



“THEY ARE FORGETTING ABOUT US”

THE LONG-TERM MENTAL HEALTH IMPACT OF WAR AND EBOLA IN
SIERRA LEONE

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Cover photo: A person suspected of having Ebola waits inside a makeshift tent at a government hospital to get checked by doctors in Kenema City, Sierra Leone, 23 August 2014.
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1. EXECUTIVE SUMMARY

Sierra Leoneans have experienced multiple and cumulative traumatic exposures in recent decades, including most significantly the 1991-2002 civil war and the 2014-2016 Ebola epidemic. The country is now experiencing the various ramifications of the COVID-19 pandemic. Long after these experiences, the mental health impact lasts. Yet like many other low-income countries that have gone through conflict and crises, mental health services are nowhere near the level needed to meet people's needs and fulfil their rights. The government has yet to make the investments needed to realize its policy commitments on mental health, compounded by the fact that donor support has also been insufficient.

Mental health is a human right, a key component of the right to the highest attainable standard of health. According to the World Health Organization (WHO), mental health is "a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community". Applying this approach Amnesty International examined the long-term mental health impact of the war and Ebola on people who have experienced related trauma and the barriers facing them, together with the wider population, in accessing quality mental health and psychosocial support.

Amnesty International's findings are based on research conducted between November 2020 and May 2021. Researchers interviewed 55 people, including 25 Sierra Leoneans who were directly exposed to violence during the war or who contracted the Ebola virus, referred to here as war and Ebola survivors. They reside in the following districts: Kenema, Kono, Port Loko, Western Area Urban and Western Area Rural districts. Others interviewed included Sierra Leonean mental health professionals; members of civil society organizations, including the Mental Health Coalition – Sierra Leone; international aid workers involved in mental health programmes; public health specialists and mental health experts; government officials; and staff members from the country offices of the WHO and World Bank.

On 19 April 2021, Amnesty International sent letters summarizing its findings and requesting related information to the ministries of health and social welfare. At the time of publication there had been no response.

In Sierra Leone, as in many countries around the world, there is no up-to-date data on the prevalence of mental health conditions in the general population, itself a violation of the government's human rights obligations. But research in many countries has consistently shown the negative impact of emergencies on mental health. The WHO estimates that more than one in five people in settings of large-scale violence have a mental health condition. Mental health professionals and experts told Amnesty International that— notwithstanding the resilience shown by the population—mental health needs in Sierra Leone are significant.

Meanwhile, there is major stigma concerning mental health conditions in Sierra Leone, with common myths attributing them to supernatural causes. Traditional healers remain a primary point of contact for many families, and health literacy is generally low. Government health policies and officials, including the President, have acknowledged the importance of mental health, and there have been policies and strategies dedicated to the improvement of the country's mental health system. But implementation has been fraught with challenges. Furthermore, attempts to repeal and replace the colonial-era, discriminatory legislation, the 1902 "Lunacy Act", have faced repeated delays (a review is currently in the works).

Sierra Leone is obliged under a range of regional and international treaties it has ratified to respect, protect and fulfil the highest attainable standard of physical and mental health. This requires it to ensure the availability, accessibility, affordability and acceptability of quality health facilities, goods and services, including mental health treatment and care. It also requires recognizing and addressing the role of underlying determinants of health—including social, economic and environmental determinants—as key to good mental health and wellbeing. At the same time higher-income countries have an obligation to respond

to requests to provide international assistance and co-operation to ensure the progressive realization of the right to mental health as a component of the right to health.

War and Ebola survivors described to Amnesty International the traumatic experiences they endured—often multiple—and the resulting distress. War survivors spoke of witnessing their homes being burned down and their loved ones being killed, of being on the run for extended periods fearing for their lives and of surviving brutal attacks, including amputations. “I begged them, I said, ‘Please spare me in the name of God’... They said, ‘We are God here, we decide whether you live or you die,’” said 57-year-old Marie as she described how rebel forces cut off her left hand in the late 1990s.

Ebola survivors spoke of being so physically ill they did not know whether they would survive and of being surrounded by others bleeding to death; several described immense grief resulting from losing multiple family members. “They died, and I was the only one to cover them up. Even though I was on a drip, I had to crawl on the floor to cover their faces,” said 29-year-old Kaday, recounting her time at the hospital alongside four siblings in 2014. Many Ebola survivors faced further psychosocial effects after they were discharged, as fearful community members stigmatized and discriminated against them. Widespread fear of infection and misinformation were among the factors perpetuating that stigma.

People interviewed said that, years later, they still experience a range of symptoms of distress which they link to their exposures during the war and the Ebola epidemic. These include feelings of sadness, anger outbursts, irritability, troubles with sleep, nightmares and intrusive thoughts. Several Ebola survivors spoke of a persistent fear of death and of COVID-19 being particularly triggering. “You still have the perception that since you were an Ebola patient, you will die any time soon. I have this mindset and I always think I will die any time and that keeps scaring me,” said 42-year-old Titi.

Both war and Ebola survivors said that physical impairments, lingering chronic pain and other health complications are also a source of ongoing distress; the inability to afford quality health care services and medication compounds the impact. The limited availability of assistive devices and prostheses—items essential to enabling persons with disabilities to live active, independent lives—has also affected the mental health of some war survivors who were interviewed. Survivors of the war and Ebola spoke of reduced livelihood opportunities and what they described as the government’s broken promises of social protection. Mental health experts stress that poverty is a strong risk factor affecting mental health, a notion mirrored by the testimonies of many survivors who said their financial peril has left them feeling abandoned. “In so many ways, they are forgetting about us,” Mariatu, a 40-year-old Ebola survivor, said of the government and of international organizations that once provided aid.

In the immediate aftermath of their traumatic experiences—amid widespread lack of services and resources—some survivors received psychosocial support, while others did not. Counselling during and after the war came overwhelmingly from Muslim and Christian clerics and NGOs, including faith-based groups. Family support was crucial for many. Mental health support was more robust around the Ebola crisis, according to survivors’ accounts and other evidence; the efforts, led by humanitarian actors and the government, included the deployment of mental health nurses who were newly-trained and added to the public health system. Several people interviewed who received mental health and psychosocial services during these emergency periods highlighted the value of this kind of support, which, for example, played a key role in enabling Ebola survivors to overcome community stigmatization. But many people were left out of such support; of the 25 survivors interviewed, nine war survivors and two Ebola survivors said they had received no or minimal counselling services even during that emergency period.

After the emergency phase, the provision of mental health services has dwindled. At the time of Amnesty International’s interviews, out of 25 war and Ebola survivors, 15 said they did not know about any current psychological counselling services, be it through government health facilities or NGOs. Some survivors expressed concerns about public mental health services, including pertaining to privacy and costs. Some said these services were only for people with “severe” mental health conditions. Their testimonies reflect the dearth of psychosocial interventions away from where services are concentrated at medical facilities whilst also underscoring the need to improve confidence in government services and to increase public mental health literacy. In the absence of community-based care, many have been relying on peer support networks. “The only counselling we do now is... survivor-to-survivor,” said Lansana, a 30-year-old Ebola survivor.

Amnesty International’s research shows that while psychosocial interventions provided through humanitarian programming during the emergency phase delivered important temporary support, such responses need to become part of government services to be sustainable and effective long-term. A massive mental health treatment gap—for survivors of traumatic experiences and the wider population—persists in Sierra Leone. Despite efforts to build up a mental health system dating back more than a decade, several barriers remain

to fulfilling even the most basic levels of needed care; most of these impediments are mirrored across the county's health sector.

Among these barriers is the shortage of skilled mental health professionals. The government and international partners have undertaken efforts to train cadres of mental health professionals, but 7 million people are currently served by an extremely limited workforce that primarily consists of three psychiatrists and some 20 mental health nurses. There are no psychologists in the public workforce. The government and partner organizations have provided mental health training and sensitization to some non-specialist health workers in recent years—as well as to social workers, traditional healers, and community volunteers—but these efforts need to be more systematic and followed by close monitoring, evaluation and supervision.

The very small number of mental health nurses placed in district hospitals around the country receive insufficient support, including when it comes to appropriate physical working conditions, burnout protection and career development pathways. Several of them spend their own money to cover transport fees to clients' homes, for example. There is an extreme dearth of psychotropic medications, which are mostly donated by NGOs rather than procured by the government. And the government's statements and written commitments recognizing the importance of mental health have not translated into associated budget lines for mental health spending.

Overall, the limited formal mental health services that are available remain extremely centralized; there is a distinct shortage in community-based care. "We need that kind of support in our community and that kind of counselling services so that people who have [experienced] traumatic experiences and people who are going through all this kind of stress will be able to understand that life should go on, [that] there is a life and they need to live it," said Amina, one of several war survivors who expressed concerns about costs associated with visiting hospitals. "We want services in our community. If it's in the community, it will help people."

Globally, only around 1% of development aid for health has gone to mental health despite growing evidence showing the importance of making these investments. In the context of Sierra Leone, mental health experts and humanitarian and development actors operating in the country told Amnesty International there has been a limited number of calls made by donors related to mental health. Evidence shows the short-sightedness of this approach. For example, mental health nurses, trained and posted by 2013 as part of an investment in improving the formal health structure, played a vital role during the Ebola crisis; that experience demonstrates the importance of systems strengthening and of having this groundwork laid ahead of crises. Additionally, mental health researchers testing and implementing evidence-based interventions targeting war-affected youth through innovative delivery platforms such as schools and employment programmes have shown improvements in their daily functioning and interpersonal behaviours, as well as their ability to manage emotional responses.

Although the government of Sierra Leone faces budgetary constraints and many challenges, it needs to do much more to improve mental health services in order to fulfil both its human rights obligations and its own development goals. To do this it must explicitly request technical and financial assistance for mental health system strengthening from the UN and other regional and international partners, including the WHO. One of the key goals of that assistance must be developing a targeted plan with attention to financing—there is currently no dedicated mental health budget line—and a human resources strategy. The government should also require specific allocations (a minimum of 5%) for mental health services from donors contributing to health programmes. It must capitalize on the global momentum prioritizing mental health in the context of the COVID-19 pandemic to shore up support for sustainable systems of care.

Given the time and resources it will take to fully integrate mental health into the country's primary care system, the government should undertake a parallel effort alongside international partners to test and deliver evidence-based mental health interventions through existing delivery platforms such as front line primary health units as well as schools and programmes on nutrition and feeding; sexual, reproductive health and teen pregnancy prevention; livelihoods and employment; and poverty reduction. The government must also expedite efforts to pass new mental health legislation to replace the discriminatory and outdated "Lunacy Act" of 1902, undertaking a participatory and consultative process with stakeholders including persons with psychosocial disabilities and civil society organizations.

For their part, donors should increase their advocacy with the government to give mental health the support it deserves. They should provide technical and financial assistance, including to support capacity building to craft financing schemes and a human resources strategy needed to address the large gaps in access to mental health services. In raising contributions to mental health systems strengthening, donors must also re-double efforts to support awareness-raising campaigns aimed at combatting stigma around mental health. It is long overdue to stop treating mental health as an optional add-on but instead as an essential service and right.

2. METHODOLOGY

This report is based on research undertaken by Amnesty International between November 2020 and May 2021. It examines the long-term mental health impact of the 11-year civil war and Ebola epidemic in Sierra Leone on people who experienced traumatic events during that time and the challenges they face in accessing quality mental health and psychosocial support. The report is based on the World Health Organization’s conceptualization of mental health “as a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community”.¹

In total, Amnesty International interviewed 55 people, including 25 Sierra Leoneans who were directly exposed to violence during the war (12) or who contracted the Ebola virus (13). For purposes of brevity, the report refers to them as war and Ebola survivors. The ages of the survivors interviewed—16 women and 9 men—ranged between 28 and 73. Reached through survivors’ associations and community leaders, they reside in five districts: Kenema, Kono, Port Loko, Western Area Urban and Western Area Rural districts.

Amnesty International also interviewed Sierra Leonean mental health professionals, including mental health nurses; advocates and members of civil society organizations, including the Mental Health Coalition – Sierra Leone (hereinafter Mental Health Coalition); international aid workers involved in mental health programmes; public health specialists and mental health experts; researchers on Sierra Leone or mental health; government officials; and staff members from the country offices of the WHO and World Bank.

Some interviews were conducted in English, while others, including a majority of the interviews with survivors, were conducted in Krio, Mende or Temne, with English interpretation. Interviews were conducted remotely by telephone, email or online chat and messaging applications. For all interviews with survivors specifically, a representative from Amnesty International Sierra Leone was physically present.

Amnesty International detailed to interviewees the purpose of the research and how the information would be used. Researchers obtained oral consent at the beginning of interviews. Survivors were told they could choose not to answer any question, end the interview at any time, or withdraw the information at a later stage. There were no incentives provided to interviewees.

Amnesty International took precautions aimed at avoiding the re-traumatization of the survivors who were interviewed. Researchers gave survivors the opportunity to guide the discussion, ensured that interviews ended on more positive topics and asked questions that covered a variety of issues rather than focusing on the particular traumatic events survivors were exposed to. In addition to clarifying at the outset of interviews that they could stop or take a break at any time, researchers also periodically asked survivors whether they wished to continue. Amnesty International followed up with survivors after the interviews to see how they were doing.

To respect privacy and confidentiality as well as due to stigma associated with mental health, all survivors are assigned pseudonyms. To further preserve their anonymity, the locations provided in most descriptions are districts rather than the precise village, town or city and other identifying details have also sometimes been omitted. The referenced age of interviewees is from the time of the interview and in some cases is based on approximations provided by the interviewees, some of whom do not have birth records. The names of several other interviewees are withheld either because they are not authorized to speak publicly or so as not to undermine their work.

Amnesty International sought to relay the experiences of survivors as they described them—including how their distress manifested—without attempting to identify or label any mental health or psychological

¹ WHO, *Mental Health Action Plan 2013-2020*, bit.ly/3swnmv3 (hereinafter WHO, *Mental Health Action Plan 2013-2020*).

conditions that may have affected them. Based on the previously mentioned WHO mental health framework, Amnesty International understands mental health impacts to encompass specific mental health conditions and more general psychological distress and trauma.

Amnesty International reviewed studies by Sierra Leonean and international researchers on mental health issues in the country and in other similar contexts, as well as relevant reports by UN agencies and others. This literature review as well as interviews with local mental health advocates and international mental health experts were used to inform the methodology and research process, as well as the conclusions and recommendations. Dr Theresa Betancourt, Salem Professor in Global Practice at the Boston College School of Social Work and Director of the Research Program on Children and Adversity, who has carried out mental health research and tested and implemented mental health interventions in Sierra Leone for 20 years, reviewed this report and her feedback was incorporated.

On 19 April 2021, Amnesty International communicated its key findings in letters addressed to the Ministry of Health and Sanitation and the Ministry of Social Welfare and sought some clarifications related to those findings. At the time of publication there had been no response.

3. WAR, EBOLA AND MENTAL HEALTH

Between March 1991 and January 2002, Sierra Leone experienced an armed conflict during which tens of thousands of civilians were killed and more than 2 million people were displaced.² The war was characterized by widespread violations of international humanitarian law and human rights violations and abuses against civilians, including mass killings, abductions, rape, sexual slavery, mutilation and the recruitment and use of children by all warring parties.³ These acts, which amounted to war crimes and crimes against humanity, were carried out in a pattern purposefully designed to inflict widespread terror.⁴

The Truth and Reconciliation Commission (TRC), which was established as part of the 1999 Lomé Peace Accord to look into abuses as well as make recommendations to ensure peace, said in its findings that the war “broke long-standing rules, defiled cherished traditions, sullied human respect and tore apart the very fabric of society”.⁵ By the time it concluded its mandate in 2013, the Special Court for Sierra Leone, established by an agreement between the government and the United Nations, convicted nine men it had found to have borne some of the greatest responsibility for crimes committed during the conflict.⁶ Thousands of others suspected of responsibility for crimes during the war were not investigated or brought to justice.⁷

In 2014, as Sierra Leone was still struggling to rebuild after the war, an Ebola outbreak hit West Africa. According to the World Health Organization (WHO), between May 2014 and March 2016, there were 14,124 cases in Sierra Leone, including 3,956 deaths.⁸ An already fragile health system struggled to cope as health workers themselves lost their lives; thousands of people lost their primary care givers; families’ livelihoods were interrupted amid successive quarantines and widespread fear; and at-risk groups, such as adolescent girls, were even further marginalized and abused.⁹

There is no current, official data on the prevalence of psychological distress and mental health conditions in the general population in Sierra Leone. However, research in many countries has consistently shown that exposure to conflict and other emergencies impacts mental health—by causing new distress and mental

² Leboeuf Aline, “Sierra Leone: List of extremely violent events perpetrated during the war, 1991-2002”, Sciences Po, 5 March 2008, bit.ly/2MYW9VZ

³ See, for example, Amnesty International, *Sierra Leone: Human rights abuses in a war against civilians* (Index: AFR 51/005/1995), 13 September 1995; Amnesty International, *Sierra Leone: 1998 – A year of atrocities against civilians* (Index: AFR 51/022/1998), 1 November 1998; Amnesty International, *Sierra Leone: Rape and other forms of sexual violence against girls and women* (Index: AFR 51/035/2000), 28 June 2000; Amnesty International, *Sierra Leone: Childhood – A casualty of conflict* (AI Index: AFR 51/069/2000), 30 August 2000.

⁴ See, for example, Human Rights Watch, *Sierra Leone: Getting away with murder, mutilation, rape, New testimony from Sierra Leone*, July 1999, bit.ly/3tpXTaD

⁵ Sierra Leone Truth and Reconciliation Commission, *Witness to Truth: Report of the Sierra Leone Truth & Reconciliation Commission*, 2004, Vol. 2, Chapter 2, p. 27, bit.ly/3vKNUxT

⁶ Special Court for Sierra Leone – Residual Special Court for Sierra Leone, www.rscsl.org/

Lansana Gberie, “The Special Court for Sierra Leone rests – for good”, *Africa Renewal*, April 2014, bit.ly/3ayq0g7

Shahram Dana, “The sentencing legacy of the Special Court for Sierra Leone”, *Georgia Journal of International and Comparative Law*, 2014, Vol. 42, No. 3, p. 617, bit.ly/2PT2kwI

⁷ Amnesty International, *Amnesty International Report 2014/15: The state of the world’s human rights* (Index: POL 10/0001/2015), 25 February 2015.

⁸ These figures include “suspect, probable and confirmed” Ebola cases. WHO, *Ebola virus disease: Key facts*, 10 February 2020, bit.ly/33I7HrJ

See also, WHO, *Statement on the end of the Ebola outbreak in Sierra Leone*, 7 November 2015, bit.ly/390VRu3

WHO, *WHO statement on end of Ebola flare-up in Sierra Leone*, 17 March 2016, bit.ly/3jqzmyM

⁹ See, for example, Amnesty International, *Shamed and blamed: Pregnant girls’ rights at risk in Sierra Leone* (Index: AFR 51/2695/2015), 6 November 2015, pp. 10-13.

health conditions as well as further exposing persons with pre-existing conditions.¹⁰ In 2019, the WHO updated its estimate of the prevalence of “mental disorders” in settings with large-scale violence—based on averages in 129 studies covering 39 predominantly conflict-affected, low-income and middle-income countries including Sierra Leone—to 22%, or more than one in five people, in the affected populations.¹¹ Unlike its previous 2005 estimate, the latest WHO analysis does not include natural disasters in the review and also specifically spells out that public health emergencies, such as Ebola, were not covered.

In the context of Sierra Leone, several studies have been conducted on the mental health impact of the war and the Ebola outbreak, showing the high levels of distress they caused. Analyses of these studies point out that many of them have focused on subsets of the population or have tended to give particular attention to post-traumatic stress.¹² Also, most of the studies were conducted while the emergencies were ongoing, that is shortly after the war, or during the Ebola epidemic, for example; the main exception is a 15-year longitudinal study and associated research on the impact of the conflict on male and female children formerly associated with armed forces and armed groups (commonly referred to as former child soldiers).¹³



Travelers are stopped for screening, 25 May 2014, at one of many checkpoints that were set up on the 240km-long road from the capital Freetown to Kenema District in the east. The Ebola epidemic devastated communities and caused economic and social disruption amid repeated quarantines and pervasive fear. © Ricci Shryock

Mental health professionals, aid workers and researchers interviewed by Amnesty International have all said that—notwithstanding the resilience shown by the population—mental health needs in Sierra Leone are significant. They listed the long-lasting impact of war and Ebola among multiple stressors, alongside the recent advent of COVID-19, natural disasters such as the 2017 mudslide, pervasive poverty and challenging

¹⁰ See, for example, Amnesty International, *Excluded: Living with disabilities in Yemen’s armed conflict* (Index: MDE 31/1383/2019), 3 December 2019; Human Rights Watch, *Afghanistan: Little Help for Conflict-Linked Trauma*, 7 October 2019, [bit.ly/2MWe4wD](https://www.hrw.org/news/2019/10/07/afghanistan-little-help-for-conflict-linked-trauma); Amnesty International, *“Our hearts have gone dark”: The mental health impact of South Sudan’s conflict*, (Index: AFR 65/3203/2016), 6 July 2016; WHO, *Building Back Better: Sustainable Health Care after Emergencies*, 2013, p. 4, [bit.ly/3twGJcA](https://www.who.int/publications/m/item/building-back-better-sustainable-health-care-after-emergencies)

¹¹ In this review, the WHO uses “conflict settings”, but Amnesty International does not consider all of these contexts of large-scale violence to be armed conflicts per se under international humanitarian law. The 129 studies the review is based on were published between January 1980 and August 2017; the relevant populations experienced mass violence less than 10 years prior to the collection of data in those studies. The “mental disorders” the studies covered are: depression, anxiety, post-traumatic stress, bipolar condition, and schizophrenia. Fiona Charlson, Mark van Ommeren, Abraham Flaxman, Joseph Cornett, Harvey Whiteford, Shekhar Saxena, “New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis”, *The Lancet*, 11 June 2019, [bit.ly/3pOLege](https://doi.org/10.1016/S0140-6736(19)30826-4)

¹² Abdulai Jawo Bah, Ayesha Idriss, Maria Paola Bertone, “A scoping study on mental health and psychosocial support (MHPSS) in Sierra Leone”, Queen Margaret University’s Institute for Global Health and Development, July 2018, [bit.ly/39TTS7Q](https://www.qm.ac.uk/institute-for-global-health-and-development/research-and-publications/a-scoping-study-on-mental-health-and-psychosocial-support-in-sierra-leone/) (hereinafter Abdulai Jawo et al, “A scoping study”); Rebecca Horn, Simeon S. Sesay, Mamadu Jalloh, Amjata Bayoh, Joan B. Lavally, Alastair Ager, “Expressions of psychological distress in Sierra Leone: implications for community-based prevention and response”, *Global Mental Health* (Cambridge), 29 July 2020, Vol.7, [bit.ly/36KW2od](https://doi.org/10.1017/S1361367202000000) (hereinafter Rebecca Horn et al, “Expressions of psychological distress in Sierra Leone”).

¹³ Abdulai Jawo et al, “A scoping study”; Rebecca Horn et al, “Expressions of psychological distress in Sierra Leone”.

socioeconomic conditions in a country that ranks 182nd of 189 countries and territories on the world's Human Development Index.¹⁴ Among the conditions these specialists reported seeing commonly are psychosis conditions, depression, anxiety, post-traumatic stress and conditions related to substance use.¹⁵ Associated symptoms they described—and which can affect daily functioning and interpersonal behaviour—include: flashbacks, poor sleep, nightmares, issues with memory, difficulties concentrating, irritability, aggression and avoidance of reminders associated with trauma (such as thoughts, feelings, people and places).¹⁶

More broadly, stigma around mental health remains pervasive, often resulting in abuses against persons with psychological distress and mental health conditions, or those perceived to have them. Popular myths around mental health include blaming it on witchcraft and perceiving it as a punishment for bad actions. Survivors and mental health professionals cited widely-used derogatory terms to refer to persons showing symptoms of distress, such as “crase”, as well as referring to mental health professionals as “crase man doctor”.¹⁷ A senior aid worker in Sierra Leone who specializes in mental health told Amnesty International, “Stigma cuts across; it’s not only in the community, but even when you’re reaching to people in authority... when you’re talking about integrating [mental health] services with other [services].”¹⁸

Steady advocacy and engagement between civil society organizations and the government have gained momentum and achieved some successes, including a ban on shackling in the newly refurbished Sierra Leone Psychiatric Teaching Hospital as of 2018.¹⁹ But chaining, for example, still persists in informal settings; practically all mental health specialists and researchers interviewed by Amnesty International said they witnessed instances of shackling in homes and in traditional and faith healing centres.²⁰ Significant awareness-raising efforts and effective monitoring mechanisms are needed, especially since people do not tend to seek mental health care in official settings until the presentation of symptoms of distress is especially pronounced, and since for many people, traditional healers and faith centres remain a primary point of contact.²¹

Mental health is included in the country's Basic Package of Essential Health Services, the framework document guiding the availability of health care services and their improvement, as well as in other plans and policies such as poverty reduction strategies.²² In recent years, the government has launched and revised dedicated national policies and strategic plans on mental health specifically and has appointed a National Mental Health Co-ordinator in the Ministry of Health and Sanitation's Directorate for Noncommunicable Diseases and Mental Health.²³ The country also has an active Mental Health Coalition, an advocacy body that includes in its membership persons who use mental health services and their families, national and international NGOs, disability rights activists, mental health professionals, traditional

¹⁴ Phone interviews, November 2020 – February 2021; UNDP, *Human Development Report 2020: Sierra Leone*, bit.ly/3oSFxMY

¹⁵ Phone interviews, November 2020 – February 2021.

¹⁶ Phone interviews, November 2020 – February 2021.

¹⁷ Phone interviews, November 2020 – February 2021.

¹⁸ Phone interview, 30 November 2020.

¹⁹ Phone interviews, November 2020 – February 2021; Human Rights Watch, *Living in chains: Shackling of people with psychosocial disabilities worldwide*, 6 October 2020, bit.ly/3twMG9m (hereinafter Human Rights Watch, *Living in chains*); Partners in Health Sierra Leone, *Mental Health Program*, bit.ly/3dz3NkS

The Sierra Leone Psychiatric Teaching Hospital, formerly known as “Kissy Mental Hospital”, is the oldest psychiatric hospital in sub-Saharan Africa and Sierra Leone's only dedicated in-patient mental health facility. Before recent renovations, which were inaugurated in June 2020, it was lacking crucial infrastructure and resources, including electricity and running water, as well as medications. Working with the government, the Boston-based NGO focused on health care, Partners in Health (PIH), spearheaded the refurbishment of the 400-bed facility. Partners in Health, *Celebrating new possibilities at Sierra Leone's only psychiatric hospital*, 5 June 2020, bit.ly/2PeRNMc

Partners in Health, *PIH's new podcast, Unchain, now available to stream*, 24 November 2020, bit.ly/3xohYkO

²⁰ Phone interviews, November 2020 – February 2021; Human Rights Watch, *Living in chains*.

²¹ Phone interviews, November 2020 – February 2021; Dawn Harris, Tarik Endale, Unn Hege Lind, Stephen Sevalie, Abdulai Jawo Bah, Abdul Jalloh, Florence Baingana, “Mental Health in Sierra Leone”, *British Journal of Psychiatry International*, February 2020 (published online 22 July 2019), Vol. 17, No. 1, pp. 14-16, bit.ly/3pXS17A (hereinafter Dawn Harris et al, “Mental Health in Sierra Leone”). Streamlining the relationship between traditional healers and formal health systems, creating monitoring mechanisms and addressing overall regulatory issues remain global challenges. The WHO, which recognizes the important role of traditional healers, has acknowledged these challenges as per surveys of member states. Its 2019 global report on traditional and complementary medicine includes examples of countries that have instituted monitoring and regulatory practices, including in low-income settings. The report states that the organization is working on a project “to provide guidance to Member States on the criteria and elements of best practices for integrating [traditional and complementary medicine] into national health systems, if or when they decide to do so”. WHO, *WHO global report on traditional and complementary medicine 2019*, bit.ly/3eqfJ7E

²² Sierra Leone Ministry of Health and Sanitation, *Sierra Leone basic package of essential health services 2015-2020*, bit.ly/3tv0Rvy See also Dawn Harris et al, “Mental Health in Sierra Leone”; Abdulai Jawo et al, “A scoping study”, pp. 26-27.

²³ The National Mental Health Co-ordinator oversees a Mental Health Steering Committee that brings together representatives from other parts of the government, mental health professionals and members of the civil society in quarterly meetings to discuss mental health issues in the country. Phone interviews, November 2020 – February 2021; Joshua Duncan, Edward Munda Jah, Onaiza Qureshi, *Country profile: Sierra Leone: Analysis for mental health campaigning and advocacy*, Speak Your Mind, bit.ly/2MDfHQ4 (hereinafter Joshua Duncan et al, *Country profile*); Abdulai Jawo et al, “A scoping study”, p. 26; Dawn Harris et al, “Mental Health in Sierra Leone”.

healers and faith-based groups.²⁴ Subsequent chapters in this report detail the barriers facing the implementation of the government's policies and the work of relevant actors.

The domestic legal framework remains sorely outdated as attempts to repeal and replace the discriminatory, colonial-era "Lunacy Act" of 1902 have repeatedly stalled.²⁵ The National Mental Health Co-ordinator at the Ministry of Health and Sanitation, Kadiatu Savage, told Amnesty International that COVID-19 had delayed the process, but that the review is underway.²⁶ She said the hope is to launch the revised law—which she told Amnesty International is promised to be aligned with global standards and human rights principles such as free and informed consent—by the end of 2021 after a consultation process with various stakeholders, including persons with mental health conditions.²⁷

MENTAL HEALTH: A RIGHT, AN OBLIGATION

Sierra Leone is party to several regional and international treaties in which the right to the highest attainable standard of health is enshrined, including the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of Persons with Disabilities (CRPD).²⁸ Article 12 of the ICESCR states: "The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and *mental* health."²⁹ Article 16 of the African Charter on Human and Peoples' Rights also provides that "every individual shall have the right to enjoy the best attainable state of physical and mental health".³⁰

The right to health requires that quality health facilities, goods and services are available, accessible, affordable and acceptable.³¹ That includes "appropriate mental health treatment and care".³²

The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has reinforced that "there is no health without mental health" and that "good mental health means much more than absence of a mental impairment".³³ In multiple reports, the rapporteur has highlighted the role of social and underlying determinants of health and that, therefore, "good mental health and well-being... must be defined instead by the social, psychosocial, political, economic and physical environment that enables individuals and populations to live a life of dignity, with full enjoyment of their rights and in the equitable pursuit of their potential".³⁴

In relation to victims of violations, including in the context of survivors of Sierra Leone's civil war, international law includes an obligation that they are provided mental health care services as part of

²⁴ Phone interviews, November 2020. The coalition's "overall objective is to raise awareness and campaign for increased national commitment to mental health issues in Sierra Leone". See Mental Health Coalition – Sierra Leone, mentalhealthcoalitionsi.com

²⁵ Phone interviews, November 2020 – February 2021; Joshua Duncan et al, *Country profile*; Dawn Harris et al, "Mental Health in Sierra Leone". Aside from its outdated, derogatory language, the law subscribes to notions and understandings around mental health that long precede human rights norms and frameworks and allows for abusive practices such as isolating and detaining persons with mental health conditions against their wish in medical facilities. See WHO, *Sierra Leone: Lunacy legislation*, www.mindbank.info/item/1522

²⁶ Phone interview, 17 February 2021.

²⁷ Phone interview, 17 February 2021.

²⁸ ICESCR Article 12; CRPD Article 25.

²⁹ ICESCR, Article 12, emphasis added. For more on how the protection of mental health is an essential aspect of the right to health, see Application No. 57467/15, Amnesty International's intervention in *Savran v. Denmark* (Application No. 57467/15), European Court of Human Rights, 3 June 2020.

³⁰ African Charter on Human and Peoples' Rights (African Charter), Article 16(1). Resolution 420 (2019) of the African Commission on Human and Peoples' Rights (ACHPR) calls on state parties to "Fulfil their obligation to guarantee the full enjoyment of the right to the best attainable state of physical and mental health and the right to education in accordance with the African Charter, other regional and international standards in accordance with the principles of availability, affordability and quality". ACHPR, 420 Resolution on states' obligation to regulate private actors involved in the provision of health and education services, 14 May 2019, para 1(i).

³¹ Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14, The right to the highest attainable standard of health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), 11 August 2000, UN Doc. E/C.12/2000/4 (hereinafter CESCR, General Comment No. 14), para. 12.

³² CESCR, General Comment No. 14, para. 17.

³³ UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report, 2 April 2015, UN Doc. A/HRC/29/33, para. 76.

³⁴ UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report, 12 April 2019, UN Doc. A/HRC/41/34 (hereinafter Report of the Special Rapporteur on the right to health, 12 April 2019), summary. The CESCR's General Comment No. 14 states that among the underlying determinants of health are "food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment". CESCR, General Comment No. 14, para. 4. But as the rapporteur notes, this list is "not exhaustive in its nature and must be interpreted in the light of evolving norms and scientific evidence". Report of the Special Rapporteur on the right to health, 12 April 2019, para. 16. The Human Rights Council, which has issued three resolutions since 2016 specifically on the right to mental health, has urged states to holistically "address the underlying social, economic and environmental determinants of health" and to "develop cross-sectoral strategies for the promotion of mental health that include public policies to prevent inequality, discrimination and violence in all settings..." UN Human Rights Council, *Mental health and human rights*, 19 June 2020, UN Doc. A/HRC/RES/43/13, paras 10, 11.

the right to an effective remedy, including reparations.³⁵ In its report, which was published in 2004, the Sierra Leone Truth and Reconciliation Commission recommended the “provision of free counselling and psychosocial support for all victims... as well for their dependants if needed”.³⁶

Higher-income countries have an obligation to provide assistance for mental health as a component of the right to health, as part of their duty to respond to requests for international assistance and co-operation to ensure progressive realization of economic, social and cultural rights in lower-income countries.³⁷ As indicated by the special rapporteur, “Rights-based development co-operation should support balanced health promotion and psychosocial interventions and other treatment alternatives, delivered in the community to effectively safeguard individuals from discriminatory, arbitrary, excessive, inappropriate and/or ineffective clinical care.”³⁸

Achieving “good health and well-being” is goal 3 of the UN Sustainable Development Goals, which were adopted by the UN General Assembly in 2015 as “a shared blueprint for peace and prosperity for people and the planet, now and into the future”.³⁹

³⁵ UN General Assembly, Basic Principles on the Right to a Remedy and Reparation for Victims of Gross Violations of International Human Rights Law and Serious Violations of International Humanitarian Law, 2005, UN doc. A/Res/60/147, Principles VII(b) and IX(20) and (21); ICRC, Customary IHL, Rule 150; Universal Declaration of Human Rights, Article 8. The Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (OP-ICESCR), which underscores that all rights violations must have an effective remedy, gives victims of violations of economic, social and cultural rights or those acting on their behalf the opportunity to submit—on behalf of individuals or groups of individuals—complaints to the UN Committee on Economic, Social and Cultural Rights (CESCR) if they have exhausted all domestic remedies and have not obtained justice in their countries’ courts. The Optional Protocol to the Convention on the Rights of Persons with Disabilities (OP-CRPD) creates a similar system. Sierra Leone is not a state party to either optional protocol; it should consider ratifying them to solidify its commitments to human rights, including the right to remedy for all victims.

³⁶ Sierra Leone Truth and Reconciliation Commission, *Witness to Truth: Report of the Sierra Leone Truth & Reconciliation Commission*, 2004, Vol. 2, Chapter 4, pp. 258-259; see also Vol. 2, Chapter 3, pp. 193, 219.

³⁷ ICESCR, Articles 2, 23.

³⁸ UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Report, 28 March 2017, UN Doc. A/HRC/35/21 (hereinafter Report of the Special Rapporteur on the right to health, 28 March 2017), para. 38.

³⁹ UN Department of Economic and Social Affairs, *The 17 goals*, sdgs.un.org/goals (hereinafter UN Department of Economic and Social Affairs, *The 17 goals*)

4. SURVIVORS TELL THEIR STORIES

Amnesty International interviewed 12 survivors of traumatic experiences related to the conflict and 13 survivors of traumatic experiences related to the Ebola epidemic.⁴⁰ This chapter documents their experiences with distress, their current conditions and their access to mental health and psychosocial support.

4.1 EXPERIENCING TRAUMA

CONFLICT-RELATED TRAUMA

Survivors of conflict-related trauma described to Amnesty International a myriad of human rights violations and abuses as well as violations of international humanitarian law they experienced or witnessed during the war, and the resulting distress. Several people interviewed witnessed first-hand as their homes—at times, entire villages—were burned down by rebel forces.⁴¹ Some saw their loved ones being shot dead or came across their bodies as they ran for their lives; one man learned later that his mother was burned alive in their home while another still does not know the fate of his missing wife more than 20 years later.⁴²

Four of the interviewees have had to live with permanent physical injuries and impairments, including amputated limbs, due to being shot or hit by shrapnel in rebel ambushes or as they attempted to flee. Five other interviewees were subjected to crude amputations by rebel forces, one of the war's signature atrocities, at times after being abducted and forced to carry loot. They described resisting or pleading for their lives as the rebels proceeded to cut one or two of their hands or arms with cutlasses.

Marie, a survivor from Kono District, described what happened to her in the late 1990s:

The rebels ordered me to sit on the ground. They told me to place my hand on the ground. I laid my hands down and they chopped [my left hand]. I asked, 'Why are you doing this to me?' They said, 'If you ask another question, we will kill you.' I begged them, I said, 'Please spare me in the name of God'... They said, 'We are God here, we decide whether you live or you die.'⁴³

Marie said the fighters left her to die and that, to save herself, she had to finish severing her hanging left hand herself.

Several interviewees said they spent extended periods on the run in the bush, fearing for their lives and incurring further psychological harm due to difficult living conditions such as lack of food, water, shelter and access to health care. Zainab, who was a teenager at the time, said her one-year-old girl died after falling ill

⁴⁰ At the time of the interviews with Amnesty International, 12 of the interviewees resided in the country's Eastern Province: six in Kenema District and six in Kono District. Six resided in North West Province, specifically in Port Loko District. Seven resided in the Western Area: four in Western Urban District and three in Western Rural District.

⁴¹ This report uses "rebel forces" and "rebels" which are used in Sierra Leone to denote the Revolutionary United Front (RUF), the armed group that first launched its attacks in 1991 with the apparent objective of ousting the government, as well as the Armed Forces Revolutionary Council (AFRC), which forged an alliance with the RUF in the late 1990s. See Sierra Leone Truth and Reconciliation Commission, *Witness to Truth: Report of the Sierra Leone Truth & Reconciliation Commission*, 2004, Vol. 2, Chapter 1, pp. 3, 10-11.

⁴² Phone interviews December 2020 – January 2021.

⁴³ Phone interview, 9 December 2020.

in the bush; they had been on the run following an attack on Zainab's town in Kono District in the late 1990s in which rebel forces killed her husband, mother, sister and grandmother.⁴⁴ "We were in the bush for over three months, we really struggled... We were running from one village to another, one setting to another. And we were being chased, so we had to hide for over three months," she said.⁴⁵



This photo from 16 April 1996 shows one of many civilians who were mutilated by members of the Revolutionary United Front (RUF). The war was characterized by acts of violence against civilians perpetrated in a pattern purposefully designed to inflict widespread terror. © Patrick Robert/Sygma/Getty Images

Two interviewees described being under acute stress as they risked their lives to come out of hiding to save injured family members whom they had left bleeding in the bush after an attack by rebel forces. One of them, Amadu, who had already escaped rebel captivity once, said that the West African multilateral force deployed in Sierra Leone known as ECOMOG detained him in Kono District in the late 1990s as he tried to find a route to safety. The ECOMOG forces, which were implicated in the murder of captured rebel fighters, did not believe Amadu was a civilian until other villagers intervened.⁴⁶ Even though he was told by the ECOMOG forces to stay in Koidu City after they released him, he felt compelled to risk his life again: "I knew my wife and children were in the bush, my wife was bleeding. I was very stressed... I had to decide whether I am going to die."⁴⁷

Practically all those who were interviewed about war-related distress had experienced multiple episodes of trauma due to their own experiences and those of their loved ones. For example, Rakiatu, a survivor who was shot during the rebels' invasion of Freetown on 6 January 1999, said the bone in her right arm was shattered and doctors had to amputate the arm. But that was not the only cause of distress, she said, adding that one of her daughters, who was under 10 at the time, had been abducted by the rebels—"She was captured for over a year and I didn't know anything about her... I was in pain."⁴⁸ When the daughter was finally released, she explained she had been raped, enslaved, forced to take drugs and given "bad food", Rakiatu said. Research has shown that multiple exposure to trauma in conflicts and settings of mass violence is linked to being more prone to mental health conditions.⁴⁹

⁴⁴ Phone interview, 10 December 2020.

⁴⁵ Phone interview, 10 December 2021.

⁴⁶ Phone interview, 19 January 2021.

⁴⁷ Phone interview, 19 January 2021.

⁴⁸ Phone interview, 19 January 2021.

⁴⁹ See, for example, Stefan Priebe et al, "Experience of human rights violations and subsequent mental disorders – A study following the war in the Balkans", *Social Science and Medicine*, 30 October 2010, [bit.ly/3jDq56v](https://doi.org/10.1016/j.socscimed.2010.08.016)

EBOLA-RELATED TRAUMA

Ebola survivors interviewed by Amnesty International spoke of the immense psychological toll they experienced from the illness and its aftermath. Interviewees described being so physically ill they did not know whether they would survive—the fear of death overwhelmed them as they saw many other bleeding patients around them ultimately die. They said the confusion, the lack of information and what they described as an overall poor handling of the crisis at the time contributed to their distress and, in some cases, to the spread of the disease.⁵⁰

People interviewed described scenes of pandemonium at medical facilities and treatment centres, at times requiring patients to be transferred more than once. Hassan, a survivor in his late 50s from Kono District, described being moved to a treatment centre in Kenema City in January 2015: “The trip to Kenema was hell. Trust. It was hell... The road condition was so bad. We [were] packed like sardines in the ambulance. Can you imagine, a very minute ambulance, 11, 12, 13 people were packed there? Can you imagine? People were weak, we [were] flooding [with] vomiting, diarrhoea, everything.”⁵¹ At the treatment centre where he spent 24 days, “I was not within myself at all,” he said, adding that ultimately only 80 people survived out of close to 800 from his district who were transferred like him.⁵²

Mariama, who was pregnant when she contracted the virus in Freetown in 2015 alongside several members of her family, said she escaped from the months-long quarantine at home to go to the hospital after feeling severe pains. The police were called after word spread of her escape; she was given oral rehydration solutions and told to stay in the hospital veranda until she was later taken to an Ebola treatment camp where she was joined by other sick family members. At the treatment centre, the medical staff told her that the pregnancy must be terminated, and she was given medication to facilitate that. “I was taken to another booth where they have high-risk patients... My condition was really rough; I came outside naked and told my husband’s other wife to promise me she would take care of my son if I died... I was there all by myself and I gave birth to a [stillborn] premature baby of seven months. Nobody came to my aid, I had to do it all by myself.”⁵³ Her husband, too, died, alongside 17 members of his family.

Kaday, 29, described what it was like sharing a hospital room with her dying siblings after they all contracted the virus from a visiting aunt in 2014:

I had no strength, but I could see my two sisters and two brothers struggling for their lives. They died, and I was the only one to cover them up. Even though I was on a drip, I had to crawl on the floor to cover their faces when they died... No light, no food, no water. For three days I was living with the corpses...

Even when I needed water, I would wave to people outside and nobody would come to my aid because I was isolated. I struggled and I even begged for water... Later, when they came to take the dead bodies, they had brought a body bag for me because they thought I was dead... When I opened my eyes, they ran away, they thought the dead had awoken.⁵⁴

Nine out of the 13 Ebola survivors interviewed said the virus took the lives of multiple family members. A woman from Freetown said four of her children died, in addition to her husband and five members of his family.⁵⁵ In another case, Suzan, who contracted the virus in Port Loko City in late 2014, said she lost four family members, including her father whose death happened while she was away in a treatment centre in another district. “I did not know the way they buried my father and he was so close to me,” she said.⁵⁶ Like several other interviewees, Suzan said the inability to carry out burial rituals for loved ones caused further psychological distress.

Several of the Ebola survivors interviewed referred to themselves and family members as “going off” during that time (in reference to exhibiting pronounced symptoms of distress), attributing that to the extent of grief or pressures on families. In one case, a survivor said her husband, himself an Ebola patient at the time, would undress himself at the treatment centre and walk around naked—something he had never done before.⁵⁷

Richard F. Mollica, D. Keith McInnes, C Poole, Svang Tor, “Dose-effect relationships of trauma to symptoms of depression and post-traumatic stress disorder among Cambodian survivors of mass violence”, *British Journal of Psychiatry International*, December 1998, Vol. 173, Issue 6, pp. 482-488, bit.ly/37auXLR

⁵⁰ Phone interviews, December 2020 – January 2021.

⁵¹ Phone interview, 9 December 2020.

⁵² Phone interview, 9 December 2020.

⁵³ Phone interview, 18 January 2021.

⁵⁴ Phone interview, 9 December 2020.

⁵⁵ Phone interview, 18 January 2021.

⁵⁶ Phone interview, 10 December 2020.

⁵⁷ Phone interview, 9 December 2020.



An Ebola health worker carries the body of an infant in Freetown, 23 November 2014. Nine out of the 13 Ebola survivors interviewed by Amnesty International said the virus took the lives of multiple family members. © The Washington Post via Getty Images

Ebola survivors continued to experience psychosocial effects after they were discharged. All but one of those interviewed said they were stigmatized and discriminated against by fearful community members, something that impacted them profoundly.⁵⁸ “People would not come close to me, all of my friends ran away from me,” said Bintu, in her 50s, who contracted Ebola in mid-2014 in Kenema District alongside her daughter, who ultimately died from the disease.⁵⁹

Several survivors said community members blamed them for bringing Ebola to their areas; others said they were automatically presumed dead such that relatives and neighbours had taken their personal belongings while they were in treatment centres.⁶⁰ When she was discharged, “I only found my cooking pot,” said 70-year-old Hassanatou, adding that her neighbours took away all of her furniture, assuming she, too, had died like her three daughters who contracted Ebola.⁶¹ “I let it go because I did not have any hope again; the only hope I had was when my [daughters] were alive.”⁶²

Both survivors of the war and of the Ebola epidemic described changes in their mood and behaviour in the aftermath of these experiences.⁶³ Some said they no longer wanted to live in their villages to avoid reminders of their experiences. Several interviewees described staying indoors for months, refusing to interact with

⁵⁸ A few said they faced stigma and isolation even from some family members. Phone interviews, December 2020—January 2021. An analysis of the psychosocial impact of the West Africa Ebola epidemic stated: “Some survivors were threatened, attacked, evicted, left behind by, or excluded from, their families and communities because they were seen as tainted and dangerous. Fear and stigma of Ebola are contributed to by cultural beliefs (e.g. being a bewitched disease with those affected at fault or deserving their illness), widespread fears due to high infection risk, lack of information and misinformation.” Tine Van Bortel, Anoma Basnayake, Fatou Wurie, Musu Jambai, Alimamy Sultan Koroma, Andrew T Muana, Katrina Hann, Julian Eaton, Steven Martin, Laura B Nellums, “Psychosocial effects of an Ebola outbreak at individual, community and international levels”, *Bulletin of the World Health Organization*, 2016 (published online 21 January 2016), Vol. 94, pp. 210-214, bit.ly/3nbnHFR

⁵⁹ Phone interview, 8 December 2020.

⁶⁰ The personal effects of people who contracted the virus were often burned by health teams to prevent further spread of the disease, but the reference by survivors here is particular to when relatives and neighbors stole their remaining belongings and they were able to verify that was what had happened.

⁶¹ Phone interview, 18 January 2021.

⁶² Phone interview, 18 January 2021.

⁶³ Phone interviews, December 2020 – January 2021. Pertaining to Ebola survivors specifically, a survey—with a national sample—examining the impact of the epidemic in Sierra Leone roughly midway through the outbreak showed that 48% of respondents reported some form of anxiety or depression symptom and 76% reported at least one symptom of post-traumatic stress. Mohamed F Jalloh, Wenshu Li, Rebecca E Bunnell, Kathleen A Ethier, Ann O’Leary, Kathy M Hageman, Paul Sengh, Mohammad B Jalloh, Oliver Morgan, Sara Hersey, Barbara J Marston, Foday Dafaee, John T Redd, “Impact of Ebola experiences and risk perceptions on mental health in Sierra Leone, July 2015”, *British Medical Journal Global Health*, March 2018, bit.ly/302V6YA

others; Rakiatu, the mother of the girl who was raped by the rebels said this daughter, unlike her siblings, could no longer continue going to school.⁶⁴ Three people interviewed said they considered suicide.⁶⁵

4.2 ONGOING DISTRESS COMPOUNDED BY LACK OF SUPPORT

People interviewed by Amnesty International said that, years later, they still experience a range of symptoms of distress which they link to their exposures during the war and the Ebola epidemic. Some said the memories are too powerful to forget and that, at times, the grief can be overwhelming. “Even until now when I think about them and what happened, it is always very painful. I was just a child then,” said 37-year-old Zainab, who lost four family members when the rebels attacked her town in Kono District in the late 1990s, and whose baby later died in the bush. “Each time I recall, the entire day is bad for me.”⁶⁶

Some said they grapple with being irritable and angry, which causes them to lash out at others. “Most of the time, I am very angry, even with my kids I am angry with them... At times, I just think let me do something and let them lock me up in a cell,” said Amina, a mother of three in her mid-30s.⁶⁷ She was around six or seven years old when a projectile hit her house during the first year of the war, killing her mother and resulting in her losing her left foot. Hassan, an Ebola survivor, said:

At times, you become so temperamental... You get vexed for no reason and after some time you say, ‘Why did I get vexed to this degree?’ You start blaming yourself. You see, all the time you are disturbed... We are tormented.⁶⁸

At least five people interviewed said they have troubles with sleep, including, at times, nightmares of their past experiences. One of them, 65-year-old Rakiatu, whose right arm was amputated by doctors after she was injured in a rebel attack in 1999, said intrusive memories of what she experienced are accompanied by physical sensations: “It always comes to my mind. Even when I am asleep, it comes to my mind... When the place is hot, I sense a reaction in my [amputated] arm as if it is pumping... it happens frequently.”⁶⁹

Titi, a 42-year-old Ebola survivor, said she never got over the fear of death that accompanied her illness. “You still have the perception that since you were an Ebola patient, you will die any time soon. I have this mindset and I always think I will die any time and that keeps scaring me,” she said.⁷⁰

COVID-19 was particularly triggering for at least three Ebola survivors who were interviewed. One said she cried for three days, fearing she would “definitely not make it” if she got the new virus.⁷¹ Another survivor, Mabinty, a nurse in her late 30s said:

It was another hell... based on the information we are having that COVID is a deadly disease... it [can be] even airborne, so for me as a health worker, I became worried because there was no way for me to give up my work, I have to work. And with that you must come in contact with patients and I was afraid of infecting myself again from the past experience.⁷²

LACK OF APPROPRIATE HEALTH CARE AND SERVICES

The physical effects, impairments and lingering chronic pain associated with the traumatic experiences is also a source of ongoing distress. War survivors who were injured or subjected to amputations said they had spent months in hospitals undergoing surgeries and other lengthy medical procedures. “Even as I speak with you, I still feel too much pain—in my arms, in my neck, in my jaw. I have lived with that all of my life after the war; every day I am in pain,” said 73-year-old Ibrahim, who spent up to 18 months in different hospitals

⁶⁴ Phone interview, 19 January 2021.

⁶⁵ Phone interviews, December 2020.

⁶⁶ Phone interview, 10 December 2020.

⁶⁷ Phone interview, 8 December 2020.

⁶⁸ Phone interview, 9 December 2020.

⁶⁹ Phone interview, 19 January 2021.

⁷⁰ Phone interview, 9 December 2020.

⁷¹ Phone interview, 18 January 2020.

⁷² Phone interview, 8 December 2020. For more on the experience of health care workers specifically and the impact of the Ebola epidemic on them, see Joanna Raven, Haja Wurie, Sophie Witter, “Health workers’ experiences of coping with the Ebola epidemic in Sierra Leone’s health system: a qualitative study”, *BMC Health Services Research*, 5 April 2018, Vol. 18, Issue 1, bit.ly/3b60gYO

after he was beaten, slashed in multiple parts of his body and had both hands amputated in the late 1990s by the rebels in Kenema District.⁷³

The majority of Ebola survivors interviewed said they continue to deal with various health complications, including muscle pain and weakness, eye problems (one interviewee ultimately lost her eyesight completely), irregular blood pressure and forgetfulness.⁷⁴ “Sometimes I feel I’m going mad, I’m just confused, torment[ed]... I have serious chronic stomach pain since that time... I cannot see properly with my eyes until now, I have to use [eyeglasses]... It’s not easy for me to recall anything at all. That bothers me seriously up to this time,” Bintu said.⁷⁵

Both war and Ebola survivors said the impact of these ongoing health complications is further compounded by their inability to afford quality health care services and medication. Various schemes and plans by the government and international partners to provide free or affordable health care for war and Ebola survivors did not end up yielding systematic, effective, long-term care, survivors and their associations said.⁷⁶ “Most of the time when we feel pain in our body, and the way those pains come, you reflect a lot as if it is still the sickness that you had already. We want treatment that is sustainable and continuous,” said Christina, an Ebola survivor in her late 30s.⁷⁷

Several people interviewed said they stopped going to hospitals or buying medication and were unable to purchase needed items such as eyeglasses because they cannot afford them. In at least one case, that of Sabatu’s husband, the consequences were dire. Sabatu said her husband had required regular medical care since rebels slashed him all over his body in the mid-1990s. But after he did not go to the hospital in Port Loko District to receive scheduled medication a few years ago because the family did not have enough money, he had an episode during which he took a machete and tried to attack people in the community before being restrained and taken to the hospital.⁷⁸

All three people interviewed with lower limb amputations had crutches, but one of them and at least three others with upper limb amputations mentioned they do not have prostheses. Assistive devices and prostheses are essential to enabling persons with disabilities to live active, independent lives and, for many, they are central to upholding their inherent dignity and enjoyment of human rights on an equal basis with others.⁷⁹ Sallieu, a 45-year-old father of six who tries to do some farming work with his right hand, said:

I used to have a [prosthetic] limb, but it is damaged... I feel embarrassed... especially when I need something and none of my children are around to help me. This is something I think about every day...

It was useful to me, especially the one that had fingers like a real hand; when I wore that, you would hardly be able to tell that my arm is amputated. But now that I no longer have it, when I walk around and people stare at me, I feel embarrassed.⁸⁰

⁷³ Phone interview, 8 December 2020.

⁷⁴ Phone interviews, December 2020 – January 2021. For more on the long-term health complications Ebola survivors sustain, see, for example: WHO, *Clinical care for survivors of Ebola virus disease: Interim guidance*, April 2016, bit.ly/3d8NNGj; Centers for Disease Control and Prevention (CDC), *Ebola (Ebola virus disease)*, cdc.gov/vhf/ebola/treatment/survivors.html; Caitlyn Stulpin, “Ebola survivors face health issues long after recovery”, Heallo, 23 September 2020, bit.ly/3qmrRww; Daniel S. Chertow, “Understanding long-term effects of Ebola virus disease”, *Nature Medicine*, 29 April 2019, go.nature.com/2OyzS2g

⁷⁵ Phone interview, 8 December 2020.

⁷⁶ Phone interviews, December 2020 – January 2021. Ebola survivors were promised free health care by the government and were included in the Free Health Care Initiative (FHCI), offered to pregnant and lactating women and children under 5. The government had also established a national programme in 2015 called the Comprehensive Programme for Ebola Survivors (CPES) with the aim of improving the wellbeing of Ebola survivors. Advancing Partners & Communities, *Responding to Ebola survivor needs strengthens the health system in Sierra Leone*, bit.ly/3ptWNbG

But after international donors and partners wrapped up their involvement in CPES, implementation had been fraught with challenges including a shortage in medications and specialized care. See, for example, James Courtright, “The forgotten Ebola survivors of Sierra Leone”, NPR, 25 April 2018, n.pr/2LVbFIE

Free health care was included in the Truth and Reconciliation Commission’s recommendations; for more on promises made to war survivors—and failures to support long-term health care needs—see Edward Conteh and Maria Berghs, *‘Mi At Don Poi’: A Report on Reparations in Sierra Leone for Amputee and War-Wounded People*, Amputee and War-Wounded Association, 2014, bit.ly/3pgrAc7 (hereinafter *A Report on Reparations*, 2014). In an interview with Amnesty International, the Executive Secretary of the National Commission for Persons with Disability said the Persons with Disability Act of 2011 guarantees the provision of free medical services in public health institutions for persons with disabilities and that the commission had taken steps to ensure that provision. He acknowledged that persons with disabilities face challenges when it comes to covering the costs of medication, something, he said, the commission has been advocating for with health officials. One way to address these needs is establishing a National Development Fund for Persons with Disability, as per the country’s disability act. See The Persons with Disability Act, 2011, bit.ly/2ZcePEK

⁷⁷ Phone interview, 18 January 2021.

⁷⁸ Phone interview, 11 December 2020.

⁷⁹ UN Special Rapporteur of the Human Rights Council on the rights of persons with disabilities, Report, 9 August 2016, UN Doc. A/71/314, paras 43-54.

⁸⁰ Phone interview, 9 December 2020.

Sallieu and another interviewee whose prosthetic leg no longer fits her said they were unable to get their prostheses fixed or replaced; two other people who were never given prostheses said they gave up on trying to obtain any. Survivors said that the international non-governmental organizations that used to provide these services handed them over to the government, and that there have been issues with the government agencies that took over, including lack of funds and the necessary skillset.⁸¹ Saa Lamin Kortequee, the Executive Secretary of the National Commission for Persons with Disability, a government body, acknowledged that there is a limited availability of assistive equipment and repair facilities and said that efforts are being undertaken to train cadres locally and alleviate customs duties on imported assistive devices and technologies.⁸²

LACK OF SUFFICIENT AND SUSTAINED SOCIAL PROTECTION

Poverty and reduced livelihood opportunities are inextricably linked to survivors' mental health and overall wellbeing. Several survivors interviewed said they were unable to carry out their past income-generating activities due to several challenges stemming from their experiences, including physical and psychosocial impairments. Ebola survivor Hassan, 57, who takes irregular, day-labour jobs said: "I cannot go to work... [Ebola] kills your strength. You have muscular weakness. Even to walk [any] distance you cannot, let alone to go do handwork. It's not easy for us."⁸³

At least five interviewees resorted to begging.⁸⁴ "I need money, I need food so I do not have to keep begging. I beg for my livelihood; I don't like that. I want to eat well; I am not eating well. I want medication, I am not getting it," said Ibrahim, 73, who used to be a farmer before rebels cut off both his hands.⁸⁵ He said he is tired of having to rely on handouts from his family and community.

Ragiatu, a 37-year-old Ebola survivor who lost her husband to the virus, said she struggled to support her children even though she had received tailoring training by a faith-based aid agency as part of an intervention for Ebola survivors. She was raising her late sister's son and daughter alongside her own but had to ultimately send her sister's son to an orphanage and her own son to live with a relative. "For now, I only have the two girls with me because I cannot take care of all four; they are all attending school, and I do not have the resources to take care of them," said the Port Loko District resident.⁸⁶ The vast majority of survivors who had children raised—unprompted—the issue of their children's and grandchildren's education costs as a major source of stress, linking it to persistent distress over limited livelihood opportunities.

More broadly, the majority of the war and Ebola survivors who were interviewed spoke of feeling resentment over what they described as the government's broken promises of social protection, which they say undermines their wellbeing. War survivors interviewed by Amnesty International—the majority of whom live in camps that had been set up by NGOs for persons with amputations and other war-wounded persons—complained about dwindling or non-existent benefits such as support with livelihoods and free transport on public buses. Some said they had received skills training and basic livelihood assistance at some point, but they continued to face challenges.⁸⁷ One of them, for example, said that a tractor he had been given to help him in farming activities was now in disrepair and he had been unable to get support to have it fixed.⁸⁸

Ebola survivors were entitled to a "discharge package" after they left medical facilities, including payments that averaged around US\$70, a mattress and a bag of rice.⁸⁹ But interviews with Ebola survivors, including the President of the Sierra Leone Association of Ebola Survivors, Yusuf Kabba, indicate there were delays and discrepancies (in the amount and nature of the support and who received it at all).⁹⁰ There were

⁸¹ Phone interviews, December 2020 – January 2021. For more on barriers facing persons with disabilities in accessing rehabilitation services and assistive devices, see, for example, Justine Aenishänslin, Abu Amara, Lina Magnusson, "Experiences accessing and using rehabilitation services for people with physical disabilities in Sierra Leone", *Disability and Rehabilitation*, 30 April 2020, [bit.ly/3pbbhf9](https://doi.org/10.1080/09638237.2020.1811119)

⁸² Phone interview, 20 January 2021.

⁸³ Phone interview, 9 December 2020.

⁸⁴ Phone interviews, December 2020 – January 2021.

⁸⁵ Phone interview, 8 December 2020.

⁸⁶ Phone interview, 10 December 2020.

⁸⁷ According to a 2014 report by the Amputee and War-Wounded Association on the reparations programme, there had been inconsistencies and gaps in disbursing reparations and implementing the programme. "The long term rehabilitative and health care needs of those most severely affected victims, the setting up of pensions, free transport and educations for some victims and children of severely affected amputee and war-wounded people was ignored... By 2013, the most severely affected amputee and war-wounded people were all given payments of \$1400 and asked to sign documents giving assurances to NaCSA [the National Commission for Social Action] that they would not request any more reparations." *A Report on Reparations*, 2014.

⁸⁸ Phone interview, 9 December 2020.

⁸⁹ See, for example, Nina DeVries, VOA, "Sierra Leone Ebola survivors want more help – fast", 9 January 2016, [bit.ly/3tLPyPx](https://www.voanews.com/a/sierra-leone-ebola-survivors-want-more-help-fast/2016-01-09/)

⁹⁰ Phone interviews, December 2020 – January 2021. Anger among Ebola survivors had been festering for years; survivors filed a lawsuit against the government in the regional court of the Economic Community of West African States (ECOWAS) over allegations of corruption and mismanagement of foreign funds that were meant for Ebola response. Reuters, "Ebola victims sue Sierra Leone government over mismanaged funds", 15 December 2017, [reut.rs/3u6XmMb](https://www.reuters.com/article/ebola-sierra-leone/sierra-leone-ebola-victims-sue-government-over-mismanaged-funds-idUSKBN1E0001)

Cooper Inveen, "Ebola survivors sue government of Sierra Leone over missing millions", *The Guardian*, 5 January 2018, [bit.ly/2Zpo2K4](https://www.theguardian.com/world/2018/jan/05/ebola-survivors-sue-sierra-leone)
Yusuf Kabba, "Why Ebola survivors are suing Sierra Leone", *Al Jazeera*, 24 July 2018, [bit.ly/37lqbKS](https://www.aljazeera.com/news/2018/7/24/why-ebola-survivors-are-suing-sierra-leone)

additional, varying forms of assistance from international aid organizations, including livelihood start-up kits and income-generating opportunities, but several Ebola survivors told Amnesty International the vast majority of that support ended with the funding cycle of these programmes.⁹¹ “We should not be abandoned, they should not leave us like that... in so many ways, they are forgetting about us,” Mariatu, a 40-year-old Ebola survivor who lost her husband and four children, said of the government and international aid organizations.⁹²

“[O]ngoing poverty is a potent risk factor for mental health problems,” said Dr Julian Eaton, a public health psychiatrist and Mental Health Director for CBM Global, which has been involved in mental health-related projects in Sierra Leone.⁹³ It is well-recognized that mental health is “shaped to a great extent by social, economic and environmental factors” at different stages of life.⁹⁴ Challenges sustaining livelihoods, for example, have broader effects on accessing other rights, which can “perpetuate social inequality and have a ruinous and enduring impact on the enjoyment of the right to an adequate standard of living and, consequently, on mental health”.⁹⁵ Related, “low socioeconomic position is systematically associated with increased rates of depression. Gender is also important, mental disorders are more common in women, they frequently experience social, economic and environmental factors in different ways to men.”⁹⁶

4.3 EXPERIENCES WITH MENTAL HEALTH SUPPORT

In the immediate aftermath of their traumatic experiences—amid widespread lack of services and resources—some survivors received psychosocial support, while others did not. War survivors who said they had received some counselling said the services occurred during their extended stays in hospitals to treat complex injuries and amputations as well as post-discharge, when receiving physical rehabilitation services set up by NGOs such as Humanity & Inclusion, also known as Handicap International.⁹⁷ When these survivors were in the hospital, medical staff offered some psychological support and Muslim and Christian clerics visited the survivors and offered words of encouragement; later, alongside rehabilitation in some cases, they received some mental health support from NGOs, including faith-based groups.⁹⁸

Ebola survivors who said they had received counselling said that that was provided by government-affiliated mental health nurses and a variety of structured interventions from NGOs, including *Médecins Sans Frontières* (MSF), GOAL and Partners in Health (PIH).⁹⁹ Their accounts and other evidence indicate there was a relatively more robust effort by humanitarian actors to provide mental health support around the time of the Ebola crisis in comparison to the time of the war and its aftermath.¹⁰⁰

Testimonies of several of the people who received mental health and psychosocial services during these emergency periods highlight the value of this kind of support. Several Ebola survivors, for example, said it was crucial after their discharge amid the stigmatization that they had faced. Hassan said:

It reached a time I decided to commit suicide, because I look at myself and I don't see a need to live in this community. Nobody comes near me. Nobody talks to me... When PIH came, they provide[d] psychosocial services. They move home to home... they encourage us that all is not lost.

So, the moment the community people or our neighbours see people like psychosocial services coming to us... they started coming closer, closer, closer. At some point [PIH] created job facilities, they hired people, they formed social mobilizers, they asked you to go into the community, tell the people that the disease is true, that Ebola is real.¹⁰¹

Another Ebola survivor, Kaday, who also said she had “wanted to die” because of stigmatization in her community, described the counselling she received as “more than riches... it saved my life.”¹⁰² She said it

⁹¹ Phone interviews, December 2020 – January 2021.

⁹² Phone interview, 18 January 2021.

⁹³ Phone interview, 23 November 2020.

⁹⁴ WHO and Calouste Gulbenkian Foundation, *Social determinants of mental health*, 2014, bit.ly/2N3wbkl (hereinafter WHO, *Social determinants of mental health*). See also UN Human Rights Council, *Mental health and human rights: Report of the United Nations High Commissioner for Human Rights*, 31 January 2017, UN Doc. A/HRC/34/32, paras 13-14; Report of the Special Rapporteur on the right to health, 12 April 2019.

⁹⁵ UN Human Rights Council, *Mental health and human rights*, para 13.

⁹⁶ WHO, *Social determinants of mental health*.

⁹⁷ Phone interviews, December 2020 – January 2021.

⁹⁸ Phone interviews, December 2020 – January 2021.

⁹⁹ Phone interviews, December 2020 – January 2021.

¹⁰⁰ Phone interviews, December 2020 – January 2021. Subsequent chapters will highlight the role the Ebola epidemic played in scaling up mental health services in the country.

¹⁰¹ Phone interview, 9 December 2020.

¹⁰² Phone interview, 9 December 2020.

lasted for around a year, during which psychosocial support teams would visit her and other survivors in their homes.¹⁰³

But many people were left out of support; of the 25 survivors interviewed, nine war survivors and two Ebola survivors said they had received no or minimal counselling services during that emergency period. Notably, among those who had not received any counselling were three people who were not physically injured during the war, yet had experienced high levels of distress fleeing the violence and witnessing violations against their loved ones. They include a man who said he still has nightmares about the war, and Zainab, who, as previously mentioned, fled an attack in which four of her family members were killed. Speaking of her condition today, more than 20 years later, she said: “I weep a lot, and weep endlessly.”¹⁰⁴



A boy injured during violence that targeted the capital lies in a hospital bed in Freetown, January 1999. Some war survivors told Amnesty International that during their extended stays in hospitals, medical staff provided some psychological support and clerics visited and offered words of encouragement. © Gervasio Sánchez

After the emergency phase, the emphasis on mental health services has dwindled significantly. At the time of Amnesty International’s interviews, out of 25 war and Ebola survivors, 15 said they did not know about any current psychological counselling services, be it through government health facilities or NGOs. More broadly, a variety of concerns were expressed about accessing public mental health services, including the cost. For example, Amina, who was a child when her leg was amputated due to an injury she had sustained from a mortar attack, said she had little confidence she would receive counselling through government facilities if she did not pay for it. “If you don’t have money, you go to the hospital with your pain and your trouble, nobody will look at you except if you spend money,” she said.¹⁰⁵

Kaday said she feared being discriminated against and stigmatized if she was seen visiting the mental health unit in the district hospital.¹⁰⁶ Kaday and at least two other people interviewed said they knew of the existence of mental health nurses, but it was their understanding that they were there to prescribe medication to persons with “severe” mental health conditions.¹⁰⁷ These testimonies highlight the dearth of psychosocial interventions away from services at medical facilities whilst also underscoring the need to both improve confidence in government services and increase public health literacy around mental health.

¹⁰³ Phone interview, 9 December 2020. Kaday and several other Ebola survivors lamented the end of community-based psychosocial interventions they had had access to through NGOs during the crisis.

¹⁰⁴ Phone interview, 10 December 2020.

¹⁰⁵ Phone interview, 8 December 2020.

¹⁰⁶ Phone interview, 9 December 2020.

¹⁰⁷ Phone interviews, December 2020.



Health workers in protective gear are photographed alongside patients, 15 August 2014, at a Médecins Sans Frontières (MSF) facility in Kailahun, one of the districts hardest-hit by Ebola. Ebola survivors who told Amnesty International that they had received counselling during the crisis said it was provided by government mental health nurses and a variety of structured interventions from NGOs, including MSF. © AFP via Getty Images

Outside formal structures, several people interviewed said encouragement, support and acceptance from their families in the aftermath of their traumatic experiences were key in helping with their mental health and psychosocial wellbeing. For example, a man who lost a leg and sight in one eye due to a landmine explosion during the war said his wife’s support brought him back from the brink after he had gone into isolation and considered ending his life.¹⁰⁸ This is reinforced by one of the core findings of a landmark 15-year longitudinal study on the mental health of male and female children formerly associated with armed forces and armed groups in Sierra Leone: that families’ and communities’ acceptance—or lack thereof—has been central in influencing their long-term mental health trajectories.¹⁰⁹

And while several people interviewed highlighted the lack of access to long-term counselling services in a formal setting, they said that peers had been a primary support for them. “Among ourselves we find comfort in talking to each other,” said 57-year-old Marie, who currently lives in one of the “amputee camps” which were set up by NGOs for persons with amputations and other war-wounded persons.¹¹⁰ Lansana, a 30-year-old Ebola survivor from Port Loko City, said:

The only counselling we do now is... a colleague, survivor-to-survivor. Maybe you can explain your problem to your colleague survivor, but we don’t have a professional mental health [practitioner] to do that... In fact, we have a body, an association, a survivors’ association.¹¹¹

¹⁰⁸ Phone interview, 8 December 2020.

¹⁰⁹ At one of its stages, the study concluded that “[p]sychosocial interventions for former child soldiers may be more effective if they account for post-conflict factors in addition to war exposures.” Theresa S. Betancourt, Robert T. Brennan, Julia Rubin-Smith, Garrett M. Fitzmaurice, Stephen E. Gilman, “Sierra Leone’s former child soldiers: a longitudinal study of risk, protective factors, and mental health”, *Journal of the American Academy of Child & Adolescent Psychiatry*, June 2010, Vol. 49, No. 6, pp. 606-615, bit.ly/3aFajVM
See also Theresa S. Betancourt, Dana L. Thomson, Robert T. Brennan, Cara M. Antonaccio, Stephen E. Gilman, Tyler J. VanderWeele, “Stigma and acceptance of Sierra Leone’s child soldiers: A prospective longitudinal study of adult mental health and social functioning”, *Journal of the American Academy of Child & Adolescent Psychiatry*, June 2020, Vol. 59, No. 6, pp. 715-726, bit.ly/37G8JBf
The UN Inter-Agency Steering Committee (IASC) Guidelines on mental health and psychosocial support during emergency settings lists among its core principles promoting multi-layered supports, including help from the community and family. Placing it as the second layer in its “Intervention pyramid” for mental health and psychosocial support in emergencies, the guidelines recommend responses that aim to strengthen family and community support. The guidelines, published in 2007 following the participation of mental health practitioners, academics and humanitarian and human rights organizations, serve as a general reference for organizations providing mental health and psychosocial support services. IASC, *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, 2007, bit.ly/37zJEYt

¹¹⁰ Phone interview, 9 December 2020.

¹¹¹ Phone interview, 10 December 2020.

Some Ebola survivors even pointed out that the slogan of the Sierra Leone Association for Ebola Survivors (SLAES) is “Who feels it, knows it”. As with family and community support, peer support groups are not a substitute for mental health and psychosocial services but can contribute to positive outcomes as part of a continuum of care.¹¹²

¹¹² See, for example, Report of the Special Rapporteur on the right to health, 28 March 2017, para. 83.

5. BARRIERS TO QUALITY MENTAL HEALTH CARE

Specialized interventions for trauma-affected persons across the world tend to cease within a few years after the end of conflict and crises, as funding and international attention wane. Humanitarian and development actors maintain that what they aim for is not to perpetuate dependency but to build local capacities and strengthen systems to integrate these services within the national health framework.¹¹³ This can result in gaps in service provision while sustainable systems and services are being developed.

In the context of Sierra Leone, work to build up a mental health system in Sierra Leone started taking shape around 2009.¹¹⁴ Progress was relatively slow until the Ebola epidemic in 2014—in itself another emergency—accelerated efforts, primarily to deal with the pressing and widescale needs that arose at the time. However, there have been several barriers to integration within Sierra Leone’s health system, undermining access to quality mental health care and support for those who have experienced traumas linked to the war and Ebola as well as others with mental health and psychosocial needs.

There is a general consensus that the treatment gap for mental health and psychological conditions is huge. A figure that is often mentioned in studies, citing estimates in a 2012 WHO report, puts the treatment gap in Sierra Leone at 99.5% for persons with “any form of a mental health problem”.¹¹⁵ However, it is difficult to arrive at a precise figure given the paucity of up-to-date data on mental health and psychosocial needs in the country—a common challenge in low- and middle-income countries.¹¹⁶ The absence of this disaggregated data on mental health, which itself breaches the government’s human rights obligations,¹¹⁷ clearly “limits usefulness for service planning and policy action”.¹¹⁸ A health official acknowledged this shortcoming and

¹¹³ Interviews November 2020 – February 2021. Amnesty International interviewed a dozen people working with international and local organizations involved in humanitarian and development work in Sierra Leone, as well as public health and development experts. See also IASC reference group on mental health and psychosocial support in emergency settings, *Mental health and psychosocial support in Ebola virus disease outbreaks: A guide for public health programme planners*, 2015, p.14, bit.ly/37QAbfz

¹¹⁴ Wondimagegnehu Alemu, Michelle Funk, Tenin Gakuruh, Donald A. Bash-Taqi, Andrea Bruni, Jessica Sinclair, Aminata Kobie, Andrew Muana, Mohamed Samai, Julian Eaton, *WHO proMIND profiles on mental health in development: Sierra Leone*, WHO, 2012, bit.ly/3bCslSA (hereinafter Wondimagegnehu Alemu et al, *WHO proMIND profiles on mental health in development*).

¹¹⁵ The figure is based on global estimates of prevalence in addition to limited data on service utilization in Sierra Leone from 2009; the authors note the absence of reliable country-wide prevalence data. Wondimagegnehu Alemu et al, *WHO proMIND profiles on mental health in development*. This figure is also reflected in the government’s National Mental Health Policy, which states: “It is estimated that less than 1 percent of the total population who suffer from mental disorders are treated.” Sierra Leone Ministry of Health and Sanitation, *Mental Health Policy 2019-2028*, on file with Amnesty International. It is estimated that between 76% and 85% of people with mental health conditions in low- and middle- income countries receive no treatment for their conditions. WHO, *Mental Health Action Plan 2013-2020*.

¹¹⁶ Mental health information is often lacking in many low- and middle-income countries, with resource constraints and insufficient prioritization among the key factors. See, for example, Shalini Ahuja, Rahul Shidhaye, Maya Semrau, Graham Thornicroft, Mark Jordans, “Mental health information systems in resource-challenged countries: experiences from India,” *British Journal of Psychiatry International*, May 2018, Vol. 15, No. 2, pp. 43-46, bit.ly/3h9NwVX

Nawaraj Upadhaya, Mark J. D. Jordans, Jibril Abdulmalik, Shalini Ahuja, Atalay Alem, Charlotte Hanlon, Fred Kigozi, Dorothy Kizza, Crick Lund, Maya Semrau, Rahul Shidhaye, Graham Thornicroft, Ivan H. Komproe, Oye Gureje, “Information systems for mental health in six low and middle income countries: cross country situation analysis”, *International Journal of Mental Health Systems*, 26 September 2016, Vol. 10, No. 60, bit.ly/3f0sZAt

¹¹⁷ CESCR, General Comment No. 14, paras 20, 57, 63.

¹¹⁸ Dawn Harris et al, “Mental Health in Sierra Leone”. Another study analyzing challenges in Sierra Leone’s health system across the WHO’s six “building blocks” of health systems quotes a member of the Mental Health Coalition as saying: “[I]f we watch the ministry of health and sanitation Monitoring and Evaluation department’s charts with regards to number of cases treated, there is just one general line for mental health. With no clear, specific conditions so as to be able to say which condition really is predominant in which community, that should act like a reference point and helps with strategic planning and development.” The study points out, however, that data collection is

said it is an area in which the country could use technical and financial assistance to help guide work aimed at fulfilling better access to care.¹¹⁹ Data aside, interviewees cited the interconnected barriers covered in this chapter—most of which are mirrored across the country’s health sector—as major impediments to fulfilling even the most basic levels of needed care.¹²⁰



Members of the Mental Health Coalition march through Freetown on World Health Day, 7 April 2017, in a series of events held alongside the WHO and Ministry of Health to raise awareness about depression. The coalition has been at the forefront of activities aimed at fighting stigma surrounding mental health conditions. © Private

5.1 LACK OF A SKILLED WORKFORCE

Across the board, experts, aid workers, government officials, and mental health professionals (including mental health nurses) interviewed said the lack of sufficient numbers of mental health and psychosocial workers and specialists in the country is a major challenge in delivering quality mental health care and support.¹²¹ There have been efforts undertaken by the government alongside international partners to train cadres of mental health professionals and non-specialist staff, but overall, a significant shortage persists,

useful in as much as other factors, such as logistical limitations, would enable its use. Jessica J Fitts, Fatmata Gegbe, Mark S Aber, Daniel Kaitibi, Musa Aziz Yokie, “Strengthening mental health services in Sierra Leone: perspectives from within the health system”, *Health Policy and Planning*, July 2020, Vol. 35, Issue 6, Pages 657–664, [bit.ly/3bBx8ci](https://doi.org/10.1093/heap/ckz081) (hereinafter Jessica J Fitts et al, “Strengthening mental health services in Sierra Leone”).

¹¹⁹ Phone interview, 13 January 2021. Separately, the Executive Secretary of the National Commission for Persons with Disability told Amnesty International he had pushed for the use of the internationally-recognized Washington Group Questions in the country’s last census in 2015 in order to obtain data on disability disaggregated by type and severity but that did not come to fruition. That has, however, been remedied in the 2021 mid-term census, he said. Phone interview, 20 January 2021. The Washington Group Short Set involves six questions designed to identify if individuals have difficulty carrying out certain activities (walking, seeing, hearing, cognition, self-care and communication). It does not include a specific question on mental health, but experts say questions on aspects such as self-care and communication can potentially trace some psychosocial disabilities. Longer versions, such as the “Enhanced Short Set” include questions on anxiety and depression. See Grace Ryan, Valentina Lemmi, Fahmy Hanna, Hannah Loryman, Julian Eaton, “Mental health for sustainable development: A topic guide for development professionals”, Knowledge, Evidence and Learning for Development (K4D), January 2020, [bit.ly/3ezxVOa](https://doi.org/10.2196/k4d.12345)

¹²⁰ For more on the challenges across Sierra Leone’s health system pillars, see, for example, Colan Robinson, “Primary health care and family medicine in Sierra Leone”, *African Journal of Primary Health Care & Family Medicine*, 30 July 2019, Vol. 11, No. 1, [bit.ly/3emMunH](https://doi.org/10.2196/3emMunH) Sierra Leone Ministry of Health and Sanitation, *National Health Sector Strategic Plan 2017-2021*, September 2017, [bit.ly/303Etf](https://doi.org/10.2196/303Etf) (hereinafter Ministry of Health and Sanitation, *National Health Sector Strategic Plan 2017-2021*); Sierra Leone Ministry of Health and Sanitation, *Human Resources for Health Strategy 2017-2021*, [bit.ly/3unyZcW](https://doi.org/10.2196/3unyZcW)

¹²¹ Phone interviews, November 2020 – February 2021. These include interviews with two health officials, two senior international aid workers and three international mental health experts and public health specialists.

affecting the delivery of needed long-term professional care for war and Ebola survivors as well as for the general population.

One key—albeit limited—initiative funded by international donors was the training of 21 mental health nurses who were posted in district hospitals across the country upon completing courses at the College of Medicine and Allied Health Sciences (COMAHS) by 2013.¹²² Interviewees said this cohort of mental health nurses initially received minimal support from the government upon placement—including in some cases having no office space to work out of—and that it was not until Ebola hit that their role was properly activated.¹²³ But even after the crucial service they provided during the Ebola crisis, it took until 2019 for these nurses to receive the promotions and associated pay they were promised, prompting at least two to pursue training in other career pathways such as midwifery.¹²⁴ At most, 16 nurses from that cohort are still practicing.¹²⁵

In the subsequent eight years after the training of that first cohort, a limited number of nurses were added to the service; namely three mental health nurses who trained abroad.¹²⁶ The National Mental Health Co-ordinator at the Ministry of Health and Sanitation, Kadiatu Savage, said a cohort of eight more nurses have qualified in April 2021 after completing their donor-funded courses at COMAHS.¹²⁷ Longer-term, she said the government is trying to integrate that curriculum into its public, university-level system instead of having to rely on external funders, especially as past funders have wrapped up their support for this training programme.¹²⁸ While stigma towards the profession is sometimes cited as one of the causes for the limited mental health workforce, the health official acknowledged that more needed to be done to make the field attractive for new recruits.¹²⁹ Aside from the delay the nurses faced in getting recognized in the service scheme and being appropriately remunerated, several interviewees said there are no career development opportunities for the nurses, such as the ability to obtain advanced degrees for example.¹³⁰

According to health officials and others involved in mental health and psychosocial work in Sierra Leone, a country of over 7 million people, there are only two practicing Sierra Leonean psychiatrists for the entire nation, with an additional visiting psychiatrist from Nigeria.¹³¹ Moreover, the two clinical psychologists in the country are not practicing in the public sector.¹³²

In recent years the Ministry of Health and Sanitation, with the support of international partners including the WHO, provided mental health training and sensitization to a variety of non-specialist health workers to widen the reach of services.¹³³ This has included training nurses and doctors at the primary health care level in the WHO's Mental Health Gap Programme (mhGAP), which focuses on expanding mental health services in low-resourced countries.¹³⁴

In addition, traditional healers, often the first point of contact for persons with mental health conditions and their families in Sierra Leone, have been among the groups targeted for training in Psychological First Aid,

¹²² Phone interviews, November 2020 – February 2021. See also Dawn Harris et al, “Mental Health in Sierra Leone”; Helen Hopwood, Stephen Sevalie, Moshi Optat Herman, Dawn Harris, Katharine Collet, Abdulai Jawo Bah and Fenella Beynon, “The burden of mental disorder in Sierra Leone: a retrospective observational evaluation of programmatic data from the roll out of decentralised nurse-led mental health units”, *International Journal of Mental Health Systems*, 8 April 2021, Vol. 15, No. 31, bit.ly/3v1Mio (hereinafter Helen Hopwood et al, “The burden of mental disorder in Sierra Leone”).

¹²³ Phone interviews, November 2020 – February 2021.

¹²⁴ Phone interviews, November 2020 – February 2021.

¹²⁵ Two passed away and a third retired. Phone interviews, November 2020 – April 2021.

¹²⁶ Helen Hopwood et al, “The burden of mental disorder in Sierra Leone”.

¹²⁷ Phone interview, 3 May 2021.

¹²⁸ Phone interview, 17 February 2021.

¹²⁹ Phone interview, 17 February 2021.

¹³⁰ Phone interviews, January – February 2021.

¹³¹ Phone interviews, November 2020 – February 2021.

¹³² Phone interviews, November 2020 – February 2021. One of them, Dr Rebecca Esliker, a member of the country's Mental Health Coalition and Director of the Mental Health Programme at the University of Makeni (UNIMAK), a private university, told Amnesty International she helped launch a four-year bachelor's degree course in clinical psychology at UNIMAK. At the time of the interview, there were 12 students enrolled across three years. Phone interview, 2 November 2020.

¹³³ Phone interviews, January – February 2021. See, for example, JSI/Advancing Partners & Communities, *Strengthening access to mental health services in Sierra Leone*, 2018, bit.ly/2ZYd2mY

¹³⁴ For more on the mhGAP programme, see WHO, *Mental Health Gap Action Programme (mhGAP)*, bit.ly/3dYbL7X. The WHO had in 2011 identified Sierra Leone among the priority countries to try out mhGAP. Wondimagegnehu Alemu et al, *WHO proMIND profiles on mental health in development*. The National Mental Health Co-ordinator at the Ministry of Health and Sanitation told Amnesty International that an estimated 80% of nurses and doctors in the country had gone through an mhGAP training. Phone interview, 17 February 2021. A study published in 2020, based on interviews conducted with a wide range of health care workers and stakeholders in January 2017 and August 2018 in Bo, Moyamba and Western Area Urban Districts, found that “frontline healthcare providers in rural clinics in this study had little awareness of recent government and international initiatives such as the training and deployment of mental health nurses, the creation of a Mental Health Policy or the existence of the National Mental Health Coalition.” Jessica J Fitts et al, “Strengthening mental health services in Sierra Leone”.

said the National Mental Health Co-ordinator and members of the Mental Health Coalition.¹³⁵ Psychological First Aid enables providers to recognize symptoms of distress in the immediate aftermath of adversity, provide basic counselling and refer to specialized care when needed. Social workers, who are supervised by the Ministry of Social Welfare, received a recent round of psychological first aid training and an upgraded manual as part of the government's stepped-up efforts to respond to COVID-19, said officials from the ministries of health and social welfare.¹³⁶

It is not clear how many of the country's roughly 15,000 community health workers—volunteer community members who play a key role in health promotion—have received mental health training. Mental health is yet to be integrated into the Community Health Worker Training Programme as envisaged in the National Mental Health Strategic Plan 2019-2023, which was launched in June 2019.¹³⁷

A staff member from the WHO's country office said work around mhGAP and other specialized training “needs to be much more systematic”.¹³⁸ They added: “The work around the ministry of health having a training needs assessment and training plan and actually maintaining databases of who is trained and where they have been deployed has started, but has not yet graduated, so to speak.”¹³⁹ The WHO should provide assistance to the health ministry on that front.

The shortage in skilled workers who can provide support is felt among communities where their help is needed. For example, several Ebola survivors who knew of the placement of mental health nurses in district hospitals said that the large number of survivors who require mental health and psychosocial support far surpassed whatever limited services are currently on offer.¹⁴⁰ Bintu, in her 50s, who continued to seek the services of the mental health nurse in her district, said she found the nurse's support helpful, but that “more needs to be done”.¹⁴¹ She added: “Most of the [Ebola] survivors are frustrated... We don't have the strength, we don't have [good] health. That would make you frustrated. We are still in dire need of support... especially [with] our health... physical and mental health.”¹⁴²

5.2 INSUFFICIENT GOVERNMENT PRIORITIZATION

Despite several national policies and strategic plans that state the government's commitment to mental health, civil society members, mental health workers and others monitoring the situation in Sierra Leone said moving these commitments beyond what is stated on paper has been hampered by limited government funding and leadership and a dearth in technically-trained professionals in administrative positions relevant to mental health. “The problem is [that] the government doesn't take ownership,” said a member of the Mental Health Coalition.¹⁴³ The coalition member added that despite the creation of a post for a National Mental Health Co-ordinator in the health ministry, advocates have to continuously push for advancements in the mental health and psychosocial space.¹⁴⁴

There is no dedicated budget line for mental health, said international experts supporting system strengthening in Sierra Leone and the National Mental Health Co-ordinator.¹⁴⁵ Related, it is difficult to ascertain from the country's overall budget how much goes to mental health specifically; for example, under health ministry-related spending in the annual budget, there is one line for the entire Directorate for Non-Communicable Diseases and Mental Health, but this is not disaggregated further.¹⁴⁶ Furthermore, the majority of the limited funding the government allocates to mental health goes to the Sierra Leone Psychiatric Teaching Hospital (the country's only dedicated in-patient mental health facility) and is not routed through

¹³⁵ Phone interviews, November 2020 – February 2021. Co-ordination with traditional healers remains an area for development, interviewees said. Mental health advocates also added that monitoring practices were needed to ensure that there were no human rights abuses at traditional healing centres.

¹³⁶ Phone interviews, January – February 2021. An official from the ministry of social welfare said the government has long tapped into networks of local authorities, traditional structures and chiefs who have influence in their communities, to address the needs of communities. “We sometimes implement some of these [community-based] models subconsciously,” he said, adding that some community leaders had received mental health-related training. Phone interview, 22 January 2021. These efforts need to be standardized.

¹³⁷ Mental health experts who spoke with Amnesty International said that in addition to providing training sessions, ensuring the provision of quality services requires improving supervision and performance monitoring of community health workers and compensating this cadre of volunteers through financial incentives, including costs for transport and mobile phone top-up.

¹³⁸ Phone interview, 21 January 2021.

¹³⁹ Phone interview, 21 January 2021.

¹⁴⁰ Phone interviews, December 2020.

¹⁴¹ Phone interview, 8 December 2020.

¹⁴² Phone interview 8 December 2020.

¹⁴³ Phone interview, 2 November 2020.

¹⁴⁴ Phone interview, 2 November 2020.

¹⁴⁵ Phone interviews, November 2020 – February 2021. See also Dawn Harris et al, “Mental Health in Sierra Leone”; Joshua Duncan et al, *Country profile*; Helen Hopwood et al, “The burden of mental disorder in Sierra Leone”.

¹⁴⁶ Ministry of Finance, *Annual Budget*, mof.gov.sl/annual-budget/ See also Joshua Duncan et al, *Country profile*.

the Directorate for Non-Communicable Diseases and Mental Health, said the National Mental Health Co-ordinator.¹⁴⁷ Beyond the sole co-ordinator, there is no fully-fledged mental health programme to plan and oversee the implementation of the country's mental health policy and strategic plan.

The lack of national funding is particularly felt on the ground at the district level. The very small number of mental health nurses placed in district hospitals are left with next to no resources to fulfil their jobs. For example, several of them spend out of their own pockets to visit their clients at home, said multiple mental health professionals.¹⁴⁸ During the Ebola crisis, some of these nurses were given motorbikes to be able to do home visits—years later, the bikes are in disrepair as the nurses have no access to maintenance or they cannot meet the fuel costs, Amnesty International was told.¹⁴⁹ Related, these mental health nurses are not part of financial discussions that take place at the District Health Management Teams, “so, when resources are being discussed and distributed, they are not at the table... There is a very strong hierarchy... if you are not a doctor, it's very difficult to sit at the same table as doctors,” said a regional mental health expert with knowledge of the situation in Sierra Leone.¹⁵⁰

Several mental health professionals and advocates pointed to the lack of government spending on psychotropic medications.¹⁵¹ It is important to note that psychotropic medications can be a component of care, but they are not necessarily needed across the board. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health states: “Prescribing psychotropic medications, not because they are indicated and needed, but because effective psychosocial and public health interventions are not available, is incompatible with the right to health.”¹⁵² Although psychotropics were finally included in the country's essential medications list in 2018, the government has not been procuring them, yet another indication of the lack of funding and prioritization. Practically any stock comes from international organizations, such as Partners in Health (PIH), which supports mental health services out of hubs in Freetown and Kono.¹⁵³ Mental health professionals based outside these two districts said access to medication is a major challenge.¹⁵⁴

“There are still people that [have] deep wounds [who] have not been healed out of their pains really,” said one mental health worker, speaking of war and Ebola survivors. They added:

Many people are left out from care and the support is not there. We the health workers are there to provide the services, but what do we have to render the services? It's not there... And moreover, I don't know when the ministry will ever, ever take [mental health] as a priority... They have made a lot of promises... but when will they actually be [implemented]?¹⁵⁵

Officials from the health and social welfare ministries acknowledged that the government's spending on mental health is limited but stressed that the political willingness is there. “Mental health is part of this government's manifesto,” said one of the health officials interviewed.¹⁵⁶ Officials also pointed to remarks made by President Julius Maada Bio in June 2020 during the inauguration of PIH-supported renovations at the Sierra Leone Psychiatric Teaching Hospital, in which he addressed the importance of investing in mental health, spoke about seeking regional support to establish the country's first drug treatment and rehabilitation centre and ordered the creation of a presidential task force on mental health (at the time of this report's

¹⁴⁷ Phone interview, 17 February 2021. See also Joshua Duncan et al, *Country profile*. Regarding health care spending in general, the Mental Health Strategic Plan 2019-2023, which cites figures from 2014, states that the government contributes roughly 7% of the total expenditure on health. Close to 47% comes from donors, around 12% from NGOs, while out-of-pocket spending is at 33%. That document states that, in 2014, the total expenditure on health constituted 21.7% of the gross domestic product (GDP). Sierra Leone Ministry of Health and Sanitation, *Mental Health Strategic Plan 2019-2023*, on file with Amnesty International (hereinafter Ministry of Health and Sanitation, *Mental Health Strategic Plan 2019-2023*). See also Dawn Harris et al, “Mental Health in Sierra Leone”. The most current estimate found at the time of writing dates to 2018; it shows that health expenditure was 16% of the GDP. The World Bank, *Current health expenditure (% of GDP) - Sierra Leone*, bit.ly/3bRzrYF

¹⁴⁸ Phone interviews, January 2021. See also Jessica J Fitts et al, “Strengthening mental health services in Sierra Leone”.

¹⁴⁹ Phone interviews, January 2021. Interviewees said these motorbikes were provided during the Ebola crisis through the WHO, which covered fuel and other expenses at the time. In recent years, other international partners provided some support to cover maintenance and fuel, but that these programmes have come to end.

¹⁵⁰ Phone interview, 27 January 2021.

¹⁵¹ Phone interviews, November 2020 – January 2021.

¹⁵² Report of the Special Rapporteur on the right to health, 28 March 2017, para. 79.

¹⁵³ Phone interviews, November 2020 – February 2021. See also Dawn Harris et al, “Mental Health in Sierra Leone”; Jessica J Fitts et al, “Strengthening mental health services in Sierra Leone”.

¹⁵⁴ Phone interviews, January 2020.

¹⁵⁵ Phone interview, 12 January 2021.

¹⁵⁶ Phone interview, 13 January 2021. See also Abdul Rashid Thomas, “Investing in mental healthcare will impact socio-economic development – says president Bio”, *Sierra Leone Telegraph*, 4 June 2020, bit.ly/3s0k7m2 Sierra Leone Peoples' Party (SLPP), *New direction: People's manifesto*, bit.ly/3dKbvJ6

publication, the task force had not been constituted).¹⁵⁷ An official from the Ministry of Social Welfare said increased work on mental health and psychosocial wellbeing included having a psychosocial pillar as “a very integral part” of the national COVID-19 response structure, with improved co-operation between his ministry and the health ministry as well as collaboration with UN agencies, including UNICEF.¹⁵⁸ The government must capitalize on the global momentum prioritizing mental health in the context of the COVID-19 pandemic to shore up support for sustainable systems strengthening.

At present, the government needs to do more for its actions to meet its stated promises. “I think fundamentally the simplest way to measure government commitment is the degree to which they invest in an area,” said Dr Julian Eaton, a public health psychiatrist and Mental Health Director for CBM Global, which has been involved in strengthening mental health services in Sierra Leone.¹⁵⁹ He added that while it is understandable that the government’s resources are limited, “the way forward, I think, for countries that are dependent on international development resources for funding basic health and education is to get the government sufficiently committed to tell... international funders, ‘We want 5% of our international [health] funding to go to mental health’... Our voice is still not sufficiently strong in the room compared to HIV and maternal health and others who are very much closer to the senior decision-makers in health.”¹⁶⁰

5.3 ISSUES WITH SERVICE DELIVERY

According to the National Mental Health Strategic Plan, mental health services are meant to be included in the Free Health Care Initiative but “no policy document states this”.¹⁶¹ The mental health plan calls for a clear delineation of the package of mental health services that should be delivered cost-free.¹⁶² That is imperative, as evidenced by Amnesty International’s interviews: mental health professionals said a consultation is meant to be free-of-charge, but there were varying explanations as to why people sometimes do end up having to pay for services.¹⁶³

The limited formal mental health services that are available remain very centralized. Mental health nurses serve out of outpatient clinics, or Mental Health Units, placed in general hospitals (12 district hospitals and three general facilities in Freetown), rendering their support practically out of reach for people outside urban centres.¹⁶⁴ As previously mentioned, these nurses do not receive any formal transport support to be able to travel—across rugged roads and in some cases by boat—to access people who need care in the districts’ expansive administrative divisions. “And many [people] in the interior can’t move to come [to us] because the transportation [cost] is too high,” said one mental health professional.¹⁶⁵

¹⁵⁷ See State House Media and Communications Unit, “President Julius Maada Bio explains why massive investment in mental health matters in present-day Sierra Leone”, 4 June 2020, bit.ly/3aZSh0d

State House, *Statement by his excellency, Dr. Julius Maada Bio, President of the Republic of Sierra Leone on the occasion of the formal commissioning of the renovated Sierra Leone Psychiatric Teaching Hospital Complex, Freetown – 4 June 2020*, bit.ly/3er2cwJ

¹⁵⁸ Phone interview, 22 January 2021. For more on Sierra Leone’s National COVID-19 Preparedness Response Plan, the structure of the response and collaboration with international partners, see Kevin Grieco and Yasmina Yusuf, *COVID-19 series: Sierra Leone’s response to COVID-19*, Oxford Policy Management, May 2020, bit.ly/3emD5v2

¹⁵⁹ Phone interview, 23 November 2020.

¹⁶⁰ Phone interview, 23 November 2020. Dr Eaton is one of 28 international commissioners of *The Lancet* Commission on Global Mental Health and Sustainable Development, which published its landmark report in 2018 aimed at reframing the prioritization of mental health within the context of achieving the Sustainable Development Goals. The report acknowledges that countries of all income levels allocate a much lower proportion of their health budgets to mental health than is needed; it recommends that, in general, low- and middle-income countries should increase mental health allocations to at least 5% of their health budgets. Vikram Patel et al, “*The Lancet* Commission on mental health and sustainable development”, *The Lancet*, 9 October 2018, Vol. 392, Issue 10157, pp. 1553-1598, bit.ly/3cxEjTa (hereinafter Vikram Patel et al, “*The Lancet* Commission on global mental health and sustainable development”).

Experts interviewed for this report said the emphasis in Sierra Leone on certain programmes such as maternal health, for example, is understandable given that the country has one of the highest maternal mortality rates in the world. But they said that is why integration of mental health across all programmes and interventions is important. Phone interviews, November 2020 – February 2021.

¹⁶¹ Ministry of Health and Sanitation, *Mental Health Strategic Plan 2019-2023*.

¹⁶² It also acknowledges shortcomings in The Persons with Disability Act of 2011. While the act mentions the provision of free health care, the absence of any policy document defining who persons with disabilities are or the package of services they are entitled to has resulted in persons with mental health conditions not being covered by the act. Ministry of Health and Sanitation, *Mental Health Strategic Plan 2019-2023*.

¹⁶³ Phone interviews, January 2021. More broadly, the country’s National Health Sector Strategic Plan 2017-2021 acknowledges that according to reports from the subnational level, beneficiaries of the Free Health Care Initiative have ended up being charged, partially attributing that to “the high numbers of unsalaried staff that populate Sierra Leone’s health facilities”. Ministry of Health and Sanitation, *National Health Sector Strategic Plan 2017-2021*.

¹⁶⁴ Phone interviews, November 2020 – January 2021. See also Dawn Harris et al, “Mental Health in Sierra Leone”; Helen Hopwood et al, “The burden of mental disorder in Sierra Leone”. It is not clear how many of the 12 Mental Health Units in district hospitals are currently staffed. In-patient mental health care, which is not the focus of this report, is only available at the Sierra Leone Psychiatric Teaching Hospital in Freetown. The hospital also provides outpatient services.

¹⁶⁵ Phone interview, 12 January 2021.

Moreover, as previously indicated, the load is simply too large for a single mental health nurse to cover an entire district (as is the case in practically all Mental Health Units). Mental health nurses either have to cut back on the number of people they respond to or the quality of care ends up being affected by the workload, Amnesty International was told by mental health professionals and experts involved in or across the service delivery scene in Sierra Leone.¹⁶⁶ The current structure puts “a lot of pressure on very few individuals without really conceptualizing systems that are adequate or cognizant about the professional development support to those individuals, given the level of demand and given how few mental health professionals there are in the country... I haven’t seen a very robust, ongoing professional development investment for mental health workers in Sierra Leone nor are there well-articulated mechanisms for monitoring quality and preventing burnout and providing support for those few professionals,” said a mental health researcher and expert.¹⁶⁷

Integrating mental health services in primary health care—as per WHO recommendations—has been fraught with challenges, resulting in limited outcomes.¹⁶⁸ Experts pointed out that for such integration to work, it hinges on having functional basic services with functioning components such as a working referral system and appropriate physical infrastructure and human resources. “Where primary care itself is very, very fragile and weak... to add an additional layer of services is hard,” said Dr Julian Eaton who had been involved in systems strengthening in Sierra Leone.¹⁶⁹ A larger investment in building capacity in primary care is needed.¹⁷⁰ One approach to address this limitation is for the government to work with international partners and mental health experts to test and deliver evidence-based mental health interventions through existing community-based platforms, including front line primary health units as well as schools and programmes on nutrition and feeding; sexual, reproductive health and teen pregnancy prevention; livelihoods and employment; social protection; and poverty reduction. The subsequent chapter of this report expands on examples of the testing and implementation of low-cost, evidence-based mental health interventions in Sierra Leone through innovative delivery platforms that currently exist, such as schools and employment programmes.

Amnesty International’s interviews with civil society members and aid workers indicate that, currently, there is a rather limited number of mental health programmes run by local and international NGOs.¹⁷¹ There are almost none seeking to specifically address lingering trauma resulting from the war and the Ebola epidemic. As previously mentioned, including through survivors’ testimonies, the vast majority of trauma-related interventions in Sierra Leone occurred during the period of emergency response and did not translate into sustainable community-based service, underscoring the need for technical and financial investments in mental health systems strengthening. Such responses need to become part of government services to be effective long-term. NGOs “started implementing good programmes. They had all this counselling going on. Once the emergency was over, they’re gone. And there was no continuity. So, what is happening? People are relapsing,” said Dr Rebecca Esliker, psychologist and director of mental health programmes at the University of Makeni.¹⁷² Interviewees from local and international NGOs said funding has traditionally been harder to come by for longer-term mental health and psychosocial work.¹⁷³

¹⁶⁶ Phone interviews, January 2021.

¹⁶⁷ Phone interview, 17 January 2021.

¹⁶⁸ Phone interviews, November 2020 – January 2021. See also Dawn Harris et al, “Mental Health in Sierra Leone”; Jessica J Fitts et al, “Strengthening mental health services in Sierra Leone”. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health maintains that “The right to health requires that mental health care be brought closer to primary care and general medicine, integrating mental with physical health, professionally, politically and geographically.” This ensures accessibility of services for everyone, including persons with disabilities and others “who are traditionally isolated from mainstream health care”. Report of the Special Rapporteur on the right to health, 28 March 2017, para. 78.

¹⁶⁹ Phone interview, 23 November 2020. The challenges facing integrating mental health services into primary care, especially in countries facing constraints in resources, are widely recognized, including by the WHO. In a 2008 report detailing the justification and advantages of integration, the WHO and the World Organization of Family Doctors (a global NGO representing family physicians and general practitioners from around the world, also known as WONCA) present 12 examples of best practice from countries with varying economic and political contexts, including two classified as low-income. The report, which stresses that “numerous low- and middle-income countries have successfully made the transition,” maintains that there is no single best practice model that can be followed and that “successes have been achieved through sensible local application of broad principles.” WHO and the World Organization of Family Doctors, *Integrating mental health into primary care: A global perspective*, 2008, bit.ly/3gEnl9i

¹⁷⁰ Jessica J Fitts et al, “Strengthening mental health services in Sierra Leone”.

¹⁷¹ Among the examples of the few current programmes Amnesty International was told about by mental health professionals and local and international aid workers operating in the country is the work of PIH, which delivers services through the government health structure. In Kono district, for example, the organization initiated a community-based mental health programme, utilizing a network of community health workers and psychosocial counsellors it has trained and supported; one of their projects is focused on persons with mental health conditions who are homeless. Another example is that of Humanity & Inclusion, also known as Handicap International, working alongside its Sierra Leonean partner, the Community Association for Psychosocial Services (CAPS), to promote mental health awareness in communities in Freetown and its environs, particularly targeting informal settlements and rural communities and linking them to care. CBM Global is supporting the Mental Health Coalition and the University of Makeni in running a multi-year, anti-stigma programme in a number of districts, utilizing evidence-based approaches to support and empower persons with psychosocial disabilities to share their experience and challenge the social exclusion they often experience. Phone interviews, November 2020 – January 2021.

¹⁷² Phone interview, 2 November 2020.

¹⁷³ Phone interviews, November 2020 – February 2021. More on donor-related issues is in the subsequent chapter.

When crises subside, “services delivered within a single integrated, community-based system can, when necessary, be tailored to address the needs of different sub-populations” such as Ebola and war survivors.¹⁷⁴ However, as Amnesty International’s interviews and other research indicate, co-ordination across sectors and providers has not been optimal.¹⁷⁵ One mental health professional practicing in the country said this was another consequence of the lack of a fully-fledged national mental health programme.¹⁷⁶

Testimonies of survivors highlighted the need for comprehensive community-based interventions, and how their dearth has been a barrier for those who may want to access care. “We need that kind of support in our community and that kind of counselling services so that people who have [experienced] traumatic experiences and people who are going through all this kind of stress will be able to understand that life should go on, [that] there is a life and they need to live it,” said Amina, who is among the war survivors who expressed concerns about costs associated with visiting hospitals.¹⁷⁷ She added: “We want services in our community. If it’s in the community, it will help people.”¹⁷⁸

¹⁷⁴ IASC reference group on mental health and psychosocial support in emergency settings, *Mental health and psychosocial support in Ebola virus disease outbreaks: A guide for public health programme planners*, 2015, p.14, bit.ly/37QAbfz

See also WHO, *Mental Health Action Plan 2013-2020*.

¹⁷⁵ Phone interviews, November 2020 – February 2021. Abdulai Jawo et al, “A scoping study”; Theresa S. Betancourt, Nathan Hansen, Jordan Farrar, Ryan C. Borg, Tamora Callands, Alethea Desrosiers, Cara M. Antonaccio, Makeda J. Williams, Joseph Bangura, Robert T. Brennan, “Youth Functioning and Organizational Success for West African Regional Development (Youth FORWARD): Study protocol”, *Psychiatric Services*, 9 December 2020, bit.ly/3c1AjKH (hereinafter Theresa S. Betancourt et al, “Youth FORWARD: Study Protocol”); Helen Hopwood et al, “The burden of mental disorder in Sierra Leone”.

¹⁷⁶ Phone interview, 13 January 2021.

¹⁷⁷ Phone interview, 8 December 2020.

¹⁷⁸ Phone interview, 8 December 2020.

6. INVESTING IN MENTAL HEALTH

Despite growing attention to the importance of mental health and psychological wellbeing in recent years and calls for better integration of mental health and psychosocial programming in humanitarian response as well as in strengthening sustainable systems of mental health care in conflict-affected settings, “international development assistance for mental health has never exceeded 1% of all development assistance for health.”¹⁷⁹ This lack of prioritization not only undermines a fundamental human right, disregards the value of psychological wellbeing and excludes persons with psychosocial disabilities, it also overlooks the tangible socioeconomic impact—“for every \$1 invested in scaled-up treatment for depression and anxiety, there is a \$4 return in better health and productivity.”¹⁸⁰

In the context of Sierra Leone, humanitarian and development actors said there has been an extremely limited number of calls made by donors related specifically to mental health, meaning that oftentimes providers have to resort to securing funding for mental health and psychosocial work by inserting it under other projects.¹⁸¹ This despite evidence that investing in mental health and psychosocial support has positive impact and outcomes. Within the context of investing to improve formal health structures, for example, the training of the 21 mental health nurses by 2013 has shown the importance of having this groundwork done ahead of crises, as they went on to play a linchpin role in the provision of services during the Ebola crisis.¹⁸² “The argument for us has largely been around justifying investment in strengthening systems because... disaster risk-reduction and building resilience in systems in advance is a much better investment than trying to do it as part of a kind of heroic response process,” said Dr Julian Eaton, a public health psychiatrist and Mental Health Director for CBM Global, which oversaw the training of the first cohort of mental health nurses.¹⁸³

Outside the health system, applied research has shown the value of integrating evidence-based mental health interventions for war-affected youth into innovative delivery platforms such as schools and employment programmes, for example. Researchers behind the Youth Readiness Intervention—which was born out of a 15-year longitudinal study on the impact of the war on male and female children formerly associated with armed forces and armed groups—looked at the impact on young people who received the

¹⁷⁹ WHO, United for Global Mental Health, World Federation for Mental Health, *World Mental Health Day: an opportunity to kick-start a massive scale-up in investment in mental health*, 27 August 2020, bit.ly/3qYTrPw

See also *The Lancet Global Health*, “Mental health matters”, 1 November 2020, Vol. 8, Issue 11, bit.ly/3b0slln (hereinafter *The Lancet Global Health*, “Mental health matters”); Seth Mnookin, *Out of the shadows: making mental health a global development priority*, World Bank Group and WHO, 2016, p. 13, bit.ly/304BVxn (hereinafter Seth Mnookin, *Out of the shadows*).

¹⁸⁰ *The Lancet Global Health*, “Mental health matters”; WHO, “Investing in treatment for depression and anxiety leads to fourfold return”, 13 April 2016, bit.ly/2QZntWG

Dan Chisholm, Kim Sweeny, Peter Sheehan, Bruce Rasmussen, Filip Smit, Pim Cuijpers, Shekhar Saxena, “Scaling-up treatment of depression and anxiety: a global return on investment analysis”, *The Lancet Psychiatry*, 12 April 2016, Vol. 3, Issue 5, pp. 415-424, bit.ly/3xM6Qyl

For more on the economic impact and making the case for investing in mental health, see also Seth Mnookin, *Out of the shadows*.

¹⁸¹ Phone interviews, November 2020 – February 2021.

¹⁸² The training of the nurses was part of a programme that was initially funded by the European Union (EU), and then received another round of funding from the German Federal Ministry for Economic Cooperation and Development (BMZ). Phone interviews, November 2020.

¹⁸³ Phone interview, 23 November 2020. See also Brandon Gray, Julian Eaton, Jayakumar Christy, Joshua Duncan, Fahmy Hanna, Sekar Kasi, “A proactive approach: Examples of integrating disaster risk reduction and mental health and psychosocial support programming”, *International Journal of Disaster Risk Reduction*, 15 February 2021, Vol. 54, bit.ly/3ejqfie

intervention through educational programmes versus those who had not.¹⁸⁴ “Not only did we improve symptoms of emotion dysregulation [that is, the poor ability to manage emotional responses], we also observed improvements in daily functioning and interpersonal behaviours. We also saw that young people who got the intervention were six times more likely to persist in the school programme,” said the project lead, Dr Theresa Betancourt, Salem Professor in Global Practice at the Boston College School of Social Work and Director of the Research Program on Children and Adversity.¹⁸⁵ She added that teachers, who were not told who had received the intervention and who was in the control group, reflected in their reports that those in the former group were “better behaved, better prepared”.¹⁸⁶

Dr Betancourt and her colleagues are currently implementing a related, expanded study and intervention, integrated within existing livelihoods and youth employment programmes.¹⁸⁷ Centred around local ownership, this body of work is based on an understanding of the limitations of the health care infrastructure in Sierra Leone and, therefore, the need to—through other platforms—shift tasks to lay workers who are trained and supervised closely. It serves as an example of the feasibility of implementing culture-specific, trauma-informed interventions in low-resource settings. “Yes, we can’t go back and undo the war exposures, but we can do things about the post-conflict environment, about attachment relationships, about access to getting back into school, having schooling programmes that are attuned to the psychosocial needs, integrating mental health into schooling, into livelihoods programmes and dealing with community relations. Those are all areas where we can have impact, and those investments are not being made,” said Dr Betancourt.¹⁸⁸

A staff member from the WHO’s country office said it has been difficult to mobilize resources that reflect the same thinking around the need to build systems rather than just responding during crises.¹⁸⁹ Both this WHO staff member and a staff member from the World Bank’s country office acknowledged that mental health systems strengthening in Sierra Leone competes against other priorities and is not at the level where it should be.¹⁹⁰ This is also evident in the number of dedicated technical experts made available to support the country. The WHO no longer has a resident mental health expert in the country office as it did during the Ebola crisis and as it currently does in some other West African countries.¹⁹¹ Sierra Leonean and international mental health advocates and the WHO country office staff member said that having a resident mental health focal point in international agencies such as the WHO can be key to elevating the work and to help build technical capacity to design stronger implementation, financing and human resources plans to actualize the mental health policy.

While the government’s political will and interests are critical in determining what resources are allocated, international agencies and financing institutions do have the ability to influence areas of engagement when they make an issue a priority. A psychologist, who is also an international mental health and psychosocial support advisor, said it has been their experience in the more than 30 countries where they worked, including Sierra Leone, that “governments listen to the UN.”¹⁹² Noting that investment in mental health lags behind everywhere and not just in low-income countries, they added that UN agencies—in line with their stated commitments—should be more proactive in supporting and promoting mental health and psychosocial wellbeing. “It’s a little bit of an egg and chicken situation, you could end up not doing anything because ‘it’s not in the government’s [agenda] so it’s not in the UN’s agenda, and because it’s not in the UN agenda, it’s not in the government’s’ and you go around in circles,” they said.¹⁹³ They noted that growing requests globally for country-level technical assistance, after the UN prioritized mental health in their COVID-19 response plan, showed that “when the UN leads like that, countries respond.”¹⁹⁴

¹⁸⁴ The Youth Readiness Intervention combines “evidence-based common practice elements from cognitive-behavioral therapy (CBT) and group interpersonal therapy (IPT) to address cooccurring mental health symptoms and functional problems that may impede life success and functioning in war-affected youth.” Theresa S. Betancourt, Ryan McBain, Elizabeth A. Newnham, Adeyinka M. Akinsulure-Smith, Robert T. Brennan, John R. Weisz, Nathan B. Hansen, “A behavioral intervention for war-affected youth in Sierra Leone: A randomized controlled trial”, *Journal of the American Academy of Child & Adolescent Psychiatry*, December 2014, Vol. 53, No.12, pp. 1288-1297, [bit.ly/2O3Kt4Z](https://doi.org/10.1093/aacap/53.12.1288) (hereinafter Theresa S. Betancourt et al, “A behavioral intervention for war-affected youth in Sierra Leone”).

¹⁸⁵ Phone interview, 17 January 2021. See also Theresa S. Betancourt et al, “A behavioral intervention for war-affected youth in Sierra Leone”.

¹⁸⁶ Phone interview, 17 January 2021.

¹⁸⁷ Phone interview, 17 January 2021. Theresa S. Betancourt et al, “Youth FORWARD: Study Protocol”.

¹⁸⁸ Phone interview, 17 January 2021.

¹⁸⁹ Phone interview, 21 January 2021.

¹⁹⁰ Phone interviews, 21 and 28 January 2021.

¹⁹¹ Phone interviews, November 2020 – February 2021. A regional mental health expert said that other countries in the region where governments had prioritized mental health as an area of engagement (for example, Ghana) had more than one national and international WHO staff members stationed in country offices with a focus on mental health and non-communicable diseases. Phone interview, 27 January 2021.

¹⁹² Phone interview, 4 February 2021.

¹⁹³ Phone interview, 4 February 2021.

¹⁹⁴ Phone interview, 4 February 2021.

Another international expert, Dr Julian Eaton of CBM Global, said that beyond their technical and financial assistance obligations, donors should be more active advocates “as they have much higher-level conversations with the government about funding allocations”. He added that donor governments should be “mobilizing that political power outside of the context of the specific programme they fund by having a more strategic oversight, saying ‘mental health is something that we want to drive.’ There is so much that civil society can do... What we can't do is speak to the president and genuinely shift things at a very high political level. We're stuck at [a certain] level of advocacy.”¹⁹⁵

Furthermore, an aid worker who had been involved in the Ebola response programme in Sierra Leone said donors should commit to having continuity of services as a core part of the regular monitoring and evaluation they undertake after the completion of programmes, to ensure that beneficiaries are not abandoned. “I would say we need to revisit whatever has been implemented after two or three years to see what happened,” they said.¹⁹⁶ After projects are handed over to the government, donors “should do another survey and then we can re-engage the stakeholders on how to keep [work] going. But I would say little attention is given after” funding cycles conclude.¹⁹⁷

Mental health experts, professionals and advocates interviewed for this report said improving access to mental health and psychosocial services in Sierra Leone and similar contexts requires a longer-term political and financial commitment from donors.¹⁹⁸ This is particularly important to avoid a pattern that has been recreated time and again in conflicts and crises—short-term psychosocial responses that leave little behind in terms of sustainable systems of care, even as they are clearly still needed. Some of the mental health development projects in Sierra Leone which Amnesty International was told about had three- to five-year funding cycles. Those are relatively longer cycles compared to psychosocial interventions happening in humanitarian response contexts. Yet, mental health experts said strengthening national systems and building capacity is painstaking work that takes time to achieve sustainability and address the long-term needs of survivors.¹⁹⁹ While scaling-up services requires time and resources, research on mental health costing analysis shows that expanding basic, evidence-based interventions in and of itself does not necessarily come at a premium. For example, it has been estimated that a core package of mental health care interventions would cost around US\$3-US\$4 per capita a year in Sub-Saharan Africa.²⁰⁰

Long-term engagement also aligns with donors honouring their commitments towards the UN's Sustainable Development Goals.²⁰¹ In the words of *The Lancet* Commission on Global Mental Health and Sustainable Development, which brought together research on mental health from around the world to advocate for action: “Although ‘no health without mental health’ is an important aspiration, the era of ‘no sustainable development without mental health’ has begun.”²⁰²

¹⁹⁵ Phone interview, 23 November 2020.

¹⁹⁶ Phone interview, 19 January 2021.

¹⁹⁷ Phone interview, 19 January 2021.

¹⁹⁸ Phone interviews, November 2020 – February 2021.

¹⁹⁹ Phone interviews, November 2020 – February 2021. An expert on international development assistance said that in regard to financial commitments, while it may be unlikely to get funding institutions to sign on to cycles that are longer than five years upfront, one approach would be to frame mental health as a “programmatically area of engagement” with subsequent cycles of funding that would enable having a rolling investment over a longer period of time. Phone interview, 28 January 2021.

²⁰⁰ Carol Levin and Dan Chisholm, “Cost-effectiveness and affordability of interventions, policies, and platforms for the prevention and treatment of mental, neurological, and substance use disorders”, in *Mental, neurological, and substance use disorders: Disease control priorities*, Third Edition (Vol. 4), 14 March 2016, bit.ly/30HViwA

²⁰¹ The UN Sustainable Development Goals “recognize that ending poverty and other deprivations must go hand-in-hand with strategies that improve health and education, reduce inequality, and spur economic growth...” UN Department of Economic and Social Affairs, *The 17 goals*.

²⁰² The Commission, which presented a new framing of the global mental health agenda in light of the Sustainable Development Goals urged that “mental health services should be scaled up as an essential component of universal health coverage and should be fully integrated into the global response to other health priorities, including non-communicable diseases, maternal and child health, and HIV/AIDS.” Vikram Patel et al, “*The Lancet* Commission on global mental health and sustainable development”. The WHO launched a special initiative on mental health, which aims to raise funds “to ensure universal health coverage involving access to quality and affordable care for mental health conditions in 12 priority countries to 100 million more people”. See WHO, *Special initiative for mental health (2019-2023)*, 2 May 2019, bit.ly/3nOIOOC

7. CONCLUSION AND RECOMMENDATIONS

Years after the end of the Sierra Leonean civil war and the Ebola epidemic that hit the country, people who were exposed to traumatic events during that time continue to experience psychosocial difficulties—emotional distress, lingering physical effects and economic disadvantage compound their marginalization. Meanwhile, public mental health services are extremely limited and psychosocial programmes and interventions that were accessible through non-governmental organizations and international agencies during the emergency phase have all but come to an end. At the same time these interventions have not translated into sustainable systems of care for the many in need among survivors of traumatic experiences and the wider population. It is a pattern that repeats globally across multiple conflicts and crises.

More broadly, although mental health is emerging as a global health and human development imperative, it remains underfunded across the world. There is a growing understanding, however, that this needs to change. A state of good mental health and wellbeing is not a luxury. It is a fundamental human right. It also benefits the wider society as enjoying the right to good mental health is critical to people's ability to have functioning interactions in their community and perform daily activities such as going to school and work and raising a family.

The government of Sierra Leone has taken steps in recent years to lay the groundwork for improving mental health support and the delivery of services. However, much-needed legal reform to replace the colonial-era Lunacy Act is urgently required to align Sierra Leone's legal framework with its international human rights obligations. And while government policy documents underscore that mental health is a cross-cutting issue, much more needs to be done to translate these strategies into action. Given the strong connection between wellbeing and underlying determinants, multi-sectoral co-operation is required to conceptualize effective, low-cost, community-based interventions and develop innovative financing schemes. Attention must be paid to at-risk sub-populations—where underlying determinants abound—such as Ebola and war survivors and their families.

To ensure effective service delivery, the government needs to make a cabinet-wide commitment to expand the networks and platforms of mental health services and scale up a trained and supported workforce of professionals to deliver mental health services across the country. Given the known links between mental health, functioning and economic prosperity, the Maada Bio administration has an opportunity to strengthen its development agenda by integrating serious investments in mental health into its strategy to recover from a history of conflict and the ravages of the Ebola outbreak.

In return, donors must ensure that mental health is an integral component of all humanitarian and development aid and that beneficiaries they have once supported continue to receive needed support through serious investments in sustainable and high-quality mental health care. Donors need to be proactive advocates of ensuring that the government prioritizes mental health. The case for investing in mental health has been made by the UN and key global actors. Donor governments and agencies need to deliver on that in order to ensure that they are, as the WHO recommends, “building back better” in regions exposed to compounded adversity.

TO THE GOVERNMENT OF SIERRA LEONE

- Ensure that adequate technical assistance for mental health system strengthening is in place, including by requesting the WHO to scale up technical assistance resources to develop a targeted plan, with attention to financing and a human resources strategy, in coordination with UN agencies such as UNICEF and UNFPA and development actors such as the World Bank, the US Agency for International Development (USAID) and the UK's Foreign, Commonwealth and Development Office (FCDO);
- Work with development actors to secure the resources and technical assistance to test and evaluate innovative approaches for the delivery of community-based mental health services using existing platforms that currently have reach in Sierra Leone such as co-locating evidence-based mental health interventions in primary health units, sexual and reproductive health and teen pregnancy programmes, services related to women's health and antenatal care, nutrition and feeding programmes, schools, employment and livelihoods initiatives and poverty reduction programmes;
- Require specific allocations for mental health services (a minimum of 5%) from donors contributing to health and other development programmes and mainstream mental health into all development and humanitarian assistance;
- Enhance the role of the National Mental Health Co-ordinator in the Ministry of Health and Sanitation with separate budget lines and scaled-up staffing to ensure that attention goes beyond the Sierra Leone Psychiatric Teaching Hospital to the development and expansion of community-based mental health services and initiatives to integrate mental health into existing delivery platforms;
- Integrate and mainstream mental health concepts across the work of all the government's sectors, rather than limiting it to the health sector, to ensure that underlying social, economic and environmental determinants of health are factored, including through cross-sectoral strategies that address alleviating social inequalities;
- Increase public awareness about mental health and re-double efforts to alleviate stigma and discrimination—including within government departments and public services—towards persons with psychosocial disabilities by scaling up media campaigns and direct community engagement, and by ensuring the co-operation of all government ministries in cascading this through their various structures;
- Expand the cadre of trained mental health nurses. Improve support to existing mental health nurses by ensuring that they have acceptable working conditions, including appropriate office space and means of transport or relevant costs. Ensure that they have adequate clinical supervision and ongoing professional development and support systems to minimize burnout;
- Improve the integration of mental health care into primary health care services by ensuring that training efforts are more systematic and that they are followed by supervision, monitoring and evaluation efforts to guarantee the quality of services and that referral pathways to specialists are working;
- Scale up mental health training for and supervision of community health workers and strongly consider providing them with financial incentives, including mobile phone top-up and transport allowances. In the meantime, consider delivering support and filling gaps through already-trained health and social workers via mobile teams to underserved areas;
- Support and empower peer networks given survivors' reliance on them and their role in promoting psychosocial wellbeing. Develop and test the effectiveness of peer-to-peer models of mental health intervention with adequate attention to supervision and ensuring links to mental health professionals to handle situations such as suicidality, child abuse, family violence and intimate partner violence;
- Support efforts to establish national mental health and psychosocial curricula across different educational programmes. Increase awareness campaigns aimed at destigmatizing mental health professionals and undertake steps to ensure that the profession is attractive, including by improving career development pathways for current mental health professionals;
- Continue engagement with traditional and faith healers and standardize engagement with community leaders and traditional structures to spread awareness about mental health and referral pathways and to help alleviate stigma and discrimination against persons with psychosocial disabilities;
- Expedite efforts to pass new mental health legislation, taking note of comparative best practice, to replace the discriminatory "Lunacy Act", and fulfil promises to have an inclusive and participatory

consultative process with stakeholders, including persons with psychosocial disabilities and civil society organizations. Ensure that the new law complies with regional and international human rights law and standards;

- Improve dialogue with survivors of the Ebola virus and their families and survivors of war-related events and their families as well as their representative organizations to have an up-to-date assessment of their needs and address shortcomings in their access to health care services, social safety net programmes and livelihood support networks;
- Ensure the placement of trauma-informed, evidence-based interventions in communities with a high concentration of survivors of the Ebola virus and war-related incidents;
- Establish a National Development Fund for Persons with Disability as per The Persons with Disability Act of 2011. Ensure that the National Disability Commission receives political and financial support to fulfil the rights of persons with disabilities, including the provision of assistive devices and means to ensure equal access to health care services;
- Ensure that psychosocial disability is considered throughout the application of The Persons with Disability Act and the work and provisions of the National Development Fund for Persons with Disability, after the fund is established;
- Ratify the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Optional Protocol to the Convention on the Rights of Persons with Disabilities.

TO INTERNATIONAL DONORS, INCLUDING THE UNITED STATES, UNITED KINGDOM, EUROPEAN UNION MEMBER STATES, THE WORLD BANK, AND THE AFRICAN DEVELOPMENT BANK

- Increase financial and technical assistance to the government of Sierra Leone to support the improvement of the availability and quality of mental health services given the complex history of trauma in the country;
- Support national capacity building through funding and twinning technical experts in health systems strengthening to provide accompaniment to Sierra Leonean officials, and help guide the government in crafting financing schemes and a human resources strategy needed to address the large gaps in access to mental health services;
- Expand support for awareness-raising campaigns aimed at combatting stigma around mental health and discrimination against persons with psychosocial disabilities;
- Increase funding for research aimed at testing methods to expand and sustain quality in innovative mental health delivery approaches in Sierra Leone. Opportunities exist in Sierra Leone to study barriers and facilitators to integrating evidence-based mental health services into primary care, school settings, employment and livelihoods programmes, social protection programmes and sexual and reproductive health programmes (including programmes targeting teen pregnancy prevention);
- Ensure that mental health care is mainstreamed across all humanitarian and development support within the health sector and beyond, in line with the targets of the Sustainable Development Goals and calls for including mental health as an essential component of universal health coverage. Include human rights compliant benchmarks, indicators and reporting obligations regarding progress as well as an explicit plan for transitioning emergency responses into sustainable social services and mental health system strengthening;
- Provide technical and financial support to efforts aimed at the training of the mental health workforce, including mental health nurses, psychiatrists, psychologists, clinical social workers and community health workers. Provide support, too, to the development of curricula and the creation of mental health, psychological and social care educational programmes as part of a larger human resources strategy for mental health;
- Ensure that mental health and psychosocial services provided through humanitarian programming are transitioned to sustainable systems of care by committing to advocate for and fund longer-term mental health reform so that they are of a duration that adequately addresses needs;
- Ensure the presence of ongoing independent monitoring and evaluation after the completion of programmes and interventions including through creating community advisory boards as a means of keeping track of implementation and ensuring that beneficiaries' access to services is ongoing, and to evaluate sustainability and re-engage stakeholders if need be;

- Provide technical and financial assistance to the government of Sierra Leone to undertake a comprehensive mental health needs assessment—including a well-designed epidemiological survey examining the mental health of adults, children and youth—to help gather quality, disaggregated data that would inform policy implementation and service delivery improvements;
- Advocate for and support trauma-informed, evidence-based mental health interventions for survivors of the Ebola virus and their families and survivors of war-related events and their families as part of initiatives to strengthen and sustain high quality mental health services in Sierra Leone;
- Work with relevant Sierra Leonean authorities to ensure that social safety net programmes are adequately catering to and fulfilling the rights of survivors of the Ebola virus and their families and survivors of war-related events and their families;
- Provide technical and financial assistance for the provision and maintenance of assistive devices and prostheses to enable persons with disabilities to live a full and equal life.

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“THEY ARE FORGETTING ABOUT US”

THE LONG-TERM MENTAL HEALTH IMPACT OF WAR AND EBOLA IN SIERRA LEONE

People in Sierra Leone have experienced multiple traumatic exposures in recent decades, including most significantly the 1991-2002 civil war and the 2014-2016 Ebola epidemic. Natural disasters, difficult socioeconomic conditions and more recently the COVID-19 pandemic have caused further challenges. The mental health impact of these exposures is long-lasting, yet the country’s mental health services remain extremely limited.

Based on 55 interviews, Amnesty International examined the long-term mental health impact of the war and Ebola on people who have experienced related trauma as well as the barriers facing them, together with the wider population, in accessing quality mental health and psychosocial support. Among these barriers are the shortage of skilled mental health professionals, the lack of community-based care and insufficient government and donor spending.

Despite budgetary constraints, the government of Sierra Leone must prioritize mental health; it is a fundamental human right and public good. The government must seek technical and financial assistance to strengthen its mental health system. It must expedite efforts to pass new mental health legislation to replace the “Lunacy Act” of 1902. Donors should increase their advocacy with the government to give mental health the support it deserves, provide needed technical and financial assistance and ensure that mental health is mainstreamed across their programming.