

## **Implementing the World Health Report 2001 recommendations for integrating mental health into primary health care: A situation analysis of three African countries: Ghana, South Africa and Uganda**

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### **Abstract**

Integrating mental health into primary health care is widely promoted for a host of reasons, chief among which is providing a more comprehensive health care service. However, only a few countries have adequate mental health resources to undertake the integration of mental health into primary health care in a uniform manner, with wide variations among countries. This paper examines the extent to which two low-income countries (Ghana and Uganda) and one middle-income country (South Africa) are managing the integration of mental health into primary health care using the recommendations of the WHO World Health Report, 2001. Primary and secondary data sources from a situational analysis of mental health services in the three countries were analysed. The findings indicate that significant challenges remain in integrating mental health care into primary health care. Poor or uneven implementation of policy, inadequate access to essential drugs and lack of mental health specialists are some of the reasons advanced. Aside from better human resource planning for mental health, integration may be advanced by the development of packages of care which adopt a task-shifting approach suited to a country's needs.

### **Introduction**

It is widely acknowledged that, globally, countries pay scant attention to mental health issues, with high income countries (HIC) spending only about 5% of their health budgets on mental health, and low- and middle-income countries (LMICs) spending a miniscule 1% on average (Hamid, Abdulla, Bauta, & Huang, 2008; WHO, 2001). In 2005, the World Health Organization (WHO) reported that 70% of African countries contributed less than 1% of their health expenditure to mental health.

The call to scale up mental health services has been given impetus by the 2007 *Lancet* series on global mental health, which identified the integration of mental health care into primary health care as a key strategy (*Lancet* Global Mental Health Group, 2007). The reasons for integrating mental health into primary health care were most recently reiterated by the WHO and the World Organization of Family Doctors (WONCA) (WONCA, 2008). On the demand side, the enormous burden of mental disorders in all societies and the interwoven nature of mental and physical health problems bolster the argument for integrating mental health services with

primary care. On the supply side, integration promises greater affordability and more cost effective and comprehensive care.

Recognizing the scarce resources in LMICs, the WHO (2001) recommended a stepped approach that takes account of the practical realities of providing mental health services in low resource settings, and promotes the view that even in low resource contexts, a minimum level of mental health care can be provided (see Table I).

Despite the international exposure of the WHO (2001) recommendations, little research has documented the extent to which they have been implemented, particularly in African countries. The aim of the current study was to examine the extent to which existing mental health systems were aligned with the WHO (2001) recommendations in three African countries: South Africa (as a middle-income country), Ghana and Uganda (as low-income countries).

### **Methods**

This study used primary and secondary data sources from situational analyses conducted by the Mental

Table I. Minimum actions required for mental health care – a stepped approach (adapted from WHO, 2001).

Recommended action	Low level resource country (Ghana, Uganda)	Medium level resource country (South Africa)
1. Provide treatment in primary care	<ul style="list-style-type: none"> <li>Recognize mental health as a component of primary health care</li> <li>Include the recognition and treatment of common mental disorders in training curricula of all health personnel</li> <li>Provide refresher training to primary care physicians (at least 50% coverage in 5 years)</li> </ul>	<ul style="list-style-type: none"> <li>Develop locally relevant training materials</li> <li>Provide refresher training to primary care physicians (100% coverage in 5 years)</li> </ul>
2. Make psychotropic drugs available	<ul style="list-style-type: none"> <li>Ensure availability of five essential drugs in all health care settings</li> </ul>	<ul style="list-style-type: none"> <li>Ensure availability of all essential psychotropic drugs in all health care settings</li> </ul>
3. Give care in the community	<ul style="list-style-type: none"> <li>Move people with mental disorders out of prisons</li> <li>Downscale mental hospitals and improve care within them</li> <li>Develop general hospital psychiatric units</li> <li>Provide community care facilities (at least 20% coverage)</li> </ul>	<ul style="list-style-type: none"> <li>Close down custodial mental hospitals</li> <li>Initiate pilot projects on integration of mental health care with general health care</li> <li>Provide community care facilities (at least 50% coverage)</li> </ul>
4. Educate the public	<ul style="list-style-type: none"> <li>Promote public campaigns against stigma and discrimination</li> <li>Support non-governmental organizations in public education</li> </ul>	<ul style="list-style-type: none"> <li>Use the mass media to promote mental health, foster positive attitudes and help prevent disorders</li> </ul>
5. Involve communities, families and consumers	<ul style="list-style-type: none"> <li>Support the formation of self-help groups</li> <li>Fund schemes for non-governmental organizations and mental health initiatives</li> </ul>	<ul style="list-style-type: none"> <li>Ensure representation of communities, families, and consumers in services and policy making</li> </ul>
6. Establish policies and programmes	<ul style="list-style-type: none"> <li>Revise legislation based on current knowledge and human rights</li> <li>Formulate mental health programmes and policy</li> <li>Increase the budget for mental health care</li> </ul>	<ul style="list-style-type: none"> <li>Create drug and alcohol policies at national and sub-national levels</li> <li>Increase the budget for mental health care</li> </ul>
7. Develop human resources	<ul style="list-style-type: none"> <li>Train psychiatrists and psychiatric nurses</li> </ul>	<ul style="list-style-type: none"> <li>Create national training centres for psychiatrists, psychiatric nurses, psychologists and psychiatric social workers</li> </ul>
8. Link with other sectors	<ul style="list-style-type: none"> <li>Initiate school and workplace mental health programmes</li> <li>Encourage the activities of non-governmental organizations</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen school and workplace mental health programmes</li> </ul>
9. Monitor community mental health	<ul style="list-style-type: none"> <li>Include mental disorders in basic health information systems</li> </ul>	<ul style="list-style-type: none"> <li>Institute surveillance for specific disorders in the community (e.g. depression)</li> </ul>
10. Support more research	<ul style="list-style-type: none"> <li>Survey high-risk population groups</li> <li>Conduct studies in primary health care settings on prevalence, course, outcome and impact of mental disorders in the community</li> </ul>	<ul style="list-style-type: none"> <li>Institute effectiveness and cost-effectiveness studies for management of common mental disorders in primary care</li> </ul>

Health and Poverty Project (MHaPP) in all three of the above countries. The overall aim of MHaPP was to explore mental health policy development and implementation in four African countries: Ghana,

South Africa, Uganda and Zambia (Flisher *et al.*, 2007). The situational analyses comprised the first phase of the project, with interventions occurring in the second phase.

In each country the situational analysis sought to understand the current status of mental health policy development and implementation at national, provincial and district level. For the district level, an in-depth analysis was conducted of one or more typical districts as case studies within each study country. Quantitative methods were employed, which made use of the World Health Organization Assessment Instrument for Mental Health Systems (WHO-AIMS) Version 2.2 and the WHO Mental Health Policy and Plan Checklist and the WHO Mental Health Legislation Checklist. Qualitative methods employed semi-structured interviews and focus group discussions with key stakeholders to develop an understanding of the processes and issues affecting mental health policy development and implementation at all levels.

The data sources from these situational analyses in the three countries were used to examine the extent to which the countries were aligned with the WHO (2001) recommendations. As the focus of the study was on the integration of mental health into primary health care, only the first seven of the ten WHO recommendations were explored. Secondary published and unpublished research reports from the situational analyses were used to examine the situation with regard to the recommendations at national and provincial levels. Similarly, at district level, a combination of secondary and primary data sources were utilized to gain an understanding of what was actually on the ground according to the reports of district level stakeholders.

#### *Country district sites and sample*

Each country chose one or more district sites to provide a case study of a district mental health system. The Ghanaian, South African, and Ugandan district sites are part of the worldwide INDEPTH network which are demographic surveillance sites (DSS) which continuously provide demographic and health information (INDEPTH Network, 2002).

In Ghana, a district in a rural setting (Kintampo) was chosen as a representative case study as it was typical of widespread levels of poverty and limited provisions for mental health care. At the time of the study the population of the district stood at 140,000 located in 22,475 households (an average of six per household) spread over 4000 compounds. At 4000 km<sup>2</sup>, the DSS site is situated in one of the largest districts in the region. The district has high levels of poverty and illiteracy. Many households lack basic amenities such as water and electricity, and infrastructure is poorly developed.

In South Africa, a sub-district within a rural district (Umkhanyakhude) was chosen as a representative case study. The target district has high levels of

poverty and unemployment typical of most rural areas in South Africa. Many households lack basic amenities such as water and electricity and there is a lack of proper infrastructure in some areas. The district population was 503,760 at the time of the study with the district covering 12,819 km<sup>2</sup>. Due to the large area, it is divided up into five local authority areas (sub-districts). One of these sub-districts was the study site with a population of 168,508 covering an area of 1417 km<sup>2</sup>.

In Uganda, two district sites were chosen. One is an urban district (Wakiso) with a relatively well-organized health delivery system. The district covered a total area of 2704 km<sup>2</sup> and a population of 957,280 people at the time of the study. The second site (Mayuge) is typical of many rural areas in Uganda and is part of the worldwide INDEPTH network. The population was over 326,567 people at the time of the study, with an area of 4672.22 km<sup>2</sup> with only 23.38% being land, the rest being water.

#### *Data collection*

Primary data sources were derived from semi-structured interviews and focus group discussions with key informants at district level. Interview schedule templates were developed for each stakeholder group covering the key issues that needed to be investigated for the situational analysis, including management frameworks and intersectoral links to support the delivery of mental health care in the district, care, treatment and rehabilitation of people with common and serious mental disorders, and socio-economic and cultural factors that play a role in mental health service delivery and uptake. While the questions were not specifically developed to assess the implementation of the WHO (2001) stepped framework for the integration of mental health into primary health care, together with provincial and national data collated in the country reports, the situational analyses were broad enough to encompass the WHO recommendations.

In order to ensure that the data collected across country sites was consistent and conformed to uniform standards, the format and range of questions to be addressed was formulated in collaboration with each participating country to ensure content and face validity of each of the proposed instruments prior to data collection (Schilder *et al.*, 2004) and adapted for country-specific issues by country partners. Key stakeholder groups included district managers, district hospital personnel, primary health care personnel, community level workers, traditional healers, private health care providers and service users. In addition, key informants from the social development/social welfare sector, educational sector, criminal justice system as well as spiritual and NGO

sector were interviewed in each country. Respondents were interviewed in English or in a local language. Interview questions in which a local language was used were translated and independent back-translation checks applied to ensure accuracy of translation and meaning.

A total of 35 semi-structured interviews were conducted in the district sites in Ghana and South Africa and 20 in Uganda. A further six focus group discussions were held in Ghana, 12 in South Africa and five in Uganda. All the data were collected by in-country research officers who had received training in interview and focus group discussion methods.

#### *Qualitative data analysis*

The primary qualitative data were analysed using the framework approach which was developed for applied policy research (Ritchie & Spencer, 1994). A coding framework was developed using the classification of low- and middle-income countries and the WHO recommendations for the minimum actions required (see Table I) and applied in the analysis of the data. The secondary data were analysed using a narrative review approach (Educational Research Review, 2009).

#### *Ethical approval*

Approval for the study was obtained from the Research Ethics Committee, Faculty of Health Sciences, University of Cape Town, the Research Ethics Committee of the Faculty of Humanities, University of KwaZulu-Natal, and the Research Ethics Committees of the national and provincial Departments of Health in each of the countries.

### **Results**

The results are presented in terms of the minimum actions required of each of the countries described in the World Health Report (WHO, 2001), depending on their classification as a low- or middle-income country. In applying these criteria, a better-resourced country is expected to have fulfilled all the criteria applicable to a low-resourced country.

- Overall WHO Recommendation: Establish national policies, programmes and legislation and provide treatment in primary care. For medium resource contexts, create drug and alcohol policies at national and sub-national levels and increase the budget for mental health care and locally relevant training materials. For low resource contexts, revise legislation in line with current knowledge and human rights, formulate mental health

programmes and policy, and increase the budget for mental health care.

#### *South Africa*

In South Africa, decentralization and integration of mental health into primary health care is recognized in the white paper for the transformation of health care in South Africa (Department of Health, 1997) and policy guidelines for mental health services had also been in place since 1997 (Draper *et al.*, 2009). The implementation of these policy guidelines, however, was found to be uneven across the provinces, given the lack of official status of these guidelines and insufficient directives as to how these should be taken up. Integration of mental health care into primary health care was further compromised by mental health budgets being allocated at the discretion of the provincial Departments of Health and not ring-fenced (Lund, Kleintjes, Kakuma, & Flisher, 2010).

Further, since 1997 decentralization and integration appear to have focused more on serious psychiatric disorders that require hospitalization. This process was found to be characterized by de-hospitalization rather than de-institutionalization, with a focus on emergency care and symptom management and insufficient allocation of resources to community-based care and psychosocial rehabilitation (Lund *et al.*, 2010; Petersen *et al.*, 2009). Deinstitutionalization had been assisted by the passing of the Mental Health Care Act of 2002. The Act is consistent with international human rights and standards (WHO, 2005) and demands, *inter alia*, that psychiatric patients are provided with a 72 h observation and referral service at a nearby general hospital. While district responses suggest a good understanding of the Act, it had been imperfectly implemented in that provincial and district mental health is greatly under-resourced, with improvements needed in monitoring and quality assurance measures of mental health care (Lund, Stein, Flisher, & Mehtar, 2007). At the time of the study there had only been nominal efforts at expanding psychosocial rehabilitation (largely provided by NGOs), mostly in urban centres, and at ensuring care for more common mental disorders such as anxiety and depression at primary health care level (Petersen *et al.*, 2009).

Given that there was little training outside of universities and nursing colleges, training materials typically comprised manuals of norms and standards as prescribed by the legislation rather than additional training in mental health. Anecdotal evidence suggests a wide variety of training manuals exist which have not been standardized or compiled into national

training resource materials. While there are some attempts to provide in-service training, primary data district level responses suggest that this is not systematic or well recorded, as reflected in the following quote from the district health manager:

We would like to have every clinic with at least a mentally trained person, not from an orientation view but from a proper qualification in mental health. But in the absence of that reality we do run courses on introduction to mental health for primary health care people to be able to operate at the clinic.

### *Ghana*

Ghana adopted a mental health policy document in 1994 and revised it in 2000. The policy emphasizes decentralization of mental health services and the development of community health care. Health professionals at the district level were mostly unaware of the existence and provisions of this mental health policy, or the Mental Health Act of 1972. This is represented in the primary data by comments from a primary health care clinic doctor and a manager of education in Ghana:

I haven't even heard of the mental act.

Frankly speaking, I have never come in contact with it [Mental Health Act, 1972]. This is the first time of hearing or seeing it.

Further, few resources are allocated to mental health, including those with serious mental disorders, with virtually no programmes for such high risk groups as children, adolescents and older people. It was apparent that at the level of districts, the care of people with mental disorders was severely constrained by the budget. This was worsened by the fact that mental health care was subsumed under an integrated budget and not ring-fenced. The district coordinator indicated that:

Respondent (R): We don't have a specific portion dedicated to mental health. It is integrated. We do not receive money specifically for mental health activities.

Interviewer (I): So with this integrated budget how well do you manage in caring for mental health problems?

R: We just do what's within our reach; whatever we can do to help the people. The budget is not enough and you cannot come out with specific programmes. That is the limitation. Because we don't have an earmarked budget, even what we have, it is too small. So, we cannot do more than we are doing now and is even worse because there is no one who is responsible for that aspect on the team.

### *Uganda*

Uganda developed a draft mental health policy in 2000 and mental health is one of 12 key services to be provided as part of the minimum health care package. It was recognized as being part of primary health care, but there were few or no implementation guidelines to enable policy implementation, resulting in little integration of mental health services, or at least poor understanding of integration of mental health with primary health care (Kigozi & Ssebunnya, 2009). Primary level data supports this view. As suggested by a district health manager:

The bad thing is that they have generated so many policies. Everything is policy, policy, but implementation of these policies is not there. People concentrate so much on developing the policies but they leave implementation to whom it may concern. They spend so many hours, days, money in developing the policies. They should put the same commitment in implementation. When you develop the policy, develop the implementation guidelines as well. So, there is a big gap there.

In addition, a teacher had the following to say:

More proactive action is needed so that what is on paper is translated into reality...But as long as it remains on paper and on air – speaking on radio, even in languages people don't understand – we shall continue having very many people crying for help and dying.

While the national health policy recognizes mental health care as a key component of the National Minimum Health Care Package and is bolstered by a separate mental health budget in the Ministry of Health, the relatively small budgets and poor implementation and the under-prioritization of mental health at district level means that little of this funding finds its way to mental health activities (Kigozi & Ssebunnya, 2009).

### *Summary*

While all three countries endorsed integrating mental health care into primary health care, and in the case of Uganda and South Africa have included mental health interventions as part of the core package of primary health care services, the lack of a policy (South Africa) or the failure to enact policy (Ghana) or provide implementation guidelines (Uganda) makes integration of mental health care into primary health care difficult in reality. This is further compromised by inadequate and, in the case of Ghana and South Africa, lack of dedicated budgets for mental health at district level.

*Overall WHO Recommendation: Make psychotropic drugs available*

*South Africa (Ensure availability of all essential psychotropic drugs).* The five categories of essential psychotropic drugs recommended by the WHO are part of South Africa's essential drug list (EDL). Access to drugs is therefore generally satisfactory. Free access is available to 80% of the population; with 100% availability of psychotropic drugs in mental hospitals, 96% in psychiatric units in general hospitals and 88% in outpatient mental health facilities (Lund *et al.*, 2010). This appears to have filtered all the way down to the district level as confirmed by primary level data. According to a psychiatric nurse at district level:

Medication wise, I think yes the hospital has all the necessary drugs you know that are required to treat patients. I've not experienced a situation where we've ordered a drug for the patient and they've said that the hospital pharmacy doesn't have [it]. It might be a situation in the clinics sometimes that they run out and then I've just got to do an order from the pharmacy and they deliver those meds to the clinics.

*Ghana (Ensure availability of 5 essential drugs in all health care settings).* While some psychotropic medication was available, access was generally considered to be inadequate. There was a list of essential medicines including antipsychotics, anxiolytics, antidepressants, mood stabilizers and antiepileptic drugs (Doku *et al.*, 2008). However, there appeared to be chronic shortages, and when medication was unavailable, patients had to purchase drugs at their own expense through private drug stores, making these drugs unaffordable to many. As revealed by a primary health care district doctor in the primary data:

We don't have many of the drugs used in managing mental health. We have very few of them available. Antidepressants, they have to buy from outside.

*Uganda.* Similarly, while psychotropic medication is part of the EDL in Uganda, access to psychotropic medication was also considered generally inadequate, though certain drugs such as chlorpromazine and carbamazepine were available. Kigozi, Ssebunnya, Kizza, Copper, and Ndyabangi (2010) reported that only 37% of community-based psychiatric inpatient units had at least one psychotropic medicine of each therapeutic class (antipsychotic, antidepressant, mood stabilizer, anxiolytic, and antiepileptic medicines) available in the facility. Limited access to drugs is supported in the primary

data as suggested by a primary health care nurse as part of a focus group interview:

We do have some...like chlorpromazine...carbamazepine...but we don't go much into that. Anything beyond that...we just don't have a programme for that.

A psychiatric nurse indicated that shortages occur even with these drugs and have to be sourced, if available from pharmacies, or pharmaceutical agents directly.

I: Now what resources or services are available in the entire district for mental health?

R: The only thing which is here, we've got some, little, drugs. We've got phenobarbitone and phenytoin. Last time we had those manic cases running out of (the) place...We requested for haloperidol, we requested for chlorpromazine, it was nowhere to be seen, in the whole district. Not even the other drugs shops around or pharmaceutical agents. These drugs were not there.

*Summary.* All categories of essential psychotropic drugs recommended by the WHO are part of South Africa's essential drug list (EDL) and widely available in South Africa, even at a district clinic level. The range and availability of drugs in the case of Ghana and Uganda was, however, limited, even when the essential psychotropic drugs were included on an EDL.

*Overall WHO Recommendation: Give care in the community. Close down custodial mental hospitals and initiate pilot projects on integration of mental health care with general health care as well as provide community care facilities (at least 50% coverage)*

*South Africa (Initiate pilot projects on integration of mental health care with general health care).* In keeping with the Mental Health Care Act of 2002 (Department of Health, 2004), over half of all general hospitals have been assigned to provide assessments of psychiatric emergencies with a 72-h timeframe. This involves 131 of 251 district hospitals, 28 of 59 secondary hospitals, and 14 of 33 tertiary hospitals (Lund *et al.*, 2010). Further, there are a number of community residential facilities (63), 53% of which are provided by the Department of Health and the remainder by the South African Federation for Mental Health (SAFMH), an NGO (Lund *et al.*, 2010). Largely located in urban areas, these district level responses suggest that services are hampered by practical issues such as transport and the long distances that patients have to travel to attend support groups, with rural areas being

particularly under-resourced as reflected in the primary level data by the following quotation from an NGO representative in one of the sub-districts:

R: Well we have some [support groups] in the rural areas but mainly here in the towns [two towns about 150 km from the research site]...because you see the problem is that we don't have the...we only have two cars. That's a logistical problem.

I: Are there any groups, specifically in the sub-district?

R: Not at present no.

*Ghana (Develop general hospital psychiatric units).* There are three psychiatric hospitals in the country with 80% of the mental health budget allocated to these hospitals (Doku *et al.*, 2008). Psychiatric units in general hospitals are limited. In the district case-study site there was one district hospital in the Kintampo North district which acts as a referral centre, which theoretically should provide mental health services but there were no specialist mental health professionals working in the hospital. As reflected in the primary level data by this district hospital administrator:

I: Are all of the mental health staff full-time members of staff of the unit here?

R: For now we don't have a single mental health staff in the hospital.

I: So you don't even have a single one?

R: There is none. I think a Ghanaian psychiatrist was arranging to get a nurse to come and the hope was that if that had materialized then the person would have been attached to the hospital to see to cases that come to the hospital. But for now it is zero.

*Uganda.* Until recently, mental health services were centralized and services were available only at the national mental hospital (Kigozi *et al.*, 2008). With decentralization, secondary mental health services in the form of health centres existed, but the reality was that integration of mental health services was not given much attention as described in the primary level data by the urban district hospital manger.

I: So, you don't have any psychiatric beds in...Hospital

R: No. When we get those violent cases, we send them to Jinja.

I: For those that you don't refer, do you provide any follow-up medication and care as outpatient mental health patients?

R: Yah, that is part of the general medical service provision, but it doesn't have the psychiatric component yet. Because when they come, they will be seen as general

patients, not specialized patients. We lack specialized cadres. You can't say "when this one comes, he should be seen by so and so". They are just seen as general patients.

*Summary.* All three countries have reduced custodial hospital care and have attempted to provide decentralized care in various forms, from outpatient treatment to short-term stay care. However, the extent and quality of decentralized care has much to be desired at district level across the study countries. While South Africa has made progress with respect to legislation requiring dedicated beds for a 72-h observation period in general hospitals, there is not blanket coverage. Further, there are insufficient staff dedicated to mental health care as well as an inconsistent approach to task shifting, with in-service training programmes for general primary health care personnel being provided on an ad hoc basis. With respect to Ghana and Uganda, psychiatric services were meant to have been introduced into general hospitals in the case of Ghana and health centres in the case of Uganda. However, there was a shortage of mental health specialists in both countries preventing this from becoming a reality, with a limited appreciation of mental health by general health care personnel.

*Overall WHO Recommendation: Educate the public. For medium resource contexts, use the mass media to promote mental health, foster positive attitudes, and help prevent disorders. For low level resource contexts, promote public campaigns against stigma and discrimination and support NGOs in public education.*

*South Africa.* The Department of Health oversees public education and has promoted awareness campaigns in collaboration with the South African Federation for Mental Health (SAFMH) and other professional, consumer and advocacy bodies, e.g. the South African Depression and Anxiety Group (SADAG). However, public education campaigns are very unevenly applied across the country (Lund *et al.*, 2010). Prevention and promotion activities in the district are largely limited to awareness days, particularly in schools and normally organized by school nurses (Petersen *et al.*, 2009). School-based initiatives organized by the Department of Education appear to also be very limited and confined to secondary prevention, providing referral networks for problems identified within the school setting. School-based programmes, particularly for substance abuse as well as sexual violence were identified as a major need by teachers as were programmes to increase parental involvement with their children. Kakuma *et al.* (2010) reported that less than 20% of

primary and secondary schools have school-based mental health promotion and prevention activities and were found in only three provinces, with a fourth indicating that 51–80% of schools have such programmes. Primary level district data supports these findings of a paucity of mental health promotion programmes. A hospital psychologist had this to say:

The school health nurses set up awareness days like . . . tobacco day, substance abuse things like that . . . So we've still got a long way to go because another challenge that has come to the fore is that the youth are abusing alcohol; are abusing some substances though we don't know what these substances are and then the alcohol which then aggravates the situation.

*Ghana.* In Ghana, mental health promotion educational messages appeared to be provided as part of more general public health awareness programmes as reflected in the following quotation from a district hospital manager:

Yes I think there are educational programmes that go on from time-to-time through the public health unit in the district. Usually they carry out health talks on the air and when they go to the communities at bars, sometimes they will talk about programmes to educate people (about) maybe substance abuse and other problems that can lead to mental health problems. So I think there are programmes that are part of general public health education that is carried out.

*Uganda.* In Uganda, the involvement of NGOs in mental health awareness is suggested to have reduced stigma and discrimination (Kigozi & Ssebunnya, 2009). At a district level, however, medical staff indicated a severe lack of mental health awareness programmes, recognizing the need for such programmes:

We actually need a programme in Mayuge district concerning mental health . . . whereby people can get educated about mental health . . . and get the services. Recruitment of mental health staff is also important. And we need to educate the whole public about mental health.

*Summary.* In South Africa while there is evidence of some school-based mental health promotion programmes in a few provinces, mental health promotion was largely limited to the occasional media activity and generally poorly established and uncoordinated. In Ghana and Uganda, public

awareness campaigns for mental health were also very limited.

*Overall WHO recommendation: Involve communities, families and consumers. Ensure representation of communities, families and consumers in services and policy making. For low resource contexts, support the formation of self-help groups and fund schemes for NGOs and mental health initiatives*

*South Africa.* Provincial and national level data suggests that involvement of communities, families and consumers in the provision of services and policy making was minimal, with a few support groups having been established by NGOs (Lund et al., 2008). District responses in the primary level data confirm these findings, suggesting that there is little involvement of users or their families in the provision of services. Formal programmes to assist families and users in the transition back into the community are limited to health staff advising families on how to care for family members on their return home as suggested by this excerpt from a focus group interview with community health workers.

I: So when you visit families and individuals in your communities what is it that you do in trying to support and care for the people with mental health problems?

R: I had somebody who did not want to take his medication and would just rebel against his family members so what I used was give them nice things like cakes and juice or make him tea. He would take his medication after that . . . As time went on, he got used to it and would let him give him medication without giving anything first. After that I told his parents that they could now also give him medication and they did.

I: And what do others do in providing support and care?

R: I advise their families that they must love them and teach them everything. Like the one I often visit, he herds cattle but sometimes he loses some of the cows or leaves them wondering around. But I tell them not to beat him up because if they do, it confuses him even more. I tell them to speak to him politely.

*Ghana.* National level data suggests that engagement of communities in policy development process in Ghana was minimal (Doku et al., 2008). At district level primary level data suggests that support groups in Ghana are sparse. The lack of community support leaves mental health patients severely vulnerable



according to this primary health care doctor:

As at now we don't have any community organization where we can refer those people to, so all that we do is we manage them at the hospital and then sometimes we succeed and other times we don't.

*Uganda.* At the national level, Uganda also appeared to have minimal engagement with communities, service users and families in policy development (Kigozi *et al.*, 2008). Within the Ugandan district sites primary level data also suggests minimal community engagement in the delivery of mental health services with few community mental health support structures linked with the health care service. Primary health care nurses indicated that while outreach programmes existed, these were not directed specifically to mental health as suggested in this extract:

I: Do you have links with any (community) mental health programme running in the district?

(Silence)

R4: We don't know of any such programmes.

I: How about in your hospital? I guess you have some outreach programmes?

R2: We have an outreach programme; but not for mental health.

This view is further supported by a district level social worker:

I: So what about people with mental health problems, do they have any kind of support groups?

R: No, am not aware of any.

I: So, they are all on their own?

R: Yes. They are all on their own.

*Summary.* Nationally, across all three country sites, community engagement in the development of mental health policies appeared to be minimal. At district level there was also little evidence of the formal involvement of communities, families and users in supplementing formal health care through, for example, the development of support groups for people with mental disorders.

*Overall WHO Recommendation: Develop human resources. Create national training centres for psychiatrists, psychiatric nurses, psychologists and psychiatric social workers in medium resource contexts. Train psychiatrists and psychiatric nurses in low resource contexts.*

*South Africa.* In South Africa as a whole, there is an average of 0.28 psychiatrists, 0.32 psychologists and

10.08 nurses per 100,000 head of population (Lund *et al.*, 2010). However, these resources were widely disparate between urban and rural areas. There were no specific training centres for mental health specialists located at the hospitals who were trained at a university or nursing college. As part of ongoing training, the Health Professions Council had implemented a continuing education requirement for all medical doctors, psychologists and occupational therapists, which was up to the respective professionals to fulfil and not the responsibility of district authorities.

*Ghana.* In Ghana, national level data suggests that the low level of human resources in mental health was partly attributed to an ageing work force, but also due to attrition as a function of specialist health care staff leaving the country or migrating to general health care (Doku *et al.*, 2008). Further, in-service training for mental health specialists at district level appeared to be minimal as reflected in the primary level data by this quotation from the district coordinator in Ghana:

Yes, but with regards to mental health I can confidently say that, since I completed SRN, the basic courses, a mental health workshop has never been organized for us. So every time you have to read whatever you come across and use that knowledge to share with other people. That is the neglected aspect.

*Uganda.* In addition to inadequate training of specialists in mental health care, primary health care personnel indicated that the orientation to mental health that they received as part of their training was insufficient to promote favourable attitudes to providing mental health care (Kigozi *et al.*, 2008). Despite the suggestion of some improvement nationally (increased recognition of mental health as a public health issue, government attempts at formulating policy for integrated services, improved drug supply system, involvement of NGO sector in reducing stigma/discrimination), it would appear that negative attitudes about mental health among health workers in general persisted and contributed to a lack of interest in training in mental health care among some health care workers found at a district level (Kigozi & Ssebunnya, 2009).

*Summary.* Understandably the development and training of specialist mental health personnel received greater attention in South Africa, given greater access to training resources than in the low-income countries (Ghana and Uganda). In-service training of specialist and primary health care

personnel in mental health care does, however, appear to need greater attention across all three countries.

## Discussion

The sum of evidence from a situational analysis and various secondary sources of Ghana, South Africa and Uganda indicates that significant challenges remain in integrating mental health care into primary health care for both low- and medium-resourced countries. Each of the countries had legislation and policies which promoted the integration of mental health within primary health care to varying degrees. However, across all country contexts, policy did not appear to have readily translated into systematic meaningful action. While South Africa had policy guidelines, implementation across provinces was uneven, with provinces being responsible for allocating mental health budgets and implementing policy guidelines, which tended to be perceived as not having the same authority as an actual mental health policy. This situation may find significant relief in enacting a national mental health policy. What appeared to emerge in the case of Ghana and Uganda was that despite having a policy, authoritative communication of policy frameworks to health personnel at regional and district levels was required together with implementation plans for which there was an adequate budget.

In the absence of a formal mental health policy in South Africa, the Mental Health Act of 2002 appeared to have had an important role to play in decentralization efforts, such as the legal requirement to establish dedicated psychiatric beds in a large percentage of general hospitals which are tasked with providing a 72-h observation and referral service for psychiatric patients.

In a somewhat contradictory manner, while all countries had psychotropic medication as part of an essential drugs list (EDL), accessibility in low-income countries was still poor, while in the case of South Africa it would appear to have advanced the care and treatment of people with mental disorders. In Ghana and Uganda this was an issue of affordability. Access to psychotropic medication in low resource contexts may be addressed by requesting drug companies to find ways in which to drastically reduce the cost of medication, much in the way anti-retroviral drugs have been reduced in cost (Loewenson & McCoy, 2004).

In addition to insufficient resources for psychotropic medication in the LICs, regardless of the resource level (low or middle income), a further challenge for implementing plans for integrating mental health into general health care would still appear to be the lack of available specialist mental

health professionals as has also been suggested by Jenkins *et al.* (2009). While South Africa as a medium resource country has greater resources to meet this challenge, the continued loss of specialist health personnel to high income continues to prove to be a challenge, and this was also true for Ghana. Ogilvie, Mill, Astle, Fanning, & Opere (2007) report that the current estimate of health worker density is lower in sub-Saharan African than the estimated 1:1000 in the rest of Africa and is well below the minimum 2.5:1000 required to meet the Millennium Development Goals. Ogilvie *et al.* (2007) estimated that more than 23% of physicians practising in the USA received their medical education elsewhere and that 64% of that group originated from low- or middle-income countries. At least 12% of African-educated physicians (10,936) were practising in the USA, UK and Canada from 1992–2003. Migration of nurses is considered to be even more critical given their numbers and the basic care they provide. Migration of nurses from South Africa to the UK from 1998 to 2003 accelerated more than 2.5 times from 599 to 1480. In Ghana, this was a 6-fold increase, from 40 to 255 in the same period (Ogilvie *et al.*, 2007). One possible policy solution that seems to have found favour is to facilitate technology and knowledge transfer electronically as well as the temporary return of skilled personnel to their country of origin without the threat of losing their visa status (Ogilvie *et al.*, 2007).

The need for adequate human resource planning which takes a realistic account of available specialist resources is central to ensuring that policy is translated into practice. Even though South Africa has a greater number of specialist mental health personnel, a large proportion of these do not service the public health sector (Petersen *et al.*, 2009). Further, low budgets are always going to be a problem in LMICs given the low priority given to mental health in the context of the greater burden of communicable diseases. A number of examples exist globally of programmes that have adopted task shifting that can be adapted for use in such settings (Chatterjee *et al.*, 2008; Mohlakoana, 2003; Patel *et al.*, 2005). In addition to this resource planning is the need for the development of packages of care for specific disorders as recommended by Patel and Thornicroft (2009) which include resources and training manuals.

A limitation of the study was that the qualitative interview questions developed for the situational analysis across the three levels and three countries were not based on the WHO (2001) minimum criteria for integrated primary mental health within different country contexts. As a result, the availability of data on some of the criteria was weak. Nevertheless, the data available do provide useful

information on some of the challenges confronting LMICs in meeting the WHO minimal criteria and support the need for a task-shifting approach where there is greater use of trained non-specialist workers to deliver packages of care for specific mental disorders under the supervision of specialists. This model has been articulated in the 2007 *Lancet* series (*Lancet* Global Mental Health Group, 2007). In the second phase of the Mental Health and Poverty Project (MHaPP) district demonstration projects have been implemented in all three countries which have adopted this approach to address the identified gaps (e.g. Petersen *et al.*, 2009). Preliminary results from the district demonstration site in South Africa suggest that the adoption of a task-shifting approach within a supervisory framework for closing the treatment gap for depression is promising (Petersen, 2010). Other packages of care developed by the other countries as part of these district demonstration sites will hopefully prove as promising – building up the evidence for the adoption of integrated packages of care using a task-shifting approach to close mental health treatment gaps in LMICs.

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