Sharing mental health research resources in Africa – the place of all inclusive consortia

It is now generally evident that the prevalence rates of various mental disorders in Africa are similar if not identical to those found in the West.[1,2] Poverty and the relative deficiency of human resources are compounding factors that make it unlikely for replication of psychiatric and mental health services in the same quality and quantity as currently provided in resource-rich countries.[3,4] This not withstanding, it is not necessary for such services to be imported wholesale into the peculiar socio-cultural Africa context, or for quality and quantity to be measured in the same way as is done in the resource-rich countries. This means that Africa must find its own home-grown evidence-based policies and practices that allow for service to be available, accessible, affordable and appropriate within the socio-cultural and economic contexts prevailing in Africa. This can only be achieved through contextually designed operational research to determine contextually appropriate solutions to the myriad of mental health issues and challenges facing Africa.

Despite the multiplicity of socio-economic and cultural contexts in Africa there are similarities. A major, but plausible, assumption is therefore that, what is applicable in one country is more likely than not to be applicable in another African country. By working together, to identify individual priorities, strengths, weaknesses, gaps and ensuring sustainability, countries in Africa will also avoid unnecessary and costly duplications. In order to strengthen research in Africa, human expertise in research methodologies, determination of research priorities, proposal and grant writing, epidemiology, statistics, scientific paper writing etc. are most needed. Lack of such expertise limits research in Africa. The Continent has strength in resources, particularly human resources, and a collective approach would contribute towards availability of such resources for all countries.

A human resource that is available in South Africa, for example, can be made available in any other country in Africa, without necessarily depleting the services of the country of origin. This would have been impossible a decade ago. Today however, information technology has significantly reduced the hindrance to associations and collaborations brought about by location and distance. Indeed, virtual universities have become a common phenomenon across the Continent as in the rest of the world. Thus, people do not have to practically leave the familiarity and security of their stations for their expertise to be made available in any other country. Similarly, human resources available in resource-rich countries can be made available in any other country. The issue that remains therefore is whether or not we are indeed willing to work together, to pool ideas and avoid unnecessary duplication (while not unduly situated away from our usual stations).

The concept of African collective endeavour in mental health does exist. An example is the Pan-African Psychometric Initiative (PAPI) with its secretariat at the Africa Mental Health Foundation (AMHF) and under the patronage of Professor Norman Sartorius. The results of collective endeavour in Africa was recently demonstrated when University teachers of mental health in Africa came together under the auspices of AMHF to pool their expertise in putting together The Africa Textbook of Clinical Psychiatry and Mental Health.[5]

To this end, the concept of consortia, which would assist in pooling together human resources in Africa and enable us to work with those in the North, South, West or East who are ready to work with us, is in my view, a viable concept. It is in this regard that the Welcome Trust UK is to be congratulated for its endeavour to encourage the formation of a consortium for Capacity Building in Mental Health Research in Africa (http://www.wellcome.ac.uk/doc_wtd028338.html). Other organizations should be encouraged to do the same, even if for specific aspects of mental health.

However, it is important to take into account a few realities that pertain to Africa, some of which are purely political. The best research scientists are not necessarily based in universities and some of the best research does not always come from universities. In Kenya, a government institution, the Kenya Medical Research Institute (KEMRI), conducts nearly all the operational medical research in Kenya. It is the best funded institution, attracts full-time researchers, and has the best research network within Kenya and with the rest of the world. The Africa Medical and Research Foundation (AMREF) is a non-governmental international body that undertakes nearly all the community-based preventive and rehabilitative medical research in Kenya and several other countries. AMREF has the best human and physical resources, and the best research networks within and outside Kenya. Both KEMRI and AMREF are the preferred sources of opinion and advice for the government. BasicNeeds UK leads in the provision of research in mental health and poverty in Africa in general and more specifically in Kenya. EQUINET, another international NGO, is providing the lead on health in Africa particularly in the area of human resources. The Africa Mental Health Foundation (AMHF), another NGO, has evolved into a hub of mental health researchers of various backgrounds and professions. It brings government departments, public and private universities, public and private bodies together for research dedicated to evidence-based policy, practice in and promotion of mental and neurological health and healthy behaviour. In Kenya, even though the Prisons department has a fairly well funded (at

least on paper) research unit which recognises the need for research in the prisons population, they do not have the human research capacity to do so. Nobody can doubt the potential impact of research in such a population. A newly established inter-ministerial centre for research on crime in Kenya, with great potential, is in desperate need of capacity to research on the myriad aspects of crime. Outside Kenya, the South African Medical Research Council, a government body, does a great deal of good research and is (at least in my opinion) the leader in research in medical, psychological and social aspect of drugs and alcohol use and abuse in Africa. One will find many similar examples in many other parts of Africa, where the most critical research is undertaken outside university institutions.

The aforementioned scenario, of important research taking place outside universities, is likely to become further entrenched in the future. Universities are more focused on churning out students whose numbers are on the increase because of socio-economic and political pressures at a time when public funding is dwindling. The reality is that taking on more students has become, first and foremost, the most viable source of income for paying salaries. The more time one puts into teaching, the more they earn on top of their salaries. The University of Nairobi is making an effort to support research by providing grants of up to a maximum of about US$ 1,500 per year to full professors and about half that amount for the most junior lecturers. However, the total allocation is just under US$ 1.5 million for about 1,400 academic staff. This is a most welcome gesture but a mere drop in the ocean. We must therefore accept the fact that new patterns and facts are emerging on who does more research than whom and why. These realities cannot be in ignored.

Emerging consortia must therefore take into account these realities on the ground and be inclusive if they are to make an impact across the board. The costs of such all inclusive consortia should not increase in relation to the number of members or institutions involved since it is a virtual association involving relatively less physical movement or the need for physical facilities. People, not structures, make institutions. Indeed, the more institutions are involved, the more cost-effective the benefits.

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