Mental health capacity building in northern Sierra Leone: lessons learned and issues raised

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Ten years after a brutal and protracted war, Sierra Leone remains very much in recovery. Despite the need for increased and long term mental health services, such resources remain scarce. Mental health capacity building is required, and includes: the community sensitisation of mental illness and treatment; the training of health professionals and lay persons; the advocacy for changes in national mental health policy; and the provision of mental health services. The authors worked during a two-year period (2010 – 2012), supporting a community mental health capacity building project in northern Sierra Leone that was designed to address these issues. A study was conducted among different agency and community stakeholders to assist in the end-of-cycle programme evaluation. The results illustrate the broader challenges of providing mental health services in the county, and a discussion of issues and challenges that are likely to be applicable to similar projects in Sierra Leone, and other low or middle income countries, is provided.

Keywords: evaluation, mental health capacity building, Sierra Leone, sustainability

Introduction

Previously ignored or neglected in national health care systems, the provision of psychiatric services in low to middle income countries (LMIC) has now become part of an international dialogue. A 2007 special issue of *The Lancet* provided a significant voice for experts to call for a comprehensive international plan for action to improve mental health services as a means to lower the burden of disease (Lancet Global Mental Health Group, 2007). Recently, the Executive Board of the World Health Organization (WHO) adopted resolution WHA65.4, calling for a comprehensive response to the global burden of mental illnesses (WHO, 2012b). This consensus, emerging among major national and international organisations, has led to a shift where resources are now being channelled into global mental health services and their delivery.

For many LMICs, descriptions of national mental health issues have appeared within journals that have historically focused on providing emergency relief services in settings that faced natural and man-made crises. A special issue of *Intervention* (*Intervention* 9.3, 2011) was devoted to global mental health issues, and included topics such as how responses to complex emergencies can be reconceptualised in a country's health care system, the need to think long term about the provision of mental health and psychosocial assistance, and the possibility of using crisis interventions to address long standing shortages (Pérez-Sales et al., 2011). Sierra Leone is such an example. Although little is published on general mental health issues in Sierra Leone, war related publications are abundant. There have been at least four publications in *Intervention* alone

(Denov, Doucet, & Kamara, 2012; Harris, 2007; McKay et al., 2011; Stark et al., 2009) The authors wish to contribute to this dialogue by sharing recent experiences as consultants to the Mental Health, Behavioural Change, and Social Inclusion programme (referred to in this article as the mental health programme) for the University of Makeni in northern Sierra Leone. Recently, WHO identified Sierra Leone as a priority nation for piloting its mental health gap action plan (mhGAP; WHO, 2010). The authors hope these findings help to raise awareness of some issues related to the community mental health project in northern Sierra Leone and potentially similar projects in other LMIC.

Background

Sierra Leone is a small country of approximately six million people, located in western Africa, comprised of a number of different ethnic groups. Administratively, the country is divided into four geographical areas and 12 districts. Each district is further divided into chiefdoms, governed by local chiefs. The project offered services in the two northern districts of Bombali and Koinadugu.

The country has substantial natural resources, but has yet to take full advantage of them for the benefit of the population as a whole. Forty years of government corruption, coups d'état, inter-tribal conflict and mismanagement, since its independence, followed by 10 years of civil war have all taken their toll on Sierra Leoneans. Most people still rely on subsistence farming or small trading for work, have a life expectancy of less than 50 years and an adult literacy rate of 39%. The average annual income is 800 US dollars, making Sierra Leone one of the least developed countries in the world, according to the United Nations Human Development Index (United Nations Development Programme, 2007).

War of 1991–2001

It is impossible to describe Sierra Leone without mentioning the impact of the recent war. The costs have been high, with over 50,000 killed and more than a third of the population displaced. A discussion of the factors related to the conflict is beyond the scope of this paper, and has been well covered by others. Indeed, it is difficult to find any outside coverage of Sierra Leone that does not focus on the conflict. Articles and images on the use of child soldiers, amputations, sexual violence, forced labour, and large scale massacres are widely available.

It is perhaps these graphic images of the conflict that has led to large scale international responses, ranging from direct combat to post conflict consultation, direct social service delivery, and policy making. Early post conflict social and mental health services focused on reconciliation, child soldier reintegration, and trauma related counselling. Many of these services were provided by international nongovernmental organisations (NGOs). The past five years have seen a rapid departure of these NGOs, having completed their projects and therefore moving their resources to other parts of the world.

There has been considerable debate on how well these projects achieved sustainability following the international NGOs departures (Bolten, 2008). The influx of international aid organisations after the war, created its own autonomous economy that sometimes fostered dependence. Local personnel working for NGOs often times did not find similar employment following the end of their contracts. Medical and social services provided by international

NGOs were never replaced by their local counterparts. Beneficiaries of vocational training, provided as part of rehabilitation of youth soldiers, have never had the opportunity to work in their new trades.

Ten years after the war, a significant number of social and political issues remain relevant. Population pressures are still problematic. Freetown, the country's capital, received a substantial burden of displaced persons. They had initially fled the rebel advances during the war, but have since chosen to remain in the city. Some of the same pre conflict risk factors, described by Abdullah (1998), such as high unemployment (especially among its youth), concerns about crime and drug use, and the loss of familial ties are all mentioned, and are as equally significant today as they were before the war. Many members of vulnerable populations, such as child soldiers (Betancourt et al., 2010) and young women associated with the Revolutionary United Front (RUF) rebels (Burman & McKay, 2007), experienced all of the stressors above, in addition to stigma and community rejection.

Mental health services in Sierra Leone

Health care in Sierra Leone is provided primarily through a combination of services offered by the government, local and international NGOs, and faith based organisations. Traditional healers and traditional birth attendants provide a significant amount of health care services (Ministry of Health and Sanitation (MOHS), 2009b).

Government health care services are based on a primary health care concept (MOHS, 2009b), with three levels of peripheral health units (PHUs), district hospitals, and regional/national hospitals. PHUs include community health posts (CHP) and are staffed by state enrolled community health nurses. CHPs are housed at the village level.

More complicated cases are referred to community health centres, which are staffed by community health officers (CHOs) and are located at the level of Chiefdom. CHOs also provide supervision of CHPs. Both types of PHUs can refer to the district hospital, which provides secondary level care, as well as housing the District Medical Officer, who has primary responsibility for all services and clinical personnel for the district. Bombali and Koinadugu comprise two of the 12 districts in Sierra Leone.

Mental health services are severely lacking. The only psychiatric hospital is in Freetown and the recent retirement of the sole psychiatrist left the country without a board certified psychiatrist. There are only two formally trained psychiatric nurses in the capital, and none outside it. Until recently, there was no professional training programme in mental health. With the support from a multiple partner mental health capacity project funded by the European Commission and called *Enabling Access to Mental Health*, the University of Sierra Leone's College of Medicine and Allied Health Sciences recently approved 12 and 18 month training programmes in mental health nursing. The first class cohort, of 22 students, was matriculated in January 2012 and is expected to complete both didactic and clinical training by mid 2013.

A number of international NGOs trained Sierra Leoneans in mental health intervention skills in their 'training of trainers' programmes after the war. Some of those trained continue to be employed by local agencies following the international NGOs' completion of projects, but many others have been forced to look for different forms of work (Asare & Jones, 2005).

In addition to the shortage of providers, the services that do exist operate independently. There is little coordination between

agencies, other than arranging for hospitalisations in Freetown. At the national level, the MOHS recently adopted a national mental health policy and strategic plan, four years after receiving a draft (MOHS, 2009a; 2009b). The rights of those with mental disorders remain tenuous, however, as the existing mental health act ('*The Lunacy Act*') is over a century old, and contributes to further discrimination and alienation from society (MOHS, 2009a).

The mental health project
In 2008, the Catholic Agency for Overseas Development (CAFOD) of Sierra Leone provided funding for a three year project, in partnership with five local NGOs in the northern provinces, in order to address the lack of treatment for people with mental disorders and to advocate for their inclusion in the community. The lead partner was the University of Makeni (UNIMAK), a Catholic university run by the Diocese of Makeni, which had created the mental health programme (2006) as part of its community service to improve mental health for the residents of Bombali and Koinadugu districts. UNIMAK provided 120 hours of awareness and intervention training to nurses, and 40 hours of awareness and sensitisation workshops to traditional healers, prison and police officers and social workers. Two hospitals in the two provincial capitals set up centres in partnership with UNIMAK to provide free medication and counselling services to those with mental illness, and advice and support to their families. Community outreach efforts to promote awareness of mental health issues were conducted by a local justice, peace and human rights commission, and a radio station run by the Diocese. A Catholic charity in Makeni also agreed to provide access to livelihood support for those having

completed their treatment. A significant amount of the project's early administration and training was done through a network of international experts and volunteers.

Methods
The evaluation began with JS reviewing the available documents and discussing the objectives for the evaluation with CAFOD and UNIMAK administrators. The following research objectives for the evaluation were established: review the impact of the 2008–2011 project; assess the extent to which the programme goals and outcomes were met; document project achievements and best practices; identify gaps in the project implementation; and offer recommendations for ways forward in the project. The method of programme evaluation employed can best be described as primarily a qualitative case study. Individual and focus group interviews, with structured interview guides, were used. By using this approach, the interviewer had an outline of topics or issues to be covered, but was free to vary the wording and order of the questions, to some extent. Interview guides were prepared for partner organisation staff, government agency personnel, counselling centre clients and their families, and community members in different areas within the two provinces. When possible, corroborative evidence from the project's didactic and report data, as well as a review of counselling centre records, was sought to verify interviewee reports. While not part of the program evaluation, during his stay, the second author (BP) re-entered data collected by programme staff for a 2008 baseline morbidity survey in the Bombali and Koaingugu districts. This survey was unique in its inclusion of both community health workers and traditional healers in estimating the region's mental health problems, and how they were

addressed. Secondly, a review protocol was developed for examining counselling centre records for the approximately 270 clients, in order to provide a detailed understanding of a variety of social, medical and diagnostic factors affecting clients served by counselling centre.

Data collection and analysis

To assure adequate coverage and language abilities, five university students were recruited and received training on how to use the interview guides and record responses. Interviews with key stakeholders took place in the two districts, and in Freetown, from 29 August – 21 September 2011. A total of 260 people were interviewed, in approximately eight towns and villages. After the interview data was recorded and organised, they were analysed using inductive and interpretive processes and summarised by identifying significant themes and patterns from similar respondents (Braun & Clarke, 2006; Leedy & Ormrod, 2005).

Ethics

The Freetown office of CAFOD and the vice-chancellor, Father Joseph Turay, of the University of Makeni approved permission to discuss the findings of the end-of-cycle project evaluation. The institutional review board of the Adler School of Professional Psychology approval was also provided to the second author to publish archival results from his findings in this paper.

Findings

Issue one: government buy-in and sustainability

One major issue was sustainability. Efforts to assure the long term offering of mental health services in Sierra Leone faced a lot of challenges. The different NGOs that had arrived during, and immediately after, the war provided needed training and mental health services, but they mostly worked independently of government oversight and adoption, and their programmes were only short term. The authors interviewed several nurses, CHOs, and volunteers who received multiple trainings from NGOs with inconsistent outcomes. Few medical personnel were sufficiently trained to diagnose and prescribe medication properly. Training recipients rarely developed advanced skills from subsequent programmes.

Those who could offer services, whether ancillary or direct, were often poorly paid and constantly under the threat of losing their position at the end of a project cycle. Two counsellors, employed at one centre treating over 600 clients, received less than 25 US dollars a week and did not know if they would be able to continue working at the end of a three-year contract. Community outreach services were adversely affected when volunteers for the local peace, justice, and human rights commission left for paid positions.

Other support issues were easily observed. At the service level, nurses and counsellors lacked consistent supplies to do their work. Much of the therapeutic benefits that clients received were adversely affected by the lack of a reliable supply of medication. Record keeping was also difficult in the clinics. Most documents were recorded in journal entry books, or on scraps of paper, which made storage and retrieval of client data difficult for both service providers and administrators.

The authors concluded that sustainability would require formal ownership for providing services by the Sierra Leonean government. Recent steps taken by the government appear promising for assuring expanded delivery of services for the long term. The recently adopted mental health policy (MOHS, 2009a), outlines a plan to

improve access to mental health services. Changes related to sustainability include: the integration of mental health services into a comprehensive health care coverage: fostering effective collaborative partnerships; networks for mental health with different stakeholders, involving community participation in all stages of service delivery; and decentralising services. The policy also states that medications for psychiatric conditions should be included in the national, essential medicines list. Finally, it includes a plan to develop mental health curricula, for both general and specialised health workers, at major medical training institutions in the country.

Issue two: impact of location

Like other resource limited countries, geographical distance and transport difficulties outside of the capital or regional towns were frequently seen as a problem for acquiring services, attending training opportunities, or learning from outreach efforts. Families seeking treatment for an ill family member found it difficult enough to reach the regional town for initial treatment, let alone travelling to Freetown for specialist hospital treatment where the family would also have to continue providing support and meals. Frequent relapses of patients were reported by families, primarily because of lack of medication and transport difficulties.

> '*To move with a sick person is not easy, the cost of feeding, housing and transportation and other related charges are also barriers.*' (Family member)

Being situated even a short distance from the regional towns affected programme outcomes. Community members' awareness of the counselling centres dropped substantially if they lived outside the two regional capitals. Many heard about the mental health programme for the first time during the interviews. They were interested in hearing more, and many requested that services be provided in their own community.

Geographical issues also affected the selection of those who receiving training. It was more difficult to train health workers in Koinadugu than in Bombali, due to transportation difficulties. The original training programme was intended for more highly qualified nursing staff working in PHUs, so as to offer localised support to those suffering from mental illnesses. However, a large number of trainees came from the regional hospital in Koinadugu with lower levels of qualification and not easily accessible to those in outlying villages. The level of the course had to be adjusted, particularly for those who did not have high literacy skills. This distorted the level of trained workers across different chiefdoms.

These experiences indicated the need to plan for services that do not concentrate on urban areas. Possible solutions that our interviewees proposed, included the provision of mobile clinics or providing better training and logistical support for nurses in the rural PHUs.

Issue three: collaboration between traditional healers and MOHS

Like other settings in Africa, traditional healers play a prominent role in providing mental health services in Sierra Leone. As well as their historical and cultural importance in tribal society, traditional healers were an important resource for help when many formally educated Sierra Leoneans fled the country, during and after the war. Additionally, traditional healers are mentioned in the national strategic plan for mental health services. According to the recently adopted national mental health

policy (MOHS, 2009a), a *'collaboration with traditional and spiritual healers in the detection, treatment and follow-up of people with mental disorders will be further explored and researched, with a view to define clear roles and responsibilities within the next five years.'*

Our observations confirmed the impact of traditional healers in mental health care in the northern provinces. A review of counselling centre intake records found that over 90% of clients received treatment from traditional healers prior to coming to the two counselling centres. In the morbidity estimate survey, traditional healers appeared equally sensitised to the prevalence of mental disorders in their community as health workers; the two groups did not differ in their community estimates of various psychiatric and substance-related disorders. The one exception to this was for psychosis, in which the traditional healers consistently estimated higher numbers.

Despite similar levels of engagement in the community, the two groups appeared to work independently of each other, and traditional healers and community health workers consistently underestimated the number of people being treated by the other group. Both parties felt their own methods addressed the real causes of mental health problems. A few traditional healers thought that medical personnel relied mainly on *'encouragement and prescribing medication,'* resulting in non lasting treatment, while their way was to try by all means to know the root cause of the problem and find a lasting solution. In turn, some nurses interviewed believed only they addressed the real cause of a client's problem.

Both groups expressed a desire to work more closely together to help clients. Our observations, however, suggest that more effort will likely be required from the nurses and community health workers to bridge the differences between the two approaches. The authors found that traditional healers were more open to learning new things from the *'western'* approach and did not believe their livelihoods to be threatened by the offering of free services by the centres, as illustrated in the following:

> *'After the training, I now do things different. Whenever I receive a case of such a nature I try, as much as possible, to give courage to them, provide food, shelter, and clean them instead of discriminating against them, or tying them up. Therefore, I made a positive change to cure such people. Some with difficult problems, I refer to the centre.'* (Traditional healer)

They also showed a high commitment to disseminating all they had learned from workshops run by the mental health programme to other healers.

Conversely, medical personnel seemed to think their knowledge was superior and demonstrated less openness to learning from, or referring clients to, traditional healers. At a national mental health coalition conference that the second author attended, a heated exchange between the two occurred when one traditional healer stated that he diagnosed and treated problems. Medical personnel objected to his use of the term *'diagnose'*, which they believed that only they could use.

Interviewees indicated that the more they knew about the respective skills, expertise and approaches of others, the closer they could work collaboratively to help clients and families or refer to each other when appropriate:

> *'We need to work as one, as a team, to solve this problem of mental health in the country, to find a real solution.'* (Traditional healer)

'It is very good to work together, to form a big umbrella – nurses, traditional healers [University of Makeni] UNIMAK.' (Nurse)

Interviewees indicated that collaboration and improved understanding would be enhanced by the provision of joint training, regular meetings, and more discussion. The current programme, however, separated its training between ministry of health employees (nurses, midwives and health workers) and community members (traditional healers, prison officers and police). Future projects would likely benefit from integrating these groups more into its training activities.

Issue four: training and support need to be socially and culturally appropriate

A review of the project's didactic materials provided to professionals and lay persons, and interviews with trainees, indicated that the curriculum of the mental health programme and other NGO projects heavily emphasised the biomedical model. Highly advanced and westernised counselling techniques were reported being presented, especially in the form of brief workshops by international visitors, which were never followed-up to determine their effectiveness. Some topics, such as violence risk assessment and criminal offender profiling, were covered more in-depth than was probably warranted within the social context of Sierra Leone. Conversely, topics looking at specific social and cultural aspects of mental illness, and appropriate treatments for Sierra Leone, were often omitted. A more holistic approach of assessment and intervention seemed necessary in order to make future training more relevant. In training, the importance of social and community support and working with families was often neglected in favour of an individual approach. However, in practice, nurses and

the staff at the counselling centres interviewed emphasised the importance of supporting the whole family, as opposed to direct support to clients.

One interesting finding was how the nurses adapted their new knowledge to their work. When asked what they understood by 'counselling', their descriptions were often consistent with western notions of intervention, such as not giving advice, letting the person make his or her own decisions, or providing encouragement. However, when giving examples from their actual work, they usually described more direct and less autonomous methods, such as telling their clients exactly what to do: 'I tell them to stop taking drugs and to control themselves', 'I give them a positive solution' or 'I show them the right way.' While this was not what they were taught during the training, it may be appropriate in the sense that they may have adapted a western counselling model to better fit into their own cultural ways of helping.

The authors concluded that more practice based research is needed in Sierra Leone in order to determine how to adapt interventions that were developed elsewhere, often in high income countries, to determine what works. The mental health programme has recently adopted WHO's mhGAP as its curriculum to assist primary care workers in identifying and treating mental health care at a local level. Based on WHO recommendations, the guidelines should be adapted to meet a particular setting (WHO, 2010).

Livelihood support post treatment was cited, by one third of clients and half of families interviewed, as important to help maintain improved mental health and aid integration back into the community, but said this was not offered. This aspect of the programme was not successful, as the NGO

tasked with providing access to livelihood support did not achieve this.

Issue five: stigma and community sensitisation
Stigma remained a problem for the people treated at the counselling centre and their families. Some reported community members *'laughing, shouting, being bad or rude'* to them. However, an equal number said they were treated well and people were friendly; *'people feel sorry for me and always pray and help me.'* Community members themselves expressed tolerant views in interviews, but when considering the social desirability of this question and the stigma reported by others, this may not have reflected the reality.

Even among health professionals, there remains a stigma. While mentioning how they would no longer be afraid to approach those with mental illness, or attribute blame to clients for their illnesses, some still mentioned the more serious cases as *'the crazies.'* Colleagues made disparaging comments to nurses about their work with those with mental illness: *'now you are one of them.'* These attitudes are reflected at the national level by the low priority given to mental health, the lack of resources and training in this field, the restriction of medication access in the provinces, and the delay in adopting the national mental health policy.

However, providing direct services, community outreach efforts and training appear to have reduced stigma toward those with mental disorders. One aspect of training, that was appreciated by most participants, was an overview of different mental illnesses and alternative understanding of the causes of mental illness. Many trainees, as well as community members, initially ascribed the causes as *'evil spirits, fetishes, curses and witchcraft.'* After receiving training, nurses made statements suggestive of improved perceptions toward those with mental illness, such as:

> *'Before I associated [mental illness] with evil spirits, curses or swearing, but now I am able to know that it is cause by alcohol, drug, stress and disappointment'.*
> *'Before this time I was thinking that the client is the cause of the illness, but going through training, I realise that he is not the cause and he is not aware of the act* (his actions and illness)*.'*
> *'Now I know it is not caused by demons and witchcraft, and can be helped'.*

This led to a kinder, more humane approach towards those suffering from mental illnesses and a reduction of fear when approaching someone with a mental health problem, including: *'I don't avoid them now,' 'be friendly with them and encourage them as well,' 'I use dialogue, patience, kindness'* or *'I encourage by giving hopes that they will one day make it up* (be ok)*.'* It was not uncommon for nurses to also mention that they provided food and clothing. The success of the training and outreach programmes to reduce stigma occurred in other settings too, as illustrated below:

> *'For them [mentally ill] not to be left out, but included. To speak to them not harshly but cool, calm and to cajole them and provide food, clothing and accommodation.'* (Police officer)

Radio programmes were the most successful outreach activities in terms of reaching out and disseminating information to community members. At the counselling centre, most of the clients interviewed stated that any negative attitudes towards them changed for the better after they had received support and had recovered.

Issue six: alcohol and substance abuse

'In 2009, I discovered he is a cocaine and mar-
ijuana addict, intoxicating himself. That your
son, who you have educated to college level, is
doing such harmful acts is really frustrating.'
(Father)

Substance abuse appears to be of great
concern, with many community members
citing it as the number one cause of mental
illness. Media reports by television and radio
journalists appear to have heightened
community awareness about substance abuse.
The growing problem of illicit drugs, particu-
larly marijuana (djamba), and alcohol were
cited by community members, families,
police, the former psychiatrist, and other
agencies as a major cause of mental illness.
Both traditional healers and PHU health
workers estimated that alcohol, marijuana,
and poly substance abuse disorders occur at
least twice the rate as other mental disorders
within the community. About a third of clients
at one counselling centre had substance
abuse noted in their records. However, there
appeared to be confusion about the relation-
ship between substance use and other
disorders. Many of the centre clients were
diagnosed with 'drug induced psychosis,' although
it is unlikely that the counsellors distinguished
drug intoxication from psychosis.
Illegal drugs are more available and easily
accessible since the war, and interviewees said
peer pressure and frustration due to unem-
ployment were leading to increased use. These
issues warrant further study to ascertain to
what extent drug abuse is actually leading to
mental illness and what effective treatments
and interventions might be applied.

Issue seven: the war and mental illness

Numerous NGO reports on Sierra Leone
recite the impact of the war on mental
health, but understanding the actual
relationship of the conflict to mental illness
has been challenging. Additionally, there is
considerable debate about the relationship
between armed conflict and mental health,
even in the global literature (Miller &
Rasmussen, 2010; Summerfield, 1999). In
2002, one year after the end of hostilities,
the WHO's pilot epidemiological survey
found that Sierra Leone corresponded to
the expected rate of mental illness, (approxi-
mately 3% of the population) and that this
did not appear connected to the war (Jensen,
2002; World Health Organization, 2012a).
When asked what they believed caused men-
tal illness, only three out of 28 clients and
families interviewed thought their problems
were linked to the conflict. The remainder
said their illness started after 2003, with the
majority citing 2007 – 2011. Most, including
community members, attributed the causes
of mental illness to drugs, 'evil spirits', fetishes,
'frustration or disappointment', family problems
and poverty. Because of the significance
of this issue, one of the supplementary
questions for interviewers was to ask about
the impact of the war, if interviewees did
not spontaneously mention it. This did not
result in significant affirmative responses.
In the review of 270 counselling centre
records, only 5% of patients reported having
war related trauma. The clinicians at the
counselling centre were not only trained
in trauma related issues, but also had
significant personal tragedies related to the
war. It is unlikely that they would have
minimised war related mental illness.
Finally, in the morbidity survey, post-
traumatic stress disorder was the lowest esti-
mated disorder, both in the community
and in treatment by traditional healers and
community health workers.
Doubtless, there is much continued suffering
as a consequence of the conflict in the

northern region (Mughal, 2012), with the death of loved ones, displacement, and the destruction of property, but this evaluation adds to an increasing amount of evidence from other studies to suggest that war does not necessarily lead to an increase in mental illness. In addition, issues of truth and reconciliation, and rebuilding community cohesion may be more effective than counselling programmes in addressing the impact of war (Betancourt & Williams, 2008). Fambul Tok ('Family Talk'; Terry, 2011) is another interesting example of reconciliation implemented by Sierra Leoneans themselves.

Issue eight: programme management
Our findings indicated that program management and administration had a significant impact on aspects of the mental health programme. Despite the large number of NGOs that worked in Sierra Leone and employed host country nationals, numerous problems related to day-to-day management and record keeping were observed. The likelihood of finding personnel who had previous employment history in development organisations was good, but often found that staff lacked skills to perform some tasks, such as writing reports, liaising with other agencies or representing the programme at a senior level. No staff member indicated an interest in documenting nor contributing to a paper setting out the programme achievements, their views or lessons to be learned from their experiences.

At the proposal level, the authors noted unfounded assumptions about human behaviour, rather than formal evidence, guided the programme objectives. For example, one stated project goal was *'to reduce criminality and conflict caused by those with mental health problems'*. No evidence existed to support

this was the case in Sierra Leone, and other research does not indicate a correlation between mental illness and committing crime or becoming involved in conflict. Programme goals and outcomes were not always clear or achievable, and the authors felt that future programmes would benefit from clearer strategic goals with realistic, concrete and measurable objectivities that reflected the mental health needs of the communities being served.

At the administrative level, there were tensions between some of the five partner organisations and the authority of the *'lead'* agency was not always respected. There were also staff tensions within the individual organisations and managing staff behaviour became difficult. Numerous accusations of discrimination, corruption, favouritism, misappropriation of funds, and other misconduct were made. The veracity of these accusations was often impossible to ascertain, but the damage was evident. At one agency, only one person remained working after two years. Cursory efforts to improve employee and management relations were attempted, such as creating activity and field report forms and conducting weekly staff meetings, but they were not maintained.

Little monitoring or evaluation was done by any of the partner organisations. Annual reports submitted to funding agencies often times simply repeated information in the original proposal, without updating progress made on desired outcomes or communicating current needs and priorities. Key documents were lost, including the training course curricula, making attempts to cross check information and employ triangulation methods difficult. Documents that did exist were difficult to find when preparing our evaluation.

Nurses, traditional healers, and other stakeholders were rarely contacted after the

workshops, despite expressing interest. This would have reinforced learning and helped newly trained personnel with the considerable ongoing challenges of the work. These included situations where clients were difficult to manage, time consuming, reluctant to comply with taking medication or had no family support, the high relapse rate, *'the difficulty to convince them of the cause of mental health problems, for them to accept that it is not caused by witchcraft or evil spirits and is curable'*, and the lack of adequate facilities and medication. Almost all said they needed follow-up support and that it had been promised, but was not forthcoming: *'since it's been a long time without UNIMAK getting back to us, we want to know if you are not interested in us any longer?'*

Any research that was done was not incorporated into programme planning or evaluation. For example, a morbidity survey to determine estimates of mental disorders in the northern provinces was conducted at the beginning of the project. Approximately a dozen personnel were trained in the administration of a questionnaire and transported to 90 PHUs to survey community health workers and traditional healers. The results of this study were never used, nor did the staff members attach any importance to the findings.

In LMICs that do not possess sufficiently trained mental health service providers, it is important for NGOs to determine the level of skills for local host candidates to work as senior administrators and managers, which are specialist positions in their own right. Similar projects should anticipate its major sponsors providing greater oversight, guidance and support of personnel to assure smooth operations. A realistic, workable and acceptable system of documentation and communication is also needed, plus a method for duplication and back-up of important records and data. Staff skills should be more closely audited and shortfalls should be addressed by providing the necessary supervision, training, and mentoring to assure that support staff succeed in their own chosen profession.

Strengths and achievements of the programme

'Before, people pointed fingers at me because I was not well. Now I want them to point fingers at me because I am well and I hope to be a good example to them, showing that you can recover.' (Male client, aged 20 years)

Despite the difficulties we saw at the organisational level, these issues are not uncommon in similar studies in Africa (Hanlon, Wondimagegn & Alem, 2010) and it was clear that most stakeholders benefited from the various activities. The family member of one client stated: *'he is now feeling better. . .it has helped him to cope up and improve on his health and behaviour.'* Another said: *'we hoped treatment would bring back his and our pride: this was achieved 80% positive'.* Two clients who had received treatment and recovered said: *'now I can sleep peacefully without any complaint and no more cold infection. Fantastic!'* and *'it changed my thoughts and ways of doing things.'*

The strengths we saw came in the deliverables, especially in efforts to provide support/counselling and sometimes medication to those who needed it, reaching out and raising awareness in the community through radio messages and offering training workshops to nurses, traditional healers, police and prison staff:

'You learn how to refer them and encourage them to attend clinic, to be attentive to them, to take care of them when they are in distress. Specifically I learnt how to communicate with

them, now I am not afraid of them.' (Police officer)

Through the training, nurses became more aware of the pressures on family members and their need, too, for encouragement and support. Examples of how they incorporated training into their work included giving family members *'words of encouragement, condolence and hope,' 'telling families it's not their fault,' 'not be harsh with the ill person because they are not with their normal senses'* and *'offering advice on how to manage their stress and problems.'* The authors found all these examples were confirmed in interviews with family members and were much appreciated.

At the national level, the mental health programme raised the profile of mental health concerns by becoming a partner at national strategic level, contributing to the government mental health strategic plan and the mental health policy. It was an active member of the Mental Health Coalition, an important lobbying and advocacy group. It also organised and co-ordinated activities annually for World Mental Health Day, the last of which commemorated the adoption of the national policy. The programme was also successful in becoming a principal partner in future mental health capacity projects through its role in *Enabling Access to Mental Health.* Finally, successful training of 22 psychiatric nurses illustrated a long term impact of the CAFOD project that was never originally planned.

Conclusion

'We are glad that you and your organisation have started visiting, you are warmly and happily welcome as we believe, with time, your organisation will work in this community and other communities.' (Family member)

Although we do not wish to minimise the impact of the war, programmes need to now go beyond the often quoted *'trauma related issues pertaining to the war'* as a rationale for providing mental health services. Mental health problems are far wider reaching. Our findings indicate that future programmes and services need a greater emphasis on reducing stigma, providing education and information about mental illness, and focusing on culturally appropriate community and social support for those suffering from mental illness, and their families. These programmes need to be guided by, and contribute to, government policy and address the needs of all those suffering from the wide diversity of mental health problems.

The final words come from a client who received support from the mental health programme:

'I am feeling better, and I hope medication, counselling, love, encouragement, and income will help me stay better. Thanks a lot to the mental health organisation, and its donors and workers. And also to community members.'

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