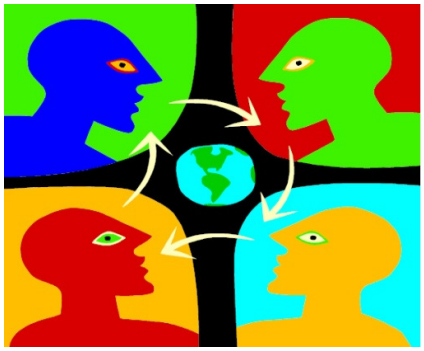
WHO MIND
Mental Health in Development



WHO proMIND: Profiles on Mental Health in Development

SIERRA LEONE

Mental Health Policy and Service Development
Department of Mental Health and Substance Abuse
World Health Organization

World Health Organization

WHO Library Cataloguing-in-Publication Data

WHO proMIND: profiles on mental health in development: Sierra Leone.

1.Mental health. 2.Mental health services. 3.Health policy. 4.Sierra Leone. I.World Health Organization.

ISBN 978 92 4 150417 1 (NLM classification: WM 140)

Suggested Citation:
Alemu W. Funk M. Gakurah T. Bash-Taqi D. Bruni A. Sinclair J. Kobie A. Muana A. Samai M. Eaton J. WHO Profile on mental health in development (WHO proMIND): Sierra Leone. Geneva, World Health Organization, 2012.

This and other profiles on mental health in development can be sourced from:
http://www.who.int/mental_health/policy/country/countrysummary/en/index.html

For feedback or suggestions for the improvement of this publication, please email Dr Michelle Funk (funkm@who.int)

SIERRA LEONE

'To make available to all the people in Sierra Leone, in collaboration with a range of partners, affordable, accessible, sustainable and integrated high quality mental health services.'

Acknowledgements
This publication has been produced as part of the World Health Organization's (WHO) profiles on mental health in development (WHO proMIND), and has been written and edited by:

Dr Wondimagegnehu Alemu, The WHO Representative for Sierra Leone
Dr Michelle Funk, Coordinator, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, WHO, Geneva
Dr Tenin Gakuruh, Technical Officer, Office of the WHO Representative for Sierra Leone
Dr Donald A. Bash-Taqi, Director of Post-Graduate Training, Non-communicable Disease and Research, Ministry of Health and Sanitation, Sierra Leone
Dr Andrea Bruni, Office of the WHO Representative for Sierra Leone
Ms Jessica Sinclair, Mental Health Policy and Service Development, Department of Mental Health and Substance Abuse, WHO, Geneva
Ms Aminata Kobie, National Professional Officer, Office of the WHO Representative for Sierra Leone
Dr Andrew Muana, Head of NCD and Focal Point in Mental Health, Ministry of Health and Sanitation; Medical Superintendent, Sierra Leone Psychiatric Hospital, Sierra Leone
Dr Mohamed Samai, Deputy Director of Post-graduate Training, NCDs and Research, MoHS; Head, Department of Pharmacology and Therapeutics, College of Medicine and Allied Health Sciences
Dr Julian Eaton, Mental Health Advisor, CBM International, Lomé, Togo

The preparation of this profile would not have been possible without the support of the following staff from WHO:

Dr Sebastiana Da Gama Nkomo, Acting Regional Advisor for Mental Health and Substance Abuse, WHO Regional Office for Africa, Brazzaville, Republic of Congo
Mrs Carina Ferreira-Borges, Technical Officer for Mental Health and Substance Abuse, WHO Regional Office for Africa, Brazzaville, Republic of Congo
Dr Diosdado-Vincent Nsue-Milang, HPR, WHO Regional Office for Africa, Brazzaville, Republic of Congo
Dr Luis Gomes Sambo, Regional Director, WHO Regional Office for Africa, Brazzaville, Republic of Congo

(WHO proMIND): SIERRA LEONE
Potential partners interested in finding out more about mental health in the Republic of Sierra Leone should also contact project partners based in-country (contact details on page 7).

WHO proMIND
Potential partners and donors interested in supporting or funding WHO proMIND projects should contact Dr Michelle Funk (funkm@who.int), Coordinator, MHP, Department of Mental Health and Substance Abuse, WHO, Geneva, Switzerland.

More information about WHO MIND and WHO proMIND projects is available on the website: http://www.who.int/mental_health/policy/en/

THE PROJECT

"To make available to all the people in Sierra Leone, in collaboration with a range of partners, affordable, accessible, sustainable and integrated high quality mental health services."

KEY ACHIEVEMENTS FOR MENTAL HEALTH IN SIERRA LEONE

- Situation analysis on mental health in Sierra Leone
- Development of the first Mental Health Policy for the country
- Finalization of the National Mental Health Strategic Plan
- Commitment of the Ministry of Health and Sanitation to integrating mental health into primary health care and general hospitals
- Establishment of a Mental Health Steering Committee
- Establishment of a National Mental Health Coalition of stakeholders
- Creation of strategic partnerships to implement the Mental Health Policy and Plan
- Launch of the Mental Health Policy and Plan
- Training of 187 mental health care workers including nurses and Community Health Officers from across the country between April, 2011 and March, 2012 with the support of Mercy Ships (in collaboration with WHO & MoHS)
- Establishment and intake for a Certificate and Diploma in Psychiatric Nursing in 2012

NEXT STEPS FOR SIERRA LEONE

- Establishment of a National Mental Health Coordinator position
- Implementation of the National Mental Health Strategic Plan
- Integration of mental health into other programmes such as reproductive and child health, school and adolescent health, HIV/AIDS and TB
- Decentralising services, and introducing mental health into primary health care
- Drafting of mental health legislation in line with international human rights standards
- Human resource development for mental health. Specialists and mid-level professionals are needed
- Building capacity of human resources to deliver mental health treatment and care
- Supporting and strengthening the participation of mental health service users

OVERVIEW

After a decade-long civil war, Sierra Leone is moving towards the restoration of its infrastructure and public services, including its general and mental health delivery systems.

The number of people affected by mental illness is significant. It is estimated that 715,000 people are currently suffering from mental disorders, with only 2,000 receiving treatment. Because of the country's limited resources for providing mental healthcare there is a substantial treatment gap in Sierra Leone.

The Ministry of Health and Sanitation, in collaboration with the WHO, is working to reduce the treatment gap and is planning specific activities to provide quality mental health care at primary, secondary and tertiary levels.

The Ministry of Health and Sanitation aims to integrate mental health into the overall Primary Health Care system and community-based care services in order to provide affordable, acceptable and accessible mental health services as part of the comprehensive health services package available in Sierra Leone.

HISTORY AND MILESTONES

2002

The report Mental Health and Substance abuse in Post Conflict Sierra Leone describes the current state of mental health in Sierra Leone. The first Systematic Needs Assessment on Mental Health and Substance Abuse Survey was undertaken in October, under the direction of the Ministry of Health and Sanitation with the support of WHO (1).

2004

The WHO Country Cooperation Strategy (CCS) Sierra Leone (2004-2008) clearly recognizes mental health as a priority area.

2008

Mental Health is introduced in Sierra Leone's poverty reduction strategy entitled An Agenda for Change: Second Poverty Reduction Strategy, PRSP II (2008-2012).

2009

Two WHO missions to Sierra Leone occur. The first, in March, assesses the mental health situation in Sierra Leone, and the second, in October, reviews the mental health situation in the country and assists in the development of a policy and plan.

A full-time Mental Health Officer is appointed to the WHO Country office in Sierra Leone.

The Mental Health Policy is drafted between October and December. In December, a validation meeting is held for the Mental Health Policy, with participants from MoHS, MoSW, WHO, and several other relevant organizations.

2010

The National Mental Health Strategic Plan (2010-2015) is drafted and finalized, and the Mental Health Policy is finalized and printed. In September 2010, the first mental health users and families association was established.

2011

Sierra Leone is identified as a priority country in Africa for roll-out of mhGAP.

Strategic partnership between key players in mental health in Sierra Leone and Ministry of Health and Sanitation cemented under Enabling Access to Mental Health Programme.

Establishment of National Mental Health Coalition, who organised first national mental health conference.

New psychiatric nurse training course (at College of Medicine and Allied Health Sciences, COMAHS) enrolled its first students.

2012

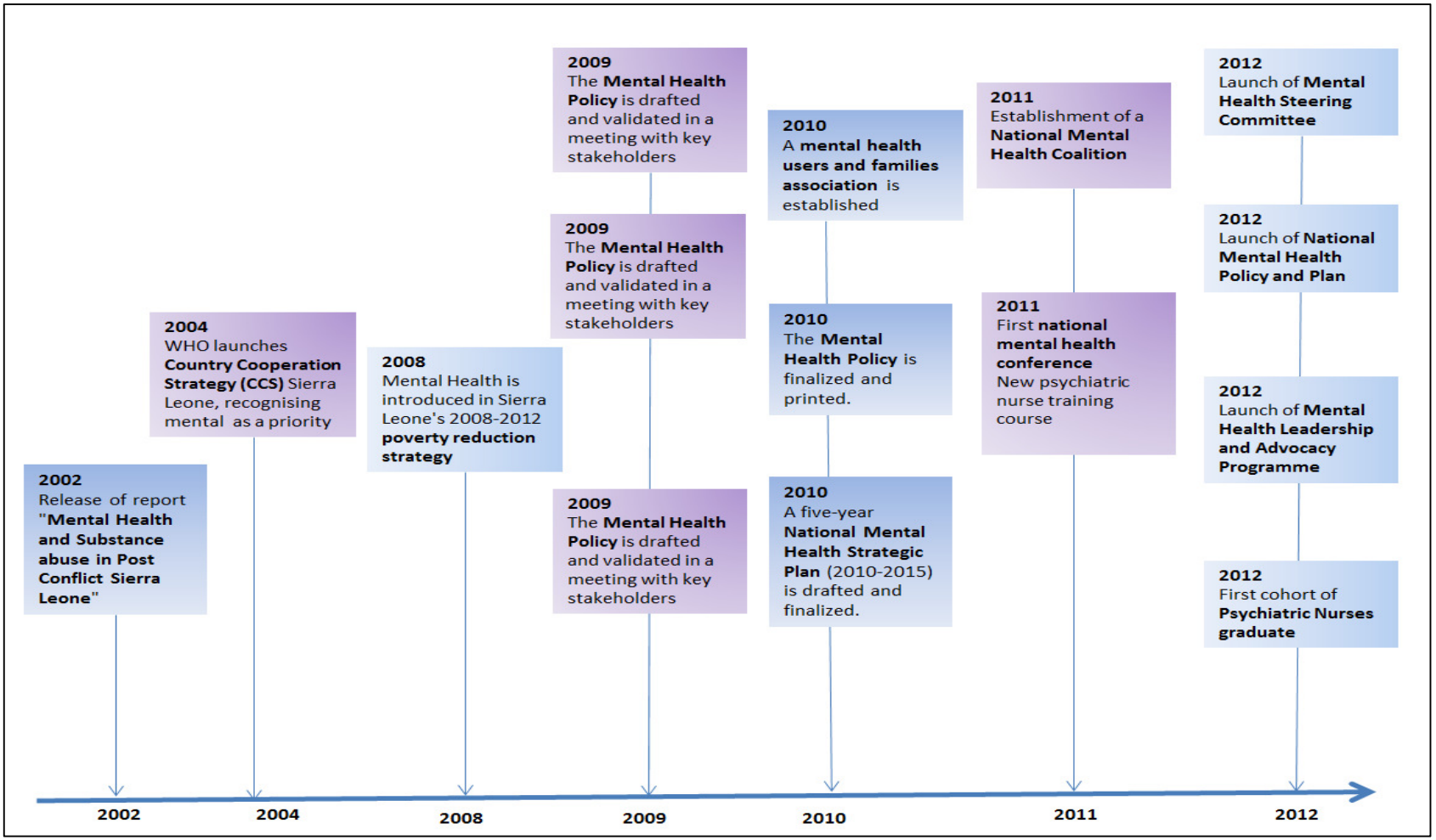
Mental Health Steering Committee launched under Ministry of Health and Sanitation.

National Mental Health Policy and Plan launched.

Mental Health Leadership and Advocacy Programme launched, with 7 mental health leaders receiving training in public mental health and service development.

First cohort of Psychiatric Nurses graduate from College of Medicine and Allied Health Sciences, Freetown.

Timeline


2002
Release of report "Mental Health and Substance abuse in Post Conflict Sierra Leone"
2004
WHO launches Country Cooperation Strategy (CCS) Sierra Leone, recognising mental as a priority
2008
Mental Health is introduced in Sierra Leone's 2008-2012 poverty reduction strategy
2009
The Mental Health Policy is drafted and validated in a meeting with key stakeholders
2009
The Mental Health Policy is drafted and validated in a meeting with key stakeholders
2009
The Mental Health Policy is drafted and validated in a meeting with key stakeholders
2010
A mental health users and families association is established
2010
The Mental Health Policy is finalized and printed.
2010
A five-year National Mental Health Strategic Plan (2010-2015) is drafted and finalized.
2011
Establishment of a National Mental Health Coalition
2011
First national mental health conference
New psychiatric nurse training course
2012
Launch of Mental Health Steering Committee
2012
Launch of National Mental Health Policy and Plan
2012
Launch of Mental Health Leadership and Advocacy Programme
2012
First cohort of Psychiatric Nurses graduate
2002
2004
2008
2009
2010
2011
2012

OFFICIAL DOCUMENTS

DEVELOPMENT AND POVERTY REDUCTION POLICIES, STRATEGIES AND PROGRAMMES

- Sierra Leone: Poverty Reduction Strategy Paper, International Monetary Fund, Republic of Sierra Leone, World Bank, 2008. http://www.imf.org/external/pubs/ft/scr/2008/cr08250.pdf

HEALTH AND MENTAL HEALTH POLICIES, PLANS AND PROGRAMMES

- Mental Health Policy, Republic of Sierra Leone, Ministry of Health and Sanitation, March 2010
- Mental Health Strategic Plan, Republic of Sierra Leone, Ministry of Health and Sanitation, July 2010
- National Health Sector Strategic Plan, Government of Sierra Leone, Ministry of Health and Sanitation http://www.whosierraleone.org/NHSSP%20SL%20%202010-15.pdf
- WHO Country Cooperation Strategy, 2008-2013 http://www.whosierraleone.org/Publication/Sierra%20Leone%20CCS%202008-13%20English.pdf

SITUATIONAL ANALYSES

- Mental Health and Substance Abuse in Post Conflict Sierra Leone. The First Systematic Needs Assessment, 2002

MAIN PARTNERS

NATIONAL LEADING PARTNERS

Dr Donald A. Bash-Taqi, Director of Post Graduate Training, Non-Communicable Disease and Research, Ministry of Health and Sanitation
Email: dabashtaqi@yahoo.com

Dr Mohamed Samai, Head of Research and Deputy Director of Post Graduate Training, Non-Communicable Disease and Research, Ministry of Health and Sanitation
Email: dhmsamai@yahoo.com

WHO COUNTRY OFFICE

Dr Wondimagegnehu Alemu, WHO Representative
Email: alemuwo@who.int

Dr Teniin Gakuruh, Technical Officer
Email: gakuruht@who.int

Ms Aminata Kobie, National Professional Officer
Email: mahoia@who.int

WHO REGIONAL OFFICE FOR AFRICA

Dr Sebastiana Da Gama Nkomo, Acting Regional Advisor, Mental Health and Substance Abuse, Brazzaville, Republic of Congo
Email: nkomos@who.int

Mrs Carina Ferreira-Borges, Technical Officer for Mental Health and Substance Abuse,
Email: ferreiraborgesc@who.int

Dr Diosdado-Vincent Nsue-Milang, HPR-AFRO
Email: nsue-milangod@who.int

Dr Luis Gomes Sambo, Regional Director
Email: sambol@who.int

WHO HEADQUARTERS

Dr Shekhar Saxena, Director, Department of Mental Health and Substance Abuse (MSD)
Email: saxenas@who.int

Dr Michelle Funk, Coordinator, Mental Health Policy and Service Development, MSD
Email: funkm@who.int

Ms Natalie Drew, Technical Officer, Mental Health Policy and Service Development, MSD
Email: drewn@who.int

Dr Kanna Sugiura, Technical Officer, Mental Health Policy and Service Development, MSD
Email: sugiuraka@who.int

OTHER INTERNATIONAL PARTNERS

CBM International
Dr Julian Eaton, Mental Health Advisor, Lomé, Togo
Email: julian.eaton@cbm-arow.org
www.cbm.org

Global Initiative on Psychiatry (GIP)
Ms Francisca Goedhart, Deputy Director, Hilversum, The Netherlands
Email: fgoedhart@gip-global.org
www.gip-global.org

THE CONTEXT

1. COUNTRY DEMOGRAPHIC AND SOCIOECONOMIC PROFILE

Figure 1
Map of Sierra Leone

Source: reference (2)

GEOGRAPHY AND CLIMATE

The Republic of Sierra Leone is situated on the west coast of Africa and borders the North Atlantic Ocean between Guinea and Liberia (Figure 1). Its land area covers approximately 71,740 sq km of which only 30% is potentially arable. It has a tropical climate with a distinct dry and rainy season. The country is rich in natural resources, including diamonds, titanium ore, bauxite, iron ore, gold, platinum, manganese and chromite. Current human-driven threats include rapid population growth, overfishing, as well as overharvesting of timber, expansion of cattle grazing and slash-and-burn agriculture, all of which have resulted in deforestation and soil exhaustion (3).

DEMOGRAPHICS

The population of 5.8 million is becoming increasingly urbanized, with 38% of the population living in cities. As can be seen from the population pyramid in figure 2, the current population has a large youth bulge with over 41% of the population under 15 years of age, and only 5.5% over 60 years of age. The current growth rate of the population is 2.7%, owing to an extremely high fertility rate of 5.12 but counterbalanced by a very high crude death rate of 14.5 per 1,000 population.

Figure 3 below shows that by 2050, the population of Sierra Leone is projected to more than double to 12.4 million. The shape of the population pyramid will still remain quite steep with a high proportion of youth, but the working age population will increase due to a much lower projected mortality rate (4-6).

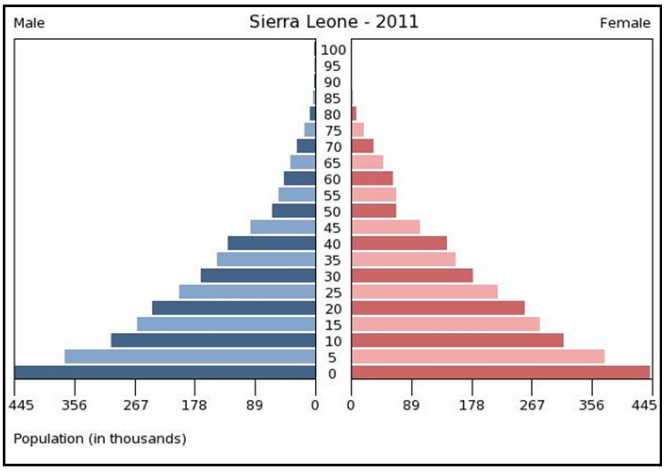


Figure 2
Age structure diagram illustrating the 2011 population in Sierra Leone.

Source: reference (7)

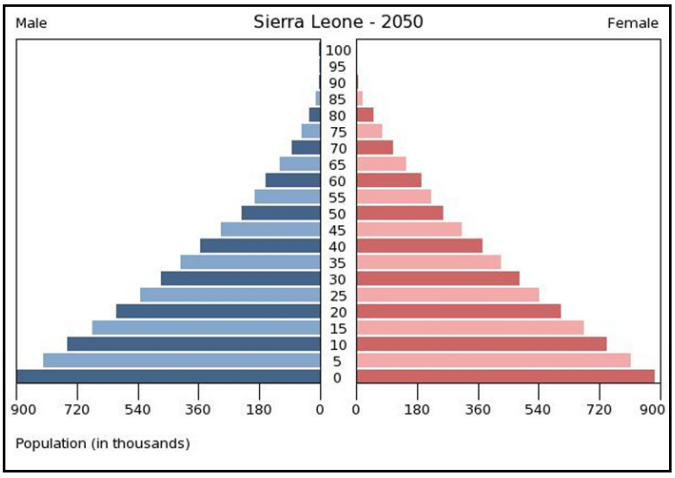


Figure 3
Age structure diagram showing Sierra Leone's population by 2050.

Source: reference (7)

MIGRATION

Population movement between Sierra Leone, Liberia and Guinea is very high and the three countries have recent histories of insecurity and civil strife. Within Sierra Leone, there is also a considerable trend towards rural-urban migration. According to the 2004 census, nearly 97% of Sierra Leone's foreign-born were of West African origin and about two thirds were from Guinea and Liberia (8).

CULTURE

Sierra Leone has approximately 20 distinct language groups and many ethnic groups including Mende, Temne, Limba, Krio, Kono, Manbingo, Fula, Kornako, Sherbro, Susu, Loko, Kissi and others. The main religious groups include Muslims, Christians and other indigenous belief groups (9).

GOVERNMENT AND ADMINISTRATION

Sierra Leone is a constitutional democracy, although its basic infrastructure was destroyed in the civil war from 1991 to 2002. With the support of the United Nations and developmental partners,

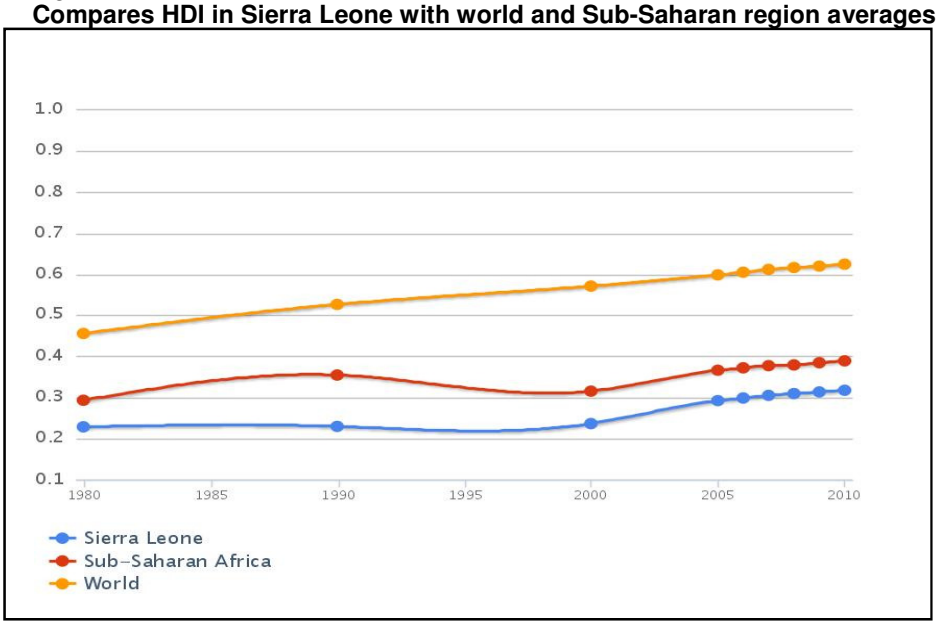
Sierra Leone commenced the rebuilding of governance infrastructure in 2002, beginning with the disarmament and demobilization of ex-combatants. This was followed by successful presidential and parliamentary elections in both May 2002 and July 2007.

Administratively, Sierra Leone is divided into four major areas: the Northern, Southern, Eastern regions and the Western Area where the capital Freetown is located. The regions are divided further into twelve districts, which are in turn sub-divided into chiefdoms, governed by local paramount chiefs. With the recent devolution of services to local communities, the country has been divided into 19 local councils that have been further sub-divided into 392 wards. Each ward is headed by an elected councillor (9).

DEVELOPMENT INDICATORS

The Human Development Index (HDI) is a composite score used by the United Nations Development Program (UNDP) to track achievements in three basic dimensions of human development; health and long life, knowledge and a decent standard of living. Figure 4 shows that Sierra Leone's very low HDI was virtually stable throughout the period of the civil war, although data was only available for the years 1980 (0.229), 1990 (0.230) and 2000 (0.236). This changed at the turn of the millennium, when Sierra Leone's HDI scores have improved and are now similar with the Sub-Saharan regional average.

Figure 4
Compares HDI in Sierra Leone with world and Sub-Saharan region averages



Source: reference (10)

In 2007, Sierra Leone was ranked the least developed country in the world. Since that time it has made considerable progress towards consolidating peace and security after a decade of civil conflict. Today, Sierra Leone's HDI is 0.317, ranked 158th in the world (10). The post-war years were characterized by high economic growth rates, averaging 6.5 percent before showing a slight decline in 2008 during the global crisis (11).

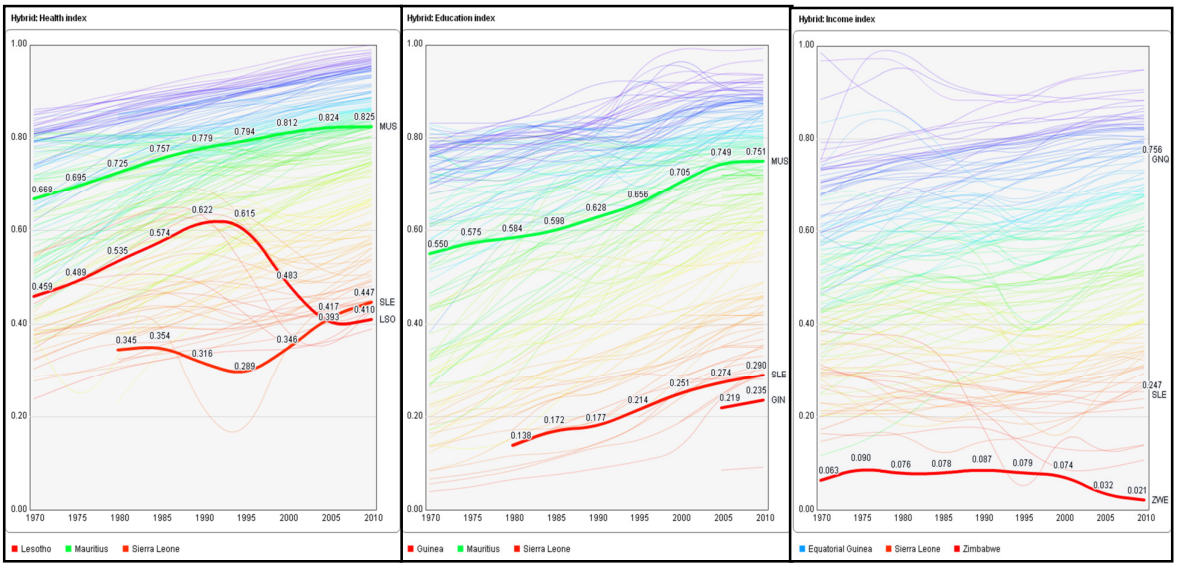
Detailed data for individual indicators can be seen in Table 1. Sierra Leone has some of the poorest health indicators in the world, including an extremely low life expectancy, a very high fertility rate and one of the highest maternal and mortality rates in the world. The high adult illiteracy rates of 48% in men and 71% in women contribute in part to the severe human resources crisis in Sierra Leone's health sector.

Indicator	Sierra Leone		Year of Data
	Male	Female	
Life expectancy at birth	46.9	49.6	2010
Healthy life years expectancy at birth	27.2	29.9	2002
Adult mortality probability between 15-60 years, per 1000 population	414	363	2009
Under-5 mortality per 100,000	160	136	2005-10
Birth rate (crude), per 1,000 population	40		2009
% births with skilled attendants	42		
Infant mortality per 1,000 live births	89		2010
Maternal mortality ratio	857		2010
% illiterate >15 years old	48.3	71.1	2010
Primary school enrolments (gross)	168	148	2010
GDP per capita (USD)	825		2010
Country income group	Low income		2010
% population below international poverty line (USD$1.25 per day)	53.4		2003
% population below national poverty line	70.2		2003-4

Table 1 Individual indicators of human development for Sierra Leone

The current level of development in Sierra Leone for each dimension of income, health and education in comparison with other Sub-Saharan states is seen in Figure 5. On the hybrid health index, Sierra Leone ranks 37th out of 43 Sub-Saharan states, or 175th in the world.

Figure 5
Three separate dimensions of the HDI for Sierra Leone and other Sub-Saharan African states



Source: reference (10)

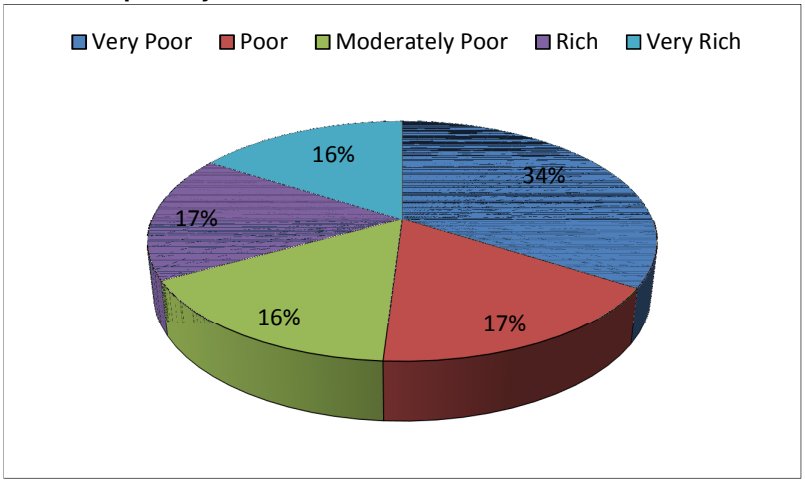
Sierra Leone is not on target to reach the majority of the Millennium Development Goals (MDGs) milestones by the year 2015, as one full decade of progress towards these was lost during the civil war. Of the eight MDGs, only one (combating HIV/AIDS, malaria and TB) is likely to be achieved, and even then only in addressing HIV/AIDS, as malaria and TB continue to remain major public health concerns. With sustained effort and improved strategies, an additional three MDGs (reducing child mortality, reducing maternal mortality and developing a global partnership for development) have the potential for being achieved. There is inadequate data to assess the attainment of universal primary education and the other three goals relating to poverty/hunger, gender equality and environmental sustainability most likely will not be met (11).

Poverty and Unemployment

Sierra Leone is ranked 180 out 182 in the Human Poverty Report with Human Poverty Index (HPI) of 47.7 (12). Nevertheless, progress has been made in creating an enabling environment for socio-economic development. In 2006, the economy underwent GDP growth estimated at 7.8%, compared to 7.3% in 2005.

As can be seen in Figure 6, 67% of Sierra Leonean households can be characterized as a subcategory of the 'poor', among which half are 'very poor'. The fact that 33% of households can still be characterized as 'rich' or 'very rich' is indicative of the extreme income inequality in the country, reflected in the almost halving of the HDI (to 0.193) when it is adjusted for inequality (10).

Figure 6
Level of poverty of households in Sierra Leone as at December 2004

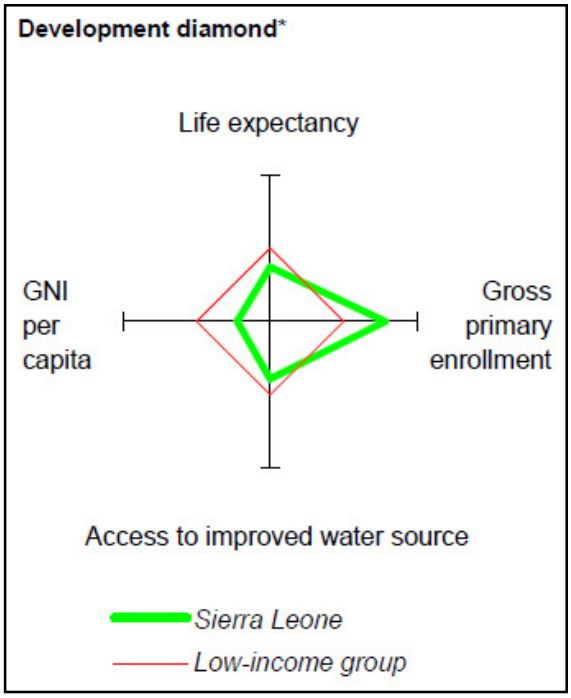


Source: reference (13)

The level of youth unemployment in Sierra Leone is currently at 46%, among the highest in the West African sub-region. The significant unemployment and underemployment in the large and growing youth population may negatively impact development and existing peace (11).

The development diamond in Figure 7, adjacent, plots four key development criteria in Sierra Leone against that of the low-income group average. In 2009, according to the World Bank, Sierra Leone had slightly lower rates of life expectancy and access to improved water source as the rest of the lower-income countries, and a much lower GNI per capita, indicative of the low regional Income HDI. The rates of gross primary school enrolment were significantly higher in Sierra Leone than in other low-income group countries.

Figure 7
Development diamond for Sierra Leone.



Source: reference (14)

2. CONTEXTUAL FACTORS INFLUENCING MENTAL HEALTH NEEDS AND SERVICES

POLITICAL INSTABILITY

The decade of civil war in Sierra Leone has challenged the delivery of social services due to poor general infrastructure and a lack of reliable electricity supply. The war destroyed basic health infrastructure and displaced health personnel negatively impacting healthcare at all levels, including the only psychiatric hospital.

Equally important as the war's effects on infrastructure are the resultant governance and capacity constraints in the public sector, including corruption and an inefficient civil service. A recent civil service reform improved pay for key professional positions, improved the association between performance and pay, and included incentives to improve service delivery to poor and often remote parts of the country (11).

Violence and Insecurity

Sierra Leone's civil war resulted in thousands of deaths and the displacement of over one third of the country's population. According to a situational analysis conducted by WHO in 2002, almost all Sierra Leoneans were exposed to severe, potentially traumatic events like having close family members killed, having houses and property looted and being attacked by rebels. More than 90% of the population in Sierra Leone has experienced a form of violence in the last several years, including physical and/or sexual abuse, mutilations, child abuse, human trafficking and domestic violence (15). The 2010 UN State of the World Population report noted that between 50,000 and 64,000 internally displaced women in Sierra Leone had experienced sexual violence by armed personnel (4).

ALCOHOL AND SUBSTANCE ABUSE

There is a high rate of both production and consumption of alcohol and illicit drugs in Sierra Leone, particularly among the young population. In 2008, it was estimated that about 90% of admissions to the Sierra Leone psychiatric hospital were drug-related (16).

Sierra Leone's President has identified illicit drugs as one of the three major risk factors threatening the stability and security of the country. Illicit drugs such as marijuana ('jamba') are locally produced or imported from abroad along "Highway 10", a West African transit zone through which large quantities of cocaine are seized en route from South America to Europe. The UN, also, has included illicit drugs as a key factor in the security component of its "Joint Vision for Sierra Leone".

Alcohol also represents a significant public health concern in Sierra Leone, with Sierra Leoneans consuming on average 9.7 litres of alcohol per capita in 2005, as opposed to 6.2 litres per capita for the rest of the WHO African region.

The high alcohol consumption is often associated with mental disorders, as well as physical illness, unsafe sex and increased risk of road accidents.

MIGRATION OF SKILLED WORKERS

There is frequent emigration of trained mental health workers from Sierra Leone, particularly among psychiatric nurses. This mostly involves staff trained abroad that have subsequently failed to return in the post-conflict period, although a greater number of skilled workers are gradually returning to Sierra Leone to contribute to the country's development. The fact that many qualified personnel were displaced or emigrated during the war and are yet to return has further exacerbated Sierra Leone's human resources crisis in the health sector (8, 16).

POVERTY AND UNEMPLOYMENT

Poverty and poor mental health exist in a vicious cycle. People living in poverty may have fewer educational and employment opportunities and may be exposed to adverse living conditions, thus placing them at higher risk of psychological stress. Furthermore, people with mental health conditions may be less productive at work and may encounter workplace discrimination or denial of employment opportunities.

The UNDP 2010 Millennium Development Goals Report on Sierra Leone stated that the poverty level (i.e. the percentage of people living on less than $1.25 per day) was reduced from 70% in 2005 to 63% in 2010.[16] Furthermore, it has been shown that high health care costs in Sierra Leone directly impact service utilization, with even modest charges tending to exclude over 50% of the population from seeking health care (9). Recently, projects such as the Free Health Care Initiative have improved access to health care for pregnant women, lactating mothers and children less than five years of age by abolishing user fees.

MENTAL HEALTH PROBLEMS AND TREATMENT IN SIERRA LEONE

3. BURDEN OF DISEASE AND TREATMENT GAP

PREVALENCE AND BURDEN OF DISEASE IN COUNTRY

The burden of neuropsychiatric conditions in Sierra Leone according to WHO 2004 age-standardized DALY rates was 2,735 DALYs per 100,000 population, representing about 4.1% of the country's all-cause disease burden (17).

There is no current data on the prevalence of mental illness in Sierra Leone. In 2002 the Ministry of Health and Sanitation conducted a systematic needs assessment survey of mental health in post-conflict Sierra Leone and found the prevalence rates to be 2% for psychosis, 4% for severe depression, 4% for severe substance abuse, 1% for mental retardation and 1% for epilepsy in the population. Cumulatively, these rates are approximately 4 times higher than the estimated global prevalence of 3% for severe mental illness(18). Similarly, a 2005 NGO community-based pilot project found that of 204 cases seen, 64% suffered from epilepsy, 24% from psychosis, 4% from depression, 4% from depressive illness and 1% from schizophrenia (15). These prevalence rates are much higher than global rates, though this may have to do with the fact that data gathering occurred immediately after the post-conflict period.

TREATMENT AND SERVICE UTILIZATION DATA

As can be seen from Table 2, an estimated 2,058 people received some form of mental health treatment in 2009, either at the Sierra Leone Psychiatric Hospital or through non-governmental or faith based organizations.

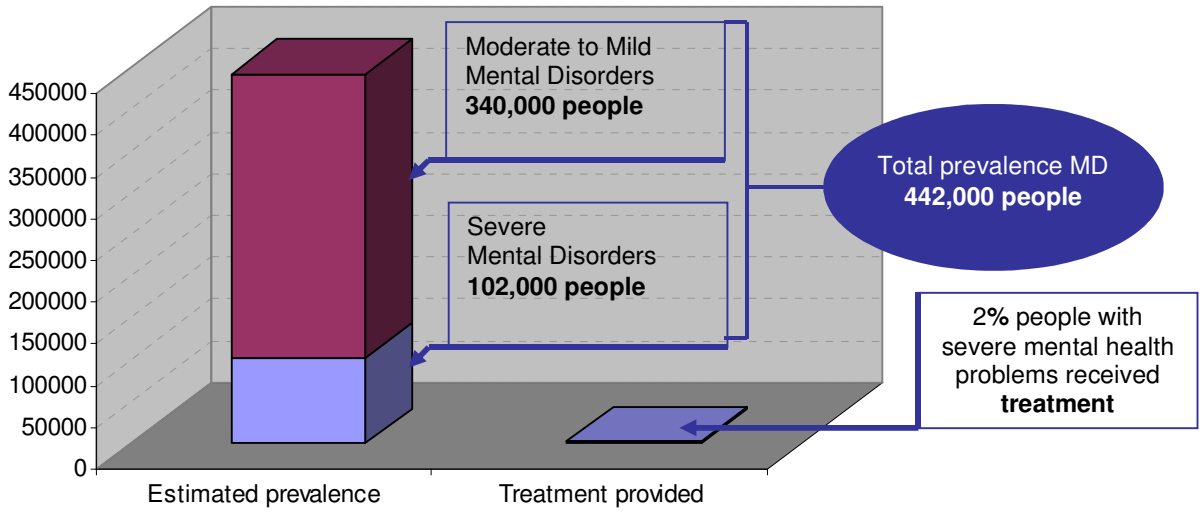
Table 2
Number of patients with mental disorders that used inpatient and outpatient services in 2009

Facility	Type	Number of Inpatients	Number of Outpatients	TOTAL
Sierra Leone Psychiatric Hospital	Govt	107	139	246
City of Rest	FBO	84	30	114
Fatima Institute (now UniMak)	FBO	0	132	132
Centre for Victims of Torture*	NGO	0	440	440
CAPS	FBO	0	1126	1126
			TOTAL	**2,058**

TREATMENT GAP

While the prevalence rates cited above are much higher than the generally accepted global estimate of 13% total prevalence, 3% for severe mental illness and 10% for mild or moderate mental illness (18), in the absence of any reliable country-wide prevalence data the treatment gap has been estimated from a conservative perspective using these global rates and the limited service utilization data available. Thus, it is possible to estimate that about 442,000 people in Sierra Leone (13% of the 3.4 million adult population) have had a mental disorder in the previous year, and about 102,000 (3% of the adult population) have suffered from a severe form. Assuming that most of the people in Sierra Leone who were treated had a severe mental disorder, then the treatment gap for severe mental disorders is 98%. If we base calculations on the total number of people with any form of a mental health problem then the treatment gap is 99.5%. Although precise figures are unavailable, these data seem plausible given that there are very few mental health services in Sierra Leone (one psychiatric hospital served by the only psychiatrist in the country who is retired and works as an external consultant). The estimated treatment gap at best, given that there will be overlap of service utilization by re-admissions and follow-up treatments, is illustrated in Figure 8.

Figure 8
Current treatment gap for people with mental disorders in Sierra Leone



MENTAL HEALTH WITHIN THE GENERAL HEALTH SYSTEM

4. MENTAL HEALTH WITHIN THE GENERAL HEALTH SYSTEM

The country's general health care system spreads across government, religious, NGO and private sectors. The Ministry of Health and Sanitation (MoHS) has multiple leadership roles, including policy formation, standard-setting, regulation, coalition-building, monitoring, oversight, and resource mobilization and accounts for approximately 50% of health care services. The remaining half is provided by NGOs and the private sector, including faith-based organizations, the private-for-profit institutions and the traditional healers.

Sierra Leone's general health governance structure is diagrammatically represented in Figure 9 and 10. Since 2004, the health sector has undergone a process of decentralization and restructuring aimed at bringing service delivery and management closer to its beneficiaries in the community. Since the end of 2008, 19 local councils have been responsible for managing the delivery of both primary and secondary health care services.

Despite this devolution of services to a more local level and a gradually improving countrywide network of healthcare facilities (particularly in primary health care), the physical distance to health facilities for rural communities still represents a major barrier to care, as the distribution of functional health facilitates remains heavily skewed towards urban centres. For example, seven of the nine tertiary care facilities and more than half of the 23 secondary care institutions are concentrated in the Western Area, mainly around Freetown. In 2006, over 50% of primary care clinics had their nearest road over 5 miles away (90 minutes walking time), and the mean time from clinics to district hospitals was over 2.5 hours (19).

- peripheral health units (community health centres, community health posts, and maternal and child health posts) for first line primary health care;
- district hospitals for secondary care; and regional/national hospitals for tertiary care.
- regional/national hospitals for tertiary care.

District health services form the core component of health care. They are composed of a network of peripheral health units (PHUs), the district hospital and the District Health Management Team (DHMT).

The PHUs are the first line health services, and are further sub-classified into three levels - basic maternal and child health posts (MCHPs) for small villages, community health posts (CHPs) for small towns, and more comprehensive community health centres (CHCs) for larger Chiefdoms. There is a weak referral system between PHUs, secondary and tertiary health care levels.

The district hospital is a secondary level facility providing support for the PHUs. It provides outpatient services for referrals from PHUs as well as the population living within its immediate environs, inpatient and diagnostic services, emergency care and technical support to PHUs.

The District Health Management Team (DHMT) is responsible for the overall planning, implementation, coordination, monitoring and evaluation of the district health services under the leadership of the District Medical Officer (DMO) (9, 16).

Figure 9. **Ministry of Health Organogram**

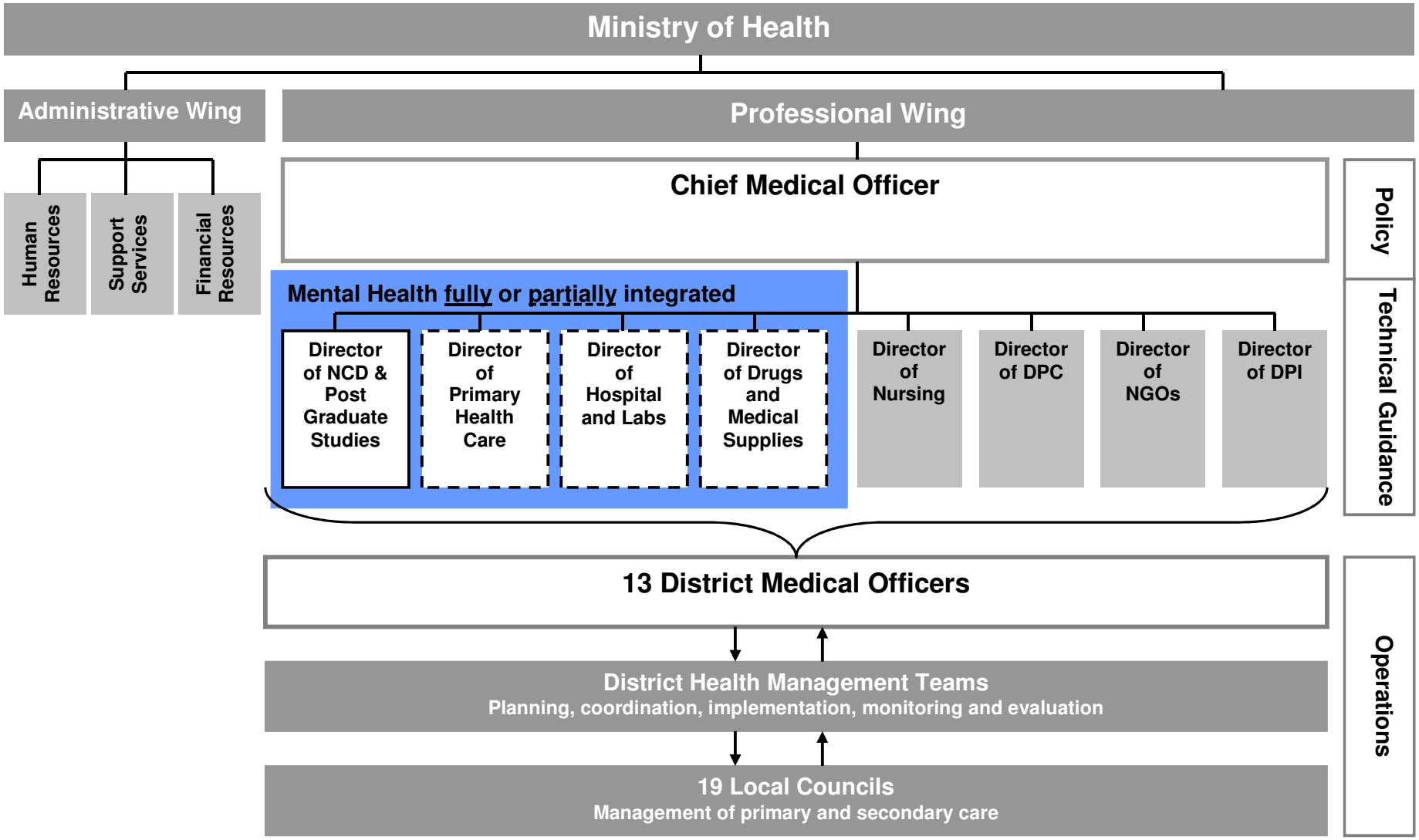
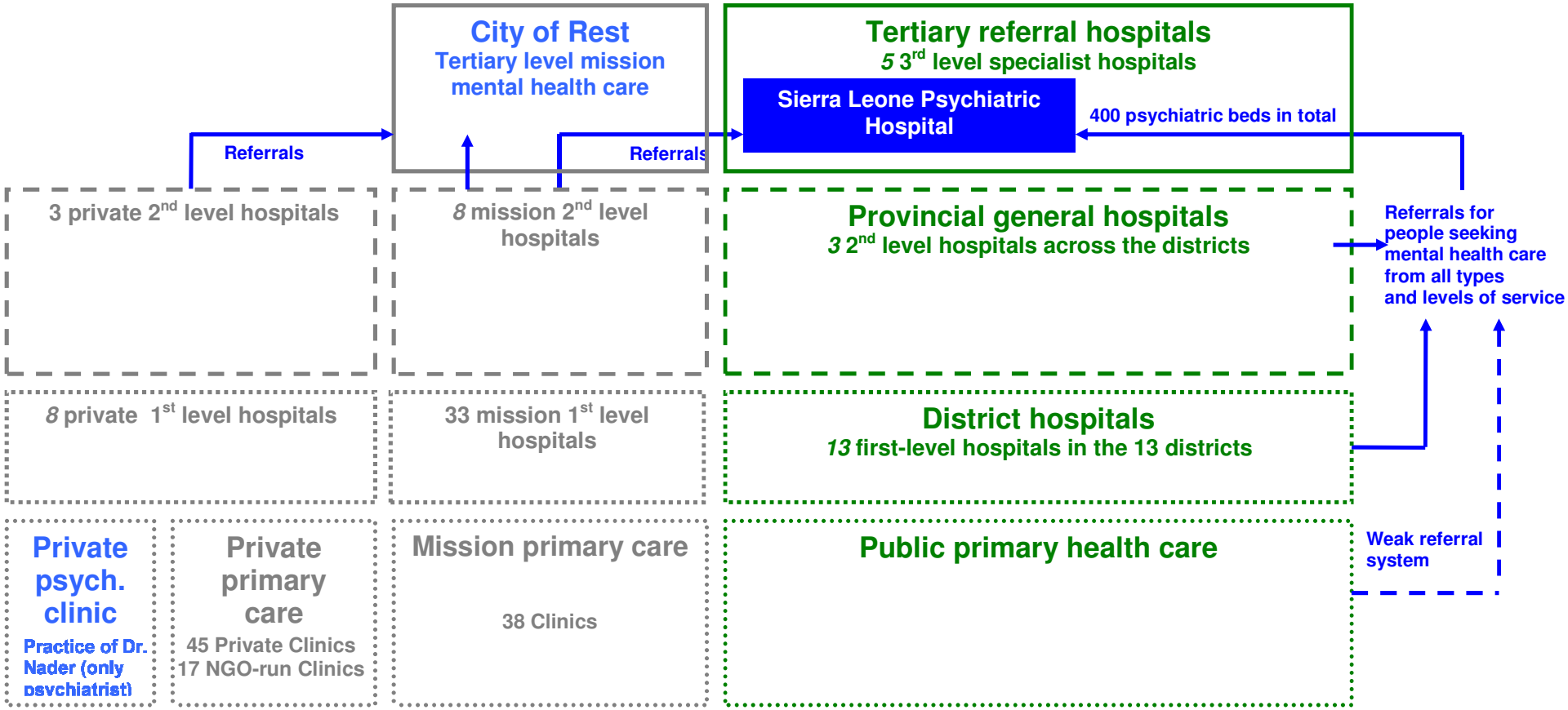


Figure 10. **Mental Health Services Within the General Health System**



COORDINATION

Within the MoHS, the Directorate of Non-Communicable Diseases and Post-Graduate Studies has integrated mental health in the Annual Operational Plan. Other relevant directorates, such as the Directorate of Primary Health Care, Drugs and Medical Supplies and Hospitals are expected to do the same in the near future (9).

Until recently, Dr Nahim, Sierra Leone's only psychiatrist, served a variety of key mental health functions in the country. He was the Director of the Sierra Leone Psychiatric Hospital, Director of Mental Health Services at the MoHS, as well as a lecturer in psychiatry at the School of Medicine and Allied Health Sciences. Currently, Dr Nahim has retired from active duty and serves only as a consultant. Most of his time is presently dedicated to private practice and weekly consultation visits at the psychiatric hospital (20).

LEGAL FRAMEWORK

The current legislation on mental health consists of the 'Lunacy Act' (1902), which needs to be reviewed in a new legislation protecting confidentiality and informed consent, promoting voluntary admissions and least restrictive alternatives. The National Mental Health Coalition has a committee dedicated to seeing this reform through.

The first Mental Health Policy and plan of the country has been adopted and printed (2010), and launched in 2012.

.

MENTAL HEALTH POLICY AND PLAN

Mental health was one of the 10 priority health problems identified in the 2002 National Health Policy (21), and one of 15 topics included in the Basic Health Package released in 2010 (22). A mental health policy has been developed, finalized and printed in 2010. It was launched formally in 2012, but is yet to be fully implemented. In addition, there has been significant success in mainstreaming mental health in other sectors, for example the national Poverty Reduction Strategy's Health Pillar (following co-ordinated advocacy by the National Mental Health Coalition).

HUMAN RIGHTS AND EQUITY

Stigmatization is a major issue in the area of mental health in Sierra Leone and it affects every aspect of service delivery including attendance at clinics, compliance with medication and particularly the availability of social support for people who are mentally ill. One research effort in a Sierra Leone community found that the majority of inhabitants believed mentally ill people to be evil, violent, lazy, stupid, and unable to marry or have children and unfit to vote (15). Mental illness in Sierra Leone is seen as either brought upon oneself as punishment for certain actions such as the breaking of taboos, or as being cast upon someone by spells and witchcraft (20).

An ethnographic study conducted at the Sierra Leone Psychiatric Hospital in 2008 described that many patients were chained to their beds either to control aggressive behaviour or to stop them from running away. Some patients were kept in isolation cells for months. Facilities were without electricity, suffered from poor sanitation and hygiene and had food shortages wherein patients went without eating for several days (16). The National Mental Health Coalition is using the WHO QualityRights toolkit to review the current situation in Sierra Leone's institutions and community services providing mental health care, and will work with them to bring about necessary reform.

5. RESOURCES FOR MENTAL HEALTH

FINANCING

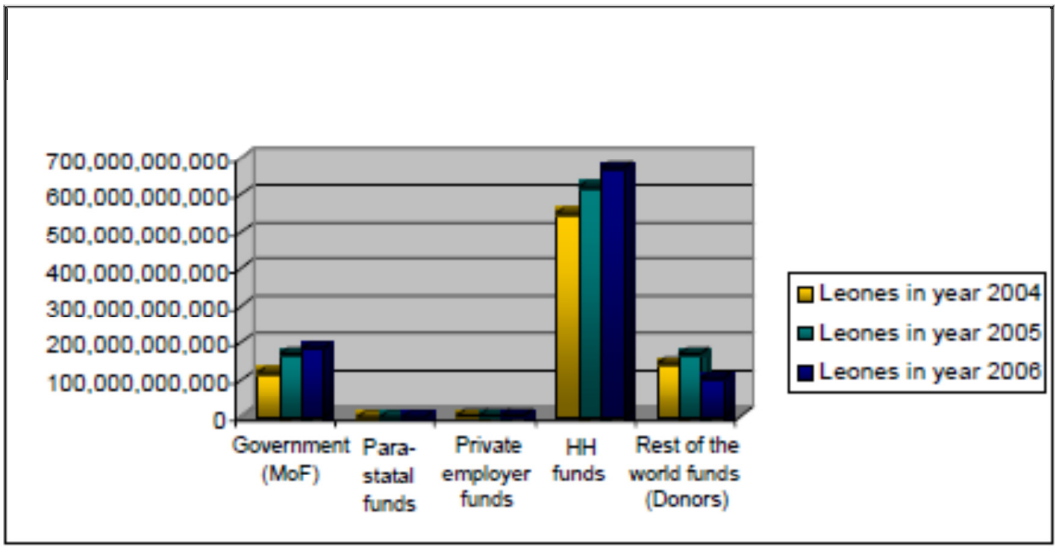
Sierra Leone has no comprehensive health financing policy or strategic plan. Government expenditure on health is of particular importance as the public health services in Sierra Leone are the major source of health care for a large proportion of people who are living below the poverty line, as well as rural areas that are not serviced by the private sector. Public spending on health as a percentage of GDP has been decreasing over past few years, last estimated at 1.4% in 2007, reflecting the fact that a high proportion (about 70%) of total health expenditure in Sierra Leone is from out-of-pocket spending. Sierra Leone also has a declining per capita expenditure on health, which at US$9 in 2008 is well below the WHO Commission for Macroeconomics and Health (CMH) recommendation of at least US$34 per person per year (9, 16, 23).

In 2010, the Government launched the Free Health Care Initiative, a programme to ensure that medical care was free to young children and pregnant women/nursing mothers. This was largely supported by DFID and included a significant improvement in remuneration for health care workers. This will however have little direct impact on mental health services.

Figure 11 below shows that the major means of financing the public health sector has been through household out-of-pocket payments (HH funds), followed by budget allocations from the Ministry of Finance as well as donor support from DFID, EU and ADB (9, 16).

There is a separate budget line for the financing of the Sierra Leone Psychiatric Hospital within the national health accounts.

Figure 11
Total health expenditure in Sierra Leone by funding source



Source: reference (9)

HUMAN RESOURCES

There is a significant shortage of healthcare workers and human resources in Sierra Leone. The 2006 MoHS human resource policy aspires to achieve adequate, well-managed, efficient and motivated human resources for health and sanitation by 2015. However, the health sector continues to be faced with increasingly inadequate human resources, a poor skills mix, a demotivated workforce and a high attrition rate that is exacerbated by the exodus of health workers during the civil war. By 2006, the shortfalls in the number of required human resources for various cadres of health workers ranged from 23% to 81% and the lack of trained human resources continues to constitute a major constraint in the development of health care services in Sierra Leone (16). Table 3 shows human resources data for Sierra Leone contrasted with the regional average for the WHO AFRO region and illustrates significant disparities, particularly in the number of health professionals (physicians, nurses and midwives).

Table 3
Health personnel (selected categories) in Sierra Leone and the AFRO region, 2004

Profession	Total	Average/1,000 Population	AFRO Regional Average/1,000 population
Physicians	168	0.03	0.22
Nurses	1,841	0.36	0.96
Midwives	-	-	0.25
Dentists	5	0.00	0.03
Pharmacists	340	0.07	0.06
Public and Environmental Health Workers	136	0.03	0.05
Community Health Workers	1,227	0.24	0.45
Lab Technicians	-	-	0.06
Other Health Workers	-	-	0.17
Health Management and Support Workers	4	0.00	0.41

Source: reference (1, 24).

In terms of mental health resources, there is only one psychiatrist and two psychiatric nurses working in Sierra Leone, all of whom are based at Sierra Leone Psychiatric Hospital. The only psychiatrist works part-time, doing a round at the hospital once per week and balancing this with lecturing at the university, private practice and a coordinating role within the MoHS. The 2005 WHO Mental Health Atlas reported that there were 200 "mental health assistants" working in Sierra Leone in addition to the other mental health human resources data presented in Table 4 below.

Table 4
Average number of mental health workers per 1,000 population in Sierra Leone, by profession.

Profession	Average/1,000 Population
Psychiatrists	0.02
Neurosurgeons	0
Psychiatric nurses	0.04
Neurologists	0.02
Psychologists	0
Social Workers	0.06

Source: reference (25)

Staff at the psychiatric hospital have cited the challenges associated with the ongoing need to recruit sufficiently qualified staff and that, due to societal attitudes towards the mentally ill, jobs at the psychiatric hospital are generally considered undesirable to nursing graduates (20).

TRAINING

Although various bodies have continued to provide training for various cadres of health care workers in local health training institutions, the intakes are very limited and the dropout rate is about 30%. Except for a few specialized facilities, none of the health workers in the country have received sufficient training to be able to provide appropriate needed care for people with mental disorders. Despite several lectures that are given covering the basics of mental health (symptoms, causes and emergency management strategies) and a two-week practicum in the Sierra Leone Psychiatric Hospital for first and second year nursing students, few nurses go on to work in mental health care. Regular training of primary health care professionals in the field of mental health is not performed, though their curricula have been recently updated (Table 5) (20, 25). A new Certificate and Diploma in Psychiatric Nursing started in 2012.

Between April, 2011 and March, 2012, Mercy Ships (in collaboration with WHO & MoHS) trained 187 mental health care workers. The training included nurses and Community Health Officers from across the country.

In 2012, the Mental Health Leadership and Advocacy Programme (mhLAP, funded by AusAID and run by CBM) was established to develop leaders and strengthen advocacy of local stakeholders. Seven mental health leaders attended a course in public mental health and leadership development in Nigeria. (See www.mhlap.org)

Table 5
Training available for mental health professionals in Sierra Leone

HUMAN RESOURCES	Training available in Sierra Leone	
	Degree Courses	Continuing Professional Development
Mental Health Workers		
Psychiatrists	No	No
Neurosurgeons	No	No
Neurologists	No	No
Psychiatric nurses	Yes (Certificate and Diploma)	Yes
Psychologists	No	No
Occupational therapists	No	No
Social workers	No	No
Traditional healers	No	No
General Health Workers		
Physicians	Yes	No
Nurses	Yes (Degree and Certificate)	No
Community Health Officers	Yes (Certificate)	No
Maternal and Child Health Aides	Yes (Diploma)	No

Source: reference (20, 25)

MEDICATIONS

Sierra Leone has a national essential medicines list and standard treatment guidelines have been developed and implemented. Health-staff at district level have been trained on the appropriate use of medication therapy (16).

All psychotropic medicines are provided by the Sierra Leone psychiatric hospital. Currently all medications are beyond their expiration date. The hospital had received psychotropic drugs in 2005 as a part of the package included in the loan from the Islamic Development Bank (IDB) to the Government of Sierra Leone in order to renovate and rehabilitate the hospital.

In 2010, a partnership between the Sierra Leone Psychiatric Hospital and the iNGO Plan International Sierra Leone has led to a donation of 20,000 USD for psychotropic medicines for the hospital. These medicines will be provided from a Netherlands-based supplier.

Table 6
Synopsis of psychotropic medicines

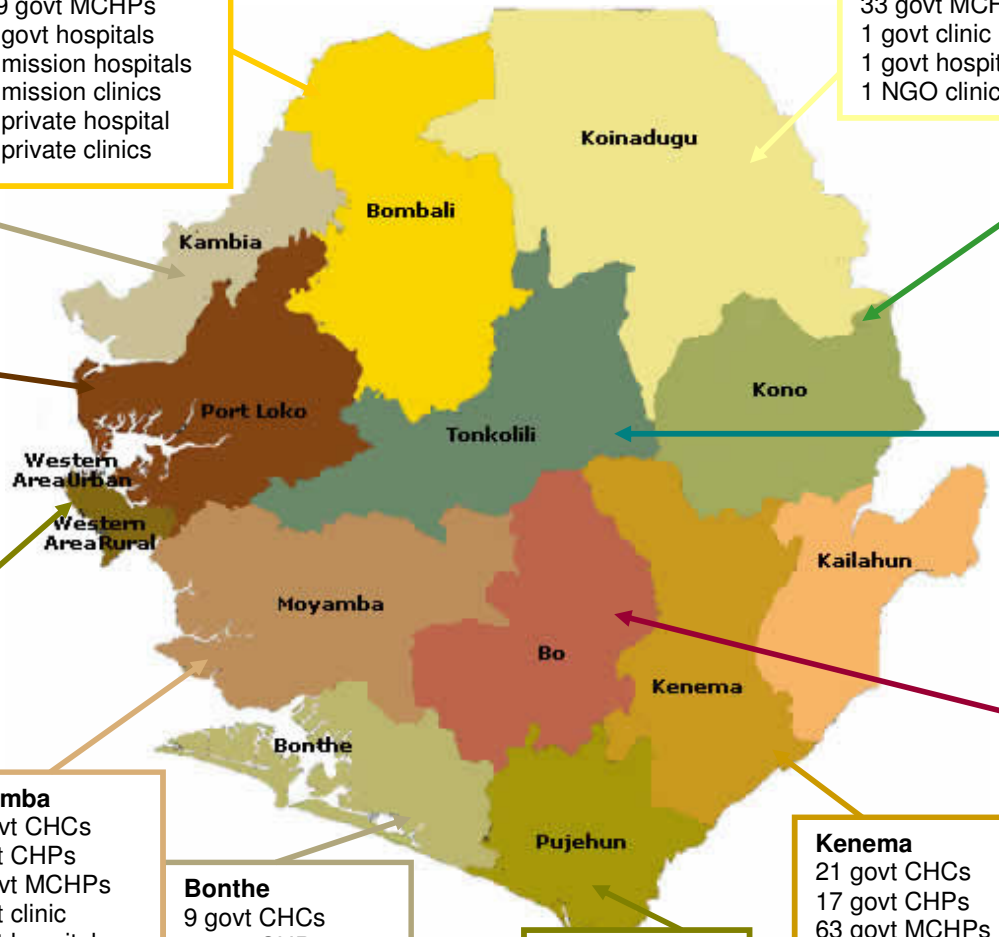
DRUG	WHO Essential Medicines for Mental Disorders at PHC (26)	National Essential Medicines List of Sierra Leone (27)	Available at Governmental Mental Health Facilities
Chlorpromazine	✓	✓	X
Haloperidol	✓	✓	X
Fluphenazine	✓	X	X
Amitriptyline	✓	✓	X
Imipramine	X	✓	X
Fluoxetine	✓	X	X
Diazepam	✓	✓	X
Lorazepam	X	✓	X
Nitrazepam	X	✓	X
Clomipramine	✓	X	X
Phenobarbital	✓	✓	X
Carbamazepine	✓	✓	X
Valproic	✓	X	X
Phenytoin	✓	✓	X
Biperidene	✓	X	X
Lithium Carbonate	X	✓	X

(Source: WHO Pharmacological Treatment of Mental Disorders in Primary Health Care: http://whqlibdoc.who.int/publications/2009/9789241547697_eng.pdf;
Government of Sierra Leone – Ministry of Health and Sanitation: National Essential Medicines List of Sierra Leone, 2004)

INFORMATION SYSTEMS

There is no mental health reporting system in Sierra Leone, and detailed epidemiological studies have not been carried out. In 2002, the MoHS carried out the first Systematic Needs Assessment on Mental Health and Substance Abuse Survey, however this was in the immediate post-conflict context and no systematic study or information-gathering mechanism has been implemented since (24).

Figure 12. **Mapping Health Care Services in Sierra Leone**
Source: reference (9)



Bombali
16 govt CHCs
20 govt CHPs
49 govt MCHPs
2 govt hospitals
2 mission hospitals
3 mission clinics
1 private hospital
3 private clinics

Koinadugu
12 govt CHCs
6 govt CHPs
33 govt MCHPs
1 govt clinic
1 govt hospital
1 NGO clinic

Kono
11 govt CHCs
15 govt CHPs
46 govt MCHPs
1 govt hospital
1 mission clinic
4 private clinics
4 NGO clinics

Kambia
11 govt CHCs
8 govt CHPs
31 govt MCHPs
1 govt hospital
2 mission clinics
1 NGO clinic

Tonkolili
9 govt CHCs
8 govt CHPs
65 govt MCHPs
1 govt hospital
2 mission hospitals
1 mission clinic
1 NGO clinic

Port Loko
11 govt CHCs
21 govt CHPs
55 govt MCHPs
2 govt hospitals
1 mission hospital
4 mission clinics
1 private clinic

Kailahun
9 govt CHCs
34 govt CHPs
12 govt MCHPs
2 govt hospitals
1 mission hospital
1 mission clinic

Western Area
20 govt CHCs
10 govt CHPs
15 govt MCHPs
7 govt clinics
12 govt hospitals
2 mission hospitals
11 mission clinics
2 private hospitals
23 private clinics
3 NGO clinics

Bo
23 govt CHCs
12 govt CHPs
50 govt MCHPs
1 govt clinic
1 govt hospital
1 mission hospital
6 mission clinics
11 private clinics
3 NGO clinics

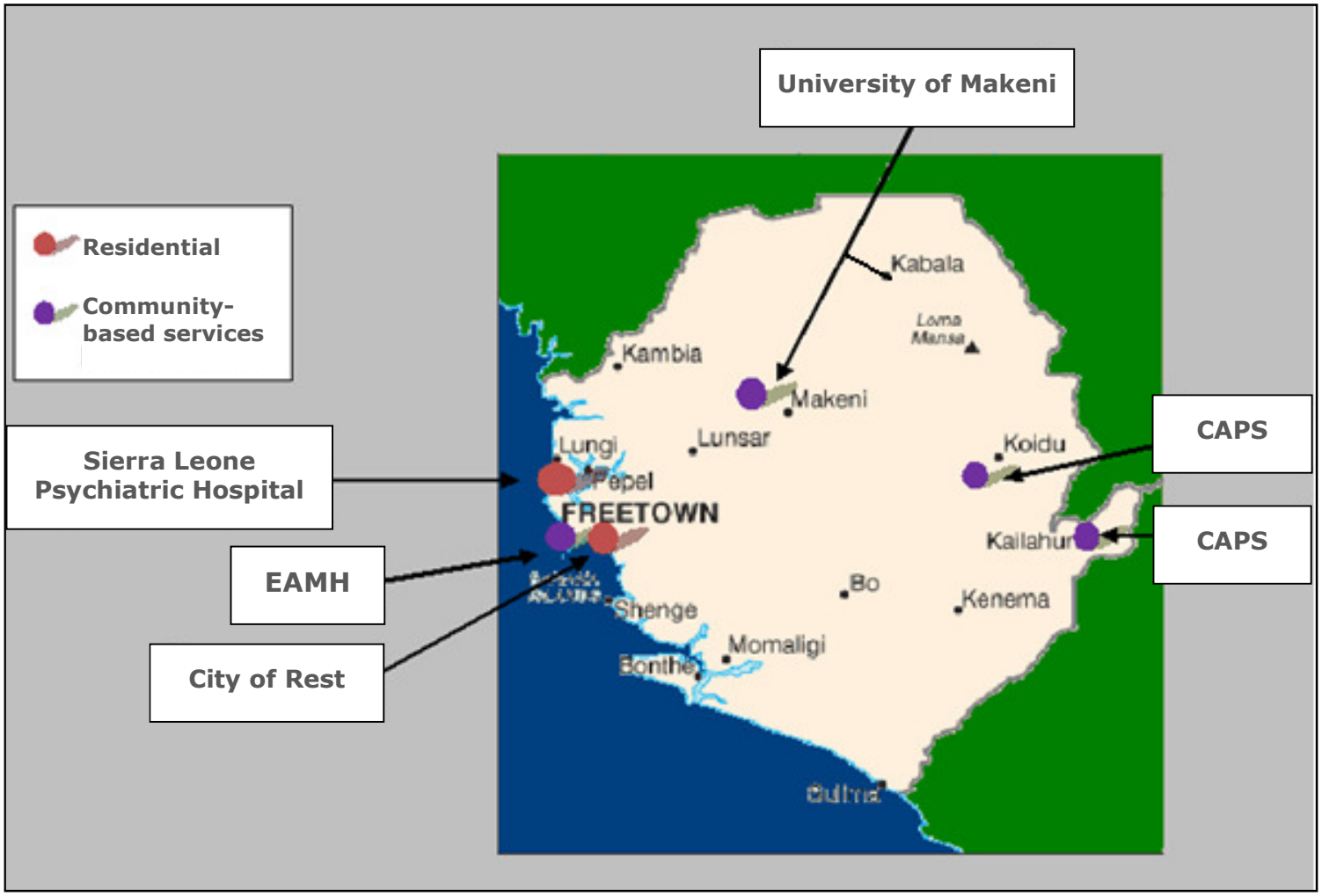
Moyamba
12 govt CHCs
6 govt CHPs
56 govt MCHPs
1 govt clinic
2 govt hospitals
5 mission clinics
1 NGO clinic

Kenema
21 govt CHCs
17 govt CHPs
63 govt MCHPs
1 govt clinic
2 govt hospitals
1 mission hospital
2 mission clinics
3 private clinics
1 NGO clinic

Bonthe
9 govt CHCs
9 govt CHPs
20 govt MCHPs
2 govt hospitals
1 mission hospital
2 mission clinics
1 NGO clinic

Pujehun
14 govt CHCs
10 govt CHPs
25 govt MCHPs
1 govt hospital

Figure 13. **Mapping Mental Health Care Services in Sierra Leone**
Source: reference (28)



FACILITIES AND SERVICES

The mental health system in Sierra Leone is comprised of organizations and institutions that devote their activities to promote, restore and maintain the mental health of the population, including healthcare provided by healthcare professionals, traditional practitioners, home care and self care (Figure 12, Figure 13). Very few facilities exist for the management of mental health in Sierra Leone. The sole psychiatric hospital - Sierra Leone Psychiatric Hospital - only resumed operation in 2006 and is currently functioning under very severe resource constraints. It is staffed by mainly auxiliary nurses, with two psychiatric nurses, and occasional visits from a retired psychiatrist. In addition to this facility, there are only three drug rehabilitation centres, two located in Freetown and one in Kenema (16).

Despite the fact that formal psychiatric care in Sierra Leone is largely only available at Sierra Leone Psychiatric Hospital, the one psychiatrist who works there reports that most mental health issues are dealt with informally at the primary care level. At best, patients go to a community health worker or to the nearest health centre because of physical symptoms such as insomnia, headaches or chest pain. In general, people do not voice concerns around mental health, so do not seek mental healthcare even if it is available. When people do feel that their health concerns are emotional or spiritual in nature, then traditional healers or religious organizations are the primary resource sought out by individuals (20).

1. Long stay facilities and specialist services

Sierra Leone Psychiatric Hospital

The only psychiatric hospital in the country, the Sierra Leone Psychiatric Hospital, is 183 years old but was renovated in 2005. The hospital, which can admit up to 400 patients, currently looks after slightly more than 100 patients, most of them presenting with co-morbid substance abuse and severe mental disorders.

Services offered at the hospital level are based on the medical model of care and exclude complementary services such as occupational therapy and rehabilitation. The hospital staff consists of one part-time psychiatrist, two qualified psychiatric nurses, a social welfare officer, a dispensary and about 60 mental attendants. It does not have the capacity to run and operate community follow up services, specialized therapy, or drug and alcohol services. Furthermore, psychotropic drugs are not available at the facility, and the last supply was delivered in 2005.

The care provided at the hospital is of a much lower quality than in any general hospital due to a lack of facilities, hygiene, security and medication. Patients are not in a position to take care of their personal items or hygiene and their clothing is insufficient. There is no proper bedding; patients must sleep on bare metal nets and springs, and some on the floor. Most of the wards do not have widows. Food is scarce in quantity and quality. Physical conditions are barely addressed. No laboratory and drug-screening service is available. Many patients are physically restrained with chains and padlocks and the dosages given of psychiatric medications are high (9, 20).

Mental Health Human Resources Sierra Leone Psychiatric Hospital	
Psychiatrist*	**1**
Medical Doctor	**1**
Psychiatric Specialist**	**1**
Psychiatric Nurse	**1**
Nurse	**3**

** The only Psychiatrist in Sierra Leone is retired, and currently working as an external consultant. He visits the hospital every Monday morning. A Cuban Psychiatrist arrived for a short-term posting in 2012*

*** Psychiatric Specialist: general nurse highly qualified in mental health (5 years training in mental health).*

City of Rest

This is a local voluntary organization based in Freetown providing support for people with substance abuse disorders and/or mental disorders. It is the only facility besides the Sierra Leone Psychiatric Hospital where residential care is offered to people with mental and substance abuse disorders, and the only centre in the country to offer rehabilitation services. City of Rest can take up to forty people at a time for residential care and has a support team of about ten staff members. Plans are under way for the construction of a new building outside the centre of Freetown.

City of Rest is a Christian faith-based organization, which is reflected in their programme that incorporates bible study and prayer to complement detoxification and psychosocial counselling.

Over time, the centre has attracted a core of chronic psychiatric patients, possibly due to a high prevalence of comorbidity of mental illness with substance abuse. It is not unusual for guests of the City of Rest to have been treated at Sierra Leone Psychiatric Hospital at one time or another (20). In 2012 City of Rest moved to new, purpose-built buildings, allowing more comfortable conditions for patients and staff.

The City of Rest now also co-ordinates the National Mental Health Coalition, made up of a wide range of stakeholders, and funded jointly by EAMH and mhLAP. They meet regularly, and have a focus on co-ordinating advocacy for commonly agreed goals that move mental health forward in the country, as well as reviewing progress in the National Mental Health strategy. They are also working in human rights, for example to support the review process for legislation, and to use the QualityRights toolkit for an assessment of the human rights situation and quality of care in institutions.

Mental Health Human Resources City of Rest	
Nurse	**1**
Counsellor*	**6**

**Counsellor: Diploma in Psychosocial Counselling*

2. Psychiatric services within general hospitals

There are no psychiatric services available in any general hospitals in Sierra Leone. The only out-patient mental health service in the country is the private clinic of the country's only permanent psychiatrist (29). The National Mental Health Policy, currently being implemented through the strategic partnership of Enabling Access to Mental Health, includes the deployment of one newly trained nurse to each District Hospital after graduation from COMAHS. The nurses currently undertaking this training course had been selected by the District Medical Officer from within each of the districts, with a view to them taking up this position at the District hospital after completion of the course. This will enable District-level service provision, most likely through hospital outpatient services, and outreach visits to PHC clinics for supervision of primary nurses and community interventions.

3. Formal community mental health services

International and Local organizations provide psychological counselling and support to people with mental disorders. Such organizations include: CAPS, CVT and the University of Makeni (formerly The Fatima institute).

Centre for the Victims of Torture (CVT)

CVT Sierra Leone, based in Freetown, was operational until September 2010 when the service was discontinued due to lack of funding. Previously, it provided community based psychosocial services to persons suffering from trauma, persons whom have been tortured, and to victims of trafficking in persons (TIP). The services offered included:

Direct mental health care, through group, individual and family counselling as appropriate to address mental health needs.

Capacity Building at the local level, including on-going intensive 'on the job' training and mentoring activities for mental health staff

Community Sensitization & Public Education activities to increase understanding of the effects of TIP, torture and trauma.

Community Association for Psychosocial Services (CAPS)

CAPS's mission is to promote and enable the healing of traumatized survivors of torture, war and domestic violence through psychosocial services for families and communities in and outside of Sierra Leone. It was created out of CVT when the CVT programme came to an end.

CAPS main area of intervention is psychosocial services through mass community sensitizations on mental health issues, screening/intake assessment, individual, family and group counselling sessions, follow up assessments and home visitations, conducting trainings on mental health issues, torture survivors, trauma and its effect on the human being, with community stakeholders and partners in development.

CAPS also provides medical assistance to clients that have medical complications through a referral system to the Government hospital in CAPS operational areas of Kailahun and Kono Districts. CAPS also conducts community healing ceremonies by empowering the communities to perform traditional purification and cleansing in order to evoke the evil spells that stained the communities during the course of the war. The other aspect of the community healing is the appeasing of the ancestral spirits at their community shrines. The importance of this is to psychologically heal the minds of the community people who believe that until these cleansing and purification are done their communities will not develop.

Mental Health Human Resources CAPS	
Counsellor*	**21**

**Counsellor: Diploma in Psychosocial Counselling*

The University of Makeni Department of Mental Health

University of Makeni Department of Mental Health is based in Makeni, Bombali District, and was founded as the Fatima Institute, before being incorporated into Sierra Leone's first private university, which is also run by the Catholic Church. It aims to promote social, political, economic and religious development in Africa. They run various mental health-related activities, particularly providing counselling activities and providing training in mental health for nurses. There is also an outreach centre which carries out activities in Kabala.

In 2008, the Fatima Institute officially launched the 'Mental Health, Behavioural Change and Social Inclusion Programme'; the Programme encourages positive behavioural change and reduction of social stigma of mental health sufferers through counselling, training, sensitization and the development of sustainable livelihoods. The Programme established two Counselling Centres in the Northern Region:

- Holy Spirit Counselling Centre: based in Makeni, which has provided counselling and treatment (including medication) to more than 500 patients over the last 5 years.
- Kabala Counselling Centre: which has provided counselling and treatment to over 200 patients, but which may need to be closed due to lack of funding.

Since 2011, The University of Makeni has been responsible for the capacity building component of the Enabling Access to Mental Health in Sierra Leone programme, supported the updating of curricula in nursing schools, and scaled up its own nurse training programme. They now offer short courses in mental health for nurses and other health workers.

Mental Health Human Resources University of Makeni	
Psychiatric Nurse	**2**
Counsellor	**2**

**Counsellor: Diploma in Psychosocial Counselling*

Enabling Access to Mental Health in Sierra Leone (EAMH)

EAMH is a programme designed to bring together the major civil society organisations and Government to scale up quality, decentralised, mental health services and improve community awareness about services and human rights issues in the country. It was developed, and is implemented, by CAPS, City of Rest and University of Makeni (above), and designed to help implement the national Mental Health Strategic Plan. It is a 5 year programme, which started in 2011, and is funded by the European Union, with international support from Global Initiative on Psychiatry (GIP) and CBM International.

Its three main interacting components are;

- Capacity building for service delivery at district and primary level, including a psychiatric nurse diploma course at the College of Medicine and Allied Health Sciences, improved mental health component of medical and nursing courses, and strengthening of systems (including information systems, medication supply, and ongoing supervision) at District level.

- A national mental health awareness campaign, focusing particularly on informal and traditional providers of care (religious leaders and traditional healers)

- Development of a National Mental Health Coalition of stakeholders for advocacy and peer support. The Coalition also provides a portal for those interested in working in Sierra Leone to contact local stakeholders. As well as service development initiatives, this has proven to be a reliable way for researchers to interact with stakeholders in the country.

  (See http://enablingaccesstomentalhealthsl.com/about-us/mh-coalition-sl/)

The Programme has very strong links with Government mental health services, and is intended to strengthen the national mental health system, and to improve capacity to provide care in the long term. It incorporates the evidence-base and guidance laid out in the WHO's mhGAP programme and works closely with the WHO to ensure best practice in the field.

4. Mental health services through primary health care

Peripheral health units (PHUs) form the basis of first line primary care and are subdivided into maternal and child health posts (MCHPs), community health posts (CHPs) and community health centres (CHCs):

- MCHPs are situated at village level for populations of less than 5000 and are staffed by MCH Aides and community health workers (TBAs, community volunteers, etc).
- CHPs exist at small town level with population between 5,000 and 10,000 and are staffed by State Enrolled Community Health Nurses (SECHNs) and MCH Aides. They provide the same types of services that are provided at the MCHPs but they also include prevention and control of communicable diseases and rehabilitation.
- CHCs are located at Chiefdom level, usually covering a population ranging from 10,000 to 20,000 and staffed with a community health officer (CHO), SECHN, MCH Aides, an epidemiological disease control assistant and an environmental health assistant. They provide all the services provided at the CHP level in addition to environmental sanitation and supervise the CHPs and MCHPs within the Chiefdom.

  A network of 927 functional PHUs exists, however mental health is not yet integrated within any of these facilities, and there is a weak referral system between primary health care and secondary and tertiary levels of care. Nonetheless, given that the primary health care network is the most equitably distributed of Sierra Leone's health services, reaching more rural and remote communities, an opportunity exists for effective integration of mental health services at this level (9, 16).

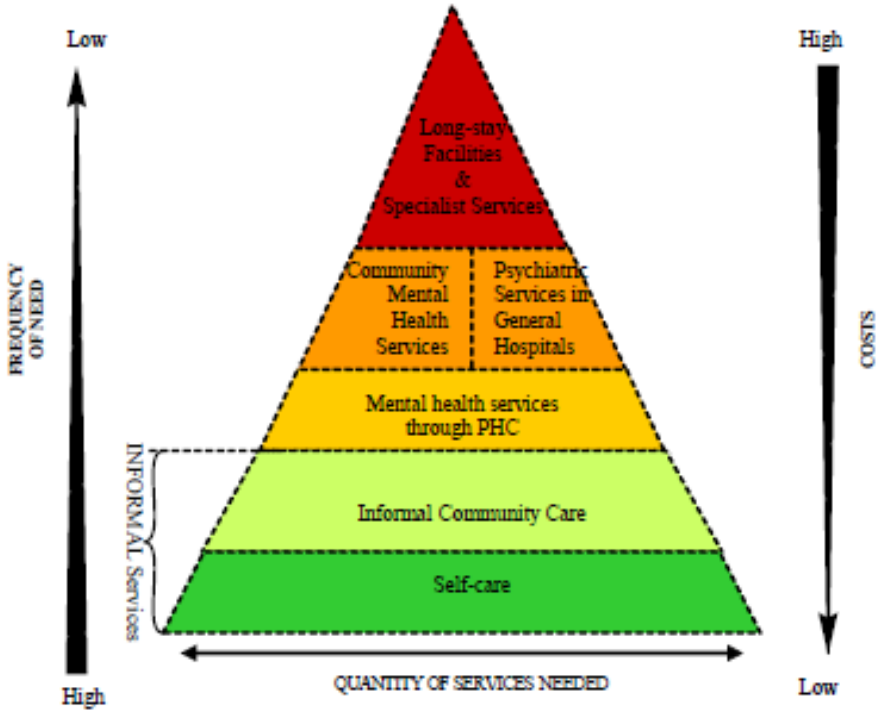
5. Informal community care

Anecdotally it is known that traditional healers play an important role in the treatment of mental disorders and in 2007, a survey found that 13% of respondents had used a traditional healer in the past month (30). Oftentimes, families seeking care for relatives with illness will stop care-seeking at the level of the traditional healer unless the patient is deemed by the family to be too aggressive, violent or socially disruptive. Traditional explanations for mental illness - including witchcraft, juju and breaking taboos - can be an impediment to seeking mental health care because the patient's behaviour is seen as being 'meant' to occur and seeking help is seen as interfering with higher powers (20).

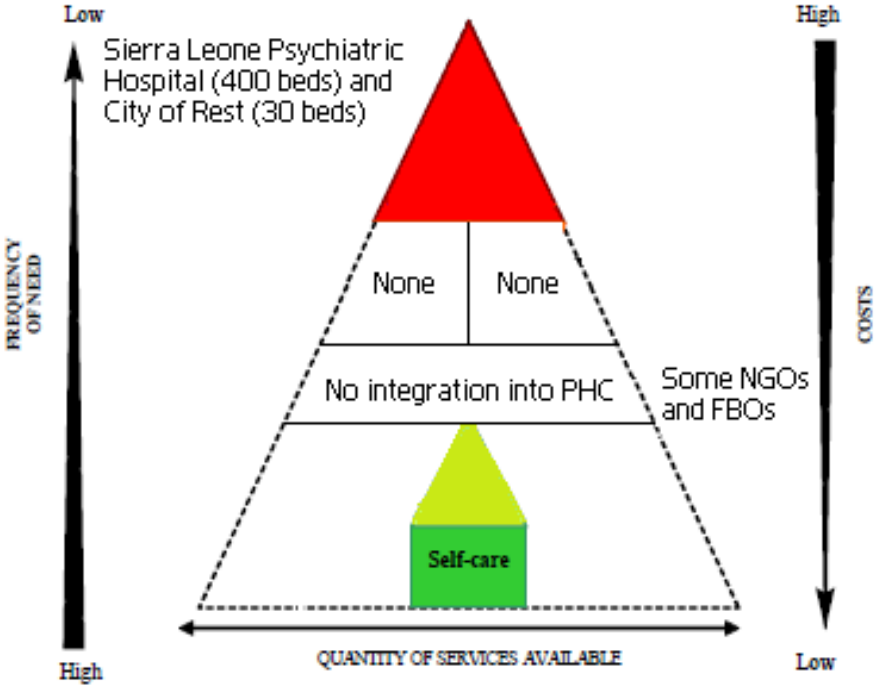
6. Self-care and family-care

A 2008 ethnographic study in Sierra Leone found that the mentally ill are often tolerated and managed within community settings, particularly within the family. It is only once openly displayed improper conduct, aggressive behaviour or abusive attitudes damage the family's relations in the community that the decision to bring the patient to the mental hospital is made. At the time of patient presentation to psychiatric care, the patient's family has frequently been trying to manage behaviour changes at home or have invested considerable sums on traditional healers in search of a cure. It is only when these efforts have been exhausted that families turn to the psychiatric hospital. Admission becomes less about treatment of the patient's illness and more of a social gesture by the family in an attempt to restore their social position and survival within the community (20).

The WHO Pyramid of Care and the reality in Sierra Leone (31)



The ideal structure for mental health care in any given country



The reality of mental health care in Sierra Leone
The levels of care that are non-existent, poorly developed or inappropriate have been removed from the pyramid of care.

BIBLIOGRAPHY

INTERNET RESOURCES

Mental health and development: Targeting people with mental health conditions as a vulnerable group
http://www.who.int/mental_health/policy/mhtargeting/en/index.html

Mental Health Gap Action Programme
http://www.who.int/mental_health/mhGAP/en/

Improving health systems and services for mental health
http://www.who.int/mental_health/policy/services/mhsystems/en/index.html

WHO/Wonca joint report: Integrating mental health into primary care - a global perspective
http://www.who.int/mental_health/policy/Integratingmhintoprimarycare2008_lastversion.pdf

WHO Resource Book on Mental Health, Human Rights and Legislation.
http://www.who.int/mental_health/policy/legislation/Resource%20Book_Eng2_WEB_07%20%282%29.pdf

WHO QualityRights Project
http://www.who.int/mental_health/policy/quality_rights/en/index.html

The WHO Mental Health Policy and Service Guidance Package
http://www.who.int/mental_health/policy/essentialpackage1/en/index.html

- The mental health context
- Mental health policy, plans and programmes - update
- Organization of services
- Planning and budgeting to deliver services for mental health
- Mental health financing
- Mental health legislation & human rights
- Advocacy for mental health
- Quality improvement for mental health
- Human resources and training in mental health
- Improving access and use of psychotropic medicines
- Child and adolescent mental health policies and plans
- Mental Health Information Systems
- Mental health policies and programmes in the workplace
- Monitoring and evaluation of mental health policies and plans

World Health Report 2001: New Understanding, New Hope.
http://www.who.int/whr/2001/en/index.html

APPENDIX

Essential psychotherapeutic medicines
(WHO Model List of Essential Medicines, 16th list, March 2009)
*Where the **[c]** symbol is placed next to the complementary list it signifies that the medicine(s) require(s) specialist diagnostic or monitoring facilities, and/or specialist medical care, and/or specialist training for their use in children.*

Psychotic disorders	
Chlorpromazine	*Injection 25 mg (hydrochloride)/ml in 2ml ampoule* *Oral liquid 25 mg (hydrochloride)/5 ml.* *Tablet 100 mg (hydrochloride).*
Fluphenazine	*Injection 25 mg (decanoate or enantate) in 1ml ampoule*
Haloperidol	*Injection 5 mg in 1ml ampoule* *Tablet 2 mg; 5 mg.*
Complementary list [c]	
Chlorpromazine	*Injection: 25 mg (hydrochloride)/ml in 2 - ml ampoule.* *Oral liquid: 25 mg (hydrochloride)/5 ml.* *Tablet: 10 mg; 25 mg; 50 mg; 100 mg (hydrochloride).*
Haloperidol	*Injection: 5 mg in 1 - ml ampoule.* *Oral liquid: 2 mg/ml.* *Solid oral dosage form: 0.5 mg; 2 mg; 5 mg.*
Depressive disorders	
Amitriptyline	*Tablet 25 mg (hydrochloride).*
Fluoxetine	*Capsule or tablet 20 mg (present as hydrochloride).*
Complementary list [c]	
Fluoxetine	*Solid oral dosage form: 20 mg (present as hydrochloride).* *a >8 years.*
Bipolar disorders	
Carbamazepine	*Tablet (scored) 100 mg; 200 mg.*
Lithium carbonate	*Solid oral dosage form: 300 mg.*
Valproic acid	*Tablet (enteric coated): 200 mg; 500 mg (sodium valproate).*
Generalized anxiety and sleep disorders	
Diazepam	*Tablet (scored): 2 mg; 5 mg.*
Obsessive-compulsive disorders and panic attacks	
Clomipramine	*Capsule 10 mg; 25 mg (hydrochloride).*
Medicines used in substance dependence programmes	
Nicotine replacement therapy	*Chewing gum: 2mg, 4mg.* *Transdermal patch: 5mg to 30mg/16 hrs; 7mg to 21mg/24 hrs*
Complementary list [c]	
Methadone*	*Concentrate for oral liquid 5 mg/ml; 10 mg/ml.* *Oral liquid 5 mg/5 ml; 10 mg/5 ml.* **The square box is added to include buprenorphine. The medicines should only be used within an established support programme.*

Source: reference (32)

REFERENCES

1. World Health Organization. Sierra Leone: Country health system fact sheet. 2006. Available from: http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=1281&Itemid=2111.
2. United Nations Cartographic Section. Available from: http://www.un.org/depts/Cartographic/english/htmain.htm.
3. U.S. Department of State. Background note: Sierra Leone. Available from: http://www.state.gov/r/pa/ei/bgn/5475.htm.
4. United Nations Population Fund (UNFPA). State of World Population 2010. 2010. Available from: http://www.unfpa.org/swp/2010/web/en/pdf/EN_SOWP10.pdf.
5. World Health Organization. The World Health Report 2006 (2004 data). 2006. Available from: http://www.who.int/whr/2006/annex/06_annex1_en.pdf.
6. United Nations Data. Crude death rate (per 1,000 population). 2008; Available from: http://data.un.org/.
7. U.S. Census Bureau. International Database. Available from: http://www.census.gov/population/international/data/idb/informationGateway.php.
8. Government of Sierra Leone, Statistics Sierra Leone. 2004 population and housing census. Analytical report on population distribution, migration and urbanisation in Sierra Leone. 2006.
9. Government of Sierra Leone, Ministry of Health and Sanitation. National health sector strategic plan 2010-2015. 2009.
10. United Nations Development Programme. Sierra Leone: Country profile of development indicators 2010; Available from: http://hdrstats.undp.org/en/countries/profiles/SLE.html.
11. Government of the Republic of Sierra Leone. Millennium development goals progress report 2010. 2010. Available from: http://www.undp.org/africa/documents/mdg/sierraleone_september2010.pdf.
12. Unite Nations Development Programme. Human poverty index. 2009; Available from: http://hdrstats.undp.org/en/indicators/97.html.
13. Statistics Sierra Leone. Analytical report on poverty. Available from: http://www.statistics.sl/.
14. World Bank. Development Indicators: Sierra Leone. 2009. Available from: http://devdata.worldbank.org/AAG/sle_aag.pdf.
15. Asare J, Jones L. Tackling mental health in Sierra Leone. British Medical Journal, 2005, 331(7519):720.
16. World Health Organization. Sierra Leone: Country cooperation strategy 2008-2013. 2009. Available from: http://www.who.int/countryfocus/cooperation_strategy/ccs_sle_en.pdf.
17. World Health Organization. WHO Disability Adjusted Life Years (DALY) Estimates for 2004 by Cause for WHO Member States. 2009. Available from: http://www.who.int/healthinfo/global_burden_disease/gbddeathdalycountryestimates2004.xls
18. The WHO World Mental Health Survey Consortium. Prevalence, severity, and unmet need for treatment of mental disorders in the World Health Organization Mental Health Surveys. The Journal of the American Medical Association, 2004, 291(21):2581-2590.
19. Institutional Reform and Capacity Building Project (IRCBP) Evaluations Unit. Decentralization: What have we learned? 2009.
20. Van Gog JG. Talking about the Sierra Leone 'Kresyad': An ethnographic exploration of the Sierra Leone psychiatric hospital (unpublished MSc Thesis). 2009.
21. Republic of Sierra Leone, Ministry of Health and Sanitation. National health policy. 2002.
22. Republic of Sierra Leone, Ministry of Health and Sanitation. Basic package of essential health services for Sierra Leone. 2010. Available from: http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=5751.

23. United Nations Development Programme. International human development indicators, public expenditure on health (% of GDP), 2007 data. Available from: http://hdrstats.undp.org/en/indicators/53906.html.
24. World Health Organization. Global atlas of the health workforce, health workforce data: Regional summaries. Available from: http://apps.who.int/globalatlas/predefinedReports/default.asp
25. World Health Organization. WHO atlas on mental health: Sierra Leone. 2005. Available from: http://apps.who.int/globalatlas/predefinedReports/MentalHealth/Files/SL_Mental_Health_Profile.pdf.
26. World Health Organization. Pharmacological treatment of mental disorders in primary health care. 2009. Available from: http://whqlibdoc.who.int/publications/2009/9789241547697_eng.pdf.
27. Ministry of Health and Sanitation, Government of Sierra Leone. National Essential Medicines List of Sierra Leone. 2004.
28. WorldAtlas. Map of Sierra Leone. Available from: http://www.worldatlas.com/webimage/countrys/africa/sl.htm.
29. United Nations Development Programme. Sierra Leone: United Nations common country assessment in preparation for the United Nations development assistance framework 2008-2010. 2007. Available from: http://www.sl.undp.org/4_media/publications/common_country_assessment.pdf.
30. Institutional Reform and Capacity Building Project (IRCBP). National public services survey public services, governance, dispute resolution and social dynamics. 2007.
31. World Health Organization, World Organization of Family Doctors. WHO service organization pyramid for an optimal mix of services for mental health. In: Integrating mental health into primary care: a global perspective. 2008. p. 16.
32. World Health Organization. WHO model list of essential medicines. 2009. Available from: http://whqlibdoc.who.int/hq/2009/a95055_eng.pdf.


9 789241 504171