THE IMPORTANCE OF MENTAL HEALTH WELL-BEING WITHIN THE SUSTAINABLE DEVELOPMENT GOALS (SDGS) 2030

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ABSTRACT

Purpose: This paper calls for an improvement in mental health care in African countries. The UN's Sustainable Development Goals (SDGs) 2030 promotes overall well-being; however, progress in addressing mental health lags significantly relative to efforts to eradicate poverty, malnutrition and communicable diseases.

Method/Approach: This paper examines data reported by vested international organisations on mental health issues in African countries, and studies assessing the efficacy of current services.

Findings: Mental disorders are both triggered by and act as a precursor to poverty, unrest and other challenges. A collaborative effort involving both the public and private sector is needed to address service shortages and promote mental health.

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Originality/Value: There is growing evidence attributing a large proportion of the global health burden to mental disorders, which are projected to rise in many African countries. This paper provides recommendations to support efforts to address mental health needs as an aspect of sustainable development.

Keywords: Disability; mental health needs; mental health services; psychosocial disorders; sustainable development goals

Purpose

Mental illness is perhaps the most severely under-served health care issue prevailing in African countries. In addition to those born with a mental health condition, wars, famines, poverty and debilitating physical illnesses have taken a severe psychological toll. Those affected by unrest, illness and malnutrition often also experience post-traumatic stress disorder (PTSD), anxiety, depression and other mental health disorders, resulting in an inability to function economically and socially and contributing to further violence. Moreover, untreated depression is strongly indicated as a significant threat to the success of antiretroviral therapy and condom use in combatting HIV (Wagner et al., 2014). Based on the lack of available diagnosing and treatment facilities, many of those enduring mental health disorders have tended to seek relief through substance abuse (Gberie, 2016). The Sustainable Development Goals (SDGs) 2030 aim to ensure healthy lives and promote well-being for all. However, while significant progress is being made in addressing communicable diseases such as malaria and HIV, mental health remains among the most neglected services in the region due to associated stigma and a lack of integration.

This paper calls for an improvement in mental health care in African countries. The World Health Organization (WHO) reports that low-income countries allocate only 0.05% of GDP to mental health care (WHO, 2011); the result of this is that 75–90% of Africans who suffer from psychosocial disorders lack access to adequate care. Fewer than half of African countries have established a dedicated mental health policy (WHO, 2014), and mental health care providers in the region lack the resources to supply needed medications, identify and train sufficient caregivers, and expand services beyond meeting very basic needs. Unlike communicable diseases such as HIV/AIDS, malaria, or Ebola, aid organisations have devoted fewer economic and human resources to confronting psychosocial disorders: help is needed from the private sector to create more sustainable approaches.

Method/Approach

This paper takes an holistic view of mental health as an integral aspect of physical well-being and quality of life as well as societal cohesion and functioning, whereby

mental illnesses are both engendered by and impact overall personal well-being and broader social conditions. Mental health is defined as a state of well-being in which individuals are able to cope with the normal stresses of life while working productively and making a contribution to their families and communities (WHO, 2017). It is a crucial element in overall health and the prevention and treatment of disease.

This paper examines data on mental health prevalence and services as provided by such vested organisations as the RAND Corporation, the WHO, and Human Rights Watch (HRW), as well as studies describing nascent mental health initiatives in African countries.

CULTURAL ATTITUDES TOWARDS MENTAL ILLNESS

In 2014, Kenyan humour writer Ted Malanda published an article in the *Standard* entitled "How depression has never been an African disease", in which he argued for the nonexistence of depression in African cultures, noting the lack of relevant linguistic terms. Malanda's article reflects widely held attitudes towards depression and other psychosocial disorders, the symptoms of which have traditionally been either been ignored or attributed to a spiritual misalignment, only curable with traditional medicines and intercession with the supernatural world. In many countries, the mentally ill are considered to walk between the human world and the realm of spirits, and can be seen wandering around cities and villages alike, where they are often criminalised as vagrants and eventually removed from society.

Traditional treatments of mental illnesses are often physically debilitating and involve actions that the United Nations (UN) and HRW would describe as forms of torture. Mentally ill individuals in Ghana and Nigeria, for example, are frequently sent to 'prayer camps', where the afflicted may be chained to a tree as specialists pray for them, or beaten to expel the 'demons' believed to be controlling their behaviour. Ghana adopted a ban on such practices with the 2012 Mental Health Act (HRW, 2017).

Another common view associates mental health disorders with substance abuse, resulting in little sympathy and less interest in prioritising mental health among both governments and the general population. Substance abuse is widely cited as a contributory factor to psychosis and associated violent behaviours, even among those responsible for providing diagnosis and care. A report by HRW cited only 8–10% of all mental patients in Ghana as being affected by drug-related psychosis (HRW, 2012), however, many non-professionals often assume that substance abuse issues encompass the majority of cases.

Although there has been increase in the spotlight on psychiatric awareness in Africa, it is interesting to note that many people with chronic or severe psychiatric disorders may be unaware that effective treatment is available. The high level of stigma and the unavailability of treatment preclude early intervention. The situation is not helped by the ignorance and stigma in communities that prevents such people

from seeking appropriate help. Unfortunately, as it may be noted, our African communities have attitudes and beliefs that have played a major role in determining the manner that help is sought for successful early intervention or treatment of people that are mentally ill.

COMMON BARRIERS TO MENTAL HEALTH CARE

There are barriers to accessing mental health care in Africa, and there is limited availability of medication and health professionals. In Nigeria, there are 44 Mental Health Services in Nigeria (excluding private facilities). For a country with a population of 190 million there are only 26 National Psychiatric Hospitals and 15 private hospitals. There are several local unregistered treatment centres using unorthodox methods.

For example in Nigeria there is:

- around 1 psychiatrist per 1.5 million population;
- around 1 psychiatric nurses per 20,000 population;
- only 1% of Healthcare budget that goes towards the treatment of mental health.

The estimated cost per capita of treatment of mental illness is high in Africa. The affordability of these drugs is difficult for most Africans. Interventions are making use of newer antipsychotic drugs; in the regional analysis these were estimated to be two to four times more costly than older drugs but very much higher than predicted in Nigeria (more than I$ 10 per capita). At the time of the study, for example, 2mg risperidone could be obtained for 4.5 rupees (US$ 0.06) in Sri Lanka, compared to 255 Naira (US$ 2.50[1]) in Nigeria, a 40-fold difference (Chisholm et al., 2008). Other barriers are policy limitations, lack of education and high level of stigma.

FUNDING AND STAFFING SHORTAGES FOR MENTAL HEALTH SERVICES

The UN General Assembly's recognition of mental health and substance abuse among its SDGs in 2015 marked the first consensus among world leaders to make mental and behavioural health a global priority (UN, 2015). While critics have decried the limited resources dedicated towards psychosocial health services in African countries, governments bear the bulk of the financial burden for mental health care (WHO, 2014). Governments cite the prevalence of more acute issues requiring their attention, particularly infectious disease and malnutrition. While international aid and global pro-

[1]In 2018 the US dollar to Naira exchange rate was 450.

grammes to reduce conflict, poverty and disease have increased substantially, world governing bodies and aid organisations have done less to prioritise funding towards addressing the long-term mental health effects of these conditions.

This has contributed to a situation in which there are insufficient policies dedicated to addressing mental disorders, and very limited facilities and staff trained in the diagnosis and treatment of mental and behavioural health conditions. Across the region, day patient facilities are essentially non-existent, and outpatient services are available for only 80 out of every 100,000 people; this should be compared to 1,926 outpatients and 42.98 day patients per 100,000 people across Europe (WHO, 2011). Only 1.9 psychiatric beds are available per 100,000 people, while psychiatric wards in general hospitals are limited to one for every 3.65 million (WHO, 2014). With 22 psychiatric hospitals and 36 psychiatric wards in general hospitals, South Africa is better equipped than any other African country (WHO, 2014); however, as in other countries in the region, most of these facilities serve more as places of confinement than places of care and rehabilitation.

The current shortage of specialist mental health personnel in low- and middle-income countries has been estimated at 1.18 million (Kakuma et al., 2011), with only 1.4 mental health workers per 100,000 people in African countries (WHO, 2014). Like other African health care workers, some of those trained to treat mental illness have chosen to migrate from their home countries due to the stresses of social trauma and/or in search of better pay and working conditions. Many countries have addressed the shortages by also training primary care practitioners to administer psychiatric treatment, including social support, psychosocial therapies and medication (Mendenhall et al., 2014; van Ginneken et al., 2013). However, only 23% of countries reported that a majority of primary care doctors have received training on mental health, and only 24% reported training nurses in treating mental illnesses (WHO, 2011).

Even relatively better developed nations lack sufficient staff and facilities to provide care for the afflicted. In Kenya, where 25% the population suffers from mental disorders, ranging from depression and severe anxiety to bipolar disorder, schizophrenia and other psychotic disorders, there are only about 80 psychiatrists and 30 clinical psychologists; most of the burden of services for a mentally ill population of 11 million is borne by 500 psychiatric nurses (WHO, 2014). The situation is even more dire in Nigeria, which has only 130 psychiatrists in a country of 179 million people, leaving only an estimated 10% of the estimated 40–60 million people suffering from mental health disorders with access to professional care (WHO, 2014). Ghana, one of the few African countries to have established an official policy towards mental health, has only 20 psychiatrists for a population of 26 million, leaving a huge 97% of afflicted people without access to services (WHO, 2014). In countries torn apart by conflict, such as Liberia and Sierra Leone, the situation is particularly severe. These countries, with respective populations of four and seven million, have only one psychiatric

hospital each for hundreds of thousands of people enduring serious depressive illness, major depressive disorders or post-traumatic stress disorder (WHO, 2014).

LACK OF GOVERNANCE AND REGULATIONS

One issue that negatively impacts the quality of existing mental health services in Africa is the lack of regulations. Only a quarter of African countries have developed official manuals detailing the management and treatment of mental disorders that are available at most clinics (WHO, 2011). Moreover, while developed regions impose heavy regulations on the prescribing of medicines to treat mental and behavioural disorders, the dearth of psychiatrists has led to 61% of African countries allowing primary health care physicians to prescribe such medicines in an unregulated manner, and 9% allow nurses to do so (WHO, 2011). Even more concerning, 27% of African countries have an official policy that enables nurses to independently diagnose and treat mental disorders within the primary care system, compared to only 6% in Europe (WHO, 2011). The result is a lack of standardisation for diagnoses and treatment of mental illnesses that severely impacts the quality of these services. Only about 20% of the patients who do enter mental health facilities receive routine follow-up care (WHO, 2014), thus increasing the risk of relapse as the patients lack professional support in their recovery.

MAKING MENTAL HEALTH A SUSTAINABLE GOAL

In including mental and behavioural health disorders among its SDGs, the UN has created an opportunity for these issues to be addressed on an unprecedented scale. Governments and global and regional health organisations should seek aid from the private sector in establishing and equipping more facilities, particularly in rural areas that often lack access to any sort of mental health care. Partnerships can also be developed with the private sector to increase the availability of mental health medicines and outpatient treatment as part of other health initiatives.

However, improving mental health services in Africa cannot be achieved merely with expanded funding and facilities; rather, it requires a concerted campaign of education, training, and oversight. The WHO's Global Mental Health Action Plan (WHO, 2013) centres on strengthening effective leadership and governance for mental health, implementing policies and plans for the integration of mental health into general and community health care, and developing preventative strategies as part of the effort to promote overall mental health.

Efforts must be dedicated to recruiting and training more psychiatrists and other specialised professionals, as well as the establishment of regulations to standardise diagnosis criteria and treatment programmes. In addition, those currently employed

may require additional training to adjust cultural attitudes dismissing mental illness as a result of drug abuse or spiritual weakness. Members of the wider community also need to be educated on the causes, symptoms and treatment of mental illness, including the role of violence, imprisonment and the use of illicit drugs in exacerbating their effects; this will help to reduce stigma and increase the likelihood of people seeking professional treatment. Such education programmes need not always deride cultural notions associating mental illness with spiritual misalignment, but in some cases can rather emphasise the roles of poverty and physical and emotional trauma as stressors, in contrast with prevailing perceptions that tend to 'blame the victim'.

Several countries have recognised the need to be more proactive in addressing mental health needs. For example, the South African Department of Health has collaborated with researchers from the United States and South Africa to develop educational interventions such as the VUKA[2] family-based programme to promote overall health and mental health among HIV positive youths and their families (Bhana et al., 2014). In Uganda, RAND researchers are collaborating with the government to identify effective and sustainable approaches to integrate depression treatment into HIV care (Wagner et al., 2014). The Africa Focus on Intervention Research for Mental Health (AFFIRM), is working in Ethiopia, Ghana, Malawi, South Africa, Uganda, and Zimbabwe to promote capacity building low-cost, task-sharing interventions for severe mental disorders (Lund et al., 2015). The private sector can collaborate with governments and global health organisations to expand such programmes.

CONCLUSIONS

This paper examined the challenges and some opportunities associated with mental health issues in African countries. Mental health disorders have been demonstrated to be a precursor to unrest, substance abuse and even to exacerbate the effects of disease in Africa; it will require a collaborative effort involving both the public and private sector to address this surge. In 2001 at the World Health Assembly, the WHO charged African countries who were just beginning to address mental health issues to set priorities around the delivery of their mental health goals. They enjoined that "Choices must be made among a large number of services and a wide range of prevention and promotion strategies" (WHO, 2011). The strong message is that every country, notwithstanding its resource constraints, must do something to improve the mental health of its population.

There is no health without mental health.

[2]VUKA is a cartoon-based intervention that was developed with South African investigators, graphic artists, medical staff, adult caregivers and HIV+ adolescents. It is a family based programme devised to provide psychosocial intervention to promote health and mental health in HIV+ early adolescents.

REFERENCES

Bhana, A., Mellins, C.A., Petersen, I., Alicea, S., Myeza, N., Holst, H., Abrams, E., John, S., Chhagan, M., Nestadt, D.F. and Leu, C.S. (2014), The VUKA family program: Piloting a family-based psychosocial intervention to promote health and mental health among HIV infected early adolescents in South Africa. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, Vol. 26, No. 1, pp. 1–11.

Chisholm, D., Gureje, O., Saldivia, S., Villalon Calderon, M., Wickremasinghe, R., Mendis, No., Ayuso-Mateos, J.L. and Saxena, S. (2008), Schizophrenia treatment in the developing world: an inter-regional and multi-national cost-effectiveness analysis. *Bulletin of the World Health Organization*, Vol. 86, No. 7, pp. 542–51.

Gberie, L. (2016, 25 November), Mental illness: Invisible but devastating. Retrieved from http://www.un.org/africarenewal/magazine/december-2016-march-2017/mental-illness-invisible-devastating.

Human Rights Watch (HRW) (2012, 02 October), "Like a Death Sentence": Abuses against Persons with Mental Disabilities in Ghana. Retrieved from https://www.hrw.org/report/2012/10/02/death-sentence/abuses-against-persons-mental-disabilities-ghana.

Human Rights Watch (HRW) (2017, 09 October), Ghana: Invest in mental health services to end shackling: Minister of Finance should establish levy for mental health. Retrieved from https://www.hrw.org/news/2017/10/09/ghana-invest-mental-health-services-end-shackling.

Kakuma, R., Minas, H., van Ginneken, N., Dal Poz, M.R., Desiraju, K., Morris, J.E., Saxena, S. and Schefffler, R.M. (2011), Human resources for mental health care: current situation and strategies for action. *The Lancet*, Vol. 378, No. 9803, pp. 1654–63.

Lund, C., Alem, A., Schneider, M., Hanlon, C., Ahrens, J., Bandawe, C., Bass, J., Bhana, A., Burns, J., Chibanda, D. and Cowan, F. (2015), Generating evidence to narrow the treatment gap for mental disorders in sub-Saharan Africa: rationale, overview and methods of AFFIRM. *Epidemiology and Psychiatric Sciences*, Vol. 24, No. 3, pp. 233–40.

Malanda, T. (2014), How depression has never been an African disease. Retrieved from https://www.sde.co.ke/article/2000131772/how-depression-has-never-been-an-african-disease.

Mendenhall, E., De Silva, M.J., Hanlon, C., Petersen, I., Shidaye, R., Jordans, M., Luitel, N., Ssebunnya, J., Fekadu, A., Patel, V. and Tomlinson, M. (2014), Acceptability and feasibility of using non-specialist health workers to deliver mental health care: Stakeholder perceptions from the PRIME district sites in Ethiopia, India, Nepal, South Africa, and Uganda. *Social Science & Medicine*, Vol. 118, pp. 33–42.

United Nations (UN) (2015), *Transforming our world: The 2030 Agenda for Sustainable Development*. Retrieved from https://sustainabledevelopment.un.org/post2015/transformingourworld/publication.

van Ginneken, N., Tharyan, P., Lewin, S., Rao, G.N., Meera, S.M., Pian, J., Chandrashekar, S. and Patel, V. (2013), Non-specialist health worker interventions for the care of mental, neurological and substance-abuse disorders in low- and middle-income countries. *Cochrane Database of Systematic Reviews*, Vol. 11, CD009149.

Wagner, G.J., Ngo, V., Glick, P., Obuku, E.A., Musisi, S. and Akena, D. (2014), INtegration of DEPression Treatment into HIV Care in Uganda (INDEPTH-Uganda): Study protocol for a randomized controlled trial. *Trials*, Vol. 15, No. 1, p. 248.

World Health Organization (WHO) (2011), *Mental health atlas 2011*. Geneva, SUI: Author.

World Health Organization (WHO) (2013), *Mental health action plan 2013–2020*. Geneva, SUI: Author.

World Health Organization (WHO) (2014), *Mental health atlas 2014*. Geneva, SUI: Author.

World Health Organization (WHO) (2017), Mental health. Retrieved from http://www.afro.who.int/health-topics/mental-health.

BIOGRAPHY

'Lade Olugbemi is a Human Rights activist who is passionate about raising awareness about mental health in ethnic minority communities. She has worked in various sectors of the economy. She promotes early intervention for mental illness in the Black, Asian and Minority Ethnic (BAME) communities and campaigns to remove stigma, negative labelling and stereotyping in accessing support early. 'Lade would like to see policies change reflecting the needs of the BAME communities. She serves on the Board, delivery groups and operational panels of several governmental initiatives. This exposure highlighted a major gap in information held about mental wellbeing and illness in the BAME communities, not just in the UK but also in Africa and Asia. She is on the Board of the Reinvent African Diaspora Network (RADET), African Security Forum. 'Lade is a Motivational Public Speaker and a Mental Health First Aid trainer.