Health in National Emergency Management Policies	<ul style="list-style-type: none"> <li>• Integrate mental health into national pandemic preparedness and response plans.</li> <li>• Establish a permanent technical committee on mental health within the Ministry of Health with a clear crisis-response mandate.</li> </ul>
2) Strengthening the Multisectoral Coordination Mechanism	<ul style="list-style-type: none"> <li>• Clarify the roles of key stakeholders (Mental Health Division, Directorate of Social Action, REPOSAMS, local authorities, etc.) from the outset of the response.</li> <li>• Establish a decentralized coordination mechanism in each region (regional crisis mental health units).</li> <li>• Avoid the creation of parallel systems by ensuring vertical and horizontal integration of interventions.</li> </ul>
3) Sustainable and Dedicated Mental Health Financing	<ul style="list-style-type: none"> <li>• Allocate a specific mental health budget for emergencies within the Ministry's funding lines.</li> <li>• Create a community-based mental health intervention fund to support local actors and associations.</li> <li>• Strengthen public-private partnership mechanisms to mobilize additional resources.</li> </ul>
4) Development of an Integrated and Interconnected Information System	<ul style="list-style-type: none"> <li>• Link psychiatric services with epidemiological surveillance systems.</li> <li>• Produce real-time data on psychosocial impacts and support needs.</li> <li>• Establish a national registry of mental health actions implemented during crises.</li> </ul>
5) Sustainability of Technological Innovations	<ul style="list-style-type: none"> <li>• Develop and regulate psychiatric teleconsultation (guidelines, training, and reimbursement schemes).</li> <li>• Maintain remote assistance platforms (hotlines, listening centers).</li> <li>• Create a digital repository of standardized psychosocial care tools.</li> </ul>
6) Strengthening Community Capacities and Social Resilience	<ul style="list-style-type: none"> <li>• Train "peer helpers" and psychosocial responders in each health district.</li> <li>• Support the creation of temporary community-based shelters for individuals in mental distress.</li> <li>• Promote local knowledge and existing community networks to enhance the localization and sustainability of responses.</li> </ul>

## 5. Discussion

The analysis of mental health interventions implemented during the COVID-19 pandemic reveals a multidimensional response combining institutional coordination, community mobilization, and innovation in psychiatric practices [12]. Far from being static, this response gradually adjusted to epidemiological dynamics, illustrating both adaptive capacity and underlying structural vulnerabilities [13].

The mobilization of multidisciplinary teams—including healthcare professionals, social workers, and community leaders—enabled a holistic approach to addressing psychosocial impacts [14] [15]. The increase in psychiatric disorders during the pandemic context [16] [17] highlights the importance of initiatives such as psychiatric teleconsultations. These phone-based consultations improved both accessibility and health safety within service provision [14] [18].

The actions undertaken by community-based organizations, brought together within a dedicated network, demonstrate that community actors [14] are powerful levers for reaching vulnerable populations, particularly homeless individuals with mental illness. The creation of a community-based shelter center represents a local innovation in psychosocial rehabilitation. To maximize the impact of these adaptations, it is essential to systematize them through national standards, dedicated digital infrastructure, and sustained technical support [12].

Despite the relevance of this study in documenting institutional and community-based mental health responses during the COVID-19 pandemic, several limitations must be acknowledged. Some data could not be uniformly collected across all regions of Senegal due to institutional fragmentation, the lack of standardized reporting, and the informal nature of certain community-based interventions. While the study focuses on a critical period (2020-2021), it does not longitudinally track the post-crisis evolution of the mental health system. As a result, certain dynamics, such as the waning of activities, redeployment of resources, or abandonment of initiatives, could not be thoroughly analyzed.

## 6. Conclusions

The Senegalese experience demonstrates that a mental health response to a major public health crisis can be rapid, innovative, and multilevel. However, its sustainability relies on the quality of multisectoral coordination, the integration of community actors, and the structuring of technological innovations. This experience offers a valuable foundation for building a more resilient, equitable, and integrated mental health system that is better prepared to respond to future crises.

Ultimately, this reflective analysis reveals that, beyond its health impacts, the COVID-19 pandemic served as a catalyst for collective learning and innovation. It opens up new perspectives for strengthening psychosocial care systems—making them more inclusive, community-based, and better equipped for future emergencies.

## Acknowledgments

The author would like to extend sincere gratitude to all mental health professionals in Senegal who contributed to the psychosocial response during the COVID-19 pandemic. Special thanks go to the Mental Health Division of the Ministry of Health and Social Action, the Directorate of Social Action, and the Health Emergency Operations Center (COUS) for their unwavering institutional support. Appreciation is also extended to the Institute of Health and Development (ISED) for its academic guidance and collaboration.

Warm thanks are due to the community-based actors mobilized through the REPOSAMS network, whose commitment was instrumental in reaching vulnerable populations. The author also acknowledges the crucial support of financial partners and NGOs, whose contributions enabled the implementation of key psychosocial initiatives.

Finally, heartfelt appreciation is extended to the families who, through their solidarity and care, played an essential role in supporting individuals with mental health conditions during this unprecedented health crisis.

## Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

## References

- [1] Haggerty, K.D. (2003) Review Essay: Ruminations on Reflexivity. *Current Sociology*, **51**, 153-162. <https://doi.org/10.1177/0011392103051002091>
- [2] Smith, D. (1987) *The Everyday World as Problematic: A Feminist Sociology*. University of Toronto Press.
- [3] Maton, K. (2003) Reflexivity, Relationism, & Research. *Space and Culture*, **6**, 52-65. <https://doi.org/10.1177/1206331202238962>
- [4] Boutilier, M. and Mason, R. (2006) Le praticien réflexif en promotion de la santé: De la réflexion à la réflexivité. In: *Promotion de la Santé au Canada et au Québec, Perspectives Critiques*, Les Presses de l'Université de Laval, 399-420. <https://doi.org/10.1515/9782763702209-021>
- [5] Talla, C., Loucoubar, C., Roka, J.L., Barry, M.A., Ndiaye, S., Diarra, M., *et al.* (2022) Seroprevalence of Anti-SARS-CoV-2 Antibodies in Senegal: A National Population-Based Cross-Sectional Survey, between October and November 2020. *IJID Regions*, **3**, 117-125. <https://doi.org/10.1016/j.ijregi.2022.02.007>
- [6] Gouvernement du Sénégal (2020) Conseil des ministres du 04 mars 2020. <https://www.ouestaf.com/senegal-conseil-des-ministres-du-4-mars-2020-le-com-munique/>
- [7] Diallo, A.I., Faye, A., Tine, J.A.D., Ba, M.F., Gaye, I., Bonnet, E., *et al.* (2022) Factors Associated with the Acceptability of Government Measures to Address COVID-19 in Senegal. *Revue d'Épidémiologie et de Santé Publique*, **70**, 109-116. <https://doi.org/10.1016/j.respe.2022.03.123>
- [8] Ba, M.F., Ridde, V., Diallo, A.I., *et al.* (2021) Acceptability of Contact Management and Care of Simple Cases of COVID-19 at Home: A Mixed-Method Study in Senegal. <https://www.medrxiv.org/content/10.1101/2021.03.10.21253266v1.full>

- [9] Hossain, M.M., Tasnim, S., Sultana, A., Faizah, F., Mazumder, H., Zou, L., *et al.* (2020) Epidemiology of Mental Health Problems in COVID-19: A Review. *F1000Research*, **9**, Article 636. <https://doi.org/10.12688/f1000research.24457.1>
- [10] Tremblay, M.-C., Richard, L., Brousselle, A. and Beaudet, N. (2014) Learning Reflexively from a Health Promotion Professional Development Program in Canada. *Health Promotion International*, **29**, 538-548. <https://doi.org/10.1093/heapro/dat062>
- [11] Bisset, S., Tremblay, M.C., Wright, M.T., *et al.* (2017) Can Reflexivity Be Learned? An Experience with Tobacco Control Practitioners in Canada. *Health Promotion International*, **32**, 167-176.
- [12] Ayenigbara, I.O. (2022) Mental Health amid COVID-19 Pandemic: Appropriate Coping Strategies. *Psychiatria Danubina*, **34**, 325-333.
- [13] Chew, Q.H., Wei, K.C., Vasoo, S., *et al.* (2020) Narrative Synthesis of Psychological and Coping Responses towards Emerging Infectious Disease Outbreaks in the General Population: Practical Considerations for the COVID-19 Pandemic. *Singapore Medical Journal*, **61**, 350-356. <https://doi.org/10.11622/smedj.2020046>
- [14] Reinhard, M.A., Burkhardt, G., Grosse-Wentrup, F., *et al.* (2021) Psychosocial Support during the COVID-19 Pandemic: Interdisciplinary Concept of Care at a University Hospital. *Der Nervenarzt*, **92**, 701-707.
- [15] Adorjan, K., Pogarell, O., Streb, D., Padberg, F., Erdmann, C., Koller, G., *et al.* (2021) Role of Psychiatric Hospitals during a Pandemic: Introducing the Munich Psychiatric COVID-19 Pandemic Contingency Plan. *BJPsych Open*, **7**, e41. <https://doi.org/10.1192/bjo.2020.167>
- [16] Mukhtar, S. (2020) Psychological Health during the Coronavirus Disease 2019 Pandemic Outbreak. *International Journal of Social Psychiatry*, **66**, 512-516. <https://doi.org/10.1177/0020764020925835>
- [17] Singh, S., Roy, D., Sinha, K., Parveen, S., Sharma, G. and Joshi, G. (2020) Impact of COVID-19 and Lockdown on Mental Health of Children and Adolescents: A Narrative Review with Recommendations. *Psychiatry Research*, **293**, Article ID: 113429. <https://doi.org/10.1016/j.psychres.2020.113429>
- [18] Samaâli, S., Hakiri, A., Bouallaguia, A., Amri, G. and Ghachem, R. (2023) Assessment of Knowledge and Perceptions of Tunisian Psychiatrists regarding Telepsychiatry. *La Tunisie Médicale*, **102**, 360-365. <https://doi.org/10.62438/tunismed.v102i6.4858>