Full Length Research Paper

An assessment of mental health services in two African countries: South Africa and Nigeria

*Charlize Tutu, Pistorius Nelson and Mbeki Noah

School of Nursing and Public Health, University of South Africa, Pretoria, South Africa.

Mental health services in South Africa and Nigeria were compared using the reports of World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) of both countries. WHO-AIMS assessment reveals the extent of implementation and provision of mental health care services. South Africa has made considerable progress with restructuring its mental health care system that provides mental health care at the community level. Nigeria, in spite of adopting mental health care as part of its primary health care services and having a strong academic history in psychiatry, does not provide services in rural communities. It is important for Nigeria that mental health care nurses become advocates for mental health policy reforms to improve access, and that countries with similar challenges learn from each other about providing care for people who cannot care for themselves, namely, the mentally challenged.

Key words: Advocacy, integrated care, mental health policy, mental health services, primary health care.

INTRODUCTION

The World Health Organization (WHO) endorsed mental health as a universal human right and a fundamental goal for health care systems of all countries (WHO, 2005). The principles of primary health care at the Alma-Ata Declaration were about social justice and the right to better health for all, reaffirming the WHO's holistic approach to attaining good health and the importance of primary care. WHO World Health Report 2008 argues that a renewal and reinvigoration of primary care is important now, more than ever, as mental health problems constitute 14% of the global burden of disease being one of the leading causes of disability world-wide (World Health Organization, 2008). Integrating mental health services into primary care is the most viable way of closing the treatment gap for people with mental health problems and ensuring that they get the mental health care they need (World Organization and Association of Family Doctors [WONCA], 2008). It will also reduce discrimination of the mentally ill and increase their right to access treatment and care within their own community in the least restrictive environment, with the least restrictive

treatment (World Health Organization, 2009).

Equitable access to mental health care and the protection of rights is a central objective of many health care systems in developed and developing countries (Jacob et al., 2007). Mental health systems are generally a subsystem of the health care system, and how these services are organized, delivered and financed is significantly influenced by the way in which the overall health services system are run (Olson, 2006). The primary objective of a mental health system is to ensure that its organizations, institutions, and resources improve service provision and, thus, the mental health of the population. The WHO conceptualizes optimal actions for improved service provision as establishing national policies, programs, and legislation on mental health, providing services for mental disorders in primary care, ensuring accessibility to essential psychotropic medication, developing human resources, promoting public education and involving other sectors and promoting and supporting relevant research (WHO-AIMS, 2005).

However, mental health systems in low- and middle-income sub-Saharan African countries face challenges in ensuring optimal mental health care services (Saraceno et al., 2007). Most low-income countries do not have mental health legislation or policies to direct relevant

---

*Corresponding author. E-mail: charlize_tutu@ymail.com

programs, lack appropriately trained mental health personnel, and are constrained by the prevailing public-health priority agenda and its effect on funding. Other challenges include the complexity of and resistance to decentralization of mental health services; scarce mental health resources and a mental health budget of less than 1% of the total health budget, stigma and discrimination (Patel et al., 2007), and the frequent scarcity of public-health perspectives in mental health leadership. It is possible that these challenges have contributed to the treatment gap of mental disorders in these countries (WHO World Mental Health Survey Consortium, 2004). The importance of scaling up mental health services is essential for community well-being, this being essential to increase the impact of mental health-service interventions on a larger population (WHO, 2008).

Comparative studies show the varying health care philosophies and the differences in service provision among countries (Olson, 2006). The costs of providing health service are often cited as a reason for its poor provision. The mental health services in South Africa and Nigeria were chosen for comparison as South Africa is a middle income (MI) and Nigeria is a low middle income (LMI) country; both being rated as developing countries which have adopted primary health care as the model of care. Therefore, the aim of the study was to compare the status of mental health service provision of South Africa and Nigeria.

METHODOLOGY

A comparative analysis was done of the reports of the World Health Organization Assessment Instrument for Mental Health Systems conducted in South Africa (WHO-AIMS Report on Mental Health System in South Africa, WHO and Department of Psychiatry and Mental Health, 2007) and Nigeria (WHO-AIMS Report on Mental Health System in Nigeria, WHO and Ministry of Health, 2006). WHO-AIMS is a comprehensive assessment tool for mental health systems designed for middle- and low-income countries and consists of six domains: policy and legislative framework; mental health services; mental health in primary care; human resources; public information and links with other sectors; monitoring and research. All six domains were analyzed in both reports and provided essential information for a comparison of mental health policy and service delivery between the two countries. Other sources of South Africa information utilized for the comparison include Mental Health Policy Development and Implementation in South Africa: A Situation Analysis, Phase 1 Country Report (Lund et al., 2008); KwaZulu-Natal (KZN) Treatment Protocols for Mental Disorders; the Department of Health's (1997) Standard Treatment Guidelines and Essential Drug List; Mental Health Care Act (MHCA) No. 17 of 2002. Additional sources for Nigeria were the Essential Drug List, National Health Insurance Scheme (NHIS), Human Resources for Health Country Profile and Primary Health Care Policy documents of both countries.

RESULTS AND DISCUSSION

The six domains of the WHO-AIMS are discussed with respect to how they are provided for in Nigeria and South Africa: policy and legislative framework; mental health services; mental health in primary care; human resources; public information and links with other sectors; and monitoring and research.

Policy and legislative framework

This domain describes the type of mental health policies, programs and legislation in both countries. While South Africa has no official mental health policy, its MHCA 2002, drives its mental health services and programs. The legislation made mental health a major public health issue and identified steps needed to address relevant services and improved quality of care. The Act is grounded in the principles of respect for human rights, and the promotion and protection of those rights (WHO, 2010). Nigeria currently has a draft Mental Health Bill at the National Assembly, which is yet to be passed into law. Mental health was adopted into the nation's Primary Health Care (PHC) in 1991, which in effect became its mental health policy (Federal Ministry of Health [FMOH], 1991). Since its adoption, the policy has not been fully implemented and unrevised (WHO-AIMS, 2006). The draft Mental Health Legislation Bill, when passed, is expected to protect the rights of persons with mental disorders, ensure access to treatment and care, discourage stigma and discrimination and set standards for psychiatric practice in Nigeria.

The South African MHCA 2002 underpins a stronger human rights approach to mental health care service than previous legislation. The Act ensures that hospitalizing persons involuntarily due to harm of self and others does not take away their right. It requires certifying such persons within a 72-h assessment period, allowing a period where they can potentially be stabilized and be cared for in the community. Certification was usually done by psychiatrists and doctors, but the new Act recognizes that there are few psychiatrists, particularly in rural areas, and it enables mental health care practitioners to make such decisions (MHCA, 2002). A mental health care practitioner includes psychiatrists, psychologists, doctors, nurses, or social workers who trained in mental health. Once certified, patients are admitted to a hospital to be seen by qualified personnel. The intentions of the South African MHCA 2002 were to protect and destigmatise the mentally ill, for example, persons with mental disorders are regarded as 'mental health services users', since anyone could be predisposed as a user of mental health care services. The review and appeal process protects the rights of service users, giving them a right to representation, and the right to appeal against decisions made by mental health care practitioners concerning their care.

In Nigeria however, certification of the mentally ill is done only by psychiatrists thereby limiting the possibility

of those needing care receiving it due to the shortage of people in this profession. There are no monitoring activities for mental health services; these facilities do not have reviews or inspection of human rights protection of patients (WHO-AIMS, 2006). Most admissions are involuntary, so human rights abuse may be present as legal provisions for patients' protection from unjust discrimination are not explicit (Gureje and Alem, 2000).

Mental health services

This domain deals with how mental health services are organized and delivered at various levels of care either for promotion, prevention or treatment of mental disorders, as well as for the rehabilitation of persons with mental illnesses.

Mental health service implementation in South Africa takes place through national, provincial and district structures. A national mental health authority- the National Directorate, Mental Health and Substance Abuse- provides advice to government on mental health policies and legislation (WHO-AIMS, 2007). The Directorate comprises a director, three deputy directors, assistant directors and administrative staff. The Directorate provides policy direction to the provincial mental health authorities, who are involved in service planning, management, coordination and monitoring, and quality assessment of mental health care (Lund et al., 2008). In Nigeria however, no posts have been created in the Ministries of Health at state or national levels for mental health, and these services are often supervised by officials with other primary duties (WHO-AIMS, 2006).

Nigeria's mental health facilities consist of eight federally funded psychiatric hospitals and six state-owned mental hospitals financed and managed by various state governments, for a population of over 150 million people. Given the limited number of these hospitals, their catchment's areas often go beyond their immediate location in terms of city or even state. None of the facilities have beds for children and adolescents. There is only one private community residential facility available with 10 beds in Lagos State and it is administered by a religious organization for rehabilitation of persons with drug problems (WHO-AIMS, 2006). South Africa has 3,460 outpatient mental health facilities; 1.4% of those are for children and adolescents. These facilities serve 1,660 persons per 100,000 of the general population in a year. There are 80-day treatment facilities and 41 psychiatric inpatient units in general hospitals with a total of 2.8 beds per 100,000 population; 3.8% of these beds are reserved for children and adolescents. Sixty-three community residential facilities provide a total of 3.6 beds per 100,000 population; 23 mental hospitals provide a total of 18 beds per 100,000 population. Children and adolescents have 1% of beds reserved for their care in mental institutions across South Africa (WHO-AIMS, 2007;

Lund et al., 2008).

The lack of appropriate legislation in Nigeria has resulted in their mental health services remaining inequitable, which violates the principles of the primary health care system and essentially provides a vertical rather than an integrated service. Information about the level of mental health service in Nigeria is limited and it is therefore difficult to identify areas of need, to make informed decisions about policy direction, and to monitor progress. A consequence of this information gap is the continued neglect of mental health issues and the many unmet need for service that exists for mental health problems in the community (WHO-AIMS, 2006). In South Africa, the need to integrate mental health care into general health care has received particularly strong support. However, the extent to which this model has been implemented and its impact has not been assessed, but there are examples of good practice such as in the Moorreesburg and Ehlanzeni Districts (WONCA, 2008). The use of general health workers, usually with substantial support from mental health specialists in supportive roles at community clinics, has reduced the gap in mental health service access from which important lessons can be derived for Nigeria.

Mental health in primary care

This domain describes the organization of mental health care services at primary care levels within communities.

After the first democratic elections of 1994, South Africa embarked on a major initiative to align the country's mental health services with international trends, such as integrating mental health into primary care centers and deinstitutionalizing care (WONCA, 2008). Promulgation of the Mental Health Care Act No.17 of 2002 made primary mental health care accessible at district hospital levels and primary health care centers in the community, thereby enhancing the accessibility of mental health services (WHO-AIMS, 2007; Burns, 2008). In South Africa, general physicians (GPs) play active roles in offering primary mental health care services such as outpatient care, screening, follow-up and referral. Secondary levels of mental health care are located in regional hospitals, and tertiary level institutions provide specialized services at designated psychiatric hospitals (Burns, 2008; Mkize et al., 2004).

At the 1978 Alma-Ata conference, provision of essential medicines was identified as one of eight key components of primary health care. Among the first new health strategies in South Africa was the 1996 national drug policy, which was committed to the use of an essential medicines list including supply, distribution, education, training, information, informed decision-making and appropriate human resource development. The National Department of Health prepared and developed the Standard Treatment Guidelines and Essential Drug List which ensures that every citizen has

access to good-quality, affordable health care, including access to medicines that are safe, efficacious and an acceptable quality in the most cost-effective manner. Similarly, the Nigerian mental health policy of 1991 formulated strategies for the promotion, prevention, management, treatment and rehabilitation of mental and neurological disorders through the provision of an essential drug list (WHO-AIMS, 2006). Nigeria also uses the essential drug list and views it as a strategy to support local governments to strengthen the provision of primary health care, but the drugs are usually not available due to an absence of primary mental health care (Revised National Health Policy, 2004; WHO-AIMS, 2006).

To ensure that treatment provision is standardized, South Africa currently uses treatment protocols for mental disorders in response to the need to promote mental health of persons with mental disorders, as well as a practical guide for primary care providers to be able to manage common psychiatric disorders across district and community levels (Burn et al., 2007; WHO-AIMS, 2007). The treatment protocols are in line with the Standard Treatment Guidelines and Essential Drug List. These medicines include antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs, and are all made available in mental hospitals at district- and community-level health facilities. Provincial governments ensure the availability of these psychotropic medicines, as sufficient funds are allocated to purchase basic essential psychotropic drugs and are distributed amongst the different levels of care.

The South African treatment protocols assist non-psychiatrist clinicians such as medical officers and psychiatric nurses who are involved with day-to-day care and management of mental health care users in outreach clinics and health centers in the community (Burns et al., 2007). The use of treatment protocols is in line with the WHO recommendation that where there is a policy of community mental health care and its integration into general health services, essential drugs must be made available at these levels of care and mental health workers are authorized to administer the drugs (WHO, 2009). In South Africa, nurses in primary health care centers are allowed to use these protocols and although they are not allowed to make the initial prescription, they can prescribe during emergencies and for continue prescription (WHO-AIMS, 2007; Lund et al., 2008). In spite of the integration of mental health services in PHC and standardized treatment procedures, South Africa faces the challenges of limited mental health human resources, low ranking of mental health as a public health priority, the biomedical orientation of health care, poverty, lack of infrastructure, and poor information systems to monitor mental health service delivery, amongst other factors, which poses difficulties in realizing an improved mental health care access (Lund et al, 2007; Mkhize and Kometsi, 2008).

Nigeria has no treatment protocols and there is no uniform standard of care and management of patients across big hospitals. Uniform treatment protocols are an important guideline for proper management of care even in tertiary hospitals. Protocols act as guidelines for mental health practitioners, as these resources can be used to monitor and improve the quality of care given across these facilities. As care is institutional-based, mental health nurses work only in secondary and tertiary institutions with the psychiatrists who provide the prescriptions. Nurses are only allowed to prescribe in emergency situations (WHO-AIMS, 2006), compared to South Africa, where certain categories of nurses are designated as 'authorized prescribers' in terms of the Medicines and Related Substances Act. In addition, the need for psychiatric nurses to prescribe Schedule 5 medicines has been enabled in law (Nursing Act, 2005).

Many reasons have been advanced for failure of the primary mental health care program in Nigeria, including the fact that psychiatric care is only provided at a few large mental hospitals in big cities (Alem et al., 2008). Furthermore, there is a lack of human resources and difficulty in retaining staff, particularly in rural areas as well as poor federal or state funding of mental health service (WHO-AIMS, 2006). Historically, Nigerian mental health care service dates back to 1904, when the first asylum was opened in the southern city of Calabar. In 1907, Yaba Asylum in Lagos opened, and another facility followed in 1914 at Lantoro, Abeokuta (Ayonrinde et al., 2004). The first Nigerian psychiatrist, Dr. Thomas Adeoye Lambo, spearheaded service delivery on his return from the United Kingdom in 1952, when the Neuropsychiatric Hospital in Aro, Abeokuta, was still under construction. Lambo had just completed his training in psychiatry at the Maudsley Hospital, London, which played a central part in the development of psychiatry in Nigeria, with community practice been developed in collaboration with WHO initiatives (Boroffka, 2006). In spite of a strong academic history in psychiatry, mental health care is still institutionalized and inadequate.

The historical legacy of South African shows that mental health services provision under the Mental Health Act (MHA) No. 18 of 1973 was concerned with the welfare and safety of the community, as 'protection of society' was given priority over the rights of the individual. A reasonable degree of suspicion of mental disorder was sufficient to have anyone 'certified' to a psychiatric institution. Certification was widely open to abuse, as certified patients had virtually no recourse to assistance from the law, and could languish in hospital, against their will, for weeks or months. Patients had no meaningful right of appeal or representation. Against this backdrop of human rights infringements, psychiatrists were forced to be doctor and gaoler (Burns, 2008). Mental health services were centralized in urban cities, far from the homes and communities of most patients, which meant transporting people over great distances before service can

Table 1. Median estimate of mental health professionals working in mental health facilities per 100,000 population.

Mental health professionals	South Africa	Nigeria
Psychiatric nurses	10.08	2.41
Psychiatrists	0.28	0.15
Other medical doctors (not specialized in psychiatry)	0.45	0.49
Psychologists	0.32	0.07
Social workers	0.4	0.12
Occupational therapists	0.13	0.05
Other health or mental health workers	0.28	8.03

be accessed. The enactment of the MHCA 2002 protects the rights of people with mental disorders and rid the country of its public health legacy of the colonial and apartheid eras (WHO-AIMS, 2007).

While both countries operate primary health care systems, South Africa has integrated mental health care services in primary centers in the communities, while Nigeria operates an institutional care model, making mental health services accessible only in big institutions located in a few urban centers. Mental health care is provided in a few tertiary facilities that provide both primary and specialist care, none of which have beds for children and adolescents, as well as in a few secondary facilities that have psychiatric units with general physician support, which may not always be functional (WHO-AIMS, 2006). South African legislation made provisions for a free mental health care, whereas in Nigeria, services are paid for on an out-of-pocket basis, the goals of NHIS to provide Free Medical Care is focused on how to reduce child and maternal mortality in order to achieve the Millennium Development Goals, MDGs, (NHIS, 1999), as such mental health care service coverage in its program is low priority. Mental health service reaches only a minority of the population; it is estimated that fewer than 20% of people with mental disorders receive any services, and those who do may not receive adequate treatment (Gureje and Lasebikan, 2006).

Human resources

This domain deals with staffing, which is the key to effective mental health care services. The number of professionals providing mental health care and issues of human resource training for mental health is highlighted in both countries.

South Africa is relatively well resourced compared to other sub-Saharan countries in regard to mental health personnel, as most middle- and low-income countries have grossly inadequate manpower to deal with mental disorders (WHO-AIMS, 2006; WHO-AIMS, 2007). To assess the manpower of both countries, the median number of health and mental health professionals (per 100,000 people) are outlined in Table 1.

In South Africa, mental health professionals work in the private and public sectors (WHO-AIMS, 2007; Lund et al., 2008). The availability of nurses with training in psychiatric nursing has been greatly enhanced by the comprehensive nurse training initiated in 1986. The four-year diploma or degree programs which provide access to the nursing profession include training as a registered psychiatric nurse. Furthermore, advanced or specialist mental health care courses which for at least one academic year of 44 weeks, are being offered for registered general/psychiatric nurses or midwives (South African Nursing Council [SANC]: Regulation 212). Although most comprehensively trained nurses do not end up working in exclusively psychiatric services, their training is used in PHC settings, and district and regional hospitals.

In Nigeria, 95% of professionals who are psychiatrically trained work in tertiary institutions and the other 5% work in non-mental health care facilities (WHO-AIMS, 2006). Primary health care services are provided in rural communities but exclude mental health services, making early identification and treatment of mental health problems and the promotion of comprehensive health difficult to achieve. The provision of primary mental health care at tertiary and secondary institutions, create barriers for families and persons with mental disorders in rural communities during psychiatric emergencies. In Nigeria, psychiatric nurses are usually trained at a post-basic level for 18 months to obtain a diploma. Such persons must be a registered nurse (RN), and there are also a few generic diploma programs that provide training which run for three years, as well as a Bachelor of Nursing Science program for five years for people with a senior school certificate. Most of the trainees from the generic program work in general hospital setting due to the few psychiatric and mental health institutions in the country.

The scarcity of specialist mental health professionals in both countries is a hindrance for the development of primary mental health care (Human Resources for Health Country Profile – Nigeria, 2008; Saxena et al., 2007). To develop a coherent plan for the provision of human resources to meet the health care needs of its population, both countries should address the mal-distribution of health personnel, the disparities of mental health services

provisions between urban and rural communities, and the lack of mental health specialists and primary health care workers. They also need to address the insufficient numbers of specialist mental health workers who can provide effective training and supervision of primary care workers, reorient the education and training curriculum for health sciences, and deal with the crisis of an aging nursing profession, and the limited number of new nurses to keep pace with attrition and retirement (Lehmann, 2008; Alem et al., 2008).

Public information and links with other sectors

This domain involves the provision of information for public education on mental health and disorders, and the level of public sectors participation in mental health promotional activities and programs.

Many mental disorders require psychosocial solutions, with the most appropriate entry point for mental health promotion depending on needs, as well as the social and cultural context of each community. Government and non-governmental organizations, individuals and community health workers and volunteers play a critical role in primary mental health care by facilitating access to education, employment and rehabilitation of people with mental illness and in identifying and referring people with the disorders for early treatment, care and support. The scope and level of these activities vary among countries and while there is no single organizational approach for good service delivery, there are common factors that underlie successful models (WHO, 2009). Thus, South Africa has well established links between mental health services and various community agencies at the local level for appropriate support, such as housing, welfare or disability benefits, employment, and other social service for persons with mental disorders for prevention and rehabilitation strategies (WHO-AIMS, 2007; Lund et al., 2008). These strategies have contributed to the reduction of other social problems such as youth delinquency, child abuse, school dropouts and work days lost to illness.

The South African MHCA 2002 provides an impetus to develop projects such as early detection of mental illnesses, alcohol and drug abuse prevention, and violence against women and children. It also provides for partnerships with non-profit organizations and the formation of Mental Health Review Boards to oversee regular inspections of mental health facilities and act as external watchdogs to protect the rights of service users and their families (Lund et al., 2008).

South Africa has a coordinating body to oversee public education and awareness campaigns on mental health and mental disorders (WHO-AIMS, 2007). Advocacy and public awareness programs are carried out by the National Department of Health (Lund et al., 2008). The Department is assisted by various NGOs, the South African Federation for Mental Health, South African

Depression and Anxiety Group (SADAG) and other professional, consumer and advocacy bodies. There are public education and awareness campaigns targeting the general population, that is, children, adolescents, women, trauma survivors, and ethnic groups (Lund et al., 2008). In Nigeria, there is no coordinating body to oversee public education and awareness programs and there are no NGOs for mental health activities. There are very few public education and awareness campaigns; government agencies and professional organization involvement in mental health awareness and promotion campaigns of the public are poor, and the national human rights review commission established in 1995 is non-functional (WHO-AIMS, 2006).

South Africa has relatively good inter-sectoral collaboration in mental health care services with other organizations to promote the mental health of its people, such as the South African Police Service (SAPS), Department of Justice, Department of Correctional Services, and Department of Education. In terms of financial support for mental health service users, 1 to 20% of mental health facilities have access to programs outside mental health facilities that provide employment for users with severe mental disorders (Lund et al., 2008). Persons with mental disabilities receive a social grant known as the "Disability Grant." In contrast, Nigeria has no social support system and no legislative or financial provisions to protect and provide support for service users and their families; inter-sectoral collaboration is poor; there is no support for child and adolescent mental health; and there are no part-time or full-time mental health professional positions in primary or secondary schools (WHO-AIMS, 2006). Primary mental health care promotion activities are directed to combat stigma but with the heavy workload and manpower shortages, psychiatric nurses in Nigeria frequently focus on illness needs of individuals and families rather than mental health promotion activities.

Monitoring and research

The research domain is important in informing the development of evidence-based interventions for mental health care delivery. This item identifies the type of research conducted and how each country promotes and support relevant mental health research. Neither country has formerly defined minimum data set of items to be collected by mental health facilities, and processes for collecting patients and clinical service data also vary. Mental health research is considered essential to prevent, promote, treat and rehabilitate sufferers; hence, provisions are made to encourage researchers and funds are made available for research in South Africa (White Paper on Health). Two percent of all health publications in South Africa were on mental health (WHO-AIMS, 2007; Lund et al., 2008). Areas of research include epidemiological studies in

community and clinical samples; non-epidemiological clinical/questionnaire assessments of mental disorders; services research; biology and genetics; policy, programs, financing/ economics, pharmacological interventions, and psychosocial psychotherapeutic interventions. Generally, the proportion of health systems research focusing on PHC issues in South Africa has increased significantly since 1994. However, this research has focused primarily on quality of care and human resources for health, while aspects of PHC, such as accessibility to, and equity of care have been relatively neglected compared to publications in the area of HIV and AIDS since 1994 (Lutge et al., 2008). Similarly, Nigeria reported 3% of health publications in research being on mental health, the current scope of research in Nigeria ranges from descriptive and social science and neurobiology studies to large and multicentre epidemiological research projects. Despite the dearth of resources, a number of significant contributions have been made to both international and local psychiatric research literature (Ayonrinde et al., 2004; WHO-AIMS, 2006). Research institutions, oversight bodies and researchers, should give more attention to mental health research as information derived are used to monitor health services and is a powerful evaluation tool. An orderly collection of key information about mental health needs and service provision can transform services delivery and help focus resources on the most effective activities, and therefore offer guidance to managers and providers, as well as provide clear evidence of impact (Engelbrecht, 2000).

Conclusion

The comparison with South Africa highlights considerable gaps in mental health service provision in Nigeria in particular, with the non-implementation of integrating mental health care into the nation's primary health care services over 20 years after the adoption of this policy. As the intention of the policy were to bridge inequalities of access to mental health service, its lack of implementation raises questions about equitable access to mental health care for its citizens. A mental health policy articulated in the South African Mental Health Act protects the human rights of persons with mental disorders and ensures that these individuals have access to treatment and care, discourages stigma and discrimination, and sets standards for practice of psychiatry in every country. The lack of such legislation speaks to the low priority of mental health care in Nigeria.

There are several strengths in the South African mental health system. It has relatively well resourced mental health services including human resources, facilities and available psychotropic medications, in addition to its outreach clinics. Furthermore, it has provided for the

integration of mental health service in primary care centers and the use of protocols to maintain a standard of treatment across various levels of care. The promulgation of the MHCA 2002 in South Africa has protected the human dignity of persons and families with mental health problems. Many mental health care reforms have been implemented in South Africa compared to the current situation in Nigeria. An institutional model of care is strongly upheld in Nigeria and there is a dearth of mental health human resources and a lack of incentives for the few trained mental health professionals, which has led to an exodus of mental health care professionals into other fields of practice. Stigma plays a considerable role in accessing and providing services including health care professionals and policymakers. It is important for Nigeria that psychiatric nurses become advocates for mental health policy reform in order to improve access to quality care. Advocacy is an important nursing role, not only in terms of individual patients, but also with regard to policy and service provision.

The aim of the study was to compare the status of psychiatric service provision of South Africa and Nigeria. While the South African Department of Health is not without its challenges, it has managed to provide mental health services as part of its primary health care infrastructure in line with its national Acts and policies. Nigeria, however, has not reformed its provision of mental health services, has retained it centralized institutional care model, and has yet to prioritize the health of such persons in line with the Alma Ala Declaration. Stigma and lack of resources are no longer justifiable excuses for this lack of service provision, as there are numerous examples in sub-Sahara which provide examples of ensuring that all aspects of its citizens' health are provided for.

REFERENCES

Alem A, Jacobsson L, Hanlon C (2008). Community-Based Mental Health Care in Africa: Mental health workers' views. World Psychiatry, 7: 54-57.

Ayonrinde O, Gureje O, Lawal R (2004). Psychiatric Research in Nigeria: Bridging Tradition and Modernization. Br. J. Psychiatry, 184: 536-538.

Boroffka A (2006). Psychiatry in Nigeria a partly annotated Bibliography. Enugu: Chuka. Available at http://psychiatrie.de/data/pdf/7a/03/00/boroffka_nigeria.pdf (Accessed 28 October 2010).

Burns J, King H, Saloojee S (2007). KZN Treatment Protocol for Mental Disorders. KwaZulu-Natal Provincial Directorate for Health.

Burns JK (2008). Implementation of the Mental Health Care Act (2002) at district hospitals in South Africa: Translating principles into practice. S. Afr. Med. J., 98: 46-49.

Declaration of Alma-Ata (1978). Primary health care.

Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September, 1978. World Health Organization, Geneva. Available at http://whqlibdoc.who.int/publications/9241800011.pdf

Department of Health (1997). White Paper for the Transformation of the Health System in South Africa. Pretoria: Government Gazette. Available at URL: http://www.info.gov.za/whitepapers/1997/health.htm.

Engelbrecht B (2000). Health Expenditure Review Task Team. Guidelines for District Health Expenditure Reviews in South Africa: A guide for managers in the health sector. Durban: Health Systems Trust URL: http://www.hst.org.za/uploads/files/dher.pdf

Federal Ministry of Health (FMOH), (1991). The Federal Ministry of Health National Mental Health Programme and Action Plan. Lagos.

Gureje O, Alem A (2000). Mental Health Policy in Africa. Bull. World Health Organization, 78(4): 475-482.

Gureje O, Lasebikan V (2006). Use of Mental Health Services in a Developing Country. Results from the Nigerian survey of mental health and well-being. Soc. Psychiatry Psychiatr. Epidemiol., 41: 44-46.

Human Resources for Health Country Profile – Nigeria (2008). African Health Workforce Observatory (AHWO). Global health workforce alliance and World Health Organization. Available at http://www.unfpa.org/sowmy/resources/docs/library/R050_AHWO_2008_Nigeria_HRHProfile.pdf.

Jacob KS, Sharan P, Mirza I, Garrido-Cumbrera M, Seedat S, Mari JJ, Sreenivas V, Saxena S (2007). Mental health systems in countries: Where are we now? Lancet, 370: 1061-10677.

Lehmann U (2008). Chapter 11: Strengthening Human Resource for Mental Health Care. In 2008 South African Health Review Edited by Barren, P. (Ed): Health Systems trust.

Lund C, Kleintjes S, Campbell-Hall V, Mjadu S, Petersen I, Bhana A, Kakuma R, Mlanjeni B, Bird P, Drew N, Faydi E, Funk M, Green A, Omar M, Flisher AJ (2008). Mental health policy development and implementation in South Africa: A situation analysis. Phase 1 Country Report. Cape Town: Mental Health and Poverty Project. Phase 1 Country Report.

Lund C, Stein DJ, Flisher AJ, Mehtar S (2007). Challenges faced by South African health services in implementing the Mental Health Care Act. S Afr. Med. J., 97(5): 352-353.

Lutge E, Friedman I, Mbatha T (2008). Chapter 14: A Review of Health Research in South Africa from 1994 to 2007. In 2008 South African Health Review Edited by Barren, P. (Ed): Health Systems trust.

Mental Health Care Act (1973). No. 18 of 1973: Republic of South Africa, Government Gazette.

Mental Health Care Act (2002). No. 17 of 2002: Health Care Act. No. 24024. Republic of South Africa, Government Gazette.

Mkhize N, Kometsi MJ (2008). Community Access to Mental Health Services: Lessons and Recommendations. In 2008 South African Health Review Edited by Barren, P. (Ed): Health Systems trust, pp. 103-113.

Mkize DL, Green-Thompson RW, Ramdass R, Mhlaluka G, Dlamini N, Walker J (2004). Mental health services in KwaZulu-Natal. SAJP, 10: 8-13.

National Health Insurance Scheme (NHIS) (1999). National Health Insurance Scheme Decree No. 35 of 1999. Laws of the Federal Republic of Nigeria.

Nursing Act (Act 33 of 2005). Republic of South Africa. Available at http://www.info.gov.za/view/DownloadFileAction?id=67887 (Accessed 19 March 2012).

Olson PR (2006). Mental Health Systems Compared: Great Britain, Norway, Canada, and United States. Illinois: Charles Thomas, p. 7 Patel V, Araya R, Chatterjee S, Chisholm D, Cohen A, De Silva M, Hosman C, McGuire H, Rojas G, van Ommeren M (2007). Treatment and Prevention of Mental Disorders in Low-income and Middle-income Countries. Lancet, 370(9591): 991-1005.

Revised National Health Policy (2004). Federal Ministry of Health Abuja. Federal Republic of Nigeria.

Saraceno B, van Ommeren M, Batniji R, Cohen A, Gureje O, Mahoney J, Sridhar D, Underhill C (2007). Barriers to Improvement of Mental Health Services in Low-income and Middle-income Countries. Lancet. 370: 1164-74.

Saxena S, Thornicroft G, Knapp M, Whiteford H (2007). Resources for mental health: scarcity, inequity, and inefficiency. Lancet. 370(9590): 878-889.

South African Nursing Council (SANC Regulation 212). Regulations Relating to the Course in Clinical Nursing Science Leading to Registration of an Additional Qualification. http://www.thelancet.com/popup?fileName=cite-using-doi

World Health Organization (2004). World Mental Health Survey Consortium Prevalence, Severity, and Unmet Need for Treatment of Mental Disorders in the World Health Organization World Mental Health Surveys. JAMA, 291(21): 2581-2590.

World Health Organization (2005). WHO Resource Book for Mental Health, Human Rights and Legislation. Stop Exclusion Dare to Care. Geneva. Available at http://www.who.int/mental_health/policy/resource_book_MHLeg.pdf (Accessed 10 April 2010).

World Health Organization (2008). Mental Health Gap Action Programme: Scaling up care for mental, neurological, and substance use disorders. Geneva. Available at http://whqlibdoc.who.int/publications/2008/9789241596206_eng.pdf (Accessed 18 June 2010).

World Health Organization (2009). Improving Health Systems and Services for Mental Health (Mental Health Policy and Service Guidance Package). Geneva.

World Health Organization (2010). Mental Health and Development: Targeting People with Mental Health Conditions as a Vulnerable Group. Geneva. Available at http://whqlibdoc.who.int/publications/2010/9789241563949_eng.pdf (Accessed 24 April 2011).

WONCA (2008). Integrating Mental Health into Primary Care: A Global Perspective. Geneva. Available at http://www.who.int/mental_health/policy/Integratingmhintoprimarycare 2008_lastversion.pdf (Accessed 26 May 2010).

World Health Organization-Assessment Instrument for Mental Health Service (WHO-AIMS) Version 2:2, (2005). World Health Organization, Geneva. Available at http://www.who.int/mental_health/evidence/AIMS_WHO_2_2.pdf (Accessed 5 May 2010).

World Health Organization-Assessment Instrument for Mental Health Service (2006). WHO-AIMS Report on Mental Health in Nigeria. World Health Organization and Ministry of Health Ibadan, Nigeria. Available at http://www.who.int/mental_health/evidence/nigeria_who_aims_report. pdf (Accessed 5 May 2010).

World Health Organization-Assessment Instrument for Mental Health Service (2007). WHO-AIMS Report on Mental Health System in South Africa. WHO and Department of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa. Available at: http://www.who.int/mental_health/evidence/south_africa_who_aims_r eport.pdf (Accessed 5 May 2010).