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Why Africa needs to invest in mental health

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More than 13% of the global burden of disease is due to disorders such as depression, anxiety, schizophrenia and substance abuse. Almost three-quarters of this burden lies in low- and middle-income countries, because of extremely scarce health resources and investment. Many countries allocate less than 1% of the health budget to mental health. Poor or non-existent access to evidence-based care also leads to the need for long-term care and increased costs of care.

Mathari Hospital is the only psychiatric hospital in Kenya. Simon Maina/AFP via Getty Images

The economic burden is also significant. The global cost of lost productivity due to depression and anxiety disorders is an estimated $1.15trn a year. Around 4.7 billion days of productivity are lost.

There is good evidence that these conditions are treatable. But the estimates of people in sub-Saharan Africa receiving treatment are jarring. Only 15% of South Africans with mental health conditions receive treatment. In Ghana and Ethiopia the estimates are less than 10%.

We've spent decades researching mental health and health economics around the world. Our research has demonstrated that, for example, peer support for treating perinatal depression shows benefits that far outweigh any costs incurred in delivering the treatment. We've also seen the Healthy Activity Programme Psychological Treatment in India provide better clinical outcomes at lower costs. In a recent study in Ghana we've shown that investments in population-level screening and subsequent treatment could yield benefits greater than the costs. The findings imply that every $1 invested over a 10-year period in depression, anxiety disorders and schizophrenia treatment would accrue about $7.4, $4.9 and $1.7 in returns respectively to society.

There are compelling arguments that neglecting mental health will make it extremely difficult to attain many other targets. These include Sustainable Development Goals related to poverty, HIV, malaria, gender empowerment and education.

For example, poverty rates are two times higher in people with mental health conditions compared to those without. People living with mental illness or substance use disorders are more likely to become infected with HIV. Poor mental health weakens immunity and adherence to treatments for malaria.

Clearly, there is a case for investing in mental health and more importantly, making interventions and services accessible to all. Having set out this case we also offer recommendations on how this might be achieved.

Ways to invest

Political will and support from civil servants affect the proportion of GDP allocated to mental health. For Africa as a whole, government mental health expenditure per capita is $0.1.

Practical tips for mental health advocates to convince politicians have been offered in previous writings. These include placing arguments within the political context, working with the civil servants who advise politicians, and offering a multisectoral explanation of the wider picture of mental health.

Further, advocates must take advantage of crisis situations such as the Covid-19 pandemic to promote a long-term agenda for mental health, and lobby for major cross-government commissioned reviews. For example, the US Institute of Medicine's report on neurological, psychiatric and developmental disorders led to increased prioritisation and research investment in mental health by major international donors.

Convening an African ministerial summit on mental health financing as a strategic follow-up to the Global Ministerial Mental Health Summit held in October 2018 would be a major boost.

We propose that governments invest in making training for and practice of mental health care attractive and relevant. This can be done by offering mentorship programmes, and use of digital and mobile technologies for delivering care. Short re-skilling programmes that focus on evaluation and management of common cases in the community and outpatient setup can be conducted annually for students and healthcare staff.

A national survey on mental health conditions is key for every country because under-recognition of the prevalence and impact of mental health needs is one reason they don't get enough attention. No African country is currently doing one. But Nigeria comes close. It has a survey conducted between 2001 and 2003 – but only in Yoruba-speaking states which account for 22% of the population.

Room for improvement

There are other areas for innovation. One could be a decentralised public health spending model that allocates resources according to performance, linking funding to specific mental health needs.

Governments could introduce financial incentives that favour community care. This means community-based rehabilitation initiatives would get more support. For example, in Rwanda, a national government incentive for subnational public and nonprofit faith-based health providers increased healthcare services by 20%.

There is also a need to rethink health and life insurance. These must reflect a move towards investing in preventative medicine and not the current curative policies.

Deliberate government leadership must promote local production of psychotropic medication as was done in the case of

personal protective equipment in response to Covid-19 containment. Technology must also be used to deliver mental health services in times of public health emergencies.

Underpinning all our recommendations is sufficient and timely mental health financing. This requires a multi-sectoral strategy that shows the health and economic benefits of investing in mental health in Africa.

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