Mental Health Care in Anglophone West Africa

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This column describes the current state of resources and practice in mental health care in the Anglophone countries of West Africa: the Gambia, Sierra Leone, Ghana, Nigeria, and Liberia. Information was systematically gathered from the five countries by using a standard framework for country situation analysis. Mental health services, which are in various stages of development, are characterized by inadequate human resources and long policy neglect. Despite the low numbers of specialists, the region has made important contributions to community service development and global mental health research. Challenges include manpower development, policy and legislation updates, and increased attention to policy and budget. Although mental health service is still grossly inadequate in the context of human and material constraints, there are slowly evolving signs of positive modernization and service development. (*Psychiatric Services* 65:1084–1087, 2014; doi: 10.1176/appi.ps.201300300)

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The West African region is made up of 16 countries, whose governance and adopted official languages have been largely influenced by their colonial history. The Anglophone countries of West Africa, which gained their independence from colonial British rule around 1960 and have retained the use of English as the official language, are the Gambia, Sierra Leone, Ghana, and Nigeria. Liberia, which was established as a state where former slaves from the United States were repatriated, became independent in 1847. Similarly, Sierra Leone was created by the British for freed slaves in the 18th century and became independent in 1961.

The history of psychiatry in West Africa reflects the history of western medicine in the region, which was first introduced through hospitals established by missionary bodies such as the Roman Catholic Mission in coastal offshore islands in the early 16th century and on the mainland by the middle of the 19th century. During the colonial era, psychiatric care was commonly provided by foreigners with a poor grasp of the cultures of their patients. This often led to cultural distance in the identification of psychopathology. For example, some early psychiatrists wrote that Africans could not suffer from depression because they lacked the ability to be introspective or self-critical. Research conducted during the 1950s by Africans in the region later showed that this view was not correct (1,2).

In 1961, reflecting the extent of the professional development at this time, the First Pan-African Psychiatry Conference was convened in West Africa by Adeoye Lambo and held in Abeokuta, Nigeria.

Current resources and practices

To examine current resources and practices in mental health care, information was systematically gathered from five countries—the Gambia, Sierra Leone, Ghana, Nigeria, and Liberia—by using a standard framework for country situation analysis that covers several domains, including information on mental health services available in the country, presence of a mental health policy, prevalence of mental health conditions, presence of legislation protecting the rights of people with mental health problems, mental health financing, human resources for mental health, needs for specialist mental health services, availability of drugs, and presence of organizations working in mental health. This framework was developed to inform planning processes for mental health programs, but it also allows measurement of change in indicators or impact when it is used to gather information over time. The framework includes some standard indicators accepted as useful for international comparisons (3,4) as well as more qualitative measures assessing cultural beliefs and historical antecedents to the current context. In each country, relevant stakeholders were identified and invited to participate in the project, including individuals from civil society groups and nongovernmental organizations (NGOs), mental health professionals, and service users. Other sources of

information included published epidemiological data and government statistics and information provided by civil societies in each country. Use of such gray data was important given the low level of published empirical data on mental health services in these countries. Ethical approval was obtained for this project.

Prevalence of mental health conditions

Epidemiological surveys are scarce in the region. Among the more recent and standardized surveys is the Nigerian Survey of Mental Health and Well-being, a component of the World Health Organization (WHO) World Mental Health Survey Initiative (5), which has produced estimates of the prevalence of mental health conditions among adults in the community. The survey utilized a clustered multistage sampling of households and interviewed selected adults with the Composite International Diagnostic Interview. The survey found a lifetime prevalence rate of 12.1% for common mental disorders, defined by *DSM-IV* criteria, and a 5.8% 12-month prevalence rate. Even though about 23% of those with a mental disorder were rated to have serious and disabling conditions, less than 10% of this group had received any treatment in the preceding 12 months (5).

Similar levels of mental health burden have been reported for some of the other countries in the region (6). In Liberia, which is still recovering from the devastation of a 14-year civil war, a cross-sectional, community-based, multistage cluster survey of 1,666 adults reported that the most common mental disorders were posttraumatic stress disorder (44%), and major depressive disorder (40%) (7).

Mental health policies and legislation

All Anglophone West African countries have mental health policies of various ages. The most recent policies are those of the Gambia (2007), Ghana (2012), Sierra Leone (2009), and Liberia (2009). Such policies address service development, organization building, financing, medicine, advocacy, multisectoral collaboration, capacity building, human rights, and decentralization of services. The impact of existing mental health policies in the region has been limited by their poor implementation (8).

Ghana has the most advanced mental health legislation in the region. Nigeria and the Gambia still operate under obsolete laws that were enacted nearly a century ago. The legislation in Nigeria and Gambia do not address issues such as access to care, protection of patients from involuntary admission and treatment, protection of rights of people with mental disorders, protection of rights of families and caregivers, quality assurance, protection of rights of vulnerable groups, substance use, and issues related to legislative links with other sectors.

Financing, services, and human resources

Mental health services are largely funded via subvention from the national government in most countries under the general allocation of the Ministry of Health. None of the WHO member countries has a specific budget line for mental health at any level of government. The total mental health budget, deduced from the allocation to psychiatric facilities, ranges from .5% (in the Gambia) to 1.3% (in Ghana) of the total health budget. In the Gambia, health financing and by extension mental health financing is mainly from foreign donations. Donation as a method of mental health financing is negligible in the other countries.

Wide variations in the availability of mental health services exist across Anglophone West Africa. [A table summarizing some differences between the five countries is available in an online data supplement to this column.] However, a common trend is the disproportionately skewed organization of mental health services in favor of large, standalone mental health facilities and some units in general tertiary facilities. Countries such as Liberia, Sierra Leone, and the Gambia have only one tertiary psychiatric hospital, whereas Nigeria has ten. The comparisons are more meaningful in relation to population size. The Gambia has one psychiatric hospital per two million people, and Nigeria has one psychiatric hospital per 16 million people.

A similar trend is evident for mental health service departments within teaching hospitals, with Nigeria having the most within the region. Prison mental health facilities also exist in Nigeria. Subspecialty services are poorly developed generally and are unavailable except in Nigeria.

Community-based mental health services are poorly developed and largely unavailable in most parts of West Africa. Most people tend to receive mental health care from traditional and religious healers because of widespread beliefs about the supernatural causation of mental illness (9). However, there are ongoing efforts to pursue innovative methods of successfully integrating mental health care into primary health care in several countries, including Nigeria, Ghana, and Sierra Leone, as a way of improving access to high-quality and acceptable care (10,11).

The ratio of mental health personnel to population is far below what WHO recommends for the region. Sierra Leone has only one retired psychiatrist for six million people, and Nigeria has 160 psychiatrists for 160 million people. Furthermore, the available mental health professionals are disproportionately distributed in each country and are more likely to be concentrated in the few large mental health facilities located in a few cities. Unfortunately, the region also loses a large proportion of trained professionals to brain drain (12).

Essential psychotropic drugs as recommended by WHO are routinely available only in psychiatric and teaching hospitals. Tricyclic antidepressants, selective serotonin reuptake inhibitors, first- and some second-generation antipsychotics, and mood stabilizers (carbamazepine and sodium valproate) are available in private pharmacies in capital cities in most parts of the region, but supplies are often erratic and prices are sometimes too high for most patients.

Clinical and academic training programs

Postgraduate psychiatric training takes place in Nigeria and in Ghana. The other countries simply lack the manpower to train residents. In Nigeria and Ghana, psychiatry residency training is conducted in university teaching hospitals, psychiatric hospitals, and general hospitals. Institutions accredited for training residents are required to have an adequate number of physicians on

their faculty, who must be a Fellow of the West African College of Physicians in Psychiatry or its equivalent, such as U.K. membership in the Royal College of Psychiatrists. Twelve such institutions are accredited for training postgraduate psychiatric residents in Nigeria, and two are accredited in Ghana.

In addition to training for psychiatry residents and medical students, some institutions have training programs for other categories of health workers. Two postgraduate programs in psychiatry currently exist in Nigeria. A master's degree program in academic psychiatry and one in child and adolescent mental health are both registered with the University of Ibadan Postgraduate School in Nigeria. A noncertificate course in global mental health, consisting of courses focusing on leadership, service organization and development, and advocacy skills, has been available at the University of Ibadan since 2010 (11).

Research

The region has a rich history of research. Among some of the large and landmark epidemiological studies that have been conducted in the region are the International Pilot Study of Schizophrenia (13), the ten-nation Outcome Study (14), the Psychological Problems in General Health Care (15), and the World Mental Health Survey Initiative (16). The Indianapolis-Ibadan Dementia Project, a long-standing, longitudinal project conducted between 1992 and 2011, was an epidemiological study that compared the prevalence of and risk factors for Alzheimer's disease and other dementias between Yoruba Nigerians and African Americans (17).

Challenges

Factors limiting the growth and evolution of psychiatric practice in the region were identified, including poor funding, stigmatization (of patients and professionals), lack of public awareness about the causes of mental illness, low priority by policy makers, and loss of the few trained professionals through brain drain. In most countries, the absence of a current framework to guide the practice of psychiatry via a comprehensive mental health policy and legislation and a lack of political will to implement existing policies have also been significant challenges.

Future prospects

Several important developments point to a brighter future for mental health services in the West African region. First, there is renewed attention in WHO member countries to update mental health policies and legislation in conformity with best practices and current evidence. These efforts should provide a good foundation and a work environment that enables services development. Second, more attention is being paid to the urgent need for a task-shifting approach to the provision of mental health services in a bid to develop context-specific solutions to the treatment gap for mental disorders. Task shifting, as described by WHO, is the rational redistribution and delegation of tasks among health workers such that health care tasks are shifted from higher-trained health workers to less highly trained health workers to maximize efficient use of resources. These efforts have largely been focused on the successful integration of mental health care into primary care by using the evidence-based principles underlying the WHO Mental Health Gap (mhGAP) Action Program Intervention Guide (18) and associated resources. The efforts are yielding positive developments, including increased recognition and treatment of some priority mental health conditions, such as depression, psychosis, and alcohol use disorders, by primary care workers.

Third, the five countries have seen an increase in political stability, which has also led to improved conditions of service for health workers generally—a development that may discourage brain drain. Fourth, there are growing numbers of mental health NGOs in Liberia, the Gambia, Nigeria, Ghana, and Sierra Leone and other parts of the region, which are focusing on tackling mental health problems in the community through advocacy; mental health promotion, prevention, and treatment; and rehabilitation of individuals with mental illness. The increased reliance on evidence-based standards, such as mhGAP, and close partnerships with governments by such organizations is a significant shift from past ways of working.

Finally, the recent introduction of health insurance in the region (most successfully in Ghana) has the potential to improve access to care by reducing out-of-pocket payments and thereby lessening the burden and costs to caregivers, although coverage for mental health conditions is currently limited.

Conclusions

The current lack of psychiatric services in Anglophone West Africa and very low human and financial resources are a result of a long-term lack of prioritization of mental health issues by governments and policy makers. However, there are promising signs that the situation is slowly evolving, with more qualified personnel in decentralized settings, improved funding, and innovative approaches to scaling up care for mental and neurological disorders through the successful integration of mental health into primary care.

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