Mental health policy in Africa

In 2007, a landmark series of papers on mental health appeared in The Lancet. Some of the key messages emerging from the series were that mental disorders are inextricably linked with other concerns: there can be “no health without mental health”; mental disorders affect people in all societies, but especially the disadvantaged, vulnerable and poor; mental disorders are a leading cause of disability, mortality and loss of productivity; global mental health resource allocation is characterised by scarcity, inequity and inefficiency (with a disproportionate amount allocated to psychiatric hospitals); low cost treatments are feasible, affordable and effective for many disorders in developing countries; and the treatment gap between those that need treatment and those that receive it is enormous. However, despite the compelling arguments for addressing this egregious scenario, action tends to be limited in scope and inappropriate in nature. An example of the latter is when a large proportion of limited resources are allocated to constructing new mental hospitals, as opposed to strengthening the capacity of the health system to provide cost effective services at primary health care (PHC) level.

One approach to addressing this situation is the development and implementation of mental health policies. When based on sound evidence, and a thorough consultation process with all relevant stakeholders, these policies can harness the resources required to systematically address the mental health needs of a country. In Africa, very few countries have mental health policies, and many of the existing policies are more than two decades old. This is a very important limitation because these old policies tend to focus on processes of involuntary admission, and do not reflect recent developments in the recognition of the rights of those suffering from mental illnesses, nor modern approaches to the treatment of mental disorders. Finally, many existing policies are not informed by recent understandings of the relationship between mental illness and poverty. There are many myths about this relationship, for example that those suffering the effects of poverty are less affected by mental disorders, and once they have a disorder they are more likely to recover owing to more supportive social networks, less stigma and fewer social demands. It has now been established that those suffering from poverty are at increased risk for mental disorders, and furthermore that those suffering from mental disorders are at increased risk for poverty or deepening poverty, resulting in a vicious cycle. Once they have a disorder, living in poverty decreases the probability of recovery, through reduced access to health services, insufficient resources to pay for treatment, poor nutrition, and increased stressors such as employment loss.

These considerations provided the rationale for the Mental Health and Poverty Project (MHaPP), which is a five-year Research Programme Consortium funded by the Department of International Development (DFID) in the United Kingdom. The first phase of the MHaPP involves a situation analysis of mental health policy development and implementation in the four countries in which we are working: Ghana, South Africa, Uganda and Zambia. The full reports of the situation analyses are available on the MHaPP website (http://www.psychiatry.uct.ac.za/mhapp/). In addition, a number of papers have appeared in other journals in which selected aspects of the situation analysis have been reported.

We are proud that this issue of the African Journal of Psychiatry carries a set of six papers addressing additional aspects of the situation analysis. All the papers drew on qualitative data from semi-structured interviews, focus group discussions with a range of mental health stakeholders at national, regional and district levels. Some papers also drew on data from the WHO Assessment Instrument of Mental Health Systems version 2.2 (WHO AIMS).

Angela Ofori-Atta et al. report shortfalls in the provision of mental health care in Ghana, including insufficient numbers of mental health professionals, aging infrastructure, widespread stigma, inadequate funding, and an inequitable geographical spread of services. They conclude that there is a need to develop community-based mental health care services, improve the quality and accessibility of inpatient care, and legislation to protect human rights. Bright Alipala et al., also from Ghana, identified a number of suggestions to facilitate the improvement of the quality of care in psychiatric hospitals, including strengthening community psychiatric services, sustained efforts to reduce relapse, improving psychosocial services, and using precise diagnoses to improve recovery and reduce long-stay in-patients. Ritz Kahuma and her colleagues focused on the issue of anti-stigma and awareness-raising programmes in South Africa. They found that numerous awareness-raising and anti-stigma campaigns are in place in both government and non-government organizations across the country. Examples include the involvement of mental health service users and the use of various forms of media to educate and discourage stigma and discrimination. However, it is impossible to conclude whether such efforts are effective or cost effective as they have not been evaluated. This gap needs to be filled by rigorous research that will constitute a scientific contribution and allow for stronger evidence-based policy development. There are two papers from Uganda. Fred Kigozi et al. investigated the importance accorded to mental health by the media, and the factors that influence media coverage of mental health issues in Uganda. They found that minimal attention was paid to mental health, because mental health is perceived to have low priority and is not a major contributor to mortality. Exceptions were influenced by individual journalists’ particular interests. They conclude with a call for advocacy and sensitization of the partners in the media as a way of persuading them for more involvement in mental health initiatives. Joshua Ssebuzya et al. reported on aspects of the integration of mental health into primary health care in one rural district. They found that the expected level of integration had not been achieved, despite the fact that the mental health nurse and few primary health care nurses expressed an interest in and were committed to providing such integrated services. Finally, Sharon Klingeies et al. reported on the situation analysis of mental health services for children and adolescents in all four countries participating in the MHaPP. Besides drawing on qualitative data and the WHO-AIMS, they used data from the WHO Policy and Plan, and Legislation Checklists. They found that child and adolescent mental health (CAMH) -related legislation, policies, services, programmes and human resources are scarce, partly because of stigma and the low priority given to mental health. Scaling up needs to include anti-stigma initiatives; a greater investment in CAMH; clear policy directions, priorities and targets in country-level policies and plans; consideration of the poverty-mental health link; expansion of the roles of available mental health specialists to include training and support of practitioners in all...
situations, and engage young people, parents and local organizations at community level to promote child and adolescent mental health.

The existence of a thorough and high quality situational analysis will not make any difference to the lives of those affected by mental health problems in the absence of interventions. The second phase of the MHaPP with which we are currently busy involves the development, implementation and evaluation of mental health interventions. These interventions include three broad types. Firstly, policy planning and legislation interventions are being conducted in all four countries. These include the enactment of the current Ghanaian Mental Health Bill into law; the adoption of a new national mental health policy in South Africa, and a new provincial mental health plan in the Northern Cape province in South Africa; the adoption of a new national mental health policy and strategic plan, as well as the reform of the mental health legislation in Uganda; and the reform of mental health legislation in Zambia. Secondly, information systems interventions are being conducted in two countries: in Ghana a mental health information system has been designed and is being implemented in the three major psychiatric hospitals in the country; and in South Africa a mental health information system has been designed and integrated into the district health management information system in the Northern Cape and KwaZulu-Natal provinces. Thirdly, in all four countries a pilot district demonstration project has been developed for the training of PHC staff, and the integration of mental health into PHC. This is taking place in the Kintampo district in Ghana, the Hlabisa sub-district in South Africa, the Mayuge district in Uganda, and in one urban setting (Lusaka) and one rural setting (Mumbwa) in Zambia. It is hoped that the evaluation of these interventions will generate lessons for a range of other low and middle-income countries that wish to develop and implement mental health policies.

The papers in this issue of the African Journal of Psychiatry were developed in a writing workshop that was facilitated by Ritz Kakuma and Philippa Bird. We are grateful to them, not only for organising the workshop but also for working with the authors in getting the papers ready for submission.

Alan J. Flisher

Crick Lund and the Mental Health and Poverty Research Programme Consortium*, Department of Psychiatry and Mental Health, University of Cape Town. 
email: alan.flisher@uct.ac.za 
email: crick.lund@uct.ac.za

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References

In Memory - Alan J Flisher

Dear Colleagues

This edition of the Journal marks a very sad and somber moment. Whilst the edition was going to press we learnt of the death of Alan Fisher. The content of this edition is a tribute to Alan. He had contacted me in 2008 to discuss the possibility of a special edition of the Journal for the purposes of publishing the current content (there will be two further articles from this series in the July 2010 edition). I am sorry that Alan did not live to see his initiative appear in print. Alan’s death is a huge loss for his family, and for psychiatry. I would like to take this opportunity to extend my personal condolences to Alan’s family, and I have no doubt that this sentiment is echoed by the readership of the Journal. We wish you strength.

Christopher P. Szabo
Editor-in-Chief

See tributes to Alan J Flisher on page 150