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Reimagining global mental health in Africa

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ABSTRACT

In 2001, the WHO launched The World Health Report most specifically addressing low-income and middle-income countries (LAMICs). It highlighted the importance of mental health (MH), identifying the severe public health impacts of mental ill health and made 10 recommendations. In 2022, the WHO launched another world MH report and reaffirmed the 10 recommendations, while concluding that 'business as usual for MH will simply not do' without higher infusions of money. This paper suggests the reason for so little change over the last 20 years is due to the importation and imposition of Western MH models and frameworks of training, service development and research on the assumption they are relevant and acceptable to Africans in LAMICs. This ignores the fact that most mental and physical primary care occurs within local non-Western traditions of healthcare that are dismissed and assumed irrelevant by Western frameworks. These trusted local institutions of healthcare that operate in homes and spiritual spaces are in tune with the lives and culture of local people. We propose that Western foundations of MH knowledge are not universal nor are their assumptions of society globally applicable. Real change in the MH of LAMICs requires reimagining. Local idioms of distress and healing, and explanatory models of suffering within particular populations, are needed to guide the development of training curricula, research and services. An integration of Western frameworks into these more successful approaches are more likely to contribute to the betterment of MH for peoples in LAMICs.

SUMMARY BOX

- ⇒ Despite more visibility, clear recommendations and multiple attempts, little progress has been made in the last 20 years to improve the mental health of those in low-income and middle-income countries (LAMICs), according to the WHO.
- ⇒ This paper suggests that more of the same, even if large infusions of money were possible, will not result in significant improvement in the mental health of LAMIC populations, particularly in Africa.
- ⇒ The historic and current imposition of Western mental health models and frameworks of training, research and service development fail to be relevant or useful to those in need.
- ⇒ We imagine that if the local non-Western traditions of healthcare that are known, trusted and in tune with the lives and culture of the people they serve, are used to integrate relevant principles of mental health training, research and service delivery, real benefit will accrue.

INTRODUCTION

Year 2001 was a critical juncture in the development of global mental health (MH). That year, the WHO launched The World Health Report under the theme 'mental health: new understanding, new hope'.[1] This report highlighted the critical role MH has in promoting the well-being of individuals, societies and nations at large. It identified the severe public health impacts of mental ill health with serious socioeconomic effects. In addition, the report exposed the huge gap between people's needs for MH care and the availability of Western MH treatments.

The 2001 World Health Report was identified as 'one of the earliest and clearest global MH frameworks'.[2] In addition to a 'global framework', it made 10 recommendations to drive the development of MH services globally, but most importantly in low-income and middle-income countries (LAMICs). These were: provision of MH care in primary care settings; increasing availability of psychotropic medications; provision of care in the community; the need to educate the public about MH; involvement of families, communities and consumers in care provision; establishing national policies, programmes and legislations; development of human resources for MH; the need for intersectoral collaboration; monitoring of community MH; and the need to support more MH research.

Fast forward 20 years to 2022 when the WHO launched its world MH report under the theme 'transforming MH for all'.[2] In this report, while acknowledging that some progress was made in the preceding twenty years, the WHO reaffirms that the 10 recommendations made in 2001 are still valid while concluding, 'business as usual for MH will simply not do'. The report proposes that

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for the 2001 recommendations to be successfully implemented, nations will need to provide increased funding to meet their policy commitments.

With this in mind, we focus on the state of MH care in Africa in the wake of the 2001 World Health Report. While most recommendations for the development of MH services were meant to be global, we concentrated on Africa since the implementation of many initiatives was focused on LAMICs,[3] and because of our team's experience working in MH education, service development and research on the African continent. Three of the authors (DW, NS and AAA) are from Ethiopia and three (CP, CC and CRW) are from Canada. We are four psychiatrists and one family doctor who are working in Ethiopia, and one public health epidemiologist doing collaborative research with Ethiopian colleagues. Our shared experience is a result of ongoing engagement to assist in building health human resource capacity through the Toronto Addis Ababa Psychiatry Project and the Toronto Addis Ababa Academic Collaboration, an ongoing 20-year long global education relational model.[4] While framing our analysis as African when our experience is limited to one country may be controversial, our goal is to reflect on our observations, and the wider African literature, aiming to expand on our deep and prolonged experience within the Ethiopian context. We also recognise 'Africa is not a country'[5] and there is no single African culture[6] but a mosaic of cultures, traditions and over 2000 language groups.[7] As with many regions around the world, it is in a constant state of change.[8] We also recognise that there are few cultures that remain uninfluenced by globalisation or the Westernisation of European and North American culture, and this is a shared experience of many African countries.

In terms of methodology, we relied on three sources of data. Our starting point was the two landmark MH reports from the WHO. We conducted an in depth examination and analysis of these reports, extracting key rationales, arguments and concerns. Our second source of data was our significant shared experiential knowledge and information on Ethiopia and the region. Lastly, we drew from the wider literature highlighting the state and prospect of MH education, research and services in Africa. For these reasons, our methodology was reflective and explorative, rather than explanatory.

Global frameworks for guiding the development of MH services in LAMICs continue to render invisible key considerations for improving MH in Africa.[9] We describe aspects of the state of MH care in Africa that will remain difficult to address simply by doing more of the same. We then deliberate on some complexities and new directions for exploration. In so doing, we highlight challenges that must be managed if MH services in LAMICs are to develop in a way that reflect societal needs. We conclude with recommendations for reimagining the way we do global MH work.

The state of mental health care in Africa

MH continues to be a neglected public health issue in Africa.[10] According to the World Mental Health Atlas, some countries in Africa do not have MH services.[11] In countries where services are available the outlook is gloomy. For example, following the WHO's 2001 recommendations, there was huge investment in developing training programmes for MH professionals (including psychiatrists, psychologists, MH officers and psychiatric nurses), with programmes proliferating across the continent. Despite these efforts, there are only 1.4 MH professionals per 100 000 population on the African continent.[12] The global average of MH professionals of any discipline is 9 per 100 000 population.[12] Using another indicator of access to MH care, the situation is not any better. In 2020, annual MH outpatient visits in Africa were 94 per 100 000 population whereas the global average was 2001 per 100 000 population.[13] MH outpatient visits are far higher in some high income settings: for example, in Ontario, Canada, between 2017 and 2022 the monthly rate of MH outpatient visits was over 4000 per 100 000 population across all physician specialties and over 1000 per 100 000 population for psychiatrist visits.[14] The prospect for improved MH access in Africa is further confounded by an increase in demand as a result of increased population.[15,16] In addition, while supporting MH research was one recommendation, with resources invested over the past two decades, the amount and relevance of research that comes from the continent is still extremely limited.[17,18]

The state described above is only the tip of the iceberg. Specific challenges are both structural and attitudinal. For example, in some places in Africa, such as South Sudan, MH services are organised in response to the outcomes of a civil war that led to the suffering of millions of people through displacements and surviving the trauma of war.[19] Whether the developed model of care is organised based on these specific societal realities or based on the principle of universality that is the Western norm needs further exploration. On the other hand, South Africa has MH services organised in accordance with Western models owing to its history.[20] Attitudinal challenges determine resource allocation and prioritisation for MH services, research and education in most parts of Africa. The notions of causation, perceptions of available remedies and prejudice towards the mentally ill all influence decision-making.[21]

The WHO report called for increased funding commitment by governments as the primary way forward for MH. The WHO reported that some Western countries spent 6%–15% or more of their health budget on MH, with 24% of countries (all LAMICs), spending 1% or less on MH.[2] Given this dire statistic, even if governments commit to following their policy proclamations with more money and action, we suggest they will still fall short of meeting a desired target in the provision of MH care. All the WHO recommendations were made with good intentions, recognising a moral responsibility to urgently address global inequities. However, as the 2022 report concluded, 'business as usual for MH care simply will not do,' (WHO p6)[2] we ask the question 'what will?' Revisiting the recommendations to align them with historical,

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conceptual, structural and socioeconomic considerations may provide a way forward.

Historical considerations

The historical development of MH services, education and research in Africa has followed two main pathways: imported and imposed. Most MH services in Africa were set up by colonial institutions; they were entirely imposed[22] and after the geographic decolonisation process was completed, these institutions continued with structure and function unchanged. In Ethiopia, where there was no direct colonial history, MH services developed from indirect colonial pressures and internalised assumptions that imported Western structures were superior.[23–25] In North Africa, psychiatry was developed not only as medical science but as one of the 'weapons in the arsenal of racism and a way of negotiating citizenship'.[26] In West Africa as well, psychiatry developed through the asylum system with specific conceptualisations of the African mind.[27] While North and West African developments stem from the perspective of dealing with 'primitive madness', in East African colonies it developed as a way of dealing with problems of 'crime and disorder'.[28]

As most LAMICs have scrambled to keep up with the rest of the world, it is perhaps inevitable that they have sought the adoption of Western institutions such as education, that were effective in facilitating the formation of modern high-income country (HIC) societies. Many countries in Africa have turned to importing Western education either through sending their youth for training abroad (the majority do not return),[29] or inviting Western educational institutions and teachers to teach in newly formed African institutions (most onsite trips are less than a week). However, all teaching of MH in Africa that we are aware of, uses Western MH theories of pathology and treatment, therapy manuals, teaching videos, etc. These processes facilitated the spread of Western models of MH training and services to the region. This on its own might not be a problem if the foundations of MH knowledge were truly universal and their assumptions of society globally applicable. However, when the epistemic status of MH knowledge is not well defined, and its practice dynamic, the translation of such a knowledge base across cultures remains problematic.[30]

Conceptual considerations

One of the most significant flaws in the import or imposition of a Western MH model is a failure to examine assumptions underpinning the model's development. MH service models were developed with a particular understanding that an individual, initially a middle class European adult, equipped with a unique sense of agency and the money and tools that will enable mastery over one's life.[31 32] However, the African conception of a person is diametrically different,[33] where the central organising principle of personhood is 'connectedness' and agency that socially equips the individual with tools that enable competence in relationships.[34] Each model leads to different ideas about what constitutes particular forms of 'suffering,' how they are perceived and understood, how idioms of distress are expressed, and how particular explanatory models are shaped and organised along the domains of personal, social, environmental and spiritual relationships.[35] On the other hand, the historical development of MH services, education and research in Africa does not begin with 'universal' assumptions of personhood or conceptualisations of illness and treatments, but with an African mind invented and constructed by the coloniser.[36 37] This calls for an MH model that incorporates these differing considerations into MH service development.

Structural considerations

Mental illness has always been with us. Societies across the world have designed institutions to take care of those who suffer. For the most part, effective traditional African social institutions are based in the community. They have been made invisible by the emphasis on asylums in the past, and the more recent development of 'modern' MH services,[38] as well as by the Western assumption that traditional healing is outdated and irrelevant. In most parts of Africa, people prefer to use traditional healing institutions that are already present and located in homes and spiritual spaces.[39] These healing structures are powerful because they invoke knowledge and experience that is in harmony with people and their way of life. The merit and wisdom of recognising that the knowledge and experience contained in these institutions is important for healing is a matter open for exploration. However, their relevance, accessibility and local acceptability is undeniable.[40] If we accept that healing institutions are an irreplaceable asset for society, we must also accept that none of the imported/imposed models can claim to be a reasonable substitute. Far from being irrelevant, quaint or of historic interest only, traditional healing institutions carry the highest burden of care for the mentally ill in African communities. The low outpatient visit average of 94 visits per 100 000 population stated above for MH care in Africa becomes stark in the face of this, as the majority of 'outpatient' service is delivered completely outside 'modern' MH 'systems.'

In addition, social healing institutions have knowledge systems and methods that can be productively identified and used as a basis for developing modern MH services, as opposed to their incorporation as a cultural adjunct to the Western biomedical model. In principle and practice the majority of primary care services, be it physical or mental, in most parts of Africa, are provided by these local healing institutions.[41] Any integration that fails to acknowledge and engage these systems beyond a rhetorical nod is bound to be unacceptable to the majority of users even when accessibility claims are made. Recognising the importance of traditional healthcare systems, there have been some tentative efforts to integrate traditional and modern MH services, but this usually entails the two systems running separately and in parallel (eg,

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a traditional clinic and modern MH clinic with bidirectional referral capacity). However, this area of exploration remains at best on the margins, leading to neglect of much-needed efforts to incorporate modern MH service models into existing societal and institutional structures.[42–45] As traditional institutions are already taking on the majority of the burden of care for the mentally ill, they present modern health services with an opportunity to identify 'situated knowledges' that may be used for developing meaningful policy directions and mitigate the potential of epistemic genocide.

Socioeconomic considerations

It goes without saying that the African continent, both historically and in its present, has suffered the impacts of chronic poverty, war, conflict, natural disasters and population explosion. The impact of this enduring reality on the psychological and social development of particular societies within Africa is far from understood. Where this has been explored, analysis rarely gets further than a pathological characterisation of the reactions of people as 'traumatised'. However, we have yet to see an attempt at a comprehensive understanding of the impacts of inhabiting such a context on the overall development of the individual and societal psyche. Has it, for instance, influenced the centrality of community to the development of individuals? The attempt to reduce all reactions to suffering as trauma, and all services to the clinic, has not led to meaningful changes in the lives of people who are affected by difficult collective experiences. The fact is that most African societies continue to not only survive and cope, but in many ways thrives and flourishes, aspiring and working to building a better future. This inspires a call to explore ways people continue to resist, endure and succeed. Understanding the impact of how context shapes how to see, engage and be in the world should form the basis of models of services that aim to alleviate the burden of mental illness. As illness involves the subjective experience of individuals, being in a particular world will affect how the person reacts to that world.

The need for reimagining

The state of MH care in Africa is far from meeting the needs of African people. The complexities of delivering MH care requires careful thought to be useful to the people who need services in a continent with enduring historical, socioeconomic and structural challenges yet with rich sociocultural resources. Our hope is that by reimagining MH development in Africa we help illuminate a way forward for the development of meaningful models of global MH care. Recognising the many complicated struggles in this space, our recommendations are tentative. However, we recognise the wisdom of the WHO's assertion that 'business as usual for MH will simply not do'. While some might argue that MH services in Africa were not created with any sort of imagination to begin with, we believe that hope can spring from imagining a future society that defines itself as well, thriving and prosperous. For these glimmerings to reach the potential of possibility, there is an urgent need to reimagine relevant curriculum, research and service organisation.

Reimagining curriculum

While there are various ways of understanding the curriculum, we are framing the curriculum following Lunenburg,[46] as an explicit approach to incorporating social and philosophical perspectives. This makes it a tangible target for reimagining. The underpinnings of MH curricula throughout Africa have Western origins and this remains for now an unavoidable necessity. Many African medical schools have adopted competency-based models,[47–49] and the overall outcome of these curricula is the production of human resources with a predefined competence to enable the delivery of MH care. However, competent graduates frequently leave these training programmes with limited capacity to deal with what awaits them in practice. A basic assumption of professional practice is that the competencies of practitioners and the needs of society will align. In Africa, this alignment is hard to come by: what professionals have to offer is not what society needs or wants. Graduates are left in a state of isolation both from society and themselves. Additional competencies helpful in these circumstances are critical reflection and reflexivity. Critical reflection challenges assumptions and practices, while critical reflectivity and cultural humility involves recognising one's own social position so as to understand the experiences of others.[50] A reimagined curriculum that includes these concepts may prepare professionals to provide locally relevant, compassionate, humanistic and equitable care[51] and contribute to individual, social and systemic change.[50 52 53] A reimagined curriculum should aspire to envisage all the potential spaces for intersection and alignment and build content accordingly.

Reimagining research

In recent years, both the quantity and quality of MH research from the African continent has increased markedly. The number of international organisations that fund MH research has also gradually increased. However, we have yet to see MH research from Africa that has impacted how services are developed. Whether driven by funding agency priorities, Western academic pressures, research that serves HIC policy-makers or other interests, or the uncritical engagement of LAMIC researchers in established research priorities, the lack of service delivery research is unacceptable. Despite this, there are calls for more research in the field.[17 54] Research that does not recognise local socioeconomic, political and cultural contexts is contestable, and research without moral and societal accountability can do more harm than good. Reimagined MH research should take relevance, context and accountability as its core drivers.

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Reimagining services

As previously noted, most MH care is provided by societal healing systems which have been rendered invisible by the parallel development of more prominent 'modern' MH services that respond to a negligible proportion of the burden of care. This sad reality contributes to a lack of alignment between society and professionals as they operate in different spaces. A reimagined MH service model needs to acknowledge this lack of alignment and seek to build bridges between the two. There are knowledge systems and practices in both systems that can be used for the provision of better services to society.

CONCLUSION

This is an analysis and reflection of the state of MH in Africa, and we know that major changes will come as a result of further conversations. We have highlighted the prospect of MH services in Africa as far from bright. Despite much effort and infusion of resources, identifying and achieving relevant outcomes remains elusive. Doing more of the same or continuing to apply modern MH care models without attending to indigenous healing practices and contexts, will not bring about the required change. This calls for an in-depth consideration of factors that could contribute to formulating a more robust recommendation than 'more of the same'. Clearly, there is an urgent need for reimagining MH services, training and research regionally and globally. And happily, there are LAMIC MH scholars who can help guide the international community towards solutions. The following are recommendations for next steps. First, there is an urgent need to create a critical mass of scholars from the South and North who recognise and understand the challenges at hand. Second, a critical mass of scholars could/should spearhead the development and nurturance of critical reflection and scholarship through curriculum and the promotion of relevant research. Third, developing a programme of scholarship and research to specifically explore these issues in depth will advance the possibility of knowledge creation. Fourth, as the absence and invisibility of local healing institutions is one of the major challenges, focusing exploration on MH education, service and research models centred on historically and socially salient principles and practices will change the dominance of Western assumptions.

Finally, as these are commitments that require time and resources, a programme of continuous advocacy to ensure long-term investment will be required.

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