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ORIGINAL PAPER

Reviewing the Common Barriers to the Mental Healthcare Delivery in Africa

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Abstract
The current paper sought to thematically present common challenges associated with mental healthcare services in Africa. We largely limited our search for literature materials to studies published from 2003 to 2019 in African countries from which the findings showed that there are common challenges confronting mental healthcare services in Africa. The challenges include: inadequate mental healthcare facilities, funding constraints, shortage of professional healthcare workers, inadequate training and development scheme for mental health workers and weak mental healthcare policies. Implications for policy and practice are disclosed and recommendations are stated to trigger actions to remedy the situation. This information is beneficial for researchers, policymakers, mental healthcare providers and community members who are interested in mental healthcare issues. It was concluded that in order for Africa to enjoy successful mental healthcare service, critical and enduring attention must focus on sound and enforceable government policy on mental healthcare service, provision of adequate and regular funding, availability of adequate mental healthcare facilities, provision of training and development facilities for the mental health professionals and collaboration of mental healthcare providers.

Keywords Mental health · Mental healthcare · Mental healthcare delivery · Mental healthcare professionals · Mental healthcare challenges

Introduction

Mental health issues and mental healthcare services are critical matters that trigger key stakeholders' (primarily government) interest and intervention because of the problems they pose when the challenges confronting them are not addressed. For

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this reason, in the developed economy, mental health laws have been enacted to protect patients' rights and to strengthen mental health services through the provision of adequate mental healthcare professionals in the field and ensuring that healthcare facilities are accessible. World Health Organization (WHO) (2016) defines mental health as a state of well-being in which individuals are able to recognize their abilities, demonstrate the capacity of coping with stresses in life, exhibit the potential to work productively and contribute sufficiently in their various communities. Mental disorders on the other hand, may include: unipolar depressive disorder, bipolar disorder, alzheimerl, drug use disorder, obsessive–compulsive disorder, panic disorder, insomnia, schizophrenia, epilepsy, mental retardation and behaviours related to psychoactive substance use disorders, anxiety, stress (World Health Report 2001; Thomas et al. 2015; Rensburg and Jassat 2011; Ofori- Atta et al. 2010).

In practical terms, those with the greatest disadvantage are normally those with critical mental healthcare needs. Thus, the state of a person's mental health cannot be separated from his or her physical health, economic status, worker commitment and productivity, Millenium development goals, sustainable development, self-image and mortality rate (Mitchell and Tihonen 2009; Doku et al. 2008; Ambikile and Iseselo 2017; Skeen et al. 2010; Fournier 2011; Sorsdahl et al. 2010). Persons with mental health disorders face numerous challenges. For example, in Zambia, Kenya and other countries in Africa, persons with mental disorders are stigmatized, ridiculed, isolated, feared, scorned at, humiliated and condemned (Thomas et al. 2015; Chahine and Chemali 2009; Mayeya et al. 2004). Also, mental health patients experience loss of employment and wages as a result of mental incapacitation, go through loneliness, register high mortality rate among others (Chahine and Chemali 2009; Mayeya et al. 2004; Rathod et al. 2017).

In this paper, the authors have developed a model that shows that biomedical wellness; psychosocial wholeness, spiritual relief, employability and standard of living, education level, sustainable development, millennium development goals, peace and happiness, social status and longevity have a strong link to mental health wholeness. The essence of the model also explains the reasons why in the developed countries, there are laws, policies, programmes and structures that aim at improving and strengthening the treatments of people with mental disorders (Patel and Prince 2010). On the contrary, in the under-developed and developing countries, concerns and attitudes towards mental health needs, poverty alleviation as well as human development agenda leave much to be desired (Fournier 2011; World Health Report 2001; Ofori-Atta et al. 2010; Doku et al. 2008).

In Africa, causal factors of mental disorders vary across countries but generally include poverty, low education, conflict and disasters, and gender disadvantage (Patel 2007). Causal factors such as misuse of drugs (89.4%), misuse of alcohol (75.0%), influence from witches (44.0%) and possession by demons and divine punishment (30.0%) were found in Nigeria (Atilola and Olayiwola 2010; Kiima et al. 2004). Within the Ghanaian setting, however, causal factors include the break of relationship, road traffic accidents, financial difficulties, hereditary factors, fatal infection during pregnancy, tumour in the brain, hypertension and dementia (Osei 2013).

Statistics have shown that disorders of mental health are on the rise (Bruckner et al. 2011) and constitutes 8.1% of the Global Burden of Disease (GBD) greater than that of cancer, tuberculosis and heart disease (World Health Report 2001; Wilson et al. 2014). According to Menil et al. (2012), in Ghana, the disease burden of mental disorders represents 9% and normally high in low-income countries (Rensburg and Jassat 2011). Schizophrenia, depression disorders, epilepsy, mental retardation and behaviours related to psychoactive substance use disorders are common mental disorders in Africa (World Health Report 2001; Thomas et al. 2015; Rensburg and Jassat 2011). Depression is usually reported in Africa in general (Thomas et al. 2015) unlike substance abuse and mood disorders in Ghana (Ofori- Atta et al. 2010). Schizophrenia representing one-third was the most common mental disorder in the in-patient units followed by personality disorders in Eritrea (Ghebrat et al. 2008). Conversely, schizophrenia, depression, epilepsy and substance abuse disorders were the most common diagnoses in Ghana. However, in 2009 and 2010, schizophrenia and depression were the highest (Fournier 2011).

Adult personality and behavioural disorders and epilepsy also displayed a significant increase in outpatient's units in 2010 (Fournier 2011). Also, depression and schizophrenia were predominating in in-patient units in Ghana (Laugharne and Burns 1999). Furthermore, it has also been observed that females are highly diagnosed with mood disorders while males register high in substance abuse disorders (Thomas et al. 2015). A study conducted in four African countries showed that mentally ill patients were usually males with an average age of 34 years (Thomas et al. 2015) and they dominate outpatient services (Ofori- Atta et al. 2010). Factoring in the numerous causes and effects of mental health disorders and the need to address them, identifying barriers to effective mental healthcare delivery and providing solution to them is a very highly commendable move.

Justification of the Study, Research Questions and the Goal of the Study

The foregoing discussion shows that mental health and mental healthcare require critical attention and for that matter, the key challenges that hamper effective mental health and mental healthcare services must be addressed. One benefit of the current study is that, it has outlined the critical challenges facing mental health service in Africa and suggested the panacea for regulating them significantly.

Also, although numerous studies have explored the relevance of mental health to human development, longevity, prestige, Millennium development goals, employability, happiness and peace index to mention just a few, there is woefully scanty studies that targeted the challenges associated with mental healthcare services in Africa using literature review. In order to promote effective mental healthcare policies, practices and programs within communities in Africa countries, healthcare stakeholders need to understand the unique situation faced by mental healthcare services and practice in Africa. In response to that, this paper is a literature review where challenges commonly associated with mental healthcare delivery in Africa were thematically discussed. It is expedient to maintain that, identification of available mental health services and problems affecting mental healthcare services are

essential to aid the execution of policies and reform of mental health service delivery in Africa.

Furthermore, the review integrates and synthesizes the literature in the mental healthcare domain, bridges the gap in knowledge regarding mental healthcare challenges in Africa and suggests interventions to eradicate mental health challenges and in order to enhance the practice of mental health management in Ghana (Chidarikire et al. 2017).

The overarching research question guiding the review was: What are the challenges of mental healthcare services in Africa? In finding answers to the main research question, the study first explored the existing mental health services in Africa and barriers crippling effective performance. The purpose was to propose recommendations to remove barriers to mental healthcare services in Africa.

This implies, the review was not aimed at establishing theories or to analyse the relationship between them or to explore the extent to which the theories have been investigated or to point out insufficient theories in the field for the advancement of a new theory. Again, the study did not aim at identifying and evaluating methods in the field of study in order to point out variables, measures or methods of analysis to inform outcome-oriented study. Future studies may consider them. The formulation of the problem began with how our research question was stated which in turn was significantly influenced by the goal and focus of the review.

Methodology of the Study

Coverage/Accessible Population, Sampling and Data Collection Methods

The original intention was to engage in an *exhaustive review with selected citations* in the accessible population (that is, journal articles and WHO reports on challenges facing mental health services in Africa). The researchers tried to locate and consider every available piece of study on the subject area which have been published in journal articles in Africa largely spanning 2003–2019. The aim was to ensure the population of the study, that is, the related journal articles accessible bounded to Africa were reviewed. However, in practical terms, it turned out to be a purposeful judgmental sampling technique where the researchers explored only the central articles in the field which highlighted strongly on the data being searched for within the time range. The researchers perceived journal articles as quality and pivotal when published by reputable publishers, and more seriously when indexed in Scopus database.

Inclusion and Exclusion Criteria

Criteria for inclusion and exclusion of pivotal articles and those not pivotal were established, guided by the focus, goal and coverage of the study. Studies were included in the review if they reported on the challenges of healthcare services or they highlighted healthcare services in Africa. Furthermore, only articles written in

English were factored in the study. The researchers also ensured that there was no overlapping of data from another study. Studies on mental healthcare delivery done on Africa and published in peer reviewed journal between 2003–2019 were largely used. Some of the WHO reports on mental health were also reviewed.

Research Design, Data Collection and Data Analysis Method

Interpretive and historical case study designs were employed. The data collection method was document review (systematic review of secondary data). The process began by collecting literature materials targeting both the provision of mental healthcare services *and* challenges involved. Early in our search, we found that data were extremely limited with regard to the challenges associated with mental healthcare services. Thus, we refined our research to focus largely on challenges facing mental healthcare services. With this focus, our research was completed in three main phases. The first phase was an extensive literature search using some academic library database system to access academic journals articles on mental health services and related challenges. A systematic review on the topic was conducted. Second, the researchers also typed in keywords like mental healthcare, mental health, mental healthcare challenges pertaining to Africa, Sub-Saharan Africa, developing and low- and middle-income countries (LMICs). The searches were executed using both single and combined terms.

Hard copies of relevant materials housed directly within the Balm Library in the University of Ghana and Central University were retrieved. In order to specifically retrieve journal articles and other published papers databases such as *Academic Search Complete (Proquest)*, PubMed, *Google Scholar*, *ERIC (EBSCOhost)*, AJOL, *PsycINFO* and others spanning between 2003–2019 were deployed. The keywords such as mental health, mental disorders and services yielded 722 articles in PubMed, 894 in AJOL and 1675 in Google scholar. The search in each database was in turn combined with countries in Africa. Some names of countries were not available as keywords in the databases. Articles obtained were from South Africa, Zambia, Ghana, Uganda, Nigeria, Kenya, Tanzania, Ethiopia, Zimbabwe and Eritrea.

The researchers then examined and screened each *paper* by studying the title and abstracts (where necessary) and performing a quick scan of the document (where applicable). In all, 90 articles were retrieved, but 45 of them were judgmentally sampled for the study because they were found to provide the expected rich information. A total of 16 studies conducted in Ghana, South Africa, Uganda, Zambia, Tanzania, Kenya, Ethiopia and Eritrea were included. Endnote reference manager was used in organizing the articles. We generated a list of resources and sub-divided these resources into draft themes and we shared them between us. This allowed the researchers to simultaneously work on one developing theme. Further search was closed when it was established that reviewing articles further added nothing new. Accurate records of the date of each search, the search engine used, the data bases used, the key words and key words combinations used, and the data resulting from each search in summary form were kept.

Data Evaluation Stage

The next phase of the research involved gaining a deeper understanding of the data. An academic resource lists was reviewed; hard copies of most available sources were printed. We extracted and reviewed only articles that satisfied the criteria for inclusion, the focus and the goal of the study. With this printed out data *in front of us*, we read each source in detail while using a marker to identify key observations and features embedded in the literature. In the margins of the printed papers, we summarized the main points, phrases and findings emanating from the literature. This second phase of research focused on coding the resources for patterns and common terms and grouping them into refined themes. The exercise enabled the researchers to reduce the information in the relevant documents, identify meaningful statements and give meaning to them with a thick description. The final phase of the process involved the researchers meeting to discuss these pre-coded data. In turn, five overarching themes indicating challenges confronting mental health service in Africa were generated. These are: (a) inadequate Mental health services facilities (b). Funding challenges (c) Lack of professional healthcare workers, training and development facilities; (d) weak mental healthcare policies. The key findings that were related, were integrated and synthesized.

Truthfulness (Validity and Reliability)

To enhance validity, the researchers engaged in thorough discussion and agreed on literature materials to include and those to exempt in the study giving strong consideration to methodological rigour. Peers and experts were also consulted to review the list of references from selected articles reviewed in order to check if there was no missing article. This did not just yield initial validity alone but also the peers of the researchers suggested other relevant references for the researchers to review them in order to improve the process. This process enhanced data rigour. Moreso, only high quality journal articles were reviewed. This is explained by the reputation of the journal, the impact factor and also ensuring that many of them were indexed in Scopus.

For further rigour to ensue, the entire research report was given back to peers of the authors who were experts in the field to carry out an in-depth review; and their relevant professional comments were included in the paper.

The strategy of "bracketing" our experience with the phenomenon by explaining our positions on the phenomenon dispassionately was also employed. The findings were reviewed with other related literature and were found consistent thus suggesting possible external validity and reliability (confirmability and dependability) in other jurisdictions in Africa. Besides, the fact that some of the findings in some countries in Africa were similar to others in Africa, suggests that the findings are dependable and applicable in another context in Africa.

Ethical Considerations

All the sources of articles used in the present study were acknowledged appropriately. Authors of the current study were transparent to each other. Task were fairly shared based on mutual consent. Experts who helped to professionally design the conceptual framework embedded in this paper were paid for their services. Plagiarism check was also conducted to ensure that the authors really own the paper.

Results

The themes disclosed in the results section were generated from the secondary data when keywords such as mental healthcare challenges and mental healthcare services were repeatedly searched through the search engines and the academic databases. The common mental health challenges that came up were

i. Inadequate mental health facilities.
ii. Financial constraints.
iii. Inadequate supply of health workers and poor training and development programme.
iv. No or poor government policy on mental health and mental healthcare services.

Inadequate Mental Healthcare Services

Mental healthcare facilities (providers) include psychiatric hospitals, psychiatric units within regional and districts hospitals, community psychiatric centres and traditional and spiritual healing centres. Other facilities include residential facilities for children with intellectual disabilities, and rehabilitation facilities run by charitable and religious organizations. There are challenges associated with any of these facilities. Either, the facilities are inadequate to meet the mental healthcare needs or the process involved in administering care is inhuman or questionable thus posing a challenge. Basically, hospital care and traditional healthcare are the two major areas of care in Africa (Patel 2007). Mentally ill patients also depend on their families for care. Challenges such as inadequate healthcare facilities or infrastructure makes accessibility difficult (Bruckner et al. 2011; Rathod et al. 2017). A study undertaken in Tanzania by Ambikile and Iseselo (2017) on the challenges facing mental healthcare delivery among mental healthcare providers found lack of psychiatric wards, limited space for service provision, worn out buildings, inadequate diagnostic equipment and lack of security for care providers when caring for aggressive patients.

Thomas et al. (2015) study shows that high number of patients were found difficult to manage, and many absconded, and some re-admitted three months after discharge in South Africa. Living conditions in mental health facilities are in a deplorable state, with poor ventilation, inadequate mosquito supply and insufficient food supplies in Uganda (Cooper et al. 2010). A total of thirty-three African countries have community psychiatric centres (World Health Organization 2011). Presently,

12 countries have no community psychiatric centres (see Table I, appendix). The coverage of country-wide community care is also unclear in many countries Jacobs et al. (2007). In the WHO-AIMS Report (2001), community psychiatric care is recognized as the best option and crucial for development in mental health care. It is delivered through hospital-based outpatient clinics by professional mental health personnel's (usually psychiatrists and psychiatric nurses). Community psychiatric personnel raise awareness through campaigns and workshops on mental health (Jacobs et al. 2007) and it is necessary for the identification of undiagnosed and potential patients (WHO-AIMS Report 2001). The mandate of community mental health facilities is to provide promotional, preventive, curative and rehabilitative services to persons with mental disorder, and that is well developed in Ghana (Fournier 2011). Ghana's two community psychiatric centres are situated in the northern part of the country and are performing well (Gwaikolo et al. 2017). In contrast, the few community mental health facilities in Kenya are in deplorable state as a result of poor management (Kimma et al. (2004). There is poor psychosocial rehabilitation in South Africa, Ghana, Zambia, Kenya, Uganda (Lund et al. 2012; Foutnier 2011; Mayeya et al. 2004; Kiima et al. 2004) and this affects the patients recovering process. Countries in Africa do not attach prominence to psychsocial interventions although the who guidelines on mental health stipulates its benefits to the sustainability of patients' health in the society.

Religious Faith Healers and Mental Healthcare Delivery

Asamoah, Osafo and Adjapong (2014) deploying interview strategies and thematic analysis explored the perspective of 20 male Pentecostal clergy on the role of their churches in mental healthcare delivery in Ghana and found that Pentecostal clergy lean more towards a diabolical explanatory model of mental health than the biomedical. Subsequently, the means by which they contribute in mental healthcare delivery is by casting out the demons underlining the illness, providing material support and health education to their patients. Asamoah (2016) employing interview and participant observation strategies as well as case study and ethnography designs, conducted a study into the 'deliverance' concept within Classical Pentecostalism and Neo-Pentecostalism against historical and contemporary considerations. He found that, churches play much role in contributing to mental healthcare delivery in the health industry. However, their attribution of demons to almost all existential problems is overly stretched, and their treatment regimen to mentally ill patient is dehumanizing. The study proposed that care must be pivotal in dealing with mentally ill patients and effective collaboration among deliverance practitioners, psychologists, psychiatrists, professional counsellors and medical doctors will propel a holistic deliverance practice and enhance the dignity and value of the healing and deliverance ministry in Ghana and Africa at large on the one hand and the health industry in general.

Osafo, Adjapong and Asamoah (2015) in an effort to critically delineate and bring to light the role played by religious groups in mental healthcare, interviewed 12 clergy from the neo-prophetic Christian ministries (or churches). Employing

interpretative phenomenological analysis for analysing data, it was revealed that these clergy conceive mental illness as a diabolic rather than a biomedical one. Therefore, in treating mental ill patients, they use spiritual approaches such as inducting hope into them and engaging in prophetic deliverance. To verify if their patients are healed, they take time to observe them to be sure they have returned to normalcy; and authoritatively demand that the demons underlining the illness are completely cast out. It is clear that religious groups are engaged in healthcare service and what we need is government policy and law that regulate their excesses, enhance sanity in their practice and coordinate collaboration of all professionals in the mental healthcare service in order to ensure holistic mental healthcare provision in Ghana and Africa as a whole.

Arias, Taylor, Ofori-Atta and Bradley (2016) carried out 50 open-ended, semi-structured interviews with prophets and staff at nine Christian prayer camps in Ghana, and with staff within Ghana's three public psychiatric hospitals to explore intersectoral partnerships between prayer camps and biomedical care providers as an effective strategy to address the overwhelming shortage of mental healthcare workers in Africa and other low-income settings. They found that prayer camps are playing great role with the exception that collaborating with medical experts will be a challenge due to their widely diverse approach to attending to their patients. For example, some prayer camps believe in subjecting their patients to fasting, putting them in shackles and do not endorse long-term medication in treating them expressing concerns that long-term medication treatment regimens hide underlying spiritual causes of illness. The medical experts abhor the dehumanizing dimensions such as beatings, chaining and keeping the mentally ill in an unhygienic place.

From Islamic religion perspectives, faith healers use specific verses in the Holy Koran by reading or reciting to individuals with spiritual mental illnesses, and writing verses on pieces of paper for individuals to keep at all times (Ally and Laher 2008). Similarly, Swedish Somalis family, friends and religious faith healers read verses from the Koran to mentally ill health persons for spiritual healing. For example, Bulbulia and Laher (2013) report in their study that Imams use specific verses from the Koran and exorcist rituals for specific mental health healing purposes (Bulbulia and Laher 2013) among Somalis in Sweden. Spiritual recitation is another strategy used by Muslim faith healers to provide support to the mentally ill persons. Recitations are pronounced on natural products such as water, sugar and honey, to receive spiritual guidance.

With the strong faith of Muslims, they place much value on spirituality, believe in Allah as the ultimate healer and not in professional therapist (Hall et al. 2011). They have the notion that ignoring the Islamic religion and seeking professional assistance was like a betrayal (Weatherhead and Daiches 2010). Hall et al. (2011) argue that Muslim faith healers use the Koran in directing and encouraging individual Muslims to live dependently on others and support each other in families and kinship ties.

A cross-sectional study on the role of Imams in mental health promotion in New York communities revealed the use of Islamic teachings and beliefs within unstructured psychotherapy by Imams who are hugely contacted by Muslims (Abu-Ras, Gheith and Cournos (2008). Imams also provide different spiritual counselling and

educational services to serve the needs of mentally ill Muslim patients in America (Padela et al. 2012). Ciftci et al. (2013) and Ally and Layer (2008) report that Islamic religious teachings within psychiatric therapies serve as a useful resource for Muslims with mental health issues. Therefore, the use of Islamic teachings and directives which are more humane are utilized and enforced by Muslim faith healers in healing the mentally ill across numerous countries in the world.

Majority of patients in Africa with mental disorders utilize the services of traditional and spiritual healers. Eseigbe et al. (2014) found that 90% of patients with mental disorders living in poor urban areas access the help of traditional healers. About 70–80% of people with mental disorders access the services of orthodox health personnels before seeking treatment from professional medical personnels (Hanlon et al. 2010). Traditional healers provide greater care to mentally ill in Uganda, South Africa and Zambia (Abbo 2011; Sorsdahl et al. 2009). Evidence from a study conducted in Rwanda, South Africa and Uganda reveal immerse contribution of traditional healers in closing the gap of treatment in mental health (Abbo 2011; Schierenbeck et al. 2016). The findings from a study conducted in Ghana show 20–30% of the patients in Accra Psychiatric Hospital utilize the services of traditional healers before resorting for medical help. The pattern for Ghanaians with mental disorders involves utilizing traditional health services before seeking treatment in health facilities (Fournier 2011). Also, 20% of patients also use faith healing after leaving the hospital for spiritual reinforcement (Fournier 2011). In 2004, registered traditional healers were about 44,000 in their association in Zambia (Mayeya et al. 2004). Traditional healers outweigh the number of mental health personnels in Ghana (Ae-Ngibise et al. 2010).

Traditional and spiritual healers attend to a large number of sufferers of mental disorders in Ghanaian communities (Fournier 2011). Patients who attribute mental illness to spiritual causes seek help from churches (Kiima et al. 2004) and believe prayer is the solution to mental illness and the use of prayer drives away mental spirit possessions (Mayeya et al. 2004). People believe traditional spiritual healers are experts in the cure of mental health problems (Sorsdahl et al. 2009), because they share a common culture and have close relationships with them in the communities (Abbo 2011; Ae-Ngibise et al. 2010). Traditional healers are made up of herbalists, diviners, religious and spiritual healers. Ae-Ngibise et al. (2010) and Sorsdahl et al. (2009) report that traditional mental health care are more accessible and affordable than western mental health care in Africa.

Okasha (2007) found that faith healing and traditional healing may be effective but are characterized by injurious and inhuman methods and process (Kiima et al. (2004). Reports from Ghana reveal abuse of the mentally ill in the traditional and faith-based healing centres (Fournier 2011; Ofori-Atta 2010). In Uganda, media reports show dangerous and unethical treatments offered to the mentally ill in traditional healing centres. However, no national body inspects their activities (Ofori-Atta et al. 2010).

Inadequate Mental Health and Mental Health Service Policies

The above theme embraces three perspectives including: No mental health policy at all; insufficient mental health policy and poor enforcement of the policy. Though Abas

et al. (2003) reports of rapid growth in the number of national mental health policies, just about 42% of countries in Africa, have mental health policies (Table 1).For instance, the mental health policy in Ghana promotes integration and decentralization, mental health care in communities and districts and regulates the activities and support of traditional and faith-based healing practices (Ofori- Atta et al. 2010). A number of African countries have no mental policy or legislation to direct programmes and services (Jacobs et al. 2007) and confirms a study that found that lower proportion of low-income countries than high-income countries have guiding policies, plans, legislations and programmes on mental health (Ambikile and Iseselo 2017).

Countries such as Angola, Benin, Burundi, Burkina Faso and Cape Verde have no mental health policy (see Table 2), but have a component of mental health in health policies (Kiima et al. 2004; Ghebrat et al. 2008; World Health Organization 2011). Some countries with mental health policies require revisions in order to adequately include expansive mental health issues such as integration of mental health care (Van Rensburg 2007). Another study by Petersen et al. (2011) identified poor implementation of policy. Monteiro (2015) in his exploration into individual and community challenges that contribute to mental healthcare disparities in Africa, notes that within the African context, lack of specific policy for mental health and non-implementation of mental health care at different levels of care explain the lack of structures and services at multiple levels.

In a review of barriers to the development and implementation of mental health laws in Ghana, Kenya and Zambia, Obame (2017) argues that lack of mental health laws in over 64% African countries affect the promotion and protection of the rights of the mentally ill. According to the author, there are serious implementation and dissemination challenges of mental health policies even in countries where mental health policies have been formulated. Drew et al. (2013) also point out that many of the mental health policies require revision. They argue that the mental health laws lack precision, specifically language used is inconsistent. They explain that different terms are used to describe mental health conditions in Africa, making it ambiguous. This, however, is very problematic and is likely to affect the implementation of mental health laws. Furthermore, they explain that existing mental health laws in Africa lack clear guidelines on the capacity and competence of people with mental illness, emphasizing stigmatization and discrimination against people who are mentally ill.

Funding Constraints

Government funding is the main source of funding for the care and treatment of severe mental disorders in 79% of member states (World Health Report 2001). Lower middle-income countries spend an average of US$1.53 per capita on mental health, US$1.96 for upper middle-income countries and US$58.73 for upper-income countries (World Health Report 2001). Whereas high-income countries allocate higher proportion of health budget on mental health, lower-income countries allocate lower proportion. In Africa, financing of mental health is mainly through one's own money and taxes (refer to Table 2) (World Health Organization 2011). Many people in Africa use their money for mental health care (Wang et al. 2007).

Countries such as Bostwana, Cameroon and Cape Verde and some others use the tax-based system or insurance.

In addition, 79% of African countries spend less than 1% health budget on mental health. Empirical evidence from Wang et al. (2007) show that 35.9% of countries in Africa use tax-based (60.2%), followed by social insurance (18.7%), out-of-pocket expenses (16.4%), external grants (2.9%) and private insurance (1.9%). Whereas social insurance was the primary financing method in European countries, out of pocket was common in Africa where the income per capita is also scanty (refer to Table 2). Countries like Ghana charge small fees for the maintenance of facilities (Fournier 2011). However, there are a number of patients who cannot afford these fees thus creating a burden. In a qualitative study of Ghana's mental health Act, Walker (2015) identified financial limitations as a major contributor to implementing mental health policy. According to the author, lack of funds to support policy implementation by the mental health authority in Ghana is a major setback.

Furthermore, available funds from International donors have conditions attached which prevent an institution from making use of it for other activities. Nonetheless, a number of programs including hiring and training of human resources, building and creation of new mental health units on regional and district levels are essentially needed but funds are insufficient. Hence, he emphasized that the lack of funds is a barrier to mental health progress and improvements in Ghana and so other alternative sources of funds could be utilized. Examples are National Health Insurance and Value Added Tax (VAT).

The provision of psychosocial interventions in Africa is approximately 24% compared to 59% in Europe (World Health Organization 2011). There is little budget for psychosocial and rehabilitative interventions in Ghana (Ofori-Atta et al. 2010).

Insufficient Professional Health Workers and Training and Development Facility

Globally, high-income countries have more than 90% of mental resources and 200 times greater with psychiatrists (World Health Organization 2011). Though African countries are beginning to make strides, there are significant differences in personnel and general resources. According to Osei (2013), the ratio of doctors to patients in Ghana is 1:1.7 million, 1:1 million in Nigeria and 1:50,000 in Kenya. Evidence from Kenya shows 50 psychiatrists but only 7 are available and working in the specialist mental hospital. Mental health professionals in Africa constitutes psychiatrists (0.05%), psychiatric nurses (0.06%), psychologists (0.04%), social workers (0.03), occupational therapists (0.01) and other health workers (0.31%) (World Health Organization 2011).

The distribution of human resources is higher in psychiatric nurses than in psychiatrists (Ofori- Atta 2010; World Health Organization 2011), with lower number of psychologists and occupational therapists (World Health Organization 2011). Out of a population of 1200 trained psychiatric nurses, a study conducted in Zambia shows that a little over 500 are working in the public hospitals, due to lack of interest in mental health and migration (Mayeya et al. 2004).

Generally, psychologists and occupational therapists are insufficient in mental healthcare teams in Africa. Reports show that Ghana does not hire psychologists and occupational therapists (Fournier 2011). However, training for psychiatrists and post basic training for nurses are ongoing in Zambia (Mayeya et al. 2004). Results from South Africa show that training programs for psychiatric nurses improves the treatment of help offered to patients such as prescribing medicines and diagnosing mental health disorders (Abas et al. 2003). Interesting results from (Sorsdahl et al. 2010) show that psychiatric nurses perform most of the duties of psychiatrists by treating and prescribing medications. Empirical studies reveal a shortage of mental health professionals and lack of trained staff to manage mental health units in Africa. (Kiima et al. 2004; Mayeya et al. 2004; Chahine and Chemali 2009). Mental health resources are concentrated in the urban city centres limiting access to rural users (Cooper et al. 2010).

A study undertaken in Tanzania by Ambikile and Iseselo (2017) on the challenges facing mental healthcare delivery among mental healthcare providers found inadequate human resource and training among others. In the same study, patients identified longer waiting periods, shorter consultation periods and low satisfaction with services. They also identified misallocation of trained human resource, use of offensive language by care providers and rising number of patients in the clinic. In Zambia, respondents in a study highlighted human resource challenges such as inadequate number of health professionals, lack of in-service training and mismanagement of services by health professionals (inexperienced professionals taking the roles of clinical officers) (Sikwese et al. 2010), poor communication between psychiatric services and primary care services and difficulty of retaining staff in rural communities (Read and Doku 2012). Ambikile and Iseselo (2017) reports high level of stigma and discrimination towards mental health patients in Tanzania.

To address the shortage of human resource in Tanzania, the plans of revising mental health training programs by sending health professionals to specialize in mental health have been recommended (Ambikile and Iseselo 2017). A number of recommendations from studies conducted in Zambia included increase in qualified human resource and training of health professionals (Sikwese et al. 2010).

Discussion

The current study explored the common challenges facing mental health service in Africa. The purpose was to recommend solutions to remove or regulate the challenges so as to enhance mental healthcare delivery in Africa. The results indicate that there are clear-cut shortage of mental health services owing to the inadequate mental health facilities such as biomedical, psychiatric hospitals, primary health clinics, community psychiatric centres, rehabilitative and psychosocial interventions thus making it difficult to manage a large proportion of those with mental disorders (Bruckner et al. 2011; Rathod et al. 2017; Ambikile and Iseselo 2017; Thomas et al. 2015; Jacobs et al. 2007; Kimma et al. 2004). It was revealed that mental health

services were not provided at the primary health clinics, although many persons with mental disorders make first contact with local clinics and hospitals.

Owing to this, a number of those suffering from mental disorders patronize the faith-based healthcare and the traditional healers facilities (Eseigbe et al. 2014; Hanlon et al., 2010; Abbo 2011; Sorsdahl et al. 2009; Abbo 2011; Schierenbeck et al. 2016; Fournier 2011), thus leading to the proliferation of such alternative mental healthcare providers (Mayeya et al. 2004; Ae-Ngibise et al. 2010; Fournier 2011; Kiima et al. 2004). Traditional healers are made up of herbalists, diviners, religious and spiritual healers (Ae-Ngibise et al. 2010; Sorsdahl et al. 2009; Okasha 2007). This review supports a study that found that Africa has still not moved away from the initial phase of traditional care in the precolonial era (Kigozi 2007).

While much strides have been made concerning the necessity to augment mental healthcare provisions in low and middle-income countries, focus has been drawn and tilted towards the importance of taking advantage of local healthcare providers for low cost purpose and to augment mental healthcare delivery (Prince et al. 2007; Saraceno et al.2007). Faith-based healthcare providers have come into limelight in bridging the gap (Ae-Ngibise et al. 2010; WHO 2002). Uncountable number of faith-based healers are playing this complementary role in Ghana already (Ae-Ngibise et al. 2010; Read et al. 2009). For example as far back as 2005, churches were providing spiritual healing and deliverance to between 70 and 80% of people using them as frontline health service persons and had about 45,000 traditional healers who had registered to operate in Ghana (Ministry of Health 2005; Osafo et al. 2015).

Howbeit, some studies have found that their approaches to mental health services are cruel and their processes need some pruning and sanitization to meet the expectation of the majority (Fournier 2011; Ofori-Atta 2010; Ofori-Atta et al. 2010).

The use of traditional services in terms of medication and counselling by majority of patients diagnosed with psychosis was perceived to have better outcomes (Abbo 2011; Chidarikire et al. 2017; Sorsdahl et al. 2010; Ofori-Atta et al. 2010). However, patients return to psychiatric hospitals when traditional treatments failed (Ofori-Atta et al. 2010). Despite that, current contribution to healthcare provision by traditional healers is critically invaluable and is beyond description. This is explained by the spiritual interpretation of the cause of mental disorders as diabolic, as a result far above the domain of the biomedical and psychosocial mental healthcare providers' capabilities.

Regarding financing, it was found that most countries in Africa have a challenge. For instance, recent study in Ghana has revealed the extent to which mental health is under-resourced in the African Sub-region (Ofori-Atta, Read, and Lund, 2010). There is no budget allocation for mental health care at both regional and district levels within primary health care. This is because provisions in the mental health legislation do not specify mental health expenditure allocation at both levels (Awenva et al. 2010). Awenva et al. (2010) reports that approximately 6.2% of the healthcare budget was previously earmarked for mental health in 2005, and 3.9% in 2011. However, the majority of the budget allocations has always focused on the maintenance of the psychiatric hospitals in other African countries. This makes tracking of budgets at the community and district levels difficult (Raja et al. 2010).

Insufficient funding for mental health policies and programs is also critical in many African regions (Raja, Wood, Menil and Mannaratha 2010; Burns 2010). For

example, over 70% of African countries contribute less than 1% of their national health expenditure to mental health. (Bhana et al. 2010). However, there is an encouraging trend of a steadily increase in national mental health budget provisions in some African countries over the years (Raja et al. 2010) although Burns (2010) found out that as compared to general hospitals, budget increase was significantly lower for psychiatric hospitals. Meanwhile, other sources of funds and services for mental health are received from international development partners as against locally generated funding. The implication is that the lack of or cut-off of the foreign financial support put the financing situation in a disarray condition and hinders mental healthcare services in Africa. The less priority attached to mental health, health institutions and society at large, emanate from lack of political commitment to allocate financial resource to the sector (Awenva et al. 2010 and Faydi et al. 2011). There are also no specified sources and levels of funding for mental health policy implementation in the policies (Faydi et al. 2011). Going forward, these challenges need to be addressed in the mental healthcare delivery in Africa.

There are challenges regarding mental health policy development and enforcement in Africa although the challenges differ among the various countries due to the varying socio-economic conditions and other structural factors. According to Canavan et al. (2013), the step for ensuring better mental healthcare is having legislation that appropriates financial and other resources, but approximately half of the countries in Africa have no mental health policy (Faydi et al. 2011).

A major difficulty is the implementation of mental health policy in almost all countries in Africa. In Ghana, for instance, since the last 14 years that the mental health policy was drafted, none of the provisions in the policy have been fully implemented (Awenva et al. 2010). This is mainly because of certain barriers which include the low priority of mental health to health institutions and society at large, lack of political commitment, inadequate allocation of resources and intersectoral collaboration and lack of consultation from key stakeholders (Awenva et al. 2010; Faydi et al. 2011; Awenva et al. 2010).

In a study on the assessment of mental health policy in four African countries, results showed that mental health policies addressed community-based services, rehabilitation and mental health integration into primary health care. However, most of the legislations do not seek to protect the human rights of people with mental health problems (Faydi et al. 2011). Ghana's mental health policy for instance does not cover the integration of mental health into primary care and the protection of human rights of the users. There are also no specified sources and levels of funding for mental health policy implementation in the policies (Faydi et al. 2011). However, a large number of countries in the African region have a decentralization policy that promotes the integration of mental health services to general health (Kigozi 2007). Kenya has no mental health policy, and that limits its mental health reform agenda (Marangu et al. 2014).

In terms of shortage of human resources, doctors refer patients with mental disorders to psychiatric hospitals (Ofori-Atta et al. 2010). The reasons are that primary health practioners are unable to diagnose mental disorders, and use effective medications (Kigozi 2007). It is therefore important to adhere to the WHO's guidelines on mental health care of decentralizing and integrating mental health into general health care to increase accessibility, and perhaps deal with the unexpected

high morbidity and mortality rates among patients (Oosthuizen, Carey, and Emsley 2008). In-service training, physical infrastructure and clinical skills training is critical in prescribing medicines and diagnosing mental health disorders (Abas et al. 2003; Kigozi 2007). The care of patients with mental disorders in community psychiatric centres is affected by limited psychiatric workers (Alem et al. 2008). This situation can affect the quality of care provided in the communities.

Contributions to Scholarship and Implications for Policy and Collaboration

Solution to Mental Healthcare Challenges Framework

The below mental health and mental delivery challenges and solution framework itemizes the guidelines that provides solution to the critical challenges confronting mental healthcare services in Africa. The process within the path involves the need to first, identify the key challenges to mental health services in Africa which in the current study labelled 'A' in the model below, have been identified and reported to include: funding constraints; scarcity in supply of mental healthcare professionals; deficiency in mental healthcare facilities; and mental healthcare policy gap (World Health Organization 2011; Ambikile and Iseselo 2017; Bruckner et al. 2011; Cooper et al. 2010; Osei 2013; Fournier 2011; Ambikile and Iseselo 2017; Read and Doku 2012) (Fig. 1).

The existence of these challenges frustrate and hamper mental healthcare services, resulting in poor mental health delivery and mental health conditions. This calls for removing or regulating the challenges through a conscious, deliberate, well-thought

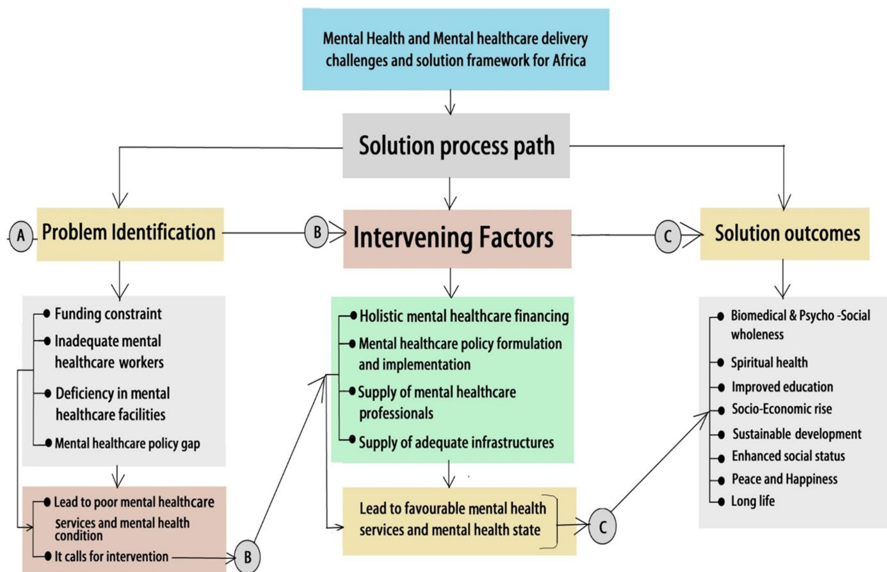

Fig. 1 Mental health and mental health delivery challenges and solution framework for Africa (Developed by authors of the current paper)

and planned intervention approaches. These intervention approaches as labelled 'B' in the model above are discovered to encompass: holistic and continuous financing from key stakeholders of mental healthcare services, including mainstream governments, quasi-government institutions, business organizations, not-for-profit organizations (e.g. churches and other religious organizations) foreign and local partners, opinion groups, individuals etc. Additionally, it is expected that mental health law that is comprehensive, precise and relevant to the local context must be passed and enforced to protect the rights of mental health patients. This includes right to life, right to health, right to protection, right to medical treatment, law or policy that triggers and enhances collaboration of mental healthcare providers for a holistic mental healthcare services in Africa and to initiate a policy that explains and provides avenue for everyone to have mental health education and care (Ambikile and Iseselo 2017; World Health Organization 2011). Policy that makes room for training and development of mental healthcare professionals must also be formulated and enforced (Mwape et al. 2010).

There should also be a stern policy on the use of some drugs that trigger mental deficiency to serve as a deterrent. A clear-cut national and enforceable policy to recruit and apportion mental health workers within district, regional and national levels will be an ideal to bridge the labour supply gap in that domain. Additionally, the laws and policies on mental health must not just be on paper but must be enforced for the realization of its full benefits. Other studies including Petersen et al. (2011) identified poor implementation of mental healthcare policy as a major hindrance to effective healthcare provision.

Mental health facilities that are well equipped with a clear-cut maintenance culture must be available at all vantage locations where needed. This will call for huge funding that must come from the key stakeholders as suggested earlier. When the interventions are effective and efficient, it will lead to favourable mental health services in Africa, which will translate into good mental health, and subsequently generate benefits to humanity including: biomedical and psych-social wholeness, spiritual soundness, improved education, socio-economic rise, sustainable development, image and reputation enhancement, peace and happiness and long life (Fournier 2011; World Health Report 2001; Ofori-Atta et al. 2010; Doku et al. 2008; Mitchell and Tihonen 2009; Ambikile and Iseselo 2017; Skeen et al. 2010; Fournier 2011; Sorsdahl 2010). It is expedient to mention that as long as mental healthcare challenges exist, more studies are needed to be conducted on that in order to find solutions to them. Fortunately the framework developed in the current study is a novel that provides panacea to the current discourse.

Implications for Policy and Collaboration

The findings have implications for mental healthcare policy, human right policy, mental healthcare workers recruitment, training and development policy, financial and budgetary allocation policies and policy for collaboration of mental healthcare providers. The human right policy that protects those with mental disorders must be made clearer and enforced in Africa. Especially, the cases arising in prayer camps where mentally ill patients are confined in fetters, bound in strong chains and whipped terribly as a healing process must be regulated and offenders must face the full rigours of the rule of law.

There should be a policy that makes provision for mental health professionals' employment every year, and when necessary, so as to curb shortages in both the urban and the rural areas. Additionally, it points to a significant role of governments to increase its priority by increasing budget provisions for mental healthcare service professionals' enrollment and the associated financial incentive package to attract professional health workers in the field. Currently, legislations are in process to regulate and incorporate traditional healthcare into bio-medical healthcare in Kenya and South Africa. This calls for signing a memorandum of understanding regarding collaboration between traditional healers and medical professionals offering healthcare to the mentally ill in Africa. The collaboration in Ghana has been suggested in some studies (Asamoah et al. (2014) but there is no sign of collaboration yet. Policy and law must come into force to regularize this move of partnership in order to provide a holistic mental healthcare delivery in African countries.

Limitation of the Study

Although the study focused on a number of African countries, not all the countries in Africa were covered. Healthcare challenges faced by Africans are similar, yet future studies can target those countries that are poorer to appreciate the degree of their challenges and the urgency to be attached to their needs. While conducting this literature review, a limitation we identified was the general lack of research addressing the challenges that confront mental healthcare delivery in Africa. Although we have articulated common challenges associated with mental healthcare delivery in Africa, further research is required to enable us adequately understand the contextual issues faced by healthcare providers. Future studies can also explore the benefits of healthcare delivery to the poor in the rural community; or find out the collaborative role of healthcare providers in Ghana and other countries in Africa.

Conclusion

There are clear mental healthcare delivery challenges in Africa, embracing government mental health policy gaps, funding challenges, inadequate mental health facilities, human resource deficiency and poor health professional training and development scheme. Key stakeholders in the mental healthcare service sector need to recognize that mental healthcare delivery in Africa face challenges that must be addressed. The authors of the current paper have developed a Mental healthcare challenges and solution framework for Africa revealing how critical interventions can address the challenges for the benefits of humanity and the African society. Additionally, the paper reveals evidence of the contribution of traditional and faith-based healers in mental healthcare delivery chain in Africa, despite their abuse of patients' rights. Instituting formal collaboration and regularizing their functions under mental health law and policy will bring sanity and holistic healthcare delivery in Africa. It is hoped that the information herein will assist governmental

leaders, policymakers, researchers, health workers, community members who have interest in supporting successful healthcare delivery and practice to do so.

Recommendations

1. Integration of mental health care and general health services are rare in Africa and must be knitted. Collaboration among healthcare providers such as traditional healers, faith-based healers, medical professionals and psychosocial experts for a holistic healthcare delivery in Africa must be encouraged and formalized. The collaborate must focus on advocacy, rehabilitation, treatment and promotion of health services.
2. Angola, Benin, Burundi, Burkina Faso and Cape Verde governments ought to conduct a research into mental health disorders and mental healthcare facilities and based on the findings, formulate a clear-cut mental healthcare policy that is separate from the general health policies in order to guide and improve mental healthcare in these countries. Those countries with irrelevant and old mental health policies are required to make revisions to adequately include expansive mental health issues such as integration and collaboration of mental healthcare practice. Furthermore, most of the mental health legislations should seek to protect the human rights of patients with mental health challenge.
3. Inequality and inadequate distribution of health professionals between and among psychiatric nurses, psychiatrists, psychologists and occupational therapist must be corrected so as to enhance equity in the distribution. Furthermore, to find a long-lasting solution to the shortage of human resources in the mental healthcare domain, scholarship for training and development activities for mental healthcare programmes must be put in place to attract more people into the profession.
4. Mental healthcare must be made attractive by instituting financial and non-financial motivational packages for the workers especially in the rural areas. For example, if attractive incentives are introduced, psychiatry nurses needed in the rural areas will be willing to go there and serve without hesitation. Rural–urban drift will then be controlled.
5. It is possible that an increase in budget and financial commitment resulting from the political will of the governments in succession will effectively deal with the financial challenges facing mental healthcare services. There must also be specified levels of funding for mental healthcare policy implementation in African countries so as to enable effective planning and budgeting by spending officers. All mental healthcare service advocates and stakeholders are advised to contribute financially for effective and efficient healthcare delivery in their home country.

Appendix

See Tables 1, 2 and 3.

Table 1 Number and percentage of African countries with Mental Health Provisions

Mental Health Policy	Mental Health Plan	Mental Health Legislation	Mental Health Hospitals	Community Mental Health Facilities	Psychosocial Interventions
19	30	20	35	33	11
42.2%	66.7%	44.4%	77.7%	73.3%	24%

World Health Organization (2011)

Table 2 A summary of countries with mental health polices, programmes, facilities and welfare benefits

Country	Policy	Care Financing	Facilities in Primary Care	Community Care	Mental Health Programmes	Non-Governmental Organizations	Disability Benefits
Angola	Absent	Out-of-pocket payment	Not available	Absent	Present- 1987	Involved- Advocacy and rehabilitation	Absent
Benin	Absent	Out of pocket	Present	Absent	Present—1997	Involved	Absent
Botswana	Present	Taxed based	Present	Present	Present—1992	Involved	Present
Burkina Faso	Absent	Out of pocket	Present	Available- Traditional treatment	Present- 2002	Involved- Advocacy, treatment, rehabilitation	Absent
Burundi	Absent	Out of pocket	Present- untrained personnel	Available- NGOs	Present—1998	Promotion, advocacy	Absent
Cameroon	Present	Tax-based/out of pocket	Absent	Absent	Present—1999	Involved	Present – public servants
Cape Verde	Absent	Taxed based	Present	Absent	Present—1986	Involved	Present- government employees
Cote d'Ivoire	Present	Out of pocket	Present	Present	Present	Involved	Present

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Table 3 Summary of specific benefits, facilities and resources in some countries

	Ethiopia	South Africa	Ghana	Uganda	Kenya	Zambia
Health facilities within the African regions						
Hospitals	0	5	3	2	0	1
Primary health clinics	8	28	17	41	–	3
Community centres	0	9	2	0	–	0
Available workers for mental health care						
Doctors	No	Yes	Yes	Yes	Yes	Yes
Nurses	Yes	Yes	Yes	Yes	Yes	No
Psychologists	No	Yes	Yes	No	Yes	No
Social Workers	No	Yes	Yes	No	Yes	No
Occupational Therapists	No	Yes	No	No	No	No
In-service Training Mental Health	None	Limited	Limited	Limited	Limited	No
Availability of Psychotropic medications	No	Yes	No	No	No	No
Mental Health rehabilitation	No	Yes	Yes	No	Yes	Yes
Budget for Mental Health	No	Yes	Yes	No	Yes	No
Disability Benefits for Mental Health	No	Yes	No	No	No	No

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