Increasing the priority of mental health in Africa: findings from qualitative research in Ghana, South Africa, Uganda and Zambia

Philippa Bird,1* Maye Omar,1 Victor Doku,2 Crick Lund,3 James Rogers Nsereko,4 Jason Mwanza,5 and the MHaPP Research Programme Consortium6

1Nuffield Centre for International Health and Development, University of Leeds, UK, 2Kintampo Health Research Centre, Kintampo, Ghana, 3Department of Psychiatry and Mental Health, University of Cape Town, South Africa, 4Butabika National Referral Mental Hospital, Kampala, Uganda, 5Department of Social Development Studies, Division of Sociology, University of Zambia, Zambia and 6The Mental Health and Poverty Project (MHaPP) Research Programme Consortium members include Alan J Flisher (Director) and Crick Lund (Co-ordinator) [University of Cape Town, Republic of South Africa (RSA)]; Therese Agossou, Natalie Drew, Edwige Faydi and Michelle Funk (World Health Organization); Arvin Bhana (Human Sciences Research Council, RSA); Victor Doku (Kintampo Health Research Centre, Ghana); Andrew Green and Maye Omar (University of Leeds, UK); Fred Kigozi (Butabika Hospital, Uganda); Martin Knapp (University of London, UK); John Mayeya (Ministry of Health, Zambia); Eva N Mulutsi (Department of Health, RSA); Sheila Zaramba Ndyanabangi (Ministry of Health, Uganda); Angela Ofori-Atta (University of Ghana); Akwasi Osie (Ghana Health Service); and Inge Petersen (University of KwaZulu-Natal, RSA).

*Corresponding author. Nuffield Centre for International Health and Development, Leeds Institute of Health Sciences, University of Leeds, 101 Clarendon Road, Leeds LS2 9LJ, UK. Tel: +44(0)113 343 4867. Fax: +44(0)113 343 6997. E-mail: p.k.bird@leeds.ac.uk

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Despite the high prevalence of mental illness, mental health remains a low priority in Africa. There has been no investigation of the views of stakeholders in Africa on why this is and what can be done. This paper reports a comparison of the views of stakeholders in Ghana, South Africa, Uganda and Zambia, focusing on the priority given to mental health by the government at the national and regional/province levels. We conducted semi-structured interviews with key stakeholders and used a two-stage approach to analysis: firstly framework analysis in each study country, followed by comparative analysis of the country data. Mental health was largely considered a low priority at national and regional/provincial levels in all four countries. We identified nine factors affecting the priority of mental health, which were grouped into three categories: legitimacy of the problem, feasibility of response and support for response. Respondents put forward a range of experiences and suggestions for increasing the priority given to mental health. We conclude with broad suggestions to raise the priority of mental health. These suggestions are particularly relevant as mental health increases in priority on the international agenda, in order to inform advocacy for increased priority for mental health in Africa.

Keywords Mental health, Africa, policy process, priority setting

KEY MESSAGES

- Mental health remains a low priority in Ghana, South Africa, Uganda and Zambia.
- Strategies to increase the priority of mental health need to address the legitimacy of mental health and the feasibility of and support for responding to mental health problems.
Introduction

Despite the high prevalence of mental illness, mental health remains a low priority in Africa (Jacob et al. 2007). Neuropsychiatric conditions account for 13% of the global burden of disease and over 5% in Africa (WHO 2008). Worldwide, unipolar depression is the third greatest single cause of disability-adjusted life years lost, and schizophrenia and alcohol misuse disorder are key causes of disability (WHO 2008). Mental health is integral to achieving the Millennium Development Goals, with far-reaching impacts on productivity and poverty and interactions with other health issues (Miranda and Patel 2005). There is also growing evidence of the cost-effectiveness of mental health services (Patel et al. 2007). Yet mental health remains under-prioritised worldwide, and especially in Africa. Only 50% of African countries have a mental health policy and many laws are old and outdated (WHO 2005).

Setting priorities in health involves making decisions about how to allocate resources between competing health issues. Understanding prioritization of health issues is broader than understanding agenda setting. Prioritization affects not only which issues get onto the policy or legislative agenda, but also the policy development process, the content of policy and the development and implementation of plans. There has been an increase in research on health priority setting in developing countries, with the development of new methods for setting priorities (Youngkong et al. 2009).

A number of frameworks have been used to understand why issues get onto the agenda or increase in priority. The rationality model deals with how decisions should be made through identification of goals and consideration of options based on comprehensive information (Walt and Gilson 1994). However, studies have shown that the health issues that are most prevalent or that can be treated in the most cost-effective manner do not always gain the highest priority (Reichenbach 2002). Other models have been put forward to develop a more realistic understanding of when, how and why health issues gain priority (Hall et al. 1975; Kingdon 1984; Reich 1995; Reichenbach 2002; Shiffman 2007; Shiffman and Smith 2007).

In particular, there have been studies on the reasons why some health issues get onto the policy agenda, while others do not (Reich 1995; Shiffman 2007). In an analysis of maternal health, Shiffman (2007) identified nine key factors that influence national agenda-setting for maternal health, which he grouped into three categories: transnational influence, domestic advocacy and national political environment. Kingdon (1984) identified three streams: the problem stream consisting of the issues faced by society, the policy stream consisting of the alternatives to address the problems, and the politics stream. Governments take action only when the three streams converge, often through the efforts of ‘policy entrepreneurs’, and windows of opportunity open.

There has been some research to understand mental health experts’ perceptions on the reasons for the low priority of mental health (Saraceno et al. 2007). However, there has been no specific investigation of the views of stakeholders in Africa: whilst it is clear that mental health remains a low priority in Africa, it is unclear why this is and what can be done. The aim of this paper is to understand the reasons for the low priority given to mental health by the government at the national and regional/province levels in four African countries in order to develop suggestions for ways to increase the priority of mental health in Africa. The objectives are: (a) to understand the level of priority given to mental health in Ghana, South Africa, Uganda and Zambia; (b) to understand stakeholders’ perceptions of the factors that affect the low priority of mental health in these countries; (c) to explore stakeholders’ experiences and suggestions on how to improve the priority of mental health and develop recommendations.

Setting the context: Ghana, South Africa, Uganda and Zambia

Ghana, Uganda and Zambia are low-income economies and South Africa is an upper-middle income economy according to World Bank classification. This is reflected in the amount spent on health per capita per year: US$21 or less in Ghana, Uganda and Zambia compared with US$295 in South Africa (2003 figures) (WHO 2006). All four countries face a range of competing health challenges, including infectious diseases (the HIV/AIDS epidemic is a particular challenge in South Africa and Zambia) and maternal and child health alongside a rise in non-communicable diseases. Life expectancy ranges from 40 years in Zambia to 57 years in Ghana (2004 figures) (WHO 2006).

The mental health policy and systems indicators in Table 1 show the low priority of mental health in the four countries. Further information from the Mental Health and Poverty Project on the mental health policy, legislation and systems in the four study countries has been published elsewhere (Draper et al. 2009; Lund et al. 2009; Awenya et al. 2010; Kigozi et al. 2010; Kleintjes et al. 2010; Ofori-Atta et al. 2010; Ssebunnya et al. 2010).

Methods

This study was conducted as part of the Mental Health and Poverty Project (MHAPP), which aimed to develop and evaluate mental health policy interventions in Ghana, South Africa, Uganda and Zambia to provide new knowledge regarding comprehensive multi-sectoral approaches to breaking the negative cycle of poverty and mental ill-health (Flischer et al. 2007). The MHAPP study used qualitative and quantitative methods to assess mental health policy content and processes. This paper reports the cross-country comparative findings on prioritization from the qualitative part of the study.

We used semi-structured interviews with national and regional/provincial level stakeholders. Primary data collection and analysis occurred in each study country. Each country employed 2-3 researchers, who had varying experience in qualitative research and training was provided by the project. We obtained ethical approval in each of the study countries and...
Table 1 Mental health policy and system indicators

<table>
<thead>
<tr>
<th>Country</th>
<th>Mental health policy?</th>
<th>Number of psychiatrists per 100 000 population</th>
<th>Number of psychiatric nurses or nurses working in psychiatric facilities per 100 000 population</th>
<th>% government health expenditure spent on mental health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ghana</td>
<td>Yes, revised 2000</td>
<td>0.07</td>
<td>2.58</td>
<td>6.2%</td>
</tr>
<tr>
<td>South Africa</td>
<td>Draft developed in 1997</td>
<td>0.28</td>
<td>10.08 (range 1.06–20.6)</td>
<td>1–8% (national expenditure unknown; wide variation between provinces)</td>
</tr>
<tr>
<td>Uganda</td>
<td>Draft developed in 2000</td>
<td>0.08</td>
<td>0.78</td>
<td>4%</td>
</tr>
<tr>
<td>Zambia</td>
<td>Yes, finalized in 2003</td>
<td>0.025</td>
<td>0.833</td>
<td>0.38%</td>
</tr>
</tbody>
</table>

Source: Data collected by the Mental Health and Poverty Project using the WHO AIMS (Draper et al. 2009; Lund et al. 2009; Kigozi et al. 2010; Ofori-Atta et al. 2010).

The semi-structured interview guides were developed collaboratively by the consortium. Each country team then adapted the guides according to the local context, for example adding and amending questions to reflect local priorities and the health system structure. Respondents included health and mental health policy makers in the Ministry of Health, politicians, health service managers, media representatives, representatives from non-health sectors, health professional unions, traditional healer unions, mental health user groups and mental health non-governmental organizations (NGOs). Country teams initially identified respondents purposively to include a diverse range of stakeholders. They also used snowball sampling to identify further respondents during interviews. Semi-structured interviews totalled 58 in Ghana, 64 in South Africa, 42 in Uganda and 65 in Zambia.

Interviews were tape recorded and transcribed verbatim. Analysis of the primary data was conducted by each country team employing a framework approach (Ritchie and Spencer 1994) and using NVivo 7 software. A coding frame structure was developed collaboratively from a priori codes and codes emerging from the findings. This was modified and added to with further emergent codes by each country to reflect the data they had collected and adaptations they had made during data collection. Comparative analysis of the national and regional/provincial level data was conducted by researchers at the University of Leeds, using the final reports from each study country as a starting point and the coded primary data to explore themes further.

Limitations of the study included time and resource constraints, which limited the range of respondent types and geographical coverage of the study and may have affected the diversity of views. Comparative analysis was initiated by a researcher who had limited involvement in data collection, which may have affected interpretation of findings.

To minimize loss of meaning and omission of important issues in the comparative analysis, we validated all comparative findings with the country researchers.

Framework for understanding the low priority of mental health

Given the complexity of policy processes, it is useful to use a framework to simplify issues and aid understanding (John 1998; Sabatier 2007). We developed a framework of three overarching categories, adapted from Hall et al. (1975), which we used to group nine factors affecting the priority of mental health. Hall et al. identified three criteria (legitimacy, feasibility and support) which affect the priority of issues based on analysis of case studies of policy change from the UK. The authors proposed that the criteria were useful to ‘simplify, organize and understand’ evidence (p. 475). This framework has since been applied to low-income settings to explain the emergence of reproductive health on the relief agenda (Palmer et al. 1999). We adapted the criteria to take account of our findings. Whereas Hall et al. defined support to include public trust of the government and the balance between satisfaction and discontent for policy change among the public, we included broader issues such as advocacy and funding. The three categories can be defined as follows:

- Legitimacy of the problem: whether people consider that the government should be concerned about the problem (mental illness and lack of services). This includes appreciation of the problem and its impact, and whether mental health is considered a valid and justifiable issue to prioritize for government intervention.
- Feasibility of response: whether the courses of action (promotion of mental health, prevention, treatment and rehabilitation for mental illness) known for mental health are considered feasible for the country to plan and implement. This includes consideration of ideologies and resources, such as human and financial resources, that are available and required to respond.
- Support for response: factors which encourage or discourage the government from increasing the priority of mental health. These may be national or international factors and may include funding or issues such as advocacy or competing targets.

Results

The low priority of mental health

Mental health was largely considered a low priority at national and regional/provincial levels in all four study countries, with some exceptions. In South Africa, some respondents from the Department of Health suggested that mental health had gained priority since 1994, when work on the mental health policy guidelines started. However, half of all the South African
respondents felt that mental health remained a low priority in reality, particularly at provincial and district levels, and that policies are not translated into mental health budgets and services. There was a similar picture in Uganda, where mental health was reported to be a high national policy priority, supported by the inclusion of mental health in key policies and plans such as the National Minimum Health Care Package. However, health workers suggested that priority remained low at implementing levels, as evidenced by insufficient funding and use of mental health funds for other activities. In Ghana and Zambia, stakeholders from health and non-health backgrounds felt that mental health was a low priority for the government and a particularly low priority at regional levels, which were responsible for implementing services and programmes. In all countries, respondents called for greater attention to mental health.

Why is mental health a low priority?
We identified nine emerging factors affecting the priority of mental health, which were grouped into three categories, adapted from Hall et al. (1975) (Table 2).

### Legitimacy of the problem
In all countries respondents explained that mental health was not considered a legitimate problem due to limited appreciation of the prevalence of mental illness among decision makers. This was attributed to a lack of epidemiological research evidence on the prevalence of mental illness and a lack of routine data from the health management information system (HMIS). In Uganda and Zambia, the lack of mental health data collected in the HMIS resulted in the burden of mental ill health being unknown. These data are required for the government to recognize mental health as a policy issue, as explained by this policy maker from Zambia:

> “When the [HMIS] documents say this is what is happening in the country and so many people are suffering because of 1, 2, 3, 4 then the government starts thinking, where have we gone wrong? Why haven’t we done this? We don’t have mental health documented as a problem... Zambia has no figures.” [Policy maker, Zambia]

Yet even though routine data indicated the high prevalence of mental illness in Ghana, where mental illness ranked 12th for outpatient consultations, it remained a low priority.

Data were not collected on the majority of people with mental illness in facility-based health information systems, so they remain invisible to policy makers. Respondents attributed this to three issues. Firstly, in all four countries a large proportion of people with mental illness do not attend health centres due to the lack of mental health services available. A second reason cited was cultural beliefs on mental illness and a preference for self-care or traditional or spiritual healers. And thirdly, respondents in Uganda noted that if people did access health centres, health workers often lacked the skills to identify and record patients with mental illnesses.

The invisibility of people with mental illness in the community was thought to contribute to the poor appreciation of the prevalence in South Africa and Ghana. Respondents noted that it was often not physically obvious when people suffered from a mental disorder. Stigma was also cited, a factor that led people to hide their mental illnesses:

> “There is a whole lot of discrimination and stigma and that is a big, big problem in the sense that if I am mentally ill I may not tell you... The issue is more or less swept under that carpet.” [NGO respondent, Ghana]

There was variable understanding of the severity and impact of mental illness. Many respondents cited mental illness as a cause of disability and households falling into poverty. However, some decision makers suggested that priorities should be based on mortality figures, rather than morbidity or social impact. In Uganda and South Africa, health managers cited the low mortality from mental illness as a reason for its low priority at province level:

> “If I have to choose between somebody who needs to be resuscitated and the mental health client and I need resuscitation equipment, then obviously that is going to be the priority because I need to save lives.” [Health programme manager, South Africa]

One respondent from Zambia suggested that it is unethical to prioritize conditions that cause morbidity (using DALYs) at the expense of conditions that cause mortality:

> “Ethically we are not supposed to use DALYs in the management of the health sector because it is totally unethical. So when you concentrate on DALYs you may end up picking the wrong things

### Table 2 Factors cited as reasons for the low priority of mental health in four African countries

<table>
<thead>
<tr>
<th>Category</th>
<th>Factor</th>
<th>Ghana</th>
<th>South Africa</th>
<th>Uganda</th>
<th>Zambia</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Legitimacy of the problem</td>
<td>Appreciation of prevalence of problem</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Understanding of severity of problem</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Poor media coverage</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>(b) Feasibility of response</td>
<td>Knowledge of appropriate interventions</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Socio-cultural beliefs on causes and treatment</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>(c) Support for response</td>
<td>Lack of funding</td>
<td>x</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Competing development and health priorities</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Lack of advocacy</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>Stigma</td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
and leave some of the key things that might be killing people . . . .”

[Ministry of Health official, Zambia]

Respondents also referred to the lack of coverage of mental health in the media, indicating that informal evidence was also important for setting priorities. Media representatives in Uganda acknowledged the prevalence and economic impact of mental ill-health, but cited the lack of mental health events and campaigns, the lack of mental health advocates and low mortality as reasons for low media interest in mental health:

“Mental illness is not that dramatic . . . it doesn’t capture media’s attention. That is one. But also two, I am not aware of anyone who has carried out a campaign to bring mental health issues on the agenda . . . we haven’t had a campaign like one that was done on HIV/AIDS.” [Media representative, Uganda]

Feasibility of response

Some respondents felt that responding to the burden of mental illness through the provision of services would not be feasible. There was some evidence that people had a lack of knowledge of appropriate interventions to prevent and treat mental illness and to promote mental health. In Uganda, for example, respondents suggested that mental health treatments were expensive, take a long time and do not produce quantifiable outcomes:

“In most cases the policy makers, I think they are interested in tangible results. But ours . . . the community based are not easy to see, sometimes it takes long . . . that is why we are also marginalized.” [Social worker, Uganda]

Socio-cultural beliefs on the causes and ways to treat mental illness were felt to hinder the development of mental health services in the four countries. Respondents stated that mental illness was often misunderstood among members of the general public and regarded as a spiritual, supernatural or moral issue, rather than a disease that should be addressed by health services. In South Africa, mental illness was viewed as odd behaviour, rather than a serious illness that could be treated; in Ghana it was feared and associated with punishment for bad behaviour. In all countries respondents stated that traditional and spiritual healers are widely used by people with mental health problems, and are usually consulted before public sector services. In Uganda some respondents considered buying drugs for mental illness a waste of resources. Whilst these views were usually not voiced by mental health policy makers or implementers, they may influence responses to mental illness:

“People don’t think mental illness is like any other illness; you are either bewitched or it is something running strictly in your family . . . They think mental illness is incurable.” [Media representative, Uganda]

Support for response

Respondents identified a number of national and international factors that were required to provide support for a response to the burden of mental illness but which were largely insufficient. Lack of funding for mental health, including government and development partner funding, was identified as a key barrier:

“Now I think the good will is there to shift the services but the funding is the problem . . . it has gone to that other priority area [HIV] which needs it probably more than mental health.”

[Provincial programme manager for mental health, South Africa]

One exception was Uganda, where an African Development Bank loan was granted following lobbying from stakeholders in the country. This led to an increase in funding for mental health from 1% to 4% of health spending, with a resultant increase in facilities and resources for mental health. In Uganda, some funding was also provided to mental health through sector-wide approaches to donor funding. However, donors in Uganda complained that their support to mental health was hampered by the low priority in the government:

“If government prioritizes, we can support. But if we want to support and they say ‘No, the other one is a bigger problem, mental illness is small’ . . . what do we do? Your government never presents mental illness as a problem to the development partners . . . .”

[Development partner, Uganda]

Competing health and development priorities acted as a deterrent to action for mental health. None of the countries’ national development priorities explicitly included mental health. In Uganda poverty eradication was cited as the main issue on the development agenda, including provision for marginalized and vulnerable groups. However, the researchers noted that people with mental illness had not been included in this category. The countries had to juggle very scarce resources to provide services for a wide range of competing health priorities. In Zambia, health sector reforms comprised specific thrusts, including HIV/AIDS, tuberculosis, water and sanitation, and child health; other issues, including mental health, did not feature prominently in health sector plans. In South Africa and Zambia in particular, attention was focused on HIV/AIDS:

“There’s HIV, there’s the ARV roll out, so there’s always other priorities and what tends to happen with mental health . . . is that it always takes the backseat.” [Health worker, South Africa]

Whilst respondents felt that advocacy for mental health was vital, they noted a lack of advocacy by user groups, health workers and managers. User groups and mental health NGOs operated in all four countries. However, respondents noted that there was little co-ordinated action to advocate for better mental health policy or implementation and service provision, in particular in South Africa:

“It [the mental health lobby] is too fragmented and it’s not being lobbied by the right people and it does not require hysteria or people getting excited, [rather] composed people who say: ‘Hey look at this’.” [NGO respondent, South Africa]

South Africa had the most developed mental health user network, with groups within the South Africa Federation for
Mental Health and independent user groups in some provinces. User groups primarily provided support and had relatively little role in lobbying and policy processes. Respondents also noted the lack of power of those who did advocate for mental health. In South Africa, although some province-level staff and mental health nurses advocated for action for mental health, they had little power to influence change. In Zambia, the clinical director for mental health was referred to as ‘voiceless’.

Stigma was identified as an overarching problem in all countries and was a cross-cutting issue, affecting legitimacy, feasibility and support. Stigma was found to affect not only mental health patients and their families, but also those who worked in mental health and even policy makers who took up the mental health cause. This acted as a strong deterrent to people advocating for mental health or working in a mental health field. One psychiatrist explained how stigma and misunderstanding discouraged people from allocating funds:

“Most of our patients are stigmatized and that even affects the allocation of funds because people don’t see how money that should be given to people who are sane [could] be given to the insane who they feel cannot contribute to society.” [Senior psychiatrist, Ghana]

Increasing the priority of mental health: experiences and suggestions

Although respondents identified a range of factors which acted as barriers to the prioritization of mental health, they had limited experience of strategies that had made a difference or suggestions for ways forward. We consider the experiences and suggestions within the three categories of legitimacy, feasibility and support. However, there was some overlap between the categories.

Legitimacy of the problem

In order to improve perceptions of the legitimacy of the problem, respondents from all four countries suggested that there was a need to improve data collected on mental health prevalence and impact, including through the HMIS:

“If I were in mental health I would work flat out to make sure that we get data on mental health, the impact it’s having in the community and on the government and the country as a whole…that is a tool that will move us forward.” [Policy maker, Zambia]

Media representatives in Uganda suggested that journalists with personal experiences of mental illness were more likely to write about the topic. Likewise, politicians and policy makers with experience of mental illness were considered more likely to take up the mental health cause. Respondents in Uganda suggested a need for training for journalists to improve media coverage. Media representatives suggested a need to improve communication on mental health, hold events and involve influential people such as politicians and celebrities to improve mental health media coverage.

Feasibility of response

There were limited suggestions put forward to improve stakeholders’ understanding of feasible responses to mental illness. There were a number of suggestions for service developments, for example in South Africa respondents suggested a need to improve community mental health services and integrate mental health into primary care. There were also calls for sensitization of policy makers to mental health interventions:

“Some of the leaders don’t have the negative attitude as such but simply don’t know what to do . . . We need massive sensitization.” [NGO respondent, Uganda]

Support for response

Most experiences and suggestions were to increase the support for mental health. International advocacy was frequently cited as a driver for change. Respondents from the Ministry of Health in Uganda and Ghana cited the World Health Report 2001 and recommendations from the World Health Organization as drivers for increased priority of mental health nationally:

“The World Health Organization has recently put stress on mental health; for the last 5 years or even earlier. So now it is on the front pages of the strategies of the World Health Organization. And so the Ministry of Health had no choice but to pick up this.” [Health policy maker, Ghana]

Improved national advocacy for mental health was called for by respondents in all countries. Respondents suggested a need for co-ordinated advocacy movements, involving user groups, NGOs and other organizations:

“I think we need . . . a strong advocate or advocates for mental health in this country, I really do. We need a group of individuals that will be able to speak up on behalf of mental health because in African society, mental health has been shunned.” [Health worker, Ghana]

In Uganda, respondents cited the strong mental health leadership in the Ministry of Health as a driving factor for recent achievements in mental health policy and service provision. In Uganda and South Africa, respondents called for leaders or ‘champions’ to drive forward the mental health cause:

“There is definitely a champion needed because it’s a whole shift, mind shift that needs to take place . . . you definitely need somebody to drive that process.” [Policy maker, South Africa]

The need to tackle the stigma surrounding mental illness was identified, for example through awareness-raising activities with the public. A number of respondents from Ghana, South Africa and Uganda drew parallels between mental health and HIV, which is also a stigmatized condition. They suggested that mental health advocates should draw lessons from HIV to improve strategies to tackle stigma and increase the priority of mental health.

Respondents also suggested a need for greater external funding from donors and international organizations. An injection of funding from the African Development Bank provided resources needed to develop mental health facilities.
and improve implementation of the draft mental health policy in Uganda.

Discussion

We identified three overarching categories of factors affecting the low priority of mental health: the low perceived legitimacy of the problem, the perceived infeasibility of responding to the problem and insufficient support to respond to the problem. Respondents put forward experiences and suggestions to increase the priority of mental health; we can put forward further suggestions, learning from previous research and other health conditions. Although the study focused on four countries in Africa, similarities between the experiences in the countries and with previous studies indicate that the findings may be applicable for other African countries.

Our findings support suggestions from previous studies that the rationality model does not adequately explain how issues get onto the agenda or gain priority (Buse et al. 2005) and that it oversimplifies the complexity of decision-making on policy issues (John 1998). Mental health decision makers had inadequate information, a constraint that has been recognized to hinder the rational decision-making process (Buse et al. 2005). A further criticism of the rationality model has been that it does not take into account actors’ interpretation of evidence (Reichenbach 2002). Although DALYS are increasingly used to define priorities internationally, they were considered inappropriate and unethical in Zambia, as they could lead to diseases that caused mortality being overlooked. Furthermore, stakeholders’ views were shaped by a broad range of sources of evidence, including wider community views and the media, and also by the national social, political and cultural context and international influences.

There were questions about the legitimacy of the problem of mental health. Decision makers had a lack of information on the burden and severity of mental illness. A self-perpetuating cycle has formed: because mental health is a low priority there is a lack of mental health services, therefore HMIS data collected on mental health is insufficient, there is a lack of data for planning and mental health remains a low priority (Figure 1). The lack of mental health data and perception that mental health indicators are not tangible and convincing has been identified as a key barrier by international mental health experts and leaders (Saraceno et al. 2007). There is a need to improve research and HMIS information collected on the burden and impact of mental illness; a series of indicators for improving mental health data collection has been put forward by the Lancet Global Mental Health Group (2007). There is also a need to develop clearer understanding of the type of information required by decision makers (e.g. DALYs, mortality data, data on socio-economic impact) to be able to collect and package information in a way that is useful to decision makers. Mental health was also not very evident in the community. People hid mental illnesses to avoid stigma and there was limited media coverage of mental health issues. Potential ways forward include supporting mental health user groups to have a more public voice or training for the media to improve the amount and quality of reporting on mental health issues.

Whilst a number of factors affected respondents’ understanding of the feasibility of responding to mental illness through the provision of services, few strategies were put forward in this category. A perceived lack of cost-effective mental health treatments among policy makers has been identified previously (Saraceno et al. 2007) and our findings support this. There is, however, growing evidence on treatment and prevention of mental disorders (Patel et al. 2007). Although some innovative approaches to development of mental health services have been put forward, including task shifting and community involvement, progress in mental health systems and service development has been slow (Saraceno et al. 2007). A need for further epidemiological and health systems research to inform the development of services in African countries has been identified in consultation with mental health experts and mental health stakeholders and researchers in low- and middle-income countries (Sharan et al. 2009; Tomlinson et al. 2009). Translation of available evidence on interventions into clear guidance for decision makers and funders may also help to fill the information gap. Further, perceptions of the effectiveness of mental health interventions are influenced by public beliefs on mental illness. Whilst public beliefs are difficult to shape, strategies may include public education, integrating services for people with mental illness into primary care and developing community services where people can see the positive effects of treatment.

Most of the suggestions put forward were to improve support for countries responding to mental illness. Generally, funding for mental health was very limited, but an injection of external funding was a key driver of change. Resource provision, including international aid, is a clear driver of national priority-setting (Shiffman 2007). The cost of providing a minimum package of mental health services in low-income countries has been estimated at US$2 per year, requiring a 10-fold increase in funding for mental health (Lancet Global Mental Health Group 2007). Given the context of low overall funding for the health sector and limited donor support for mental health, there is an urgent need for donors and NGOs to increase funding for mental health in Africa.

Our findings support the recognition that advocacy for mental health has been weak, due to the invisibility of mental health users, who are often poor, voiceless and comprise a fragmented user movement (Saraceno et al. 2007). Advocacy by powerful groups has been shown to drive prioritization of health issues,
for example breast cancer in Ghana (Reichenbach 2002). All the study countries had some user groups and NGOs working to support people with mental illness. User groups need to become more involved in advocacy work and better organize and network to be more effective. There may be a need for support, such as financial support from NGOs, to facilitate this. Policy champions or entrepreneurs have been recognized as drivers of the policy agenda; coupling the problem, policy and politics streams and opening of policy windows in Kingdon’s multiple streams theory (Kingdon 1984). The need for champions to drive forward the issue of mental health was widely suggested by respondents, although experience showed that they often lacked power and may need support. The mental health advocacy movement could learn lessons from the HIV user movement, which has successfully advocated for improved prioritization of HIV, including access to treatment and human rights. Stigma was identified as a cross-cutting barrier to increasing the priority of mental health. Tackling stigma is challenging, but a number of strategies have been put forward to tackle mental health stigma in Africa, including public education (Kakuma et al. 2010).

The influence of the World Health Report 2001 demonstrated the power of high profile reports to increase the priority of mental health. Clear recommendations from the World Health Organization were also considered useful. International trends and priorities have been cited as strong drivers of national priority in the field of maternal health (Shiffman 2007) and the lack of international targets (e.g. Millennium Development Goals) for mental health has been identified as a barrier to prioritization of mental health (Saraceno et al. 2007). Greater inclusion of mental health issues in high profile reports from international organizations and clear recommendations could provide further support.

There is a growing priority of mental health at a global level. The Global Movement for Mental Health (The Lancet 2008) advocates for the development of delivery systems for mental health care, promotes research, builds capacity and monitors progress. Our findings have indicated the importance of international information and advocacy in providing support for mental health, taking into account the information needs and social, cultural and political context. We also provide concrete evidence-based recommendations in response to calls for mental health advocacy to be informed by research on political will for improvement of mental health services (Saraceno et al. 2007).

Our analysis showed that even when changes in some categories had occurred, mental health remained a low priority. Kingdon (1984) proposed that changes are required in all three streams before windows of opportunity emerge. Whilst we cannot be clear that changes are required in all three categories, our findings suggest that a wide range of strategies will need to be employed in order to increase the priority of mental health.

**Conclusion and suggestions**

We identified factors affecting the low priority of mental health in Ghana, South Africa, Uganda and Zambia, and suggestions from respondents to improve this. Through discussion with previous research and other health conditions, we put forward some broad suggestions for researchers, local, national and international advocacy groups, NGOs and donors, international organizations, policy makers and others who are involved in making or implementing policy to increase the priority of mental health (see Box 1).

**Box 1 Suggestions to increase the priority of mental health**

- There is a need to improve information collection, translation and dissemination on mental health. Specifically, the following suggestions are put forward for researchers, governments, international organizations, donors, NGOs and others working in health systems:
  - Strengthen epidemiological and health system research on the prevalence and impact of mental illness in Africa and appropriate interventions;
  - Improve routine data collection on mental health in the Health Management Information System;
  - Develop a clearer understanding of the type of information on mental health required by government decision makers;
  - Translate evidence on interventions into clear guidance for government decision makers and funders.

- There is a need to improve awareness of mental health issues among the general public and decision makers. There is a related need to develop advocacy for mental health. Specifically, the following suggestions are put forward for NGOs, donors, international organizations, local, national and international advocacy groups and others working in mental health:
  - Support local and national mental health user groups to form networks, advocate effectively and have a public voice;
  - Strengthen international advocacy for mental health and include mental health in high profile international reports;
  - Provide training or support to the media to improve reporting on mental health;
  - Develop public awareness raising and education on mental health;
  - Integrate mental health services into primary care and community-based services.
  - Encourage greater funding for mental health from donors and NGOs.
  - Learn lessons from the experiences of HIV advocacy movements.

These suggestions are particularly relevant as mental health increases in priority on the international agenda, in order to inform those advocating for increased priority of mental health in Africa. Strategies to increase the priority given to mental health need to address the legitimacy of mental health and the feasibility of and support for responding to mental health problems.
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