THE GAMBIA

Republic of the Gambia

Republic of the Gambia

EFFECTIVE AND HUMANE MENTAL HEALTH TREATMENT AND CARE FOR ALL

KEY ACHIEVEMENTS

1. **Detailed analysis and report of the situation of Mental Health in the Gambia**
2. **Consensus on a broad approach for mental health amongst key stakeholders,**
3. **Development of the first mental health policy and strategic plan for the country,**
4. **Establishment of a national mental health coordinator position,**
5. **Commitment for integrating mental health into General Hospitals (creation of new mental health units) and Primary Health Care (training and support of staff in major and minor health centres),**
6. **Building of a coalition between formal health services, traditional healers, NGOs, communities and families to support the treatment and rehabilitation of people with mental disorders and to promote development,**
7. **Project proposal to support the implementation of the mental health policy and plan was selected as a finalist in the World Bank Development Market Place competition (104 projects selected out of 2,868 applications).**

NEXT STEPS

1. **Official adoption of the mental health policy and plan**
2. **Formation of strategic partnerships to implement the mental heath policy and plan**
3. **Launch of the mental health policy and plan**
4. **Implementation of the mental health strategic plan**
5. **Drafting of a mental health legislation in line with international human rights standards**

Potential partners and donors interested in supporting the **WHO 'Mental Improvement for Nations Development' Project** or any aspects of the implementation of the mental health policy and plan in the Gambia should contact the World Health Organisation:

Mr Bakary Sonko ▪ Dr Nestor Shivute ▪ Mr Momodou Gassama ▪ Dr Thérèse Agossou ▪ Dr Michelle Funk

THE PROJECT

OVERVIEW

Mental illness is an avoidable cause of unnecessary suffering in the Gambia. It is a major concern as prevalence is high and access to treatment low leading to many devastating consequences for individuals and families affected.

All too often mental disorders go undetected, or are wrongly attributed to supernatural forces, witchcraft or "moral weakness" and this, together with the lack of access to care and inadequate care, lead to a number of serious human rights violations.

The numbers of people affected are significant. In the Gambia, it is estimated that about 120,000 people have a mental disorder requiring treatment (27,000 affected by severe mental illness; a further 91,000 affected by a moderate to mild disorder). However, in an average year only 3,000 or so people receive treatment. This means that almost 90% of people with severe mental disorder in the Gambia are left without access to the treatment they need.

The Department of State for Health and Social Welfare in The Gambia is working to reduce this treatment gap, and to provide high quality mental health care to those in need:

- by increasing **awareness** of mental disorders so that the community is informed about the real causes of mental disorders and the treatment available.
- by providing more effective and humane treatment and care through **better health services in primary health care and general hospitals.**
- **by creating a supportive environment** through mobilizing the community, including traditional healers, village or community workers, police, teachers, family members, self-help and user groups, and NGOs.
- by developing a progressive and modern **legislation** to protect and promote the human rights of people with mental disorders, to promote access to treatment and to stop social exclusion and discrimination.
- by developing a **mental health policy and strategic plan** which set out a clear vision and concrete strategies to improve mental health and to coordinate the above actions.

MAJOR MILESTONES

- **2001: WHO Workshop in Miami.** Dr Bakary Sonko, current coordinator of the mental health draft team in the Gambia attends the mental health workshop on policy making, planning and service development. The WHO Mental Health Policy and Service Development Guidance Package is introduced to the participants.

- **May 2003: Decision of the African Commission on Human Rights** (the Purohit and Moore vs Gambia case)

In 2003 the government of The Gambia was summoned by the African Commission on Human Rights for alleged violations of human rights of people suffering from mental disorders detained in the country's only mental health facility, The Campama Psychiatric Unit. In the Purohit and Moore vs Gambia case, as it became commonly known, gross human rights violations within the Campama Hospital were revealed (communication 241/200 - 33rd ordinary session of the African commission May15-29, 2003). It is against this background that The Republic of The Gambia embarked on an exercise to address mental health service delivery within the country.

- **November 2004: Request from The Gambia to WHO for technical assistance** to help develop their draft mental health policy and plan (via Dr Shivute, WR).

WHO responds by providing the national drafting committee with relevant technical guidance material (WHO Mental Health Policy and Service Guidance Package) and access to additional resources through the web board.

- **January to September 2005: First draft and consultations.** The technical drafting committee undertakes preliminary consultations and prepares the first draft of the mental health policy and plan.

- **October 2005**: The **first draft** of the mental health policy and plan is **sent to WHO for comments** and soon after, WHO provides their feedback on the draft documents in time for revisions to be made by the Gambian technical committee prior to the first national consultation workshop;

- **28 November - 2 December 2005: Workshop on Mental Health Policy in Banjul**

WHO collaborated with the DOSH Gambia to organize a technical workshop with the aim of reviewing and discussing the mental health policy document that had been drafted by the national technical committee (and commented on by WHO/HQ, AFRO and WHO trained technical experts). This workshop was also supported by two international WHO experts. Progress was made in producing a second draft of the mental health policy and identifying key issues to be included in the second draft of the mental health plan.

The workshop highlighted the need to urgently develop a new mental health law in line with the policy directions.

- **January to October 2006: <u>Development/Elaboration of the draft policy and plan documents</u> with ongoing technical support from WHO and consultation with main stakeholder groups.**

A number of further drafts were prepared and many exchanges took place between WHO, DOSH Gambia and key stakeholders in the country.

- **October 2006: <u>2nd workshop on Mental Health Policy in Banjul</u>, with stakeholders and technical drafting committee members, and Promotion of the new policy and plan in the occasion of the <u>World Mental Health Day 2006</u>.**

✦ In the occasion of the World Mental Health Day senior government officials (Dr Tamsir Mbowe[1], Dr Mariatou Jallow and Mr Bakary Sonko) noted the importance of mental health as an integral part of health and a requirement for development. Senior WHO officials (Dr Shivute and Dr Funk) congratulated the DOSH for the progress made to date with the policy and plan and its commitment towards their implementation.

✦ The drafting committee members and other key stakeholders met to share their views and to debate some key reform issues such as the eventual closure of the Campama Psychiatric Hospital, the establishment of new mental health units integrated into the 6 main general hospitals of the country, the strengthening of mental health services through primary health care and the establishment of the post of national mental health coordinator.

✦The technical drafting committee met then for a further 3 days to incorporate final suggestions from discussions into the policy and plan documents.

- **<u>1st November 2006</u>**: Preparation and submission of a project proposal to the **World Bank Global Development Marketplace 2007** grant (DM 2007), to implement the new mental health policy and plan in the Gambia: "Supporting traditional healers to provide treatment and care of people with mental illness in partnership with health services and NGOs".

- **<u>December 2006</u>: Mental Health Policy finalised**, ready for formal government approval.

- **<u>January 2007:</u> Mental Health plan finalised,** ready for formal government approval.

- **<u>8 February 2007</u>**: Project proposal for the implementation of the mental health policy and plan selected by the World Bank Global Development Marketplace (DM) 2007 as a finalist (104 finalist projects out of 2,868)

- **<u>21-23 May 2007</u>**: Dr Nestor Shivute and Dr Bakary Sonko will travel to Washington DC to present the DM 2007 project proposal and participate in the final round of the competition.

[1] Secretary of State for Health and Social Welfare in the Gambia.

MAIN PARTNERS

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WHO Consultants

Dr Dixon Chibanda (University of Zimbabwe) & Dr Sonia Chehil (Dalhousie University).

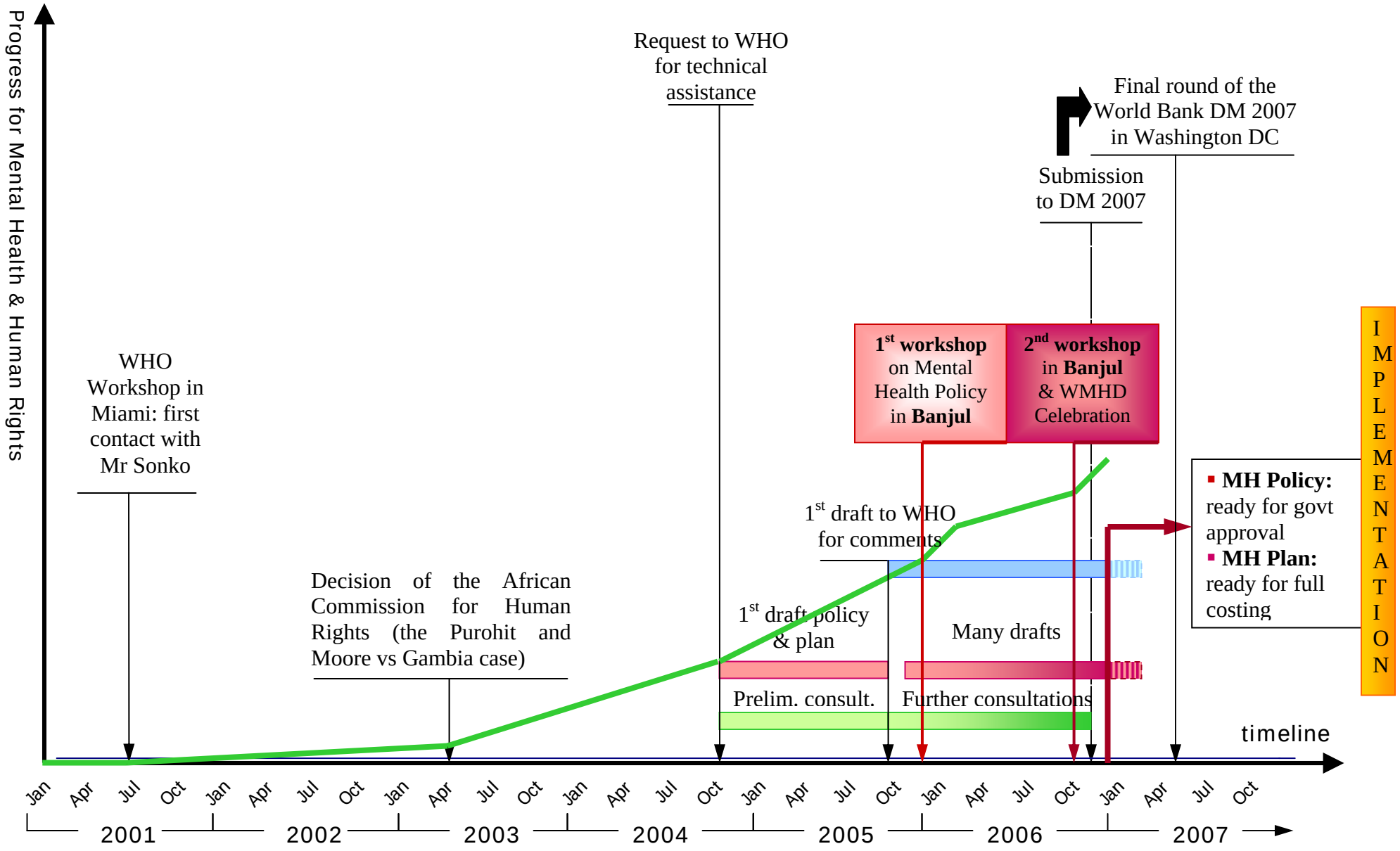
LINKS TO OFFICIAL DOCUMENTS

- Article reporting the decision of the African Commission: Report of the African commission: Purohit and Moore v Gambia. African Commission on Human and People's Rights. *The Housing and ESC Rights Law Quarterly*, vol.1, n°1, p 4-5; http://www.cohre.org/downloads/Quarterly_01.pdf

- The Gambia Mental Health Policy and strategic plan, 2007 [to come].

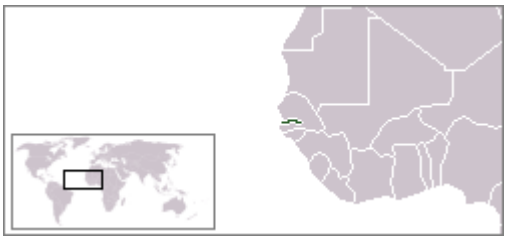
- 'Suspected Lunatic Detention Act' (mental health legislation) [to come].

- Department of State for Finance and Economic Affairs (DOSFEA), 2006. *Poverty Reduction Strategy: 2007-2011*. Banjul, November 2006. 121 pages.


Progress for Mental Health & Human Rights
Request to WHO for technical assistance
Final round of the World Bank DM 2007 in Washington DC
Submission to DM 2007
1st workshop on Mental Health Policy in Banjul
2nd workshop in Banjul & WMHD Celebration
WHO Workshop in Miami: first contact with Mr Sonko
1st draft to WHO for comments
Decision of the African Commission for Human Rights (the Purohit and Moore vs Gambia case)
1st draft policy & plan
Many drafts
Prelim. consult.
Further consultations
MH Policy: ready for govt approval
MH Plan: ready for full costing
IMPLEMENTATION
timeline
Jan Apr Jul Oct Jan Apr Jul Oct Jan Apr Jul Oct Jan Apr Jul Oct Jan Apr Jul Oct Jan Apr Jul Oct Jan Apr Jul Oct
2001 2002 2003 2004 2005 2006 2007

THE CONTEXT

① COUNTRY DEMOGRAPHIC AND SOCIOECONOMIC PROFILE



The Republic of The Gambia is located in West Africa with a population of around 1.478 million people, a rather high density (131 people per sq. km) and an annual population growth of 3.2% (2004; WHO, 2006b).

Its capital is Banjul.

Figure 1: Geographical location of the Gambia
(Source: http://en.wikipedia.org/wiki/Image:LocationGambia.png)

The Gambia has **5 major ethnic groups**: Mandinka, Fula, Wolof, Jola, and Sarahuleh.

The largest religious group is **Muslim** (comprising approximately 95% of the population), Christian (4%) and Animist (1%). The main language used in the country is **English**.

The adult literacy rate is 60.0% for men and 40.3% for women (1990; UNESCO, 2006[2]).

The proportion of the population under the age of 15 years is 40% (UNESCO, 2006), and the proportion of population above the age of 60 years is 5.9% (WHO, 2006b).

The **life expectancy at birth** is **55** years for males (uncertainty 49-61) and **59** years for females (uncertainty 52-65) (WHO, 2006b).

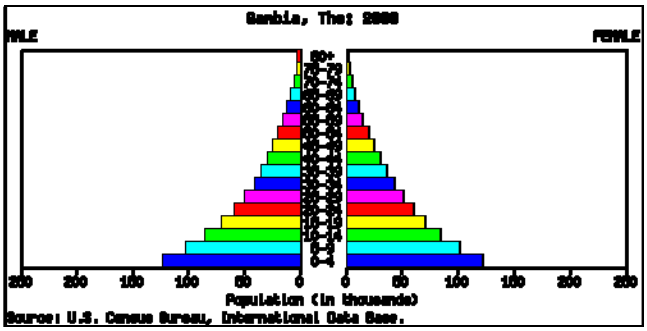
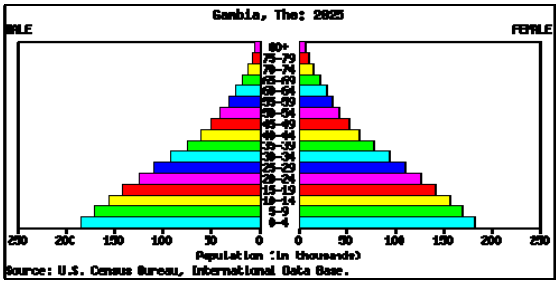


Figure 2: Age pyramid (The Gambia, 2000)
(Source:http://www.census.gov/cgi-bin/ipc/idbpyrs.pl?cty=GA&out=s&ymax=250)



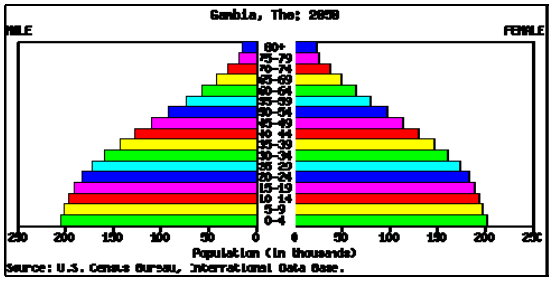


Figure 3: Age pyramids (The Gambia, Projections for 2025 and 2050)
(Source:http://www.census.gov/cgi-bin/ipc/idbpyrs.pl?cty=GA&out=s&ymax=250)

The country is a **low income group country** (based on World Bank 2004 criteria[3]). The health budget represents 6.4% of the GDP. The two primary sectors of employment and revenue are agriculture[4] and tourism.

[2] UNESCO country statistics (2004): http://www.uis.unesco.org/profiles/EN/GEN/countryProfile_en.aspx?code=2700 (last accessed 09/01/2007)

The per capita total expenditure on health (at international dollar rate) is 96$, which represents 8.1% of GDP (2003; WHO, 2006b).

The per capita government expenditure on health is 38 international $ (2003; WHO, 2006b) [ratio 0.396], with the gap mainly filled in by donor countries.

② CONTEXTUAL FACTORS INFLUENCING MENTAL HEALTH NEEDS AND SERVICES

- **Population migration**: There is a continuing rapid trend towards **rural – urban migration**, influx of refugees, seasonal and economic migrants.

- There is considerable **brain drain** affecting mental health workers (e.g. psychiatric nurses and psychiatrists).

- **Poverty** remains a pervasive problem in the country.

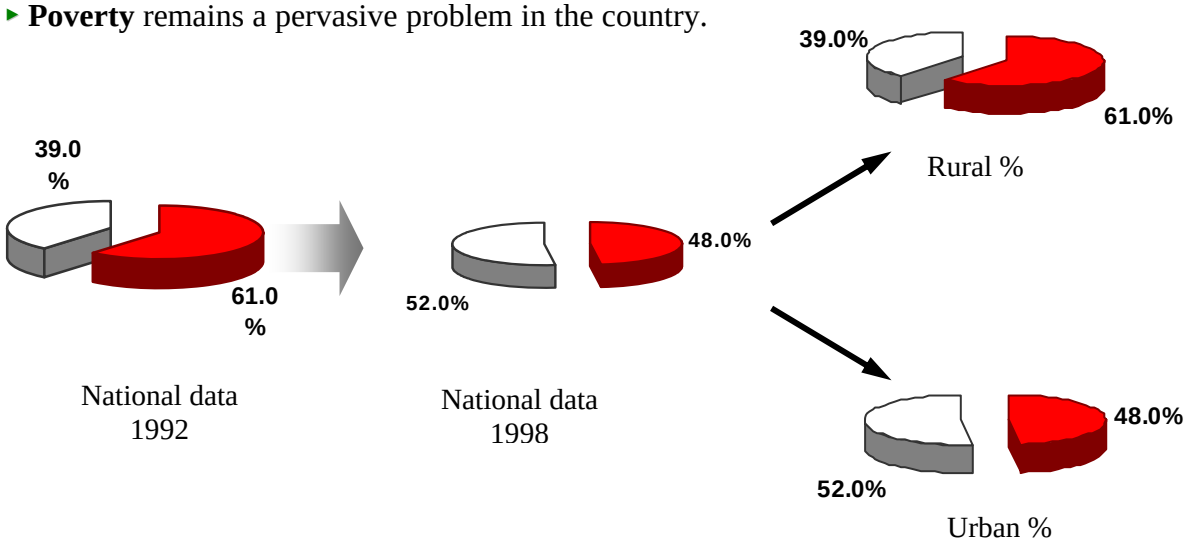


Figure 4: **Poverty level** in the Gambia, national poverty line (1998[5] Household Survey; World Development Indicators, 2006)

[3] Classification available on: http://web.worldbank.org/WBSITE/EXTERNAL/DATASTATISTICS/0,,contentMDK:20421402~pagePK:64133150~piPK:64133175~theSitePK:239419,00.html (last accessed: 09/01/2007).

[4] "Agriculture employs 75% of the population and yet contributing only 30% of the total out put of the economy (GDP)" (DOSFEA, 2006; p. 23).

[5] Data from the 2003/2004 Integrated Household Survey (HIS) are not yet available. Interim poverty measurement based on poverty lines of the past two surveys (1992 and 1998) suggest methodological weaknesses of these past 2 surveys. Those figures should therefore be considered with caution (DOSFEA, 2006).

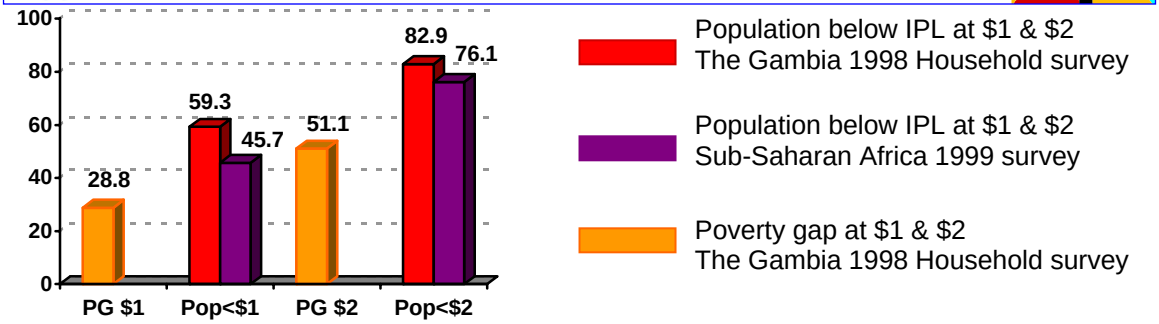


Figure 5: **Poverty levels and poverty gaps[6] in the Gambia (1998)** and Sub Saharan Africa (1999), international poverty lines (IPL) at $1 and $2 (World Development Indicators, 2006).
(Source: http://devdata.worldbank.org/wdi2006/contents/Section2.htm [table 2.7.: Poverty]).

Human Development Index (HDI)[7] (The Gambia HDI 2004 = 0.479, ranking 155/177):
While figure 6 shows HDI trends over time, figure 7 shows how, in this specific national context, HDI relates to GDP (how much economic wealth is transformed into development at the population level).

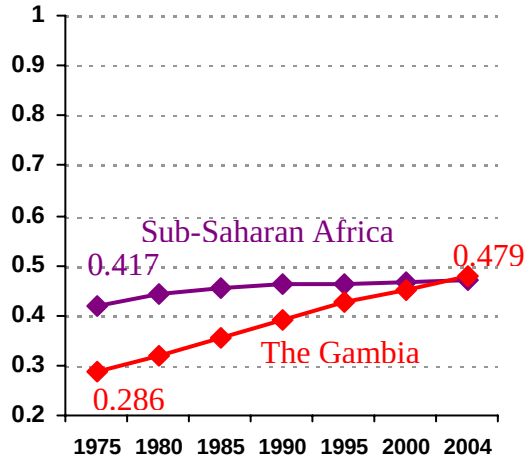


Figure 6: Human Development Trends (1975-2004)
(Source: UN Development report 2006. url: http://hdr.undp.org/hdr2006/statistics/flash/statistics_trends.cfm)

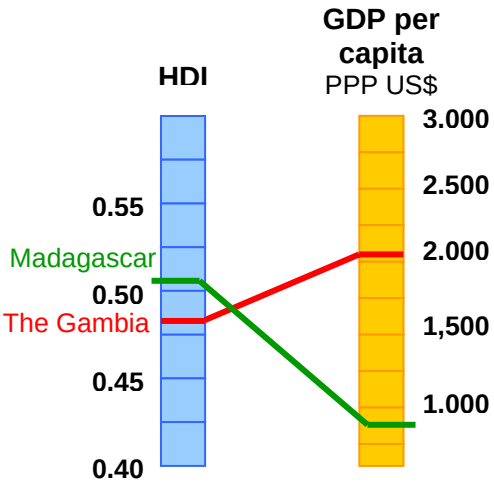
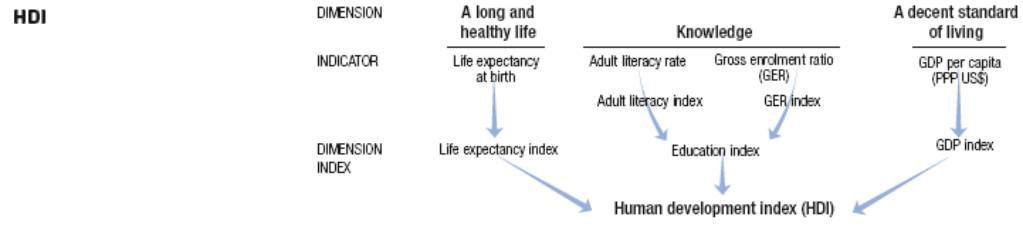


Figure 7: From HDI to Income (2004)
(Source: UN Development report 2006. url: http://hdr.undp.org/hdr2006/statistics/flash/statistics_hdi.cfm)

[6] The poverty gap is the mean shortfall from the poverty line (counting the nonpoor as having zero shortfall), expressed as a percentage of the poverty line. This measure reflects the depth of poverty as well as its incidence.
[7] The Human Development Index (HDI) is an indicator, developed by UNDP, combining 3 dimensions of development: a long and healthy life, knowledge, and a decent standard of living (see figure below).
Source: Human Development Report 2006 (UNDP), Technical Note 1.
url:http://hdr.undp.org/hdr2006/pdfs/report/Techinical_notes.pdf



- **Social welfare assistance** for homeless people and the elderly exist but people with mental disorders are excluded from assistance.

- The serious human and economic effects of **illicit substance production and abuse** present another major challenge for the Gambian society.

- The **HIV/AIDS epidemic** has preoccupied government officials and international agencies (UNAIDS, 2006, p. 12: **1,400 to 4,300 adults** are estimated **in need of retroviral therapy**).

- The African Commission for **Human Rights**, in May 2003, found many **violations** committed towards people with mental disorders and urged the government to reform their mental health law in order to protect the rights of people with mental disorders.

③ BURDEN OF MENTAL DISORDERS AND TREATMENT GAP

Based on prevalence rates from the World Mental Health Survey, 2004 it is estimated that **at least 118,000 people** in the Gambia (or **13%** of the adult population are likely to be affected by mental disorders which require varying degrees of treatment and care: approximately 27,000 people (3%) are suffering from a severe mental disorder and a further 91,000 (10% of the adult population) from a moderate to mild mental disorder.

A situational analysis conducted by Prof. Morakinyo from Obafemi Awolowo University (Nigeria) showed comparable prevalence rates to other developing countries such as Nigeria and Uganda. Illicit drugs and alcohol abuse were also highlighted as increasingly serious mental health issues in the Gambia (e.g. 6 to 8% of persons in Kanifing and Kombo North Districts categorized as alcoholics).

There is a large gap between the numbers of people affected by a mental disorder and those receiving treatment: the maximum number of people receiving treatment in 2005 in The Gambia was estimated to be 3,278 (i.e. 2.9% of all persons with mental disorders, or 12% of people with severe disorders). Therefore a maximum of 12 % of people with mental disorders will have received any form of treatment in the health system for their mental health disorder.

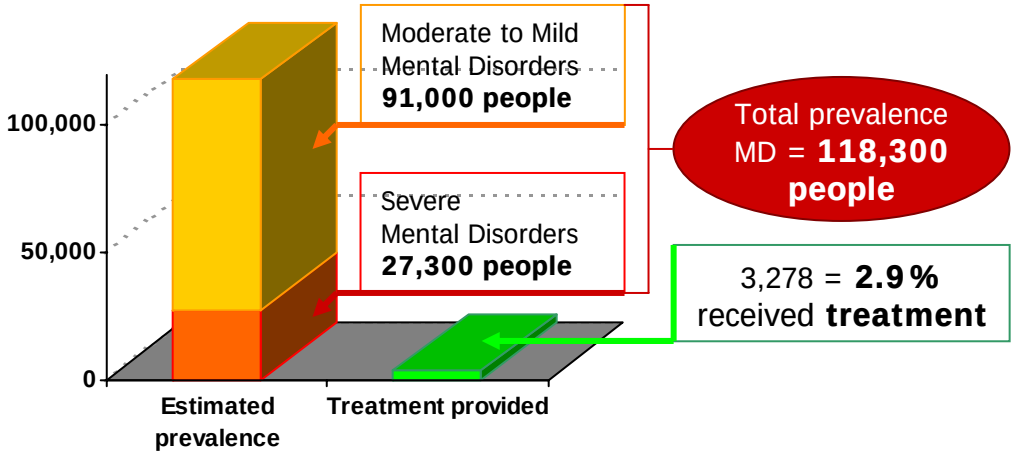


Figure 8: Treatment gap for people with mental disorders in the Gambia

④ THE MENTAL HEALTH SYSTEM

Mental health services in the Gambia are not integrated into general health services but are either delivered in parallel to them (by the CMHT, until Dec2005) or in specialized units in Banjul only (RVTH). Only a few patients benefit from the Bakindiki programme.

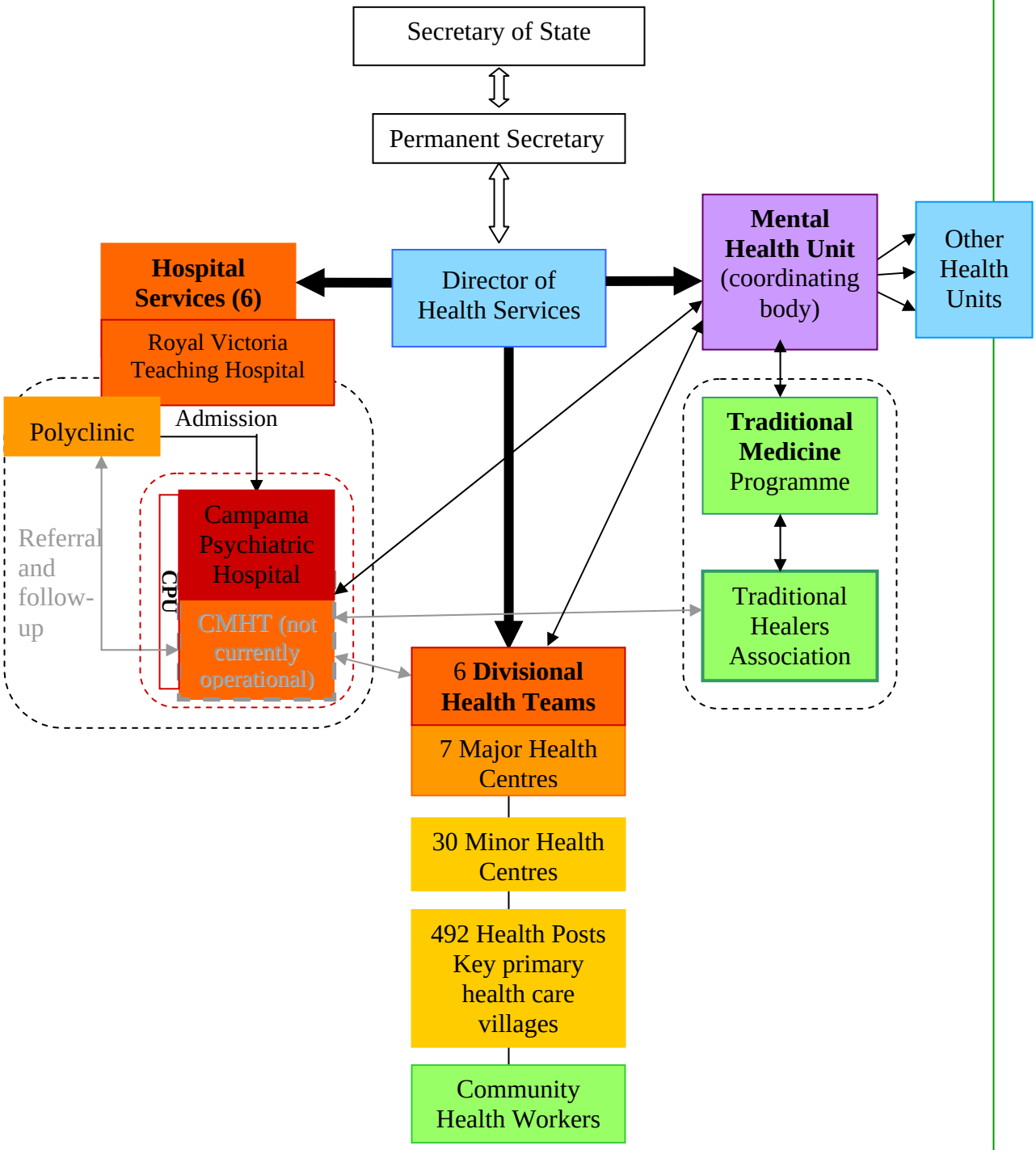


Figure 9: Organizational structure of the current Mental Health System in the general health system in The Gambia (2005-2006)

Coordination

There is currently an acting Mental Health Coordinator whose major role is to work in close liaison with other health units in order to better coordinate mental health services and activities nationally.

Legal framework, policies and programmes

The current mental health legislation, the 'Suspected Lunatic Act' of 1964, is outdated and fails to protect the human rights of the mentally ill.

Financing: There are no specific budget allocations for mental health and no details available about expenditure on mental health. The primary sources of mental health financing are grants (WHO, 2005). The mental health budget is currently primarily directed towards the upkeep of the Campama Psychiatric Unit.

Human Resources for Mental and General Health (WHO Mental Health Atlas, 2005; WHO Global Atlas of the Health Workforce)

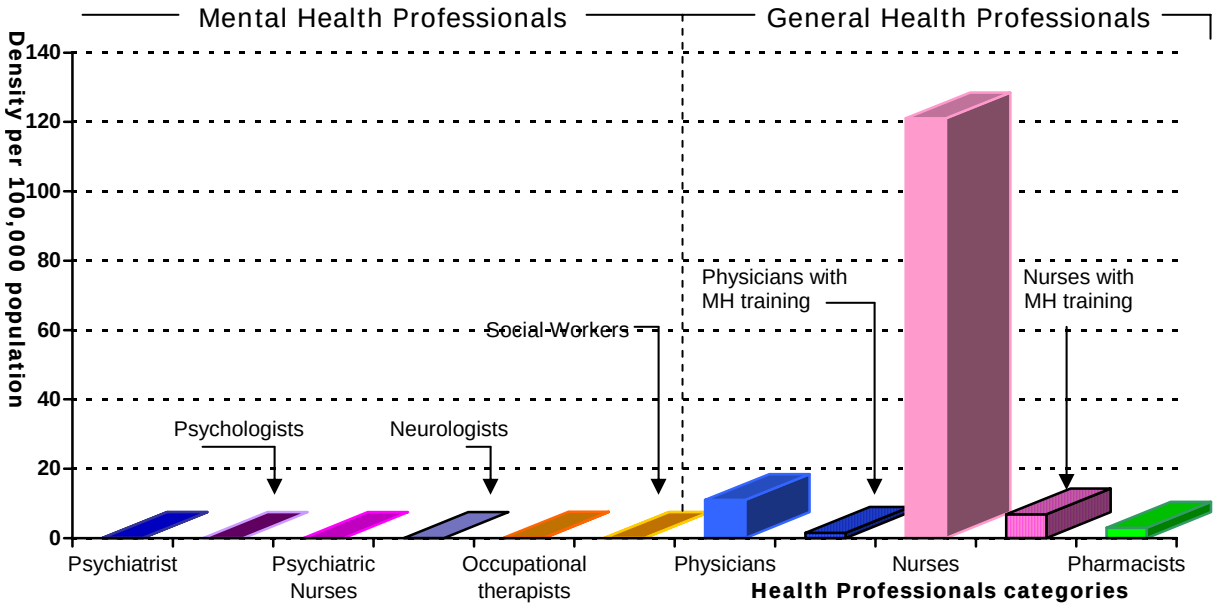


Figure 10: Human Resources for Mental Health and general Health in the Gambia (2004-2006).

(Source: World Mental Health Atlas 2005 & WHO Global Atlas of the Work Health Force. url: www.who.int/mental_health/evidence/atlas/index.htm (last accessed 09/01/2007) & http://www3.who.int/whosis/core/core_select_process.cfm?country=gmb&indicators=healthpersonnel&intYear_select=all&language=en (last accessed 09/01/2007).

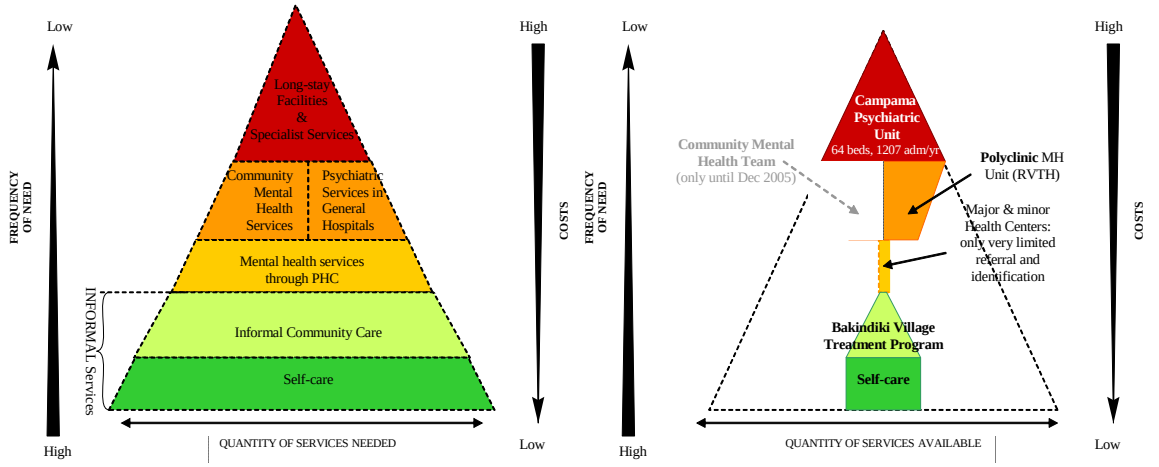
Currently, the only mental health professionals working in The Gambia are located in the Campama Psychiatric Unit (Banjul) and the polyclinic of the Royal Victoria Teaching hospital.

No incentives are currently provided to retain mental health workers in the Gambia.

Table 1: Training and work for mental health professionals in The Gambia

Human Resources	Training available in The Gambia		Currently working in The Gambia	
	Degree courses	**CPD**[8] (number/training years)	**Density** (per 100,000 population)[9]	**Number currently working in mental health**[10]
Mental Health workers				
▪ Psychiatrists	No	No	0.08	2
▪ Neurosurgeons	No	No	0.06	--
▪ Neurologists	No	No	0	--
▪ Psychiatric nurses	No	No	0	2 (MH coordinator; Matron at Campama psychiatric Unit)
▪ Psychologists	No	No	0	0
▪ Occupational therapists	No	No	0.17	0
▪ Social workers	No	No	0.08	0
▪ Traditional healers	No	15 TH trained[11]	--	12, in 6 villages
General Health Workers				
▸ Physicians	Yes	No	3.5	--
▸ Nurses	Yes	No	12.5	12
▸ Pharmacists	No	No	0.50	--

Mental Health Facilities and Services



WHO Model Pyramid

The **Gambia MH Services Structure** (2006)

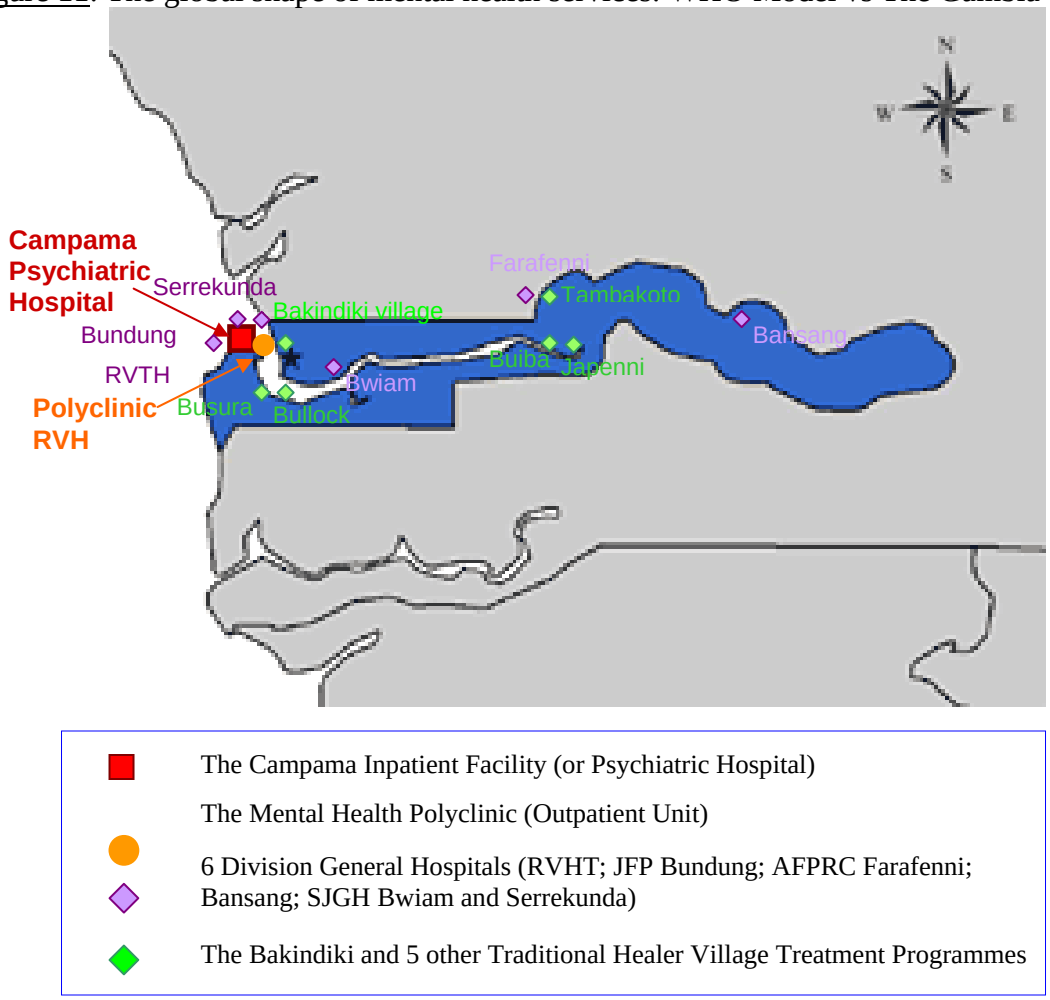
[8] Continuing Professional Development.

[9] Source: WHO Mental Health Atlas, 2005 (for mental health workers); WHO Global Atlas of the Health Workforce (for general health workers).

[10] Source: The Gambia Mental Health Policy 2007. The information gathered for the mental health policy and for WHO Atlas comes from different sources and at different points in time, and can therefore differ.

[11] Bakindiki Village treatment programme,was supervised by the Community Mental Health Team until December 2005.

Figure 11: The global shape of mental health services: WHO Model vs The Gambia



The Campama Inpatient Facility (or Psychiatric Hospital)

The Mental Health Polyclinic (Outpatient Unit)

6 Division General Hospitals (RVHT; JFP Bundung; AFPRC Farafenni; Bansang; SJGH Bwiam and Serrekunda)

The Bakindiki and 5 other Traditional Healer Village Treatment Programmes

Figure 12: Mapping of the main Mental Health Facilities and Services in the Gambia

Description of services at each level of care

▪ Long Stay Facilities & Specialist Services

Mental Health care inpatient facilities in the country are limited to one psychiatric institution, the **Campama Psychiatric Unit**, actually integrated administratively within the Royal Victoria Teaching Hospital (RVTH, in Banjul) but physically isolated. Hospital conditions are poor

Hospital admissions: In the years 2003 and 2005 there were approximately 1,207 (out of which 449 were new) and 1, 424 annual admissions for treatment to the Campama Psychiatric Unit respectively.

Psychiatric Services in General Hospitals

➢ Inpatient: The other 5 general hospitals[12] in the Gambia (Bwiam, Bansang, AFPRC Farafenni and Jammeh foundation) provide inpatient services for all health conditions except for mental health.

➢ Outpatient: The **Polyclinic Mental Health Unit**, at the Royal Victoria Teaching Hospital is headed by a Psychiatrist and assisted by a nurse attendant, has a single room allocated for outpatient mental health services.

The Unit provides curative and preventive services to all outpatients who come for monthly follow-ups. It also serves as the first point of call for almost all patients admitted to the Campama Psychiatric Unit, seeing approximately 20 to 30 patients per day. It has however restricted working hours - only on mornings during the week (8am to 2pm).

Community Mental Health Services

Community mental health services were functional from 1993 until December 2005. These services were delivered predominantly by the **Community Mental Health Team** (CMHT) based at Campama Psychiatric Unit. The team was headed by an Advanced Psychiatric Nurse Practitioner and staffed with 4 health care professionals and a driver. They were operating in parallel with general health care services, providing a range of specialized services throughout the country: monthly scheduled clinical visits, consultations and home visits on request whenever necessary as well as advocacy, prevention and promotion interventions for mental health in schools and communities, clinical outreach services to the prison, and training programmes in mental health for professionals.

➢ Other community services:

*__Operation "Save the Mind"__ was implemented in the Gambia during 2001-2003 (TV and Radio programmes, and advocacy pamphlets on mental health available in health centres).

Mental Health Services through Primary Health Care

During 1996-2005 the Community Mental Health Team (CMHT) and the Divisional Health Teams (DHTs) collaborated very closely. The CMHT used to have scheduled days for outreach clinical review visits in the 7 major health centres and minor health centres but they also intervened at anytime (depending on the degree of emergency) on the request of these health centres through the DHTs.

[12] Namely: Sulayman Junkung General Hospital (in Bwiam), Jammeh Foundation for Peace Hospital (in Bundung), AFPRC (Armed Forces Provisional Ruling Council) Hospital (in Farafenni), Bansang Hospital, Serekunda Hospital (opened since January 2007). The Royal Victoria Teaching Hospital in Banjul provides specialized mental health care through the Campama Mental Health Unit (inpatient) and the Polyclinic (outpatient).

➢ **Major Health Centers**: There are no specifically trained mental health workers at the major health centres [13]. They have their own pharmacy store with a few basic psychotropic medicines but now that the CMHT is not operational anymore *supply issues arise*

➢ **Minor Health Centers**: Only a few health care providers in the minor health facilities have the knowledge, skills and motivation to provide follow-up treatment and care for people with mental disorders.

▪ Informal Community Care

➢ **Traditional Healers**: In the last few years the Department of State for Health and Social Welfare has been working in close partnership with traditional healers in a number of districts in order to provide treatment and care to people with mental disorders. This program started in the Bakindiki village and was then extended to 5 other traditional healers villages (Tambakoto, Busura, Bullock, Buiba and Japenni).

The **Bakindiki Village Treatment Program** started with epileptic patients and was then extended to patients with psychosis. It provided 12 traditional healers with basic psycho-education, to introduce the use of low dose oral chlorpromazine and to involve the traditional healers and the community in a new approach of community based care for people with mental disorders. Follow-up treatment and support is organized through the closest health center and/or through regular appointments/consultations with traditional healers. To date a total of 300 patients have been treated through the programme, with very encouraging clinical outcomes.

➢ **NGOs**: VSO, Peace Corps and Rotary Club International have supported the mental health program in previous years, more particularly the supply of psychotropic medicines and mopeds (small motorbikes) for community follow-up.

➢ There are no Mental Health **Consumers/Users or Family associations** in The Gambia.

[13] Some of the nurses at the major health centres had attended the WHO orientation workshop on the identification and management of people with mental disorders: They were also exposed to mental health treatment and care issues as part of their undergraduate course. For example, the State enrolled nurses (SEN) and Community health nurses (CHN) received one month training (1 week lectures and 3 weeks practical in the Campama unit and the polyclinic at RVT) and Senior Registered nurses (SRN) received three months training (2 weeks theory and 10 weeks practical experience including study tour to traditional healers). Despite this exposure and training on mental health issues only a small number are providing treatment and care to people with mental illness.

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