

COMPARING THE INTEGRATION OF MENTAL HEALTH SERVICES INTO COMMUNITY PRIMARY CARE IN BURKINA FASO AND GHANA: IMPLICATIONS FOR ACHIEVING SDG TARGET 3.4(MENTAL HEALTH AND WELL-BEING)

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ABSTRACT (ENGLISH)

Mental health conditions constitute a growing public health challenge in West Africa, where access to quality mental health services remains limited due to inadequate funding, shortages of trained personnel, weak policy implementation, and the continued concentration of services in urban psychiatric facilities. This study comparatively examines the integration of mental health services into community primary healthcare systems in Burkina Faso and Ghana, with particular attention to the implications for achieving Sustainable Development Goal (SDG) Target 3.4 on mental health and well-being. The study adopts a comparative case study approach based on the analysis of peer-reviewed literature, national policy documents, WHO mental health profiles, and recent empirical studies on adolescent and adult mental health service delivery in both countries.

The analysis focuses on four key dimensions: policy and legislative frameworks, human resources and workforce training, service availability and utilization, and mental health financing. Findings indicate that Ghana has made comparatively greater progress through the enactment of the Mental Health Act 2012 (Act 846) and the expansion of community-based mental health initiatives. However, significant implementation gaps continue to undermine service accessibility and quality. In contrast, Burkina Faso experiences more profound structural challenges, including limited policy infrastructure, severe shortages of mental health professionals, inadequate financing, and heavy reliance on traditional and informal care systems. In both countries, less than one-third of primary healthcare facilities provide basic mental health services, while utilization rates among adolescents and adults remain critically low, particularly in rural communities.

The study further reveals that legislative reforms alone are insufficient to ensure effective integration of mental health into primary healthcare. Persistent barriers include widespread stigma and discrimination, insufficient training of frontline healthcare workers, inconsistent availability of psychotropic medications, fragmented referral systems, and minimal allocation of government health expenditure to mental health services. Although Ghana presents valuable lessons in policy development and decentralization, both countries demonstrate the need for stronger political commitment, operational funding, and accountability mechanisms to translate policy into practice.

The study concludes that achieving SDG Target 3.4 requires a transition from institution-centered psychiatric care to inclusive, community-based primary healthcare models that prioritizes accessibility, prevention, and early intervention. Recommended strategies include strengthening task-sharing approaches, integrating mental health into routine primary healthcare services, expanding workforce training, improving medicine supply chains, increasing domestic investment in mental health, and fostering collaboration between formal healthcare systems and traditional healers. Without urgent and sustained reforms, both Burkina Faso and Ghana risk widening the existing mental health treatment gap and failing to meet the 2030 SDG targets.

Keywords: Mental health integration, primary healthcare, Burkina Faso, Ghana, SDG 3.4, community-based care, task-sharing, stigma, health systems strengthening, West Africa.

RÉSUMÉ (FRANÇAIS)

Les troubles de santé mentale constituent un défi croissant de santé publique en Afrique de l'Ouest, où l'accès à des services de santé mentale de qualité demeure limité en raison du sous-financement, du manque de personnel qualifié, de la faible mise en œuvre des politiques publiques et de la concentration continue des services dans les établissements psychiatriques urbains. Cette étude examine de manière comparative l'intégration des services de santé mentale dans les systèmes de soins de santé primaires communautaires au Burkina Faso et au Ghana, en mettant un accent particulier sur les implications pour l'atteinte de l'Objectif de Développement Durable (ODD) 3.4 relatif à la santé mentale et au bien-être. L'étude adopte une approche comparative fondée sur l'analyse de la littérature scientifique évaluée par les pairs, des documents de politiques nationales, des profils de santé mentale de l'OMS et des études empiriques récentes portant sur la prestation des services de santé mentale pour les adolescents et les adultes dans les deux pays.

L'analyse porte sur quatre dimensions principales : les cadres politiques et législatifs, les ressources humaines et la formation du personnel, la disponibilité et l'utilisation des services, ainsi que le financement de la santé mentale. Les résultats montrent que le Ghana a réalisé des progrès relativement plus importants grâce à l'adoption de la Loi sur la Santé Mentale de 2012 (Acte 846) et à l'expansion des initiatives communautaires en santé mentale. Toutefois, d'importantes lacunes dans la mise en œuvre continuent de limiter l'accessibilité et la qualité des services. À l'inverse, le Burkina Faso fait face à des défis structurels plus importants, notamment une infrastructure politique limitée, une grave pénurie de professionnels de santé mentale, un financement insuffisant et une forte dépendance aux systèmes de soins traditionnels et informels. Dans les deux pays, moins d'un tiers des établissements de soins de santé primaires offrent des services de base en santé mentale, tandis que les taux d'utilisation des services par les adolescents et les adultes restent extrêmement faibles, particulièrement dans les communautés rurales.

L'étude révèle également que les réformes législatives à elles seules ne suffisent pas à assurer une intégration efficace de la santé mentale dans les soins de santé primaires. Les obstacles persistants comprennent la stigmatisation et la discrimination généralisées, l'insuffisance de la formation des agents de santé de première ligne, l'approvisionnement irrégulier en médicaments psychotropes, les systèmes de référence fragmentés et la faible part des dépenses publiques de santé consacrée à la santé mentale. Bien que le Ghana offre des enseignements utiles en matière de développement des politiques et de décentralisation, les deux pays démontrent la nécessité d'un engagement politique renforcé, d'un financement opérationnel adéquat et de mécanismes de redevabilité efficaces afin de traduire les politiques en actions concrètes.

L'étude conclut que l'atteinte de l'ODD 3.4 nécessite une transition des soins psychiatriques centrés sur les institutions vers des modèles inclusifs de soins de santé primaires communautaires qui privilégient l'accessibilité, la prévention et l'intervention précoce. Les stratégies recommandées incluent le renforcement des approches de partage des tâches, l'intégration de la santé mentale dans les services courants de soins primaires, l'élargissement de la formation du personnel de santé, l'amélioration des chaînes d'approvisionnement en médicaments, l'augmentation des investissements nationaux dans la santé mentale et la promotion de la collaboration entre les systèmes de santé formels et les guérisseurs traditionnels. Sans des réformes urgentes et durables, le Burkina Faso et le Ghana risquent d'aggraver davantage le déficit de traitement en santé mentale et de ne pas atteindre les objectifs des ODD d'ici 2030.

Mots-clés : Intégration de la santé mentale, soins de santé primaires, Burkina Faso, Ghana, ODD 3.4, soins communautaires, partage des tâches, stigmatisation, renforcement des systèmes de santé, Afrique de l'Ouest.

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1. INTRODUCTION

1.1 The Global Mental Health Imperative

Mental health has increasingly been recognized as a central component of global health and sustainable development. According to the World Health Organization, mental, neurological, and substance use disorders account for a significant proportion of the global burden of disease, contributing substantially to disability-adjusted life years (DALYs), reduced productivity, and premature mortality. Despite this growing burden, mental health remains one of the most neglected areas within health systems, particularly in low- and middle-income countries where treatment gaps remain extremely wide. This study finds mental health disorders are a leading cause of disability worldwide, accounting for approximately one in six years lived with disability (YLDs) globally (WHO, 2022). In 2019, an estimated 970 million people were living with a mental disorder, with 82% residing in low- and middle-income countries (LMICs) (GBD 2019 Mental Disorders Collaborators, 2022). Depression and anxiety disorders alone affect more than 500 million people globally, yet the treatment gap—the proportion of individuals with a disorder who do not receive effective care exceeds 80% in most LMICs (Patel et al., 2016).

The recognition of mental health as a global health priority is relatively recent. The Sustainable Development Goals (SDGs), adopted by the United Nations in 2015, include mental health for the first time in a global development framework. Specifically, Target 3.4 aims to "by 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" (United Nations, 2015). This target is notable for explicitly linking mental health with non-communicable diseases (NCDs) and for emphasizing both mortality reduction and positive well-being promotion.

However, the inclusion of mental health in the SDGs has not yet translated into commensurate action. Only a handful of countries are on track to achieve Target 3.4, and most LMICs lag far

behind (Reddy et al., 2025). Official development assistance for mental health remains negligible, accounting for less than 1% of development assistance for health (Charlson et al., 2019). Domestic financing for mental health in LMICs is equally inadequate, typically representing less than 1-2% of government health budgets (WHO, 2021).

1.2 The West African Context

West Africa continues to experience a substantial and growing mental health burden, driven by a complex interaction of poverty, insecurity, under-resourced health systems, and deeply entrenched stigma surrounding mental illness (Jack et al., 2014). The region records some of the lowest mental health workforce densities globally, with many countries having less than one psychiatrist per one million people (WHO, 2021). As a result, mental health services are heavily centralized in urban tertiary hospitals, leaving rural populations with extremely limited access to care and minimal integration of mental health into primary healthcare systems.

In addition, several countries in the sub region continue to rely on outdated colonial-era mental health legislation, some of which permits involuntary detention or institutionalization without adequate legal safeguards or due process (Walker, 2013). These legal frameworks often reinforce stigma and contribute to human rights concerns in the treatment of persons with mental health conditions.

The situation is further complicated by competing health priorities within overstretched health systems. Historically, West African health policy and funding have prioritized communicable diseases such as HIV/AIDS, tuberculosis, and malaria, and more recently emerging epidemics such as Ebola and COVID-19 (Bustreo et al., 2019). This has contributed to a vertical, disease-specific funding approach that has inadvertently marginalized mental health and non-communicable diseases (NCDs) (NCD Countdown 2030 Collaborators, 2018). Consequently, the region now faces a dual burden of disease, characterized by the persistent prevalence of infectious diseases alongside a rapidly increasing burden of NCDs, including mental health disorders (GBD 2019 West Africa Collaborators, 2020)

1.3 Burkina Faso and Ghana: A Comparative Rationale

Burkina Faso and Ghana provide a compelling comparative framework for examining mental health system integration in West Africa. Although both countries are geographically proximate and members of the Economic Community of West African States (ECOWAS), they differ significantly in their colonial histories, Burkina Faso under French administration and Ghana under British rule which has shaped their legal traditions, administrative systems, and health governance structures.

Despite these differences, both countries have participated in similar regional mental health reform initiatives, including the Mental Health Leadership and Advocacy Program (mhLAP) supported by CBM International (Eaton et al., 2017). Furthermore, recent empirical studies have generated comparable data on mental health service delivery, particularly among adolescents, allowing for meaningful cross-country analysis (Amenah et al., 2024).

Ghana is often recognized as a regional leader in mental health reform. The country enacted the Mental Health Act, 2012 (Act 846), which replaced the outdated Mental Health Decree of 1974 and aligns with international human rights standards, including the United Nations Convention on the Rights of Persons with Disabilities (CRPD) (Kleintjes et al., 2013). The Act established the Mental Health Authority and provides for the decentralization of services through community-based mental health care, as well as stronger protections for the rights and dignity of persons with mental health conditions.

On the other hand, Burkina Faso has made slower progress in mental health progression. The country still operates under a 1996 mental health law that predates the CRPD and does not fully align with human rights standards (Badini-Kinda et al., 2018). Mental health services remain heavily concentrated in the capital Ouagadougou and a few regional centers, with minimal community-based provision. However, Burkina Faso has benefited from mhLAP and other regional initiatives, and there are emerging efforts to integrate mental health into primary care, particularly for adolescents (Ibrahim et al., 2024).

1.4 Study Aims and Significance

This study seeks to comparatively examine how mental health services are integrated into community-based primary healthcare systems in Burkina Faso and Ghana, with a specific focus on the real-world challenges and opportunities that shape service delivery at the community level. Beyond policy intentions, it explores how care is actually experienced on the ground, including the barriers that limit access, the factors that enable progress, and the policy choices that influence outcomes. In doing so, the study directly engages with Sustainable Development Goal (SDG) Target 3.4, which calls for the promotion of mental health and well-being as part of broader efforts toward universal health coverage.

The significance of this study lies in its contribution to a more grounded and people-centered understanding of mental health system integration in West Africa. Mental health conditions do not only affect individuals clinically; they shape families, livelihoods, education, and community well-being. Yet, in many settings, services remain fragmented, under-resourced, or difficult to access. By comparing Burkina Faso and Ghana, this study highlights what is working, what is not, and why these differences matter for both policy and practice.

Importantly, the findings are expected to inform more responsive and context-sensitive policy reforms that strengthen primary healthcare systems and improve access to mental health services. The insights generated may also support policymakers, health planners, and development partners in other West African countries facing similar structural constraints. Ultimately, the study contributes to ongoing regional and global conversations on how to close the gap between mental health policy commitments and the lived reality of service delivery.

The study is guided by two overarching research questions: (1) How do Burkina Faso and Ghana compare in terms of policy frameworks, service availability, workforce capacity, and financing mechanisms for integrated mental health care? and (2) What are the implications of these differences for achieving SDG Target 3.4 by 2030?

1.5 Structure of the Paper

The paper proceeds as follows. Section 2 provides a literature review on mental health integration, SDG Target 3.4, and the West African context. Section 3 presents the research questions. Section 4 describes the methodology. Section 5 presents the results of the comparative analysis. Section 6 discusses the findings and their implications. Section 7 concludes with policy recommendations. Sections 8 through 14 address limit, competing interests, funding, data availability, and disclaimer. Section 15 provides the bibliography in APA format

2. LITERATURE REVIEW

2.1 Burden of Mental Disorders in Sub-Saharan Africa

Mental disorders are a leading cause of disability in Sub-Saharan Africa, yet they remain significantly under-recognized and under-treated. Prevalence estimates suggest mood disorders range between 3.3% and 9.8%, anxiety disorders between 5.7% and 15.8%, and substance use disorders between 3.7% and 13.3% (Jorm et al., 2020). However, these figures likely underestimate the true burden due to stigma, limited diagnostic capacity, and underreporting.

In West Africa, the burden is intensified by poverty, insecurity, weak health systems, and rapid urbanization. Conflict in the Sahel region, including Burkina Faso, has led to large-scale displacement, disrupted health services, and increased exposure to trauma (Charlson et al., 2019). While Ghana is relatively stable, it still faces economic constraints that affect health financing and service delivery.

2.2 Treatment Gap and Its Determinants

The treatment gap for mental disorders in Sub-Saharan Africa remains extremely high, exceeding 85% for common mental health conditions (Jack et al., 2014). This gap is driven by multiple interrelated factors.

At the individual level, poor mental health literacy and fear of stigma discourage help-seeking. At the community level, cultural beliefs such as attributing mental illness to witchcraft or spiritual causes often lead individuals to seek traditional or faith-based care instead of formal health services (Monteiro, 2015). At the health system level, shortages of trained professionals, inadequate infrastructure, and medication stock-outs severely limit access. At the policy level, mental health remains under-prioritized in national budgets and health strategies (WHO, 2021).

2.3 Primary Care Integration as a Strategy

Integrating mental health into primary healthcare is widely regarded as the most practical and cost-effective approach to reducing the treatment gap in low- and middle-income countries (Patel et al., 2007). Primary care is often the first point of contact with the health system, making it an ideal platform for early detection and treatment.

The WHO mhGAP program provides standardized tools for training non-specialist health workers to manage priority mental health conditions such as depression, psychosis, epilepsy, and substance use disorders (WHO, 2010). Evidence shows that task-sharing models, where non-specialists deliver basic mental health care, can significantly improve outcomes, especially for depression and anxiety (van Ginneken et al., 2013).

However, implementation challenges remain, including lack of supervision, weak referral systems, stigma, and inconsistent availability of psychotropic medication.

2.4 Mental Health Policy and Legislation in West Africa

Mental health policy frameworks in West Africa are generally weak, outdated, and poorly implemented. Many countries lack dedicated mental health budgets and rely on colonial-era legislation.

Ghana stands out as a regional leader with its Mental Health Act (2012), which promotes decentralized and community-based care. The Act established the Mental Health Authority and

Mental Health Tribunals to protect patient rights and ensure oversight of involuntary admissions (Kleintjes et al., 2013). Despite this progress, implementation remains limited due to inadequate funding and workforce shortages.

In contrast, Burkina Faso continues to rely on older legislation (1996), which is not fully aligned with the UN Convention on the Rights of Persons with Disabilities. Mental health is also weakly integrated into national health policy, with no clear implementation framework or dedicated financing.

2.5 The Mental Health Leadership and Advocacy Program (mhLAP)

The mhLAP initiative, implemented in several West African countries including Ghana, aims to strengthen leadership, advocacy, and policy development in mental health (Eaton et al., 2017). It has contributed to training health workers using the mhGAP framework and supporting mental health policy reforms.

In Ghana, mhLAP has played a role in capacity building and advocacy for the Mental Health Act. However, sustainability challenges persist due to limited funding, staff turnover, and weak supervision systems.

2.6 Empirical Evidence on Service Availability

Recent studies show that mental health services at the primary care level in West Africa remain extremely limited. Fewer than 30% of primary healthcare centers provide any form of mental health service, and most services are restricted to basic counseling (Amenah et al., 2024).

Utilization rates are also very low, with fewer than 10 adolescents per year accessing mental health support in many facilities. Rural areas are particularly underserved, and there are no standardized national guidelines for adolescent mental health services in Burkina Faso and Ghana.

2.7 Barriers to Accessing Mental Health Care

Access to mental health services is shaped by multiple interacting barriers. At the patient level, stigma, lack of awareness, and financial constraints limit service use. At the facility level, shortages of trained staff, lack of privacy, and medication stock-outs reduce service quality. At the contextual level, poverty, cultural beliefs, and reliance on traditional healers further restrict access.

These barriers are interconnected and reinforce each other, creating a persistent cycle of underutilization and unmet need.

2.8 SDG Target 3.4: Progress and Limitations

SDG Target 3.4 aims to reduce premature mortality from non-communicable diseases and promote mental health and well-being. However, mental health indicators are weakly integrated into global monitoring frameworks, making progress difficult to measure.

Sub-Saharan Africa faces significant challenges in achieving this target due to weak health systems, low investment in mental health, and the double burden of infectious and non-communicable diseases. Progress has therefore remained slow and uneven across the region.

2.9 Research Gap

Most existing studies focus on individual countries rather than comparative systems. There is limited research comparing francophone and Anglophone West Africa, particularly in relation to primary care integration of mental health services.

Additionally, adolescent mental health and frontline primary care perspectives remain under-researched.

This study addresses these gaps by providing a structured comparison of Burkina Faso and Ghana and examining implications for SDG Target 3.4.

3. RESEARCH QUESTIONS

Primary Question:

How does the integration of mental health services into community primary care differ between Burkina Faso and Ghana, and what are the implications for SDG Target 3.4?

Secondary Questions:

1. How do policy and legal frameworks support integration in both countries?
2. What is the status of mental health workforce capacity and training?
3. How available are mental health services at primary care level?
4. How is mental health financed?
5. What are the key barriers and enablers of integration?

4. METHODOLOGY

4.1 Study Design

This study adopts a comparative case study design focusing on Burkina Faso and Ghana. The design is appropriate because it allows for an in-depth examination of mental health service integration within real-world health system contexts, where policy, institutional structures, and socio-cultural factors interact in complex ways. The comparative approach enables the identification of similarities and differences between the two countries, particularly in relation to primary care integration and progress toward SDG Target 3.4.

4.2 Data Sources

The study relies entirely on **secondary data** drawn from multiple credible sources. These include peer-reviewed journal articles, World Health Organization (WHO) reports (including the Mental

Health Atlas), national policy and legislative documents, and relevant grey literature from international organizations and NGOs. Additional data were obtained from regional health reports and development agency publications to ensure a comprehensive understanding of mental health system performance in both countries.

4.3 Analytical Approach

Data were analyzed using a health systems strengthening framework, focusing on four key domains: governance and policy, health workforce capacity, service delivery, and health financing. This framework allows for a structured comparison of how mental health services are organized, resourced, and delivered within primary healthcare systems in Burkina Faso and Ghana.

The analysis involved synthesizing qualitative and quantitative information across the two countries to identify patterns, gaps, and contextual influences on mental health integration. Findings were then interpreted in relation to existing literature and the requirements of SDG Target 3.4.

4.4 Limitations

This study is based on secondary data, which limits the ability to verify the accuracy or completeness of all reported indicators. In some cases, data were inconsistent or unavailable across both countries, making direct comparisons challenging. Additionally, differences in reporting systems, time periods, and measurement approaches may affect comparability.

Despite these limitations, triangulation of multiple data sources was used to strengthen validity and ensure a balanced comparative analysis.

5. RESULTS (INTRODUCTION)

5.1 Policy and Legislative Frameworks

Ghana has made relatively stronger progress in developing a modern mental health policy and legal framework, particularly through the Mental Health Act (2012), which promotes decentralized

and community-based care. However, despite this progressive legal structure, implementation remains limited due to inadequate funding, weak institutional capacity, and shortages in service delivery infrastructure.

In contrast, Burkina Faso operates under an older and less comprehensive legal framework that is not fully aligned with contemporary international human rights standards, including the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Mental health is also weakly prioritized within broader national health policies, with limited operational guidance for integration into primary care systems.

5.2 Human Resources

Both Burkina Faso and Ghana experience severe shortages of mental health professionals, which significantly constrains service delivery at all levels of care. While Ghana has a relatively higher density of psychiatrists, psychiatric nurses, psychologists, and social workers, the overall workforce remains far below the World Health Organization (WHO) recommended thresholds for adequate service coverage.

Burkina Faso faces a more acute human resource gap, with extremely limited specialist availability and heavy reliance on a small number of professionals concentrated in urban centers. In both countries, the uneven geographic distribution of mental health workers further exacerbates access disparities, particularly for rural populations.

5.3 Service Availability

Primary care mental health service availability remains limited in both countries. Evidence from Amenah et al. (2024) provides one of the most comprehensive comparative assessments of service provision in West Africa.

The study shows that only a small proportion of primary healthcare centers in Burkina Faso and Ghana offer structured mental health services, with most facilities limited to basic counseling and referral rather than comprehensive care. Service coverage is significantly higher in urban areas, while rural facilities often lack any form of mental health support.

In addition, utilization rates remain extremely low, reflecting both supply-side constraints (limited availability of services, trained staff, and medications) and demand-side barriers such as stigma, low awareness, and cultural beliefs about mental illness.

Table 5.3.1: Comparison of Primary Care Mental Health Service Availability in Ghana and Burkina Faso.

Indicator	Ghana	Burkina Faso
PHCs offering any mental health (AMH) services	27%	<30% (no significant difference)
PHCs offering medication for severe disorders	<10%	<5%
PHCs offering specialist referral	15%	8%
National AMH guidelines	No	No

The finding that fewer than 30% of primary healthcare centers provide any form of mental health service is concerning, especially considering that “services” in this study include even basic counseling, which does not require specialist training or advanced infrastructure. Although Ghana shows slightly higher availability across some indicators, the differences between the two countries are not substantial.

A key structural challenge in both countries is the pronounced rural-urban disparity. Mental health services are largely concentrated in urban centers, with rural primary healthcare facilities significantly less likely to offer any form of mental health support. Overall, a rural PHC is

estimated to be about three times less likely to provide mental health services compared to an urban facility. This is particularly significant given that approximately 65% of Burkina Faso's population and 55% of Ghana's population reside in rural areas, where access to care is already limited.

Service utilization is also extremely low across both settings. The Amenah et al. (2024) study reports that fewer than 10 adolescents per year accessed mental health services at primary healthcare centers. While comparable adult data are limited, evidence from Ghana suggests that only about 1 in 20 individuals with probable depression seek care from formal health services (Agyapong et al., 2022), highlighting a substantial unmet need.

Where mental health services are available at primary care level, they are generally limited in scope. These services typically include basic counseling (such as supportive listening and psych education), limited prescribing of psychotropic medications (mainly fluoxetine for depression and diazepam for anxiety), and referral to higher-level facilities. However, a wide range of essential services remains unavailable at this level of care, including structured psychological therapies, management of psychosis with antipsychotic medications, treatment for substance use disorders, specialized child and adolescent mental health services, and care for intellectual disabilities.

Although formal referral pathways exist in both countries, their effectiveness is weak in practice. Evidence from Ghana indicates that fewer than 30% of referrals from primary care to psychiatric facilities result in completed consultations (Roberts, 2019). Key barriers include transport costs, long travel distances, limited feedback mechanisms between facilities, and persistent stigma associated with mental illness.

5.4 Financing for Mental Health

Government health expenditure: According to WHO Mental Health Atlas 2020, the proportion of total government health expenditure allocated to mental health is:

Table 5.4.1: Mental Health Financing in Ghana and Burkina Faso

Indicator	Ghana	Burkina Faso
Mental health as % of total health budget	<1%	<1%
Per capita mental health spending (USD)	\$0.25	\$0.12

Both Ghana and Burkina Faso allocate less than 1% of their total health budgets to mental health, a level consistent with other low-income countries but significantly below the 5–10% recommended by mental health financing experts (Patel et al., 2016). In absolute terms, per capita mental health expenditure remains extremely low approximately \$0.25 in Ghana and \$0.12 in Burkina Faso. By comparison, high-income countries typically invest between \$50 and \$100 per capita in mental health, highlighting a substantial global financing gap.

Financing mechanisms differ in structure but remain limited in effectiveness. In Ghana, the National Health Insurance Scheme (NHIS) formally covers a range of mental health services, including outpatient consultations, inpatient care, psychotropic medications, and hospital admissions. However, in practice, coverage gaps persist, particularly at the primary care level, where mental health services are not consistently integrated or adequately resourced. Medication stock-outs and uneven service availability further weaken the effectiveness of insurance coverage.

Burkina Faso's health financing system, through the Universal Health Insurance Scheme (RAMU), is less developed and provides more limited coverage for mental health services. As a result, access is more heavily dependent on out-of-pocket payments and external support, particularly for specialized care.

Donor funding plays a supplementary but limited role in both countries. Ghana has benefited from regional and international initiatives such as mhLAP and support from organizations like CBM International, while Burkina Faso has received funding primarily from WHO and bilateral development partners. However, mental health remains significantly underfunded within global health assistance, accounting for less than 0.5% of total development assistance for health in Sub-

Saharan Africa (Charlson et al., 2019). This reflects the continued marginalization of mental health within global health financing priorities.

Out-of-pocket expenditure remains the dominant mode of financing mental health care in both countries. In Ghana, studies show that households affected by mental illness often spend a substantial proportion of their income—sometimes up to 30%—on treatment-related costs, including transportation to distant facilities, medication purchases, and consultations with traditional healers (Barke et al., 2019). This financial burden contributes to widespread catastrophic health expenditure and further discourages timely access to formal mental health services.

5.5 Barriers and Enablers

Drawing on the scoping review by Adjei-Banuah et al. (2024) and supporting country-specific studies, mental health integration in primary care in Burkina Faso and Ghana is shaped by interrelated barriers and a smaller set of enabling factors operating at patient, provider, health system, and policy levels.

Barriers

Patient-level barriers

A major barrier is stigma, which remains deeply entrenched in both countries. Fear of being labeled “mad” discourages individuals from seeking formal care. In Ghana, for example, studies show that approximately 85% of respondents hold negative attitudes towards persons with mental illness (Asare, 2015). Stigma is often internalized, leading to shame, secrecy, and delayed help-seeking. Secondly, poor mental health literacy further limits access, as many individuals do not recognize symptoms such as depression or anxiety as treatable health conditions. Instead, these symptoms are often attributed to stress, poverty, or excessive thinking. The study also finds financial problems remain significant in these two countries. Although in Ghana’s the National Health Insurance Scheme (NHIS) covers some mental health services, indirect costs such as transport and medication gaps still create barriers. In Burkina Faso, out-of-pocket expenditure

also remains the dominant mode of financing mental health care, as the national insurance scheme (Régime d'Assurance Maladie Universelle, RAMU) provides only limited and uneven coverage in practice. Although mental health services are theoretically included within the universal health coverage framework, gaps in implementation, service availability, and medication access significantly restrict effective financial protection for patients. Finally, in both countries there is a strong preference of traditional and faith healers, who are often the first point of contact due to cultural explanations of mental illness, accessibility within communities, and perceived effectiveness for spiritual or psychosocial distress.

Provider-level barriers

At the provider level, one of the most persistent barriers to effective mental health integration is the inadequate preparation of primary healthcare workers, reflecting systemic gaps in pre-service and in-service training. This deficiency translates into low diagnostic confidence and an over reliance on referral or non-intervention, even in cases of common mental disorders that could be managed at primary care level through task-sharing approaches.

Beyond technical capacity, evidence from both countries points to entrenched stigmatizing attitudes among some health workers, including perceptions that individuals with mental illness are inherently violent, unpredictable, or chronically unresponsive to treatment. Such attitudes not only undermine clinical decision-making but also compromise therapeutic relationships and deter service users from re-engaging with formal care, thereby reinforcing the treatment gap from within the health system itself.

These challenges are compounded by structural workload constraints, where primary care workers operate under significant pressure from competing health priorities such as infectious diseases, maternal health, and child health programs. Within vertically structured health systems, mental health is often perceived as an “added burden” rather than an integrated component of primary care, particularly in the absence of dedicated time, incentives, or staffing allocations.

Finally, frequent shortages of essential psychotropic medicines expose a critical weakness in pharmaceutical supply chains and health system financing. Even when cases are correctly identified, the absence of reliable medication availability renders clinical management incomplete, undermining continuity of care and eroding trust in the formal health system. Collectively, these provider-level constraints illustrate that the integration gap is not merely a training issue, but a broader reflection of systemic underinvestment and weak prioritization of mental health within primary healthcare delivery structures.

Health system-level barriers

At the health system level, mental health integration continues to be constrained by the dominance of vertically structured disease programs, particularly for HIV/AIDS, tuberculosis, malaria, and immunization. While these programs have improved outcomes in priority disease areas, they have also reinforced fragmented service delivery models in which mental health remains structurally marginalized. Unlike these priority conditions, mental health lacks a dedicated program, ring-fenced funding stream, and clearly defined performance indicators, resulting in weak institutional accountability and limited visibility within routine health system planning. In addition, ineffective and poorly defined referral systems further disrupt continuity of care. Primary care providers often lack clear referral pathways, standard protocols, or feedback mechanisms from higher-level facilities, making coordination with specialist mental health services inconsistent and largely dependent on individual initiative rather than system design.

This is compounded by weak health information systems, where mental health indicators are either absent or inconsistently recorded within routine health management information systems (HMIS). As a result, decision-makers lack reliable data for planning, resource allocation, and performance monitoring, which perpetuates the cycle of underinvestment and poor service visibility.

Finally, structural constraints within primary care facilities, particularly the lack of private and confidential consultation spaces, undermine the quality of mental health care delivery. Given the sensitive nature of mental health assessments, the absence of appropriate physical infrastructure not only compromises patient privacy but also discourages disclosure of symptoms, thereby limiting accurate diagnosis and effective engagement with care.

Policy-level barriers

At the policy level, mental health continues to experience systemic marginalization, particularly when compared to high-mortality or politically salient health priorities such as malaria, HIV/AIDS, and epidemic outbreaks. This reflects a broader policy environment in which visibility and immediate mortality impact often determine prioritization, while chronic and disabling conditions such as mental disorders receive limited sustained attention.

This low prioritization is evident in persistently inadequate budget allocations, which remain below 1% of total national health expenditure in both Ghana and Burkina Faso. Such levels of financing are insufficient to support effective implementation of mental health policies, particularly efforts aimed at integrating services into primary healthcare systems.

Furthermore, weak accountability and enforcement mechanisms exacerbate implementation gaps. In both countries, mental health policies are often adopted without corresponding monitoring frameworks, performance indicators, or enforceable targets. As a result, there are minimal institutional consequences for non-implementation, allowing the persistent gap between policy intent and practical service delivery to remain largely unaddressed.

Enablers

Despite these challenges, several enabling factors support mental health integration.

Political commitment, particularly in Ghana, contributed to the passage of the Mental Health Act (2012), supported by strong advocacy from civil society and professional groups. However, sustaining this commitment remains a challenge.

Task-sharing approaches, particularly through WHO's mhGAP programme, have demonstrated that training non-specialist health workers can improve identification and basic management of mental disorders, although scale-up remains limited.

Engagement with **traditional and faith healers** has also shown promise. Pilot initiatives in both countries suggest that respectful collaboration can improve early identification of mental illness and reduce harmful practices such as chaining or physical restraint. Regional experiences, including the mhLAP programme, further demonstrate that structured engagement can improve referral pathways and reduce stigma (Eaton et al., 2017).

Finally, Ghana's **Community-based Health Planning and Services (CHPS)** system provides an important platform for integration. Community health nurses deployed at village level can be trained to identify and refer mental health cases, offering a practical entry point for expanding community-based mental health care.

5.6 Progress Towards SDG Target 3.4.

Neither country is on track to achieve SDG Target 3.4 for mental health. The indicators for which data are available show minimal progress:

- Suicide mortality: Suicide rates are likely underreported due to stigma and legal sanctions, but available data suggest rates of 5-10 per 100,000 in Ghana and 3-8 per 100,000 in Burkina Faso. There is no evidence of decline.
- Mental health service coverage: As noted, less than 30% of PHCs offer any mental health services. This is far below the levels needed for universal coverage.
- Access to essential psychotropic medications: Stock-outs are common, and availability in primary care is minimal.

Ghana has made more progress on structural indicators (policy, legislation, workforce training), but this has not yet translated into improved service availability or outcomes. Burkina Faso lags on both structural and outcome indicators, and the security crisis is likely worsening mental health outcomes while constraining service delivery.

6. DISCUSSION OF RESULTS

6.1 Summary of Key Findings

This comparative analysis reveals that while Ghana has made more substantial progress in establishing a legislative framework and policy infrastructure for mental health integration, both countries face profound challenges in translating policy into practice. The finding that less than 30% of primary healthcare centers offer any form of mental health services with utilization rates of fewer than 10 adolescents per year indicates that mental health integration remains more rhetorical than real.

Three overarching patterns emerge from the data. First, there is a substantial implementation gap between policy and practice in Ghana, and a policy gap in Burkina Faso where even the policy framework is lacking. Second, the human resources crisis including shortages of specialists, lack of primary care training, and misdistribution of existing workers is the single most binding constraint in both countries. Third, financing is inadequate both in absolute terms (less than 1% of health budgets) and in allocation mechanisms that do not incentivize primary care integration.

6.2 Explaining the Differences Between Countries.

The differences between Burkina Faso and Ghana can be explained by a combination of historical, political, and health system factors.

Colonial legacy and legal system: Ghana's British colonial heritage left a legal system based on common law, which is more amenable to progressive reform than Burkina Faso's French civil law system. The English language also facilitated engagement with international mental health movements, including the CRPD and WHO guidelines.

Civil society mobilization: Ghana has a vibrant mental health civil society sector, including the Mental Health Society of Ghana (MEHSOG) and Basic Needs Ghana, which have advocated effectively for policy reform. These organizations were supported by regional initiatives like mhLAP. Burkina Faso's civil society sector is weaker, with fewer organizations focused on mental health.

Political stability: Ghana has maintained relative political stability and economic growth over the past three decades, enabling sustained investment in health systems. Burkina Faso has experienced multiple coups (2014, 2015, 2022) and a deepening security crisis since 2015, which has diverted

government attention and resources away from health system strengthening, including mental health.

Health system structure: Ghana's CHPS program provides a platform for community-based health service delivery that can be leveraged for mental health integration. Burkina Faso's health system is more centralized, with weaker community-level infrastructure.

However, these differences should not be overstated. Despite Ghana's advantages, implementation of the Mental Health Act has been slow, and service availability remains extremely low. The lesson is that policy reform alone is insufficient; it must be accompanied by sustained investment in human resources, financing, and accountability mechanisms.

6.3 The Stigma Challenge.

Stigma emerged as a pervasive barrier across both countries, affecting help-seeking, service provision, and policy prioritization. At the individual level, internalized stigma leads to shame, secrecy, and delayed care. At the community level, social stigma leads to exclusion, discrimination, and violence. At the structural level, stigma manifests as low policy priority and inadequate financing.

Addressing stigma requires multi-level interventions. Anti-stigma campaigns can improve mental health literacy and reduce negative attitudes. Contact-based interventions, where individuals with lived experience share their stories, have been shown to be effective in high-income settings and are being piloted in West Africa. Institutional reform including the repeal of discriminatory laws, enforcement of anti-discrimination protections, and implementation of CRPD-aligned mental health services can reduce structural stigma.

However, stigma reduction is not a prerequisite for service integration. The relationship between stigma and care-seeking is bidirectional: as more individuals access care and experience recovery, stigma may decrease. Therefore, strategies that focus on improving access to effective care even in the presence of stigma may ultimately be more impactful than waiting for stigma to be reduced first.

6.4 The Role of Traditional and Faith Healers.

The reliance on traditional and faith healers as first-line providers for mental distress is a defining feature of mental health care in both countries. Estimates suggest that 60-80% of individuals with mental distress first consult a traditional or faith healer (Monteiro, 2015).

This pluralistic system has both challenges and opportunities. The challenges include: harmful practices (chaining, caning, beating, starvation); delays in accessing evidence-based care; financial exploitation; and human rights violations. The opportunities include: traditional healers are accessible (in every community), affordable (payment in cash or kind), and trusted; many provide valuable counseling and social support; and they can be partners in collaborative care.

Several collaborative care models have been piloted in West Africa. The most successful is the mhLAP approach in The Gambia, which engages traditional healers respectfully acknowledging their role and expertise while advocating for the elimination of harmful practices and the incorporation of evidence-based approaches. This approach reduced the use of chains and canes from one-third to five percent of patients (Eaton et al., 2017).

Both Burkina Faso and Ghana could benefit from scaling up such collaborative approaches. This requires: (1) mapping traditional healers and understanding their practices; (2) developing training materials that respect traditional knowledge while introducing evidence-based concepts; (3) establishing referral pathways between traditional healers and formal health services; and (4) monitoring outcomes and harmful practices.

6.5 Implications for Achieving SDG Target 3.4.

The findings have sobering implications for achieving SDG Target 3.4. With only five years remaining until 2030, neither Burkina Faso nor Ghana is on track to achieve meaningful improvements in mental health service coverage or outcomes. The treatment gap remains above 80%, and utilization rates are at near-zero levels. Several factors explain this lack of progress. First, mental health was not prioritized in the early years of the SDG era (2015-2020), with most government and donor attention focused on infectious disease threats (Ebola, COVID-19) and maternal/child health. Second, the mental health investment case demonstrating the economic returns of mental health investment has not been widely communicated to finance ministries and

donors. Third, accountability mechanisms are weak, with no consequences for missing mental health targets.

A recent World Heart Federation position statement argues that the SDG 3.4 target should be revised to include explicit mental health indicators and to cover all ages (Reddy et al., 2025). While such a revision would be valuable, it would not address the implementation challenges in countries like Burkina Faso and Ghana. What is needed is a paradigm shift in how mental health is funded and delivered: from hospital-based, specialist-delivered care to community-based, primary care-led care; from donor-dependent pilot projects to sustainable domestic financing; from neglect to prioritization.

6.6 Policy Recommendations.

Based on the comparative analysis, the following policy recommendations are proposed:

For both countries:

1. Develop and implement national guidelines for mental health integration into primary care. These guidelines should specify: which conditions should be managed at primary care level; clinical protocols for identification and treatment; medication supply chains; referral pathways; and supervision requirements.
2. Scale up training of primary care workers using the mhGAP Intervention Guide. Training should be accompanied by ongoing supervision, mentorship, and performance monitoring. Task-sharing should be formalized with clear roles, responsibilities, and career pathways.
3. Ensure consistent supply of essential psychotropic medications at primary care facilities. This requires improvements in procurement, supply chain management, and financing. Psychotropic medications should be included in national essential medicines lists and covered by health insurance.
4. Engage traditional and faith healers in collaborative care models. This requires respectful dialogue, training, referral pathways, and monitoring of harmful practices.

5. Increase domestic financing for mental health to at least 5% of the health budget. This requires advocacy with ministries of finance, economic analysis of the costs and benefits of mental health investment, and innovative financing mechanisms.
6. Integrate mental health indicators into routine health information systems. Minimum indicators should include: number of patients diagnosed with common mental disorders at primary care; prescription of psychotropic medications; referrals to specialist care; and suicide deaths.

For Ghana specifically:

1. Accelerate implementation of the Mental Health Act 2012. This requires adequate resourcing of the Mental Health Authority, establishment of community mental health teams in all districts, and enforcement of human rights protections.
2. Leverage the CHPS program for mental health integration. Community health nurses should be trained in mental health identification, basic counseling, and referral.
3. Evaluate the impact of mental health insurance coverage on access and outcomes. The NHIS should track claims for mental health services and identify gaps in coverage.

For Burkina Faso specifically:

1. Revise the 1996 mental health law to align with CRPD standards. The revised law should include provisions for community-based care, consent to treatment, and protection against involuntary detention without due process.
2. Develop a stand-alone mental health policy and strategic plan with specific targets and budgets. The plan should address the unique challenges posed by the security crisis, including mental health support for internally displaced persons.
3. Invest in mental health workforce development. This includes expanding training of psychiatrists and psychiatric nurses at the University of Ouagadougou, creating a mid-level cadre of community mental health workers, and training primary care workers.

6.7 Theoretical Contributions.

This study contributes to the literature on global mental health and health systems strengthening in several ways. First, it provides a structured comparison of two West African countries, addressing a gap in the literature that has focused predominantly on single-country studies. Second, it applies a health systems framework to mental health integration, demonstrating the interdependence of governance, human resources, service delivery, and financing. Third, it generates hypotheses about the factors that facilitate or impede integration including colonial legacy, civil society mobilization, political stability, and health system structure that can be tested in future research.

The finding that policy reform alone is insufficient to drive service integration challenges the assumption that "policy is progress." Rather, policy must be accompanied by implementation capacity, political will, financial resources, and accountability mechanisms. This finding aligns with implementation science frameworks that emphasize the distinction between adoption (policy change) and implementation (practice change).

7. CONCLUSION.

The integration of mental health services into community primary care in Burkina Faso and Ghana is at an early stage of development. Despite Ghana's advanced legislative framework and the presence of regional initiatives like mhLAP, less than 30% of primary healthcare centers offer any mental health services, and utilization rates are near zero. Burkina Faso faces even more acute challenges, with weaker policy infrastructure, severe workforce shortages, and a deteriorating security situation.

Achieving SDG Target 3.4 by 2030 will require a paradigm shift in how mental health is funded and delivered in both countries. This shift must move from rhetoric to reality, from pilot projects to scale, and from donor dependence to sustainable domestic financing. The building blocks are in place: policy frameworks (in Ghana), pilot experiences, training materials, and a growing evidence base. What is lacking is the political will, financial investment, and implementation capacity to take mental health integration to scale.

The alternative continued neglect has unacceptable consequences. Hundreds of thousands of individuals with depression, anxiety, psychosis, and substance use disorders will continue to suffer without access to effective care. Families will continue to bear the economic and social burdens of untreated mental illness. Human rights violations including chaining, long-term institutionalization, and forced treatment will persist. And West Africa will continue to fall behind the rest of the world in achieving the SDGs.

The time for action is now. With only five years remaining until 2030, accelerated efforts are urgently needed. The comparative analysis presented in this study provides a roadmap for policymakers, practitioners, and advocates seeking to translate the promise of mental health integration into reality.

8. LIMITS OF THE STUDY

This study has several limitations that should be acknowledged.

1. **Reliance on secondary data:** The study did not collect primary data but relied on existing peer-reviewed literature, policy documents, and grey literature. As a result, the analysis is limited by the availability, quality, and comparability of existing data. For some indicators (e.g., mental health spending, workforce numbers), data were drawn from the WHO Mental Health Atlas, which relies on self-report by governments and may be incomplete or inaccurate.
2. **Limited comparability of indicators:** Definitions and measurement methods vary across studies, limiting comparability. For example, the definition of "availability of mental health services" varies, with some studies including any form of counseling and others requiring medication or specialist input.
3. **Publication bias:** The peer-reviewed literature may over-represent successful programs or positive findings, as studies that find no effect or negative effects are less likely to be published. Grey literature may have the opposite bias, emphasizing challenges and failures.
4. **Lack of data on certain populations:** Most studies focus on adults or adolescents, with little data on children, older adults, or specific subpopulations (e.g., internally displaced persons, refugees,

and prisoners). The security crisis in Burkina Faso has created a large internally displaced population with likely high mental health needs, but data are lacking.

5. Limited generalizability: Findings from two countries may not generalize to other West African countries. Nigeria, for example, has a much larger population and more diverse health system, while smaller countries like The Gambia or Sierra Leone have different dynamics.

6. Inability to establish causality: With only two cases and multiple differences between them, it is not possible to establish causality definitively. The differences observed may be due to factors not included in the analysis, such as cultural differences, leadership quality, or historical accidents.

7. Rapidly changing context: The security situation in Burkina Faso is evolving rapidly, with new displacements and attacks occurring regularly. Data collected before 2024 may not reflect the current situation. Similarly, political changes in both countries could affect mental health policy and implementation.

8. Language limitations: The author has limited proficiency in French, which may have constrained the ability to access and interpret francophone sources from Burkina Faso.

Despite these limitations, the study provides a valuable comparative analysis that can inform policy and guide future research.

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10. AUTHOR CONTRIBUTIONS

This study was conceptualized, designed, analyzed, and written solely by the author. The author was responsible for literature review, data extraction from secondary sources, thematic analysis, interpretation of findings, and manuscript preparation.

11. COMPETING INTEREST

The author declares no competing interests in the conduct, analysis, or publication of this study.

12. FUNDING INFORMATION

This research did not receive any external funding. The study was conducted independently as part of academic requirements.

13. DATA AVAILABILITY

This study is based entirely on secondary data obtained from publicly available sources, including peer-reviewed journal articles, WHO reports, government policy documents, and grey literature. All sources used are properly cited in the bibliography. No primary data were collected for this study.

14. DISCLAIMER

The views and interpretations presented in this study are solely those of the author and do not represent the official position of any affiliated institution or funding body. Any errors or omissions remain the responsibility of the author.

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