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HEALTH

In West Africa, a Mission to Save Minds

By BENEDICT CAREY OCT. 11, 2015

SANDEMA, Ghana — For more than a year, Rebecca Ajadogbil had been living alone in her head, convinced that strange men were coming to capture and murder her.

Confined to a room in her family's mud-walled compound here, not far from the border with Burkina Faso, she was hundreds of miles from the nearest psychiatric ward. Those closest to her suspected that she was possessed and called in local healers, who plied her with herbal brews and chanted incantations over her.

But in a stroke of fortune that is vanishingly rare in rural West Africa, a local nonprofit heard about her and sent a nurse on a motorbike who, with the family's permission, started Ms. Ajadogbil on a generic drug that treats schizophrenia. She began feeling strangely different.

"I was not so afraid anymore," said Ms. Ajadogbil (pronounced Ah-jah-do-BIL), who was soon well enough to enroll in a skills course in sewing.

A growing number of innovative groups have begun experimenting with a similar approach in Africa and Asia: providing therapy without clinics or doctors, relying instead on mobile nurses, cheap generic drugs and community support systems. In impoverished parts of the world where psychiatry is virtually nonexistent, they say, it is the only way to begin reaching the millions of people in need.

Community-Based Rehabilitation, the nonprofit that helps care for Ms. Ajadogbil. “The trained nurses we use can do everything: diagnose, prescribe, even provide some talk therapies.”

Global health officials have long focused on deadly infectious diseases like malaria and H.I.V. But last month, the United Nations made its first commitment to “promote mental health and well-being,” pledging to slash rates of premature death from mental disorders by a third by 2030. This is part of a fledging effort to address problems “that had been virtually forgotten for many years,” said Dr. Vikram Patel, a psychiatrist, professor of international mental health and co-founder of a community-based mental health center, Sangath, in Goa State, India.

Since 2007, when a landmark series in the medical journal The Lancet helped put the issue on the map, public health researchers at Harvard have projected that the overall cost burden of mental disorders will soon outstrip that of all other categories of noncommunicable illnesses, including heart disease and cancer. By one analysis, which includes Western countries and developing regions like West Africa, depression, drug abuse and schizophrenia are on track to be the three leading causes of lost economic output by 2030.

International aid agencies have taken note and are funding a handful of rigorous trials of low-cost programs to treat severe, chronic mental disorders. The jury is still mostly out. “There’s incredibly little research on interventions for the severe illnesses and this belief that the development of community services will take care of everything,” said Dr. Alex Cohen, the course director of the global mental health program at the London School of Hygiene & Tropical Medicine.

Researchers hope the community-based supports that have been effective in reducing disability from blindness and other physical afflictions will also help people with mental illnesses.

Several studies have produced encouraging results by deploying health workers who are not doctors to treat people who have had trauma and depression. Among the successes have been group therapy for rape victims in the Democratic Republic of Congo, family and individual counseling for survivors of

“We can make such a great difference for these families precisely because the need is so great,” said Dr. Oye Gureje, a professor of psychiatry at the University of Ibadan in Nigeria.

But without reliable support, follow-up and medical supplies — particularly psychiatric drugs when needed — interventions can quickly lose traction, no matter how well trained and devoted the workers are.

The War Memorial Hospital in Navrongo, Ghana, for example, has had no stock of schizophrenia drugs since the beginning of the year, and the number of follow-up visits from patients dropped by half in the first quarter of 2015 from the same period in 2014.

“If we don’t have the medications, they stop coming,” said Frederick Adiak, a registered psychiatric nurse there. “They quickly lose faith in medical treatment entirely.”

Upended Ambitions

She wanted to be a teacher.

Her grades were good; her English was excellent; she was from a large, established family with property and animals. At 17, Ms. Ajadogbil could see a clear path from completing high school, through teacher training, to a salary, a class of her own and some independence.

The vision that displaced that aspiration came unannounced one afternoon in school 12 years ago. One moment, she was dozing off during a rest period; the next, she felt the presence of strange men coming after her. She screamed at them to stop. “My shouting didn’t stop the men; they kept coming for me,” she said. “So, what did I do? I ripped off my school uniform and ran.”

She awoke in a clinic hours later, deeply confused. The medical staff had little training in how to handle a psychotic break: the hallucinations and delusions characteristic of schizophrenia. They sent her home, where the sensation of being hunted seeped back into her thoughts.

"I had to leave school, and I couldn't go back," Ms. Ajadogbil said.

At home, she ignored everyone around her — parents, siblings, grandparents, uncles and aunts — and became more paranoid. "I got a friend's Bible and started praying so hard," she said. "I thought there were people out to kill me, and I knew no one could kill God."

Sometimes, she ran out onto the open savanna to escape the demons pursuing her. Family members exhausted traditional methods of healing. Precious animals were sacrificed to drive away the spirits disturbing her. Healers administered herbal powders, and one applied a pale dye to her face and body in an effort to purge demons.

The elders decided not to take any more chances with her wandering. For families with a psychotic relative, the choice is between always being on guard and confinement. The family decided she would be constrained with a wooden shackle — a heavy log with a hole bored through it and fitted over her ankle.

Months passed, then a year. Mental illness is a source of shame here, as in most of the world, and families do not advertise its presence. Yet each community has a chief or subchief responsible for keeping an eye out for the sick. When the Ajadogbil family's subchief learned of their predicament in 2004, he called Michael Akankpienkum, a field officer for Presbyterian Community-Based Rehabilitation.

"I got the call about Rebecca and rode out there immediately," Mr. Akankpienkum said.

He explained to the elders that he could get Ms. Ajadogbil medical care. "Anything that will help," her father said.

"I found her in the room there, painted with this herbal dye, tethered to a log," Mr. Akankpienkum recalled. "She was sitting on the floor. I came in and said, 'What is this?' "

"This is how they protect me," she answered.

"I said: 'All right, I'm going to bring you a doctor right now. Is that O.K.?' "

Ms. Ajadogbil assented. That day, a mental health nurse administered an injection containing a strong sedative and haloperidol, a drug that blunts psychosis.

"By the time we arrive, the families are usually exhausted," said Alhassan Ayanu Seinu, who is one of three mental health nurses working with Presbyterian Community-Based Rehabilitation and manages Ms. Ajadogbil's case. "They are ready to try anything, and it's usually the first opportunity they have to try modern therapies."

Ms. Ajadogbil soon fell into a long, deep sleep.

Presbyterian's strategy includes a number of elements that are now subjects of intense study around the world. Each has helped reduce disability in people with physical impediments, like river blindness.

One is known as task sharing. The program's "doctors" are in fact nurses with mental health training, aided by field workers with some basic training and good village contacts.

The second is community self-help. Mr. Akandem and his staff oversee 23 patient groups, with more than 1,000 members total, who meet regularly to advise one another and to pressure the government for the drugs or services they need.

The third is raising awareness; the organization hosts a popular radio program featuring people who have recovered from mental disorders, who talk about their experiences and what was most helpful. Finally, there is job training, in skills like sewing, animal husbandry, farming and carpentry.

A Work in Progress

The evidence that a combination of these services can lead to lasting improvement for people with severe mental illnesses is thin, but a foundation is being laid. In a 2014 study in The Lancet, psychiatric researchers in India followed 253 patients assigned to receive standard clinical care or standard care plus community supports, like regular home visits from lay health care workers

The researchers tracked the patients' symptoms and quality of life over 12 months. Both groups improved on measures of symptom severity over the course of the year. But those who received the community-based component — particularly in the most rural site, Tamil Nadu — did slightly better than the others. They were more likely to show sustained relief of symptoms like suspiciousness, withdrawal and delusions; to become more social and engaged at home; and to be working.

The role of community is particularly important for mental health interventions in remote areas. A village can effectively expel a program that offends its traditional conceptions of mental problems, just as it can expel a disruptive person with mental illness, experts say. But that same self-protective instinct can work to support new approaches if the community buys in.

A new study, funded by the Wellcome Trust, is testing this approach for people with schizophrenia in Ethiopia, delivering the entire package of interventions. "The key thing is that it's not simply home-based care for people with schizophrenia," Laura Asher, who is running the study, said by email. "It also involves awareness raising and community mobilization."

Access to medication is essential, and psychiatric drugs are cheap by Western standards in places like Ethiopia: generally no more than $1 for a monthly supply of generic antipsychotic pills. But that almost always comes out of pocket, and many people cannot afford it, Dr. Asher said. Part of mobilizing the community, she said, is setting up informal arrangements in villages in which people with means contribute to help those who cannot afford care.

Drug supply is perhaps the largest obstacle to success. In Ghana, there are shortages almost every year, in part because of delays in the government contracting process, said Humphrey Kofie, the executive secretary of the Mental Health Society of Ghana, the country's leading patient advocacy group. This drives up prices and feeds a black market for donated or subsidized drugs. Families, discouraged, fall back on traditional healers, Mr. Kofie and others said.

Still, the cost of these programs is minute compared with the cost of standard psychiatry. BasicNeeds Ghana, a mental health care program based in

costs $200 to $700 for a single appointment with a psychiatrist.

The Robert Wood Johnson Foundation has provided $280,000 through the Charities Aid Foundation of America for a trial of BasicNeeds's model in underserved areas of the United States. "It's part of a growing recognition that programs that are really effective in low-income countries, we can learn from them," said Deborah Bae, a senior program officer at the foundation.

In global cost-benefit terms, economists typically rate health care programs by the amount of disability they reduce per dollar. Historically, mental health interventions have scored poorly compared with efforts that save young lives, like neonatal care or treatment of diarrhea. A new analysis of mental health strategies in Ethiopia, for instance, found that treating schizophrenia with generic medications was about as cost-effective as treating heart disease with a combination of drugs, like aspirin and a statin — and much less cost-effective than treating depression or epilepsy. The findings, though preliminary, suggest that treating psychosis is relatively costly.

Yet there are two caveats in such calculations, experts said. One is that they are based on estimates that include the possibility of hospitalization, which is expensive. The other is that the studies do not take into account the effect of chronic psychosis on a family. "The person with psychosis becomes a full-time job for someone else in the family, and depending on how aggressive the person is, maybe more than one person," said Dr. Simliwa Kolou Valentin Dassa, a psychiatrist in neighboring Togo.

And if the disorder is seen as a result of a curse on the family, carried down through generations — a common interpretation — the entire clan comes under suspicion.

"In the end, it's a human rights issue," Mr. Kofie said. "You get people treatment because it's the right thing to do."

The first thing Ms. Ajadogbil noticed after the sedative wore off was a sense of lightness. The nurse had told her this could happen. The injection contained a drug meant to disperse the threatening delusions brought on by her

was sore but free. The dye she had worn on her face and chest for so long — that was gone, too.

"She came back to us," her father said.

New Vistas

Ms. Ajadogbil's treatment regimen, a daily dose of haloperidol, has not been without problems. She has good days and bad ones, and needs to take another medication to control the stiffness that haloperidol causes. She also has to scramble to make sure she does not run out of medication.

"I got a call from her just last week, late, because she was nearly out and needed a prescription," Mr. Ayanu Seinu said in an interview in April. "She was very anxious."

Yet her world, so small for so long, has expanded. She learned sewing skills during treatment. That allowed her to help her mother at home, and later, she found the confidence to work for pay in a nearby village. She recently married.

And she has studied the Bible deeply enough to begin believing she will be qualified to offer religious instruction to young children. She has been investigating what kinds of classes are offered locally, and what is required.

She is planning to be a teacher.

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