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Editorial

What action can national and international agencies take?

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This editorial accompanies the third paper in our series of four articles on how international donors can address mental health in low- and middle-income countries. The first paper introduced the topic and discussed core conceptual issues,[1] while the second tackled issues related to social, economic and political challenges.[2] The third article focuses on the international and national policy challenges faced in mental health, and the role that international stakeholders can play in influencing the agenda.[3] The fourth will address health system challenges.[4]

Constraints on the delivery and scaling up of effective mental health services include those relating to policy, financing, physical infrastructure, resource allocation and human resources, including numbers and skills. Policy constraints begin with the large numbers of low- and middle-income countries that have excluded mental health from their health policies and/or do not have a national mental health strategy.[5]

Notwithstanding some greater recognition of the impacts of poor mental health globally, the lack of attention given to mental health in health sector policies creates difficulties in attracting funding for mental health programmes, as donor-dependent countries make the transition to external funding based on national plans or disease specific strategies, including sector-wide approaches or health system funding platforms. Among additional policy constraints are widespread stigma towards investing in mental health at both policy and planning levels. Donors can also influence programme prioritisation or pooled funding approaches within health sector strategic plans; some concentrate (and may wish to continue to do so) on specific communicable diseases. Other constraints include a lack of public health specialists with knowledge and skills in mental health policy and planning, as well as a limited engagement with mental health professionals in the policy discourse; it may be that few mental health professionals are embedded within Ministries of Health.

Financial constraints also arise from mental health not being prioritised in national or sectoral plans. Consequently, in 70% of sub-Saharan Africa, for example, financing allocated to mental health is below 1% of the health budget, despite poor mental health accounting for over 8% of the disease burden.[5] In countries where the annual per capita allocation for health ranges from US $8 to US $12, this will not be adequate to develop a national mental health programme, let alone implement continuing professional education, support supervision, monitoring and evaluation and ensure that the key central functions of a mental health unit are to be found within the Ministry of Health.[6,7]

Limited availability of physical resources is a major constraint to service delivery and development of policies to address the infrastructure gaps. This is especially true for sub-Saharan African countries which retain old ex-colonial psychiatric institutions (often on the edge of capital cities) but are obsolete in decentralised mental health delivery systems. These under-resourced structures, which nonetheless take up much of any available funding for mental health, are now severely run down. Hence governments face the challenge of choosing between prioritising scarce mental health resources for investment in the rehabilitation of old and obsolete structures, an option often driven by the consultant psychiatrists who run these hospitals, or for building district-level decentralised units that are more accessible to the population. Policy shifts that favour decentralisation are difficult to achieve as they require not just additional new resources but also substantial political commitment from government, as well as commitment from psychiatrists and other specialists who would have to relocate away from hospitals in capital cities in order to provide more equitable access to care.

In Uganda, with the support of the African Development Bank, the 970-bed National Psychiatric Hospital has been downsized to 450 beds and 12 regional referral units have been built across the country. This has taken a ten-year commitment from the Government of Uganda, with the support of a loan.[8,9] In Tanzania, the 1000-bed National Hospital at Dodoma has been downsized to between 400 and 500 beds, with the development on site of a major training centre for psychiatric nurses and medical officers. Similarly in Kenya the 1000-bed National Hospital on the edge of Nairobi was downsized. However, in both Kenya and Tanzania demand pressures due to an increased prevalence in severe substance abuse is pushing up bed numbers again. This recent reversal in patient flows to such national hospitals could be avoided with better implementation of prevention policies and earlier detection and treatment at primary care level, together with the inclusion of small inpatient units in local district hospitals.

Resource allocation is inextricably linked to the availability of financing. Frequently the limited budget allocated to mental health units is utilised at the central ministry level and by the national psychiatric hospital; little is available for primary care level services where the vast majority of people with mental health needs can be reached. While it is important for mental health to be integrated into primary health care, this also raises a further challenge in terms of how to ensure that within a package of essential healthcare services sufficient resources are targeted towards mental health. While it is assumed that primary healthcare staff will provide mental healthcare services and requisition appropriate mental health medications in the normal way, as well provide support, supervision and outreach services, in reality widespread stigma towards mental health means that mental health needs are often excluded from provincial and district planning processes. These issues need to be addressed if mental health services are to be well delivered within primary care. There is also a need for studies that track the financing pathways, quality and access to mental health services in provinces and districts, in order to help with future planning and resource allocation.

Health workforce capacity, both in terms of numbers and skill sets, is another major policy challenge. In most sub-Saharan African countries health workers at the primary health care level range from general nurses and clinical officers (medical assistants with three years of medical training) to health workers with little or no formal training. Tanzania, Kenya, Uganda and Malawi have nurses and clinical officers at primary care level. In addition, Kenya, Ethiopia and Uganda have community/village health workers who are given short episodes of training so that they can extend the reach of primary care to the community. These community/village health workers generally play a role in encouraging vaccination and reproductive health programmes, but are also being trained to recognise clients with common mental disorders, helping to identify those with side effects as well as those in remission, and then referring individuals to health centres as appropriate. In Ethiopia, the health extension worker programme has been challenged by high attrition rates, but in Kenya specific training and supervision by community health extension workers is further strengthening the community health worker programme. Capacity is also an important issue at the policy and planning level centrally, as well as at both district and provincial levels, where there is potential for mobilising additional resources from district and provincial budgets. For example, in Kenya the primary care training programme funded by the Nuffield Trust has trained provincial and district specialist staff in advocacy and planning so that they can better access provincial and district funds.[10–12]

While there are good examples of interventions to address policy challenges, many challenges remain and are unlikely to be resolved soon unless new additional domestic and international financing is allocated to mental health. International stakeholders, including the United Nations and the World Bank, government overseas aid programmes and major third sector groups can play a key role in fostering investment and interest in mental health. They can also do more to help address ongoing

challenges experienced in many low-income countries, including the challenge of training and retaining healthcare workers in a labour market where skilled workers are also being attracted by opportunities in high-income countries.

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CONFLICTS OF INTEREST

None.

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