Mental Health Policy Implementation in Ghana and in Zambia

Many African countries do not have evidence-based policies for mental health. In the most recent WHO Atlas survey, approximately 50% of countries on the continent did not have a mental health policy, and of those that did, many were outdated.[1] However, even among those that do have policies, it is in the implementation of these policies that major challenges are encountered. Without implementation, policies remain meaningless documents that do little more than weigh down bookshelves in Ministry of Health offices. Effective implementation requires the achievement of certain clearly articulated targets and the appropriate allocation of resources, in accordance with the vision, values and principles of the policy. The implementation of evidence-based mental health policies in Africa is crucial for the strengthening of mental health systems, and the delivery of appropriate, cost-effective care to people in need.[2]

In this issue of the African Journal of Psychiatry, we are proud to present two of the remaining articles in a series on mental health policy in Africa – a series that was initiated in the previous issue of the journal. The articles report on the findings from Phase 1 of the Mental Health and Poverty Project (MHaPP), a DFID-funded Research Programme Consortium, focusing on mental health policy development and implementation in four African countries: Ghana, South Africa, Uganda and Zambia. These articles complement the 6 articles of the previous issue, by reporting new data regarding mental health policy implementation in Ghana, and the crucial role of stigma in Zambian mental health care.

In the first article, Daniel Awenva and colleagues report findings from semi-structured interviews and focus group discussions, conducted with 122 mental health stakeholders from 5 of the 10 regions in Ghana. The stakeholders identified a number of barriers to successful mental health policy implementation in Ghana, including the low priority for mental health on policy agendas; limited financial and human resources; the lack of consultation in the policy formulation and implementation process; inadequate dissemination of the policy; and the lack of evidence in informing the content of the current policy. These barriers provide key lessons for those countries that are interested in effective policy implementation. Such implementation requires the antithesis of many of these challenges, namely thorough consultation during the policy development process; the use of research evidence to inform policy; thorough and widespread dissemination of policy documentation; substantial political commitment to the policy development and implementation by senior decision-makers; and adequate financial and human resource allocation. Stakeholders interviewed in the study specifically highlighted the enactment and implementation of the Mental Health Bill, which embraces international human rights standards, and has been awaiting approval since 2006, as a crucial means of addressing these barriers in Ghana.

These principles have been clearly articulated in WHO recommendations for mental health policy development and implementation.[2,3] However, it is through the documentation of these findings in the field, as articulated by stakeholders in Ghana, that these principles are validated. Such principles are not simply the ideals of international UN agencies, but require tangible expression, if African people living in poverty with mental illness are to receive care and support in a systematic and sustainable manner.

Among the many barriers to mental health policy implementation in Africa, stigma appears to play a pivotal role. In the second article, Augustus Kapungwe and colleagues document individual and systemic stigma and discrimination against people living with mental illness in Zambia. Using 50 semi-structured interviews and 6 focus group discussions with a range of mental health stakeholders from 3 districts in the country, the authors set out to explore the presence, causes and means of addressing stigma. They found pervasive mental illness stigma and discrimination in Zambian society – evident among the general community, family members of those with mental illness, health care providers (including mental health clinicians), and government policy makers. Stigma was evident not only when study participants were asked about the topic, but also in the stigmatizing tendencies and attitudes of participants. And a variety of forms of stigma and discrimination were reported, from open attacks on people with mental illness in communities, to more insidious and systematic exclusion of people with mental illness from education and employment opportunities. The authors recommend a number of strategies for combating stigma, including education campaigns, greater policy priority for mental health, and expanded social and economic opportunities for the mentally ill. The article provides important new data regarding the extent of stigma in Zambia, and challenges outdated myths regarding the lack of stigma against the mentally ill in Africa.[4]

These articles lay a foundation for some of the interventions that are being undertaken, as part of the second Phase of the MHaPP in 2008-2010. Among others, these include the adoption of the Mental Health Bill in Ghana, and the training of primary health care workers in mental health in Zambia, the latter including efforts to tackle stigma among these care providers. The process of developing and implementing these interventions, as well as their impact, are

being documented, using the methods of participatory action research (PAR).[5,6] The findings of these intervention studies will be disseminated through a number of means, including policy briefs and case study reports, which will be available on the MHaPP website: www.psychiatry.uct.ac.za/mhapp, as well as academic peer reviewed journal articles.

As with the previous issue, the 2 articles in this issue were partly developed in a MHaPP capacity development workshop on academic writing, facilitated by Ritz Kakuma and Philippa Bird. As a consortium, we are grateful for their initiative and support. We would also like to pay tribute to the leadership and vision of Professor Alan J. Flisher, the Director of the MHaPP, who died tragically from leukemia, shortly before these articles were published. These articles are dedicated to his memory.

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