Mental Health and the Development Agenda in Sub-Saharan Africa

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This article synthesizes the views of participants in two roundtables that were convened in Nairobi (March 2007) and London (July 2008) to identify key challenges to the prioritization of mental health in Africa and possible solutions. Participants included leading development experts and policy makers from head and country offices of international donors, national directors of mental health for several African countries, key mental health and public health professionals, epidemiologists, and an international nongovernmental organization. The challenges they identified to mainstreaming mental health include lack of understanding of the contribution of mental disorders to morbidity and mortality, competition for limited resources within health reform efforts, poor distribution of interventions and lack of inclusion of mental health among core generic health indicators, lack of economic research evidence, lack of a strategic approach to human resources planning, lack of partnerships with the social development sector, and mental health professionals' need for public health skills to effectively conduct national advocacy. Potential solutions include further investment in economic research, better strategic identification of the levers and entry points for integrating mental health into health sector reform plans, more vigorous engagement of mental health professionals in general health sector reforms, strengthening the linkage between mental health and social development, and intensive resource mobilization. In summary, partnerships, underpinned by collaborative training, research, and mutual dialogue with other health and nonhealth sectors, are needed. (*Psychiatric Services* 61:229–234, 2010)

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In recent years health aid provided to governments and to nongovernmental organizations (NGOs) in sub-Saharan Africa by wealthy countries has increased—from $6 billion USD in 2000 to $17 billion in 2008. However, most is targeted to a few high-profile issues, including AIDS, tuberculosis, malaria, and childhood vaccination. Among World Health Organization (WHO) member states in Africa, 33 spend less than $50 per capita per year on health, and 11 of these spend less than $10 per capita per year (1).

There has been considerable advocacy for increasing mental health services (2–9) and for continuing epidemiological work that has shown that mental disorders are significant public health problems in Africa (Jenkins R, Mbatia J, Singleton N, et al., unpublished manuscript, 2009; Jenkins R, Mbatia J, Singleton N, et al., unpublished manuscript, 2009; 10). However, mental health is not included—even indirectly—in the United Nations Millennium Development Goals (11) and is rarely mentioned in generic policy statements, operational plans, and reports of the World Bank and WHO, either at the country or global level or in the discourse of senior staff. It seems that the receptive audience for international mental health advocacy is restricted to the mental health community and has not extended to international and national general health policy makers, sector reformers, health

economists, and other advocates for international health. Furthermore, the links between policies, plans, and budgets for mental health in health and nonhealth sectors remain very weak, so that even where mental health policies exist, resources with which to implement them are very limited.

For these reasons, two consecutive roundtables of key international donors, policy makers, and scientists were convened to analyze the challenges and identify solutions. The first was held in March 2007 in Nairobi as part of the World Psychiatric Association Regional Conference in Collaboration With the Association of African Psychiatrists and Allied Professionals. The second was convened in July 2008 in London as part of the Royal College of Psychiatrists Annual Conference.

Roundtables

The roundtables were convened by the chair (RJ), who identified important donors to Africa—the World Bank and the United Kingdom's Department for International Development—and invited individuals from the head and country offices of these organizations to attend. National directors of mental health for several African countries were also invited, along with key mental health and public health professionals, epidemiologists, and representatives of international NGOs. Three months before the roundtables were held, the chair asked the participants to prepare brief written summaries of the key challenges to the goal of making mental health a priority in Africa as well as potential solutions. Before each roundtable session, a rehearsal was conducted to address logistical issues, such as timekeeping, and to ensure that the participants could present their key points within the allotted time while adequately covering the topic.

At the roundtable, the chair introduced its members and described its purposes. The chair then invited each participant to give a summary of the key challenges, followed by a summary of solutions to these challenges and by any final additional thoughts. The statements were collated, pooled, and integrated through a number of iterations and organized by the overall themes presented below. Each integrated draft was sent to all participants in an iterative process to ensure capture of all key points and explanation and synthesis of core conceptual issues.

Challenges

Contribution of mental disorders to mortality and morbidity is not appreciated. The international health organizations have increasingly focused on the major communicable diseases, because of the prominence given to HIV, malaria, and tuberculosis in the Millennium Development Goals. Government health policy makers generally feel that they are faced with too many conflicting demands and find it easier to prioritize a few disorders rather than take a comprehensive public health approach. Disease priorities have historically been heavily influenced by consideration of mortality data. Even if policy decisions are to be based on mortality alone, mental illnesses should be considered a priority because mortality both from suicide (12,13) and from premature death from physical disease among persons with mental illnesses (14) is similar to the global mortality associated with malaria and HIV (1). Despite these data, mental illness is still not perceived by health policy makers as a major cause of mortality.

Of course, policy decisions about prioritization of health care should not be based on mortality alone. They should also take into account morbidity, disability, and the links between health conditions, such as depression and HIV. People with untreated mental illness are less likely to be productive in society (15–17), and some studies have found these economic losses to society to be considerable (18). Mental illness is a major contributor to overall disease burden (2,7,8).

Lack of economic research evidence. High estimates of disease burden from mental illness and the correlations found between mental illness and poor socioeconomic outcomes (Jenkins R, Mbatia J, Singleton N, et al., unpublished manuscript, 2009; Jenkins R, Mbatia J, Singleton N, et al., unpublished manuscript, 2009; 10,15–17) have not been sufficient to convince many policy makers of potential causal links between mental health and economic behavior. Neither have they been convinced that addressing mental health issues is a top priority for use of scarce public funds. Research is lacking on such basic topics as estimating costs, cost-effectiveness, financing, and efficiency. The low priority afforded to mental health means that it is very difficult to get funding for such work (18).

Competition within health reforms for limited resources. Modern health reforms in sub-Saharan Africa began in the 1990s with the emergence of the move toward accountable government. The basis for reforms was a recognition that existing health systems were overcentralized, inefficient, ineffective, donor driven, and unresponsive. A sectorwide approach to reforms was adopted in many countries. It often included a form of decentralization as well as the development of framework policy and planning documents that emphasized a limited set of cost-effective, prioritized health interventions and integration of vertical programs (that is, externally funded public health programs with separate "vertical" logistic, supervisory, monitoring, and distribution systems from the center to the periphery). Donor funding modalities moved from donor-controlled project support to government-managed budget support.

Within this new framework, there are both challenges and opportunities regarding how to include mental health in sector policy and plans and how to access generic funds. Despite the rationale for prioritization of mental health, in 2005 (the most recent year for which data are available), 59 of the 185 countries that provided information to the WHO Atlas project—including 21 countries in sub-Saharan Africa—still do not have a budget line for mental health in the ministry of health budget (19). Having a budget line is crucial because mental health cannot attract any other government-managed funds without one.

Scarce resources elicit counterproductive competition rather than collaboration between professionals in these specialty areas and those in mental health. Mental health, for example, is an influential factor in children's health and reproductive health, as well as in immunity, susceptibility, and prognosis related to communicable diseases such as malaria and HIV. However, it is unusual within a health system to find collaborations between organizations in these specialty areas and mental health organizations (9).

Lack of core indicators leads to invisibility and marginalization. Mental health indicators are not included among commonly agreed-upon indicators of health needs, progress, and outcomes. Setting priorities for allocating and developing resources is increasingly driven by the need to meet health indicator targets, which only reinforces the lack of attention to mental health when it is not included in the restricted set of national health indicators. The lack of investment in mental health infrastructure, information systems, and research hampers the ability of ministries of health to make an effective case to ministries of finance.

Poor distribution of interventions. Mental disorders generally respond to psychological and social interventions and to medications. At the district and primary care levels, problems with medication procurement and distribution hamper the ready availability of psychotropic medications, which is aggravated by a lack of resources, poor advance planning, and stigma about the need for mental health interventions by those involved in the distribution process. Basic psychosocial support is readily deliverable at the primary care level if teams are given appropriate general training. More complex psychotherapies, such as cognitive-behavioral therapy and interpersonal therapy, require more extensive training and sustained supervision. Thus it will be some time before adequate human resources exist to make these treatments generally available on a national population basis in sub-Saharan Africa.

Mental illness is not perceived as amenable to quick solutions. Mental health issues are not perceived by policy makers as amenable to defined and readily implemented solutions whose cost can be easily estimated and whose value can be understood without difficulty, such as medications for HIV and malaria, for which researchers have estimated the outcome per U.S. dollar spent. Medications are, in fact, a key part of addressing severe mental disorders, and the psychotropic drugs that are on the essential medicine lists of low-income countries are inexpensive, affordable, and effective. Nonetheless, better outcomes are achieved when medication is combined with psychosocial interventions. This added complexity deters health sector reformers, who are accustomed to working with what they see as more straightforward medical solutions for HIV and malaria. In practice, however, such complexity also exists in the treatment of malaria and HIV, where interventions should be multiaxial and multisectoral and should include a focus on behavior changes.

Lack of a strategic approach to human resource planning. Donors and mental health specialists often share a presumption that mental health services can be delivered only by specialists. Some senior psychiatrists in low-income countries advocate for mental health services in terms of increased spending on specialist services instead of first ensuring that mental health is well integrated into primary care services. This only antagonizes the decision makers, who see it as special pleading for an unaffordable luxury. Given the high prevalence of mental disorders in all countries (20), not even high-income countries can afford specialty care for most people with mental disorders. Assessment and treatment in primary care are essential, particularly in low-income countries, where there may be only one psychiatrist for every one to three million people rather than for every 10,000 to 25,000 people, as found in high-income countries.

The supply of mental health providers is highly problematic in most low-income countries, where the number of both primary care and specialist mental health personnel is decreasing because of training costs and emigration from rural to urban areas, from the public sector to the higher-paying NGO and private sectors, and from low-income to higher-income countries (21).

Mental health has not linked well to the social development sector. Research on etiology, epidemiology, and impact of mental disorders has demonstrated that numerous factors are involved in the causation and consequences of mental disorders and the provision of effective interventions. However, the perception that the practice of psychiatry is still based on a predominantly "medical" model alienates social development experts who would otherwise be natural partners for those wishing to improve the mental health of populations. The contribution of better mental health to social development goes beyond reducing clinical symptoms and disability and increasing workplace productivity of both patients and caretakers. For example, recent research undertaken by the World Bank in Kenya and Cambodia has shown links between economic, institutional, social, gender, and psychological dimensions of social change (22–25). However, it is unusual to find comprehensive approaches to social change that include attention to mental health, and such social efforts are rarely aligned with developments in national mental health policy.

The so-called psychosocial domain is understood by international agencies and NGOs as the psychological and social factors surrounding a major issue, such as HIV or a military conflict. This domain has recently gained attention and funding as international donors focus on providing assistance to HIV-affected populations and to populations after conflicts. Such donors find it more acceptable to talk about psychosocial issues than mental health issues, and this often leads to a narrowed policy perspective, with a donor focus on posttraumatic stress disorder rather than on the spectrum of disorders that are found in general populations and that increase in vulnerable populations (6). This narrowed focus also leads to small-scale, NGO-led psychosocial interventions rather than to

comprehensive integration of mental health policy, planning, and delivery in national health sector and non–health sector developments and civil society building. Standards, guidelines, and indicators for mental health in social development work are not well developed, and the extensive evidence of the benefits of mental health promotion—much of which is relevant for social action—has not been used (26). Senior mental health professionals do not always have the requisite public health skills for effective national advocacy.

Mental health professionals who advise or work in ministries of health often lack knowledge or skills in policy development, planning, or finance, and these individuals often find it difficult to address issues in the broader public development agenda, such as problem definition, implementation of health care systems, and definition of appropriate outcomes. This impedes their ability to take advantage of opportunities for ensuring inclusion of mental health in policy development and for implementing mental health services; thus allocated funding is often used inefficiently.

Potential solutions

Undertake economics-related research. There is already some evidence that inadequately addressing mental health problems has cost and other impacts on an already overburdened health system (18,27,28). Data showing that poor mental health leads to inefficiencies in economic productivity in sub-Saharan Africa could persuade funders that providing public funds for mental health interventions is justified and that good mental health policy is good economic development policy. Such research will need to be funded largely by richer countries' health research and development organizations because it is unlikely that the sub-Saharan African countries will be able to afford it. However, health research institutions in sub-Saharan Africa should make it clear that mental health is a core part of their responsibilities.

Other important areas for economic research and dissemination of findings in sub-Saharan Africa are awareness of and attention to the increased use of health care services by people with poor mental health, the costly misdiagnosis of somatic symptoms that are actually symptoms of unrecognized mental disorders, and the contribution of comorbid mental disorders to the prognosis of physical health problems. If mental disorders are not diagnosed and treated effectively, the rate of repeat consultations is high, which places an additional burden on health care systems (29,30). Therefore, much of the significant health investments already made by developing countries may be wasted if mental health is not appropriately addressed. For example, adherence to treatment for tuberculosis, HIV, and stroke is improved when comorbid depression is treated.

Identify the levers and entry points. Not only should mental health policies be developed (12,31,32), but mental health should be a part of all health sector reform plans (national strategic plans prepared by governments that cover a period of five to ten years), the essential packages of health care (an agreed set of prioritized cost-effective health care interventions), medium-term expenditure frameworks (government national budgets for three to five years into which health spending is integrated), and district annual operational plans, as well as the sector reforms and spending plans at national and district levels of prisons, schools, social welfare systems, and police.

Donors need to back the implementation of whole-country plans through a range of aid instruments, as is already happening through the International Health Partnership (www.internationalhealthpartnership.net). This means clear targets and effective health management information systems so that national policy makers and district health management teams can monitor needs, use of services, interventions, and outcomes. Mental health advocates need to link with other sectors, health initiatives, and programs, such as applications for funds from the Global Fund (www.theglobalfund.org) and for AIDS. There is a need to understand the broad principles of resource allocation and expenditure frameworks set by ministries of finance. It is also necessary to recognize the increased focus on the link between resource allocations and outcomes, in terms both of future allocations and of resources allocated in previous years, and thus the necessity of making full and effective use of funds within annual operational plans.

Participate in health sector reforms. Country-level sectorwide approaches and health sector reforms generally focus on development of common systems and on decentralization. Health programs such as those for malaria and HIV have longstanding sources of support and investment that help them buffer themselves from and survive changes in health system structures and operations brought about by sector reforms. However, the mental health specialty sector does not have such sources of political support and financial investment, and so it is extremely difficult for it to mobilize collectively to incorporate mental health within new reforms and to make strong contributions to decentralization and support of common systems.

Nevertheless, national mental health leaders must vigorously engage in health sector reform, understand the bureaucratic mechanisms and the potential points of influence, and be proactive in recognizing their implications in order to minimize threats and maximize opportunities for promoting sound mental health development. To do so, these leaders need to establish a strong evidence base, be strategic in influencing policy and resource allocation, and promote the integration of mental health into basic services. Thus core tasks essential to meeting population needs are integrating mental health assessment and treatment into primary care and ensuring that the district level has the capability to support and supervise primary care and to provide care for complex cases.

Regional partnerships among mental health policy makers would provide support by allowing them to share experiences of prioritizing mental health and of integrating mental health into health and social sector reforms. Long-term mentors from other countries may also provide their support to the process (Mbatia J,

Jenkins R, unpublished manuscript, 2009; Kiima D, Jenkins R, unpublished manuscript, 2010). Recognition by international donors and the African Union of the importance of mental health to the region would be extremely helpful in eliciting and pooling resources for this crucially underfunded area.

Strengthen the linkage of mental health to public health. Mental health professionals would benefit from public health training and education about principles of policy development, health sector reform, non–health sector reform, epidemiology, health economics, and research. Similarly, public health professionals would benefit from education about mental health that addresses the epidemiology, risk factors, and consequences of disorders as well as the opportunities for intervention in the health sector and relevant other sectors.

Strengthen the linkage of mental health to social development. As noted above, a renewed approach to mental health in the context of the health sector is crucial. However, this needs to be complemented by a multisectoral and multilevel perspective on mental health, with an appreciation of factors that influence mental well-being and the relationship of mental well-being to physical well-being, empowerment at family and community levels, livelihoods, productivity, human security, and the development of human, social, and economic capital. Such an analysis has recently been explored in the United Kingdom via the Foresight Project on Mental Capital and Wellbeing (33,34).

A societal perspective is not just an analytical point of view. It needs to be reflected in structures for planning and financing that realize an integrative and synergistic role for mental health capacity and expertise across sectors. Mental health initiatives need to access existing financing mechanisms, such as the Global Fund, as has been successfully done in Zambia, as well as activities and plans funded by foundations, such as the mental health training program for Kenya primary care staff funded by Nuffield (35). Mental health initiatives also need to develop a coordinated resource mobilization campaign to put mental health on an integrated global agenda. Finally, developed nations and donors must also understand the benefits of robust community-based approaches and of the non–health sectors that are also strongly related to mental health, such as social welfare, education, and criminal justice (22,24).

Resource mobilization. It is important to learn lessons from vertical programs that have been established in the area of communicable disease. These programs often result in fragmented care and increased costs. All resources will be better spent in an integrated way that strengthens rather than weakens frontline primary health care. For example, the ongoing Nuffield-funded mental health continuing professional development of 3,000 primary care workers in Kenya is being delivered through the Kenya Medical Training College and the Kenya Ministry of Health to strengthen primary care. The week of training takes a health and social systems approach and includes modules integrating an understanding of mental health with child health, reproductive health, malaria, and HIV, as well as modules addressing issues such as health information systems, collaboration with community health workers and traditional healers, and annual operational planning.

Zambia has successfully integrated mental health into Global Fund proposals for training of health staff. Tanzania, Kenya, and Malawi have integrated mental health into general health service delivery utilizing general health service budgets as set out in national health sector strategic plans and annual operational plans. These are excellent examples of systematic implementation of mental health service delivery within highly resource-constrained environments.

Conclusions

Addressing mental health issues is important for the future of sub-Saharan Africa. Much needs to be done, but there are examples of early successes and ideas for potential solutions. Furthermore, creating successful models of care in resource-constrained Africa holds important lessons for resource-constrained areas in other parts of the world, including poor areas within developed regions such as the United States and Europe.

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