

## Article

# Social, economic, human rights and political challenges to global mental health

Rachel Jenkins MA MB BChir MD (Cantab) FRCPsych FFOHM MFPH (Dist)  
Professor of Epidemiology and International Mental Health Policy, King's College London, Institute of Psychiatry, London, UK

Florence Baingana MB ChB MMed (Psych) MSc (HPPF)  
Wellcome Trust Research Fellow, Makerere University School of Public Health and Personal Social Services Research Unit, London School of Economics and Political Sciences, London, UK

Raheelah Ahmad PhD BSc DIC  
Research Fellow, Faculty of Medicine, Imperial College, London, UK

David McDaid MSc BSc  
Senior Research Fellow in Health Policy and Health Economics, LSE Health and Social Care and European Observatory on Health Systems and Policies, London School of Economics and Political Sciences, London, UK

Rifat Atun MB BS MBA DIC FRCGP FFPH FRCP  
Professor of International Health Management, Imperial College, London, UK  
And Imperial College Business School

## Introduction

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This is the second in our series of four articles about mental health and the global agenda. The first paper addressed core conceptual issues in relation to mental health in low- and middle-income countries.<sup>1</sup> This second paper addresses social, economic, human rights and political challenges to global mental health. The third paper addresses international and national policy challenges to global mental health,<sup>2</sup> while the fourth paper addresses health system challenges to global mental health.<sup>3</sup>

The social, economic, human rights and political challenges to global mental health addressed in this article include the inextricable relationship between mental health, poverty and debt; the need for more health economics research on cost-effective interventions; limited funding available to improve access to mental health services, the need for a move away from a concentration of whatever limited resources are available on specialist services in major cities alone in favour of better integration of mental health into country-wide primary care-led services; the need for careful strategic dialogue and action around public policy and its implementation; the role of

health professionals and national mechanisms in scaling up access to services; the need for an improved global architecture for mental health; the need to strengthen links between mental and social development; and finally a consideration of the importance of a human rights approach as an additional lever to argue for improvements in mental health policy and implementation.

## Mental health, poverty and debt

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Mental disorders impose a significant economic burden, not just on the individuals with the disorders but also on households, communities, employers, healthcare systems and government budgets. While there is abundant research on the economic burden of mental disorders in high-income countries,<sup>4,5</sup> information on the economic consequences of poor mental health in low- and middle-income countries is limited.<sup>6,7</sup> We draw on the few available

studies to assess the immediate economic impacts of mental disorders in low- and middle-income countries. Estimates of these economic costs are likely to be conservative; few take account of the ways in which families mobilise and redirect resources that adversely affect them, worsening and perpetuating socio-economic inequalities. When aggregated across an economy, these household costs have an important impact on the size and productivity of the labour force and on national income.

Mental disorders perpetuate the cycle of poverty by interfering with the individual's capacity to function in either paid or non-income roles, leading to decreased social, as well as economic, productivity. Thus, people with mental health problems are often the poorest of the poor, because neither they nor their family carers may be able to work. In many low- and middle-income countries, where universal access to health care and financial and social protection systems are often lacking, individuals with mental illness may spend much of their savings or borrow money to buy conventional and/or traditional medicines and may have transportation difficulties in accessing these services.

Epidemiological studies in low- and middle-income countries increasingly suggest a need for poverty reduction measures: for instance, evidence from Uganda and Ethiopia indicates that poverty and widening income inequalities are major risks for depression.<sup>8,9</sup> Breaking the chain of poverty and debt around mentally ill people is vital to addressing the United Nations' (UNs') Millennium Development Goal 1 of eradicating poverty and hunger.<sup>10,11</sup>

Poor mental health in childhood and adolescence increase the risk of poverty and other adverse economic outcomes in adulthood. About 10% of children and between 10% and 15% of young adults globally experience mental health problems. Longitudinal studies in a number of high-income countries demonstrate that untreated mental health and behavioural problems in childhood and youth can have profound longstanding social and economic consequences in adulthood. These include poorer levels of educational attainment, increased contact with the criminal justice system, reduced employment levels (with lower salaries when employed) and personal relationship difficulties.<sup>12-15</sup>

Mental disorder in parents can also adversely impact on the health, development and education of their children.<sup>16</sup> In some low-income countries children may be removed from school during health crises to provide informal care, or it may be that the parent is simply too sick to ensure that the child attends school. Even if a child does receive some schooling, there can be adverse impacts on educational outcomes for children with unrecognised and untreated mental disorders. There may also be a

disruptive impact on classmates. There are also costs for educational systems of children with unrecognised and untreated mental disorders. Poor parental health may also reduce the chances that children come into contact with primary healthcare services, which again may have consequences for their physical and mental health.

In summary, although the effects of poor health on poverty are by no means unique to mental illness, their negative impacts are greater than for most acute and chronic illnesses. These adverse impacts increase the risk of impoverishment for households that fall below the poverty line, and for those already below the poverty line they potentially could lead to starvation. They can also frequently lead to physical illnesses which present to under-resourced primary care services.

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## The need for more health economics research on the cost-effectiveness of actions to address mental illness

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In spite of the high burden of disease or poor socio-economic outcomes caused by mental illness<sup>17-19</sup> policy makers have not appropriately prioritised investments in mental health in primary care, specialist care or in non-health sectors. Research to better understand the costs of care, cost-effectiveness of key interventions and relative financing of mental health issues, especially in respect of delivery at the primary care level, is key if new additional funding is to be secured to scale up interventions for addressing mental disorders in low- and middle-income countries.<sup>6</sup> A limited number of economic evaluations suggest that in countries such as India, Chile, South Africa and Nigeria investment in mental health-related interventions, including some limited research specifically on primary care-delivered services, can be cost-effective.<sup>20-24</sup> In high-income countries mental health care has been effectively decentralised to primary and community care levels with robust evidence on the cost-effectiveness of this approach. However, this mode of delivery is not yet the norm in low- and middle-income countries. More research needs to be done, especially in low- and middle-income countries, to demonstrate the costs and benefits of delivering more mental health interventions making use of different organisational and staffing models for primary care services.

The Choosing Interventions that are Cost Effective (CHOICE) programme led by the World Health Organization has assessed the cost-effectiveness of a

wide range of interventions that significantly reduce the burden of disease in a range of epidemiological and geographical settings. It has examined schizophrenia, bipolar disorder, depression and panic disorder to estimate, for example, that cost-effective interventions, typically a combination of older off-patent antipsychotic or mood stabilising drugs and psychosocial therapy, can be provided for between US \$3 and US \$4 per capita in the low-income settings of sub-Saharan Africa (SSA) and South East Asia, or for around 10 US \$ in middle-income regions such as eastern Europe.<sup>20</sup>

Overall it has been estimated that, globally, between 300 and 500 million healthy years of life (healthy years of life measures the number of remaining years that a person of a certain age is expected to live without disability) could be gained for each additional US \$ 1 million invested in addressing health. Around one-third of the gains would come from managing severe mental disorders, schizophrenia and bipolar disorder, with the most cost-effective interventions being for depression and panic disorder.<sup>20</sup>

The CHOICE programme has, however, focused largely on healthcare interventions that improve mental health outcomes, but in high-income countries a growing body of evidence demonstrates the important role played by employment and living arrangements in improving health outcomes. Benefits of interventions within the education system or support for microcredit and other fair lending schemes to help individuals to avoid falling into unmanageable debt also need to be better understood. Hence there is an urgent need to assess the cost-effectiveness of prevention and promotion strategies, many of which lie outside the health system and take place for example in the school or workplace. The role of primary healthcare services in liaising with these non-healthcare services also needs careful consideration.

There is also very little research evidence from low- and middle-income countries on how poverty and related socio-economic factors impact on the success of mental health policy and practice.<sup>7</sup> Greater evidence on the potential economic benefits of these interventions will strengthen arguments for greater investment in health system and non-health interventions to improve mental health and thereby reduce the risk of impoverishment, adverse impact on economic productivity and poor educational achievement.

Research is also needed to demonstrate economic benefits of reduced mortality and morbidity from co-morbid physical health problems in those who are mentally ill. Other important areas for further economic research and dissemination include, *inter alia*: interventions which increase use of healthcare

services by those with poor mental health, such as the organisation of services within primary rather than just specialist care; the cost of not recognising somatic symptoms that lead to under-diagnosis of mental disorders; and how mental health problems affect the prognosis of physical health problems. Under-diagnosis and ineffective treatment of mental disorders can lead to a high rate of repeat consultations in primary care and in outpatient clinics, placing huge demands on constrained health systems in low-income countries.<sup>21</sup> Much of the significant health investment already made by developing countries may be wasted if mental health is not appropriately addressed in primary care. For example, treatment adherence for TB, HIV and stroke is improved when co-morbid depression is treated.<sup>22-24</sup>

## Implementation of policy and practice

We have highlighted the health, social and economic impacts of poor mental health, and also reflected on the need for more focus on economic research to help make the case for investment in mental health. We now turn to issues of policy development and its implementation, looking at different approaches that have been used, considering how services may be scaled up and looking at the role that primary care can play in this process. This is followed by analysis of steps needed to improve the global architecture for mental health to help support this process.

## The need for strategic dialogue around public policy and its implementation

To date, three main approaches have been used to improve mental health in low- and middle-income countries. First, the public mental health approach, which focuses on a combination of prevention and treatment of the main categories of mental disorder, as well as their integration into existing health services, particularly primary care. Second, the human rights approach, which emphasises the de-institutionalisation of people with chronic mental disorders and draws on the traditions in the West, as pioneered in Trieste, Italy in the 1970s and 1980s.<sup>25</sup> Third, a developmental approach, which targets poverty reduction to expand access to health, and

which assumes that mental health will improve with increased national wealth.

All three approaches are complementary and essential, but need careful implementation, monitoring and evaluation if they are to work effectively. What is most needed is not just greater resources but a careful strategic dialogue and action. Epidemiological transition in low- and middle-income countries means the integration of mental health into health sector reform is crucial to the foundation of functional health systems. Human rights abuses against people with mental disorders are also pervasive in low-income countries, albeit with a different profile from wealthier nations. Large mental institutions are much less common in SSA than they were in the West, or in the former Soviet Union where they are still widespread. While SSA countries often have only one dedicated mental hospital dating from the colonial era, and in general there is considerable under-provision rather than over-provision of inpatient facilities, human rights abuses are commonly found in community settings, where healers and families sometimes resort to chaining people to 'keep them safe from harm' (by wandering into dangerous areas or falling into fires), and even beating people with severe mental symptoms for want of more accessible and effective solutions. However, the largest human rights issue in SSA related to mental health is the lack of access to any meaningful care. In low-income countries decentralisation of mental health care to the primary care level would enable better integration of mental health services within the health system, but as we have noted there is limited evidence on how this can be best achieved for mental health or for other high-priority health interventions.<sup>26</sup>

Given the strong role of social determinants in mental health, rehabilitative interventions must also address poverty reduction. Livelihood interventions are increasingly being linked to mental health interventions, as demonstrated by the NGO BasicNeeds UK in Uganda,<sup>27</sup> and to psychosocial interventions such as those offered by the Transcultural Psychosocial Organisation – Uganda<sup>28,29</sup> in small pilot projects. These evaluations should provide much needed evidence on the linkages between mental health and poverty, not just in terms of causation but also in establishing a clearer view of causal links for developing effective interventions.

In both rights-fulfilment and poverty reduction, civil society, particularly through mental health service user movements, has a key role to play, as demonstrated in high-income countries and in other previously neglected disease areas such as HIV.<sup>30</sup> In low-income countries there are very few international, national and local NGOs working to address mental health, and they do not have

national coverage enabling them to meet national population needs. National NGOs tend just to have a presence in the capital city and face unfavourable environments which hinder their ability to scale up interventions. National NGOs are likely to face challenges in ensuring their long-term financial sustainability. The World Federation of Mental Health plays a key role in mobilising international action through the medium of its annual World Mental Health Days.<sup>31</sup>

## A need to use national mechanisms for scaling up mental health services

At country level, in order to establish a well-functioning mental health system for a country, mental health needs to be systematically integrated into core planning documents for the country as a whole, including not only planning for the health system, but ideally also for the other sectors. These planning documents may comprise the following; the economic recovery plan/poverty reduction strategy, a Ministry of Health mental health policy document, a national health sector strategic plan, a primary care policy, Medium Term Expenditure Frameworks (government national budgets for three to five years within which health spending is integrated), Ministry of Health annual operational plan and district annual operational plans, as well as the sector reforms and spending plans of prisons, schools and social welfare and employment services, police and courts at national and district levels.<sup>32,33</sup> In order to achieve such inclusion of mental health, there need to be systematic inputs to government committees and other relevant bodies; this will require a well-functioning mental health division within each Ministry of Health (MoH) (see Box 1).

## The need for more funding for systematic delivery of decentralised mental health care

Improved governance structures for mental health and better coordination between different actors at a national level, while critical, does not negate the need to shift funding so that it can help promote a more decentralised, primary care-led approach to mental health. Decentralisation to help improve the

**Box 1** Some functions of a Mental Health Division within a Ministry of Health (MoH)

The Mental Health Division within an MoH will need an annual budget in order to run:

- a National Intersectoral Steering Committee for mental health policy and implementation
- a National Board of Mental Health to be able to give oversight to the implementation of mental health legislation
- annual visits to each province to support, advise and supervise
- an annual meeting with heads of provincial mental health services
- provincial and district intersectoral committees and boards to oversee and drive implementation of services and legislation
- contributions to MoH grant proposals to major donors, e.g. the Global Fund
- expertise to get mental health included in National Health Sector Strategic Plan (NHSSP), Mid-Term Expenditure Framework (MTEF) and Annual Operational Plans
- staff time to sit with the other sectors including social welfare, education, employment, police, prisons, courts, as well as NGOs, to ensure mental health is appropriately integrated into policies, plans, work programmes and training curricula

effectiveness and client-centredness of planning and service delivery requires appropriate financing at regional, district and primary care level. Regions need a budget to support and supervise district level services, and to engage in intersectoral dialogue, training and service development. In turn districts need a budget to support and supervise primary care level services and to engage in intersectoral dialogue, training and service development. The primary care level needs funds to ensure uninterrupted care delivery and recruitment and retention of the primary healthcare workforce, as well as materials and transport to support and supervise volunteer community health workers to enhance community engagement and intersectoral dialogue at village level. Potentially the resources required to achieve the above are relatively modest in comparison to the benefits that could be achieved,<sup>21,34-36</sup> but careful consideration needs to be given to challenges of implementation in different contexts and settings, including looking at ways in which different actors can be incentivised to work better with each other.

### What is role of health professionals in scaling up mental health services in primary care?

Key to moving towards a more primary care-led mental health system is human resources. Health professionals such as general practitioners, nurses, public health doctors, psychiatrists, psychiatric nurses and psychologists can play crucial roles within countries for advocacy, leadership, service planning

and development, providing support for primary care, intersectoral coordination and training and inclusion of mental health in general district and regional plans.

However, especially in low-income countries, their time commitment to publicly funded services is curtailed by the higher monetary rewards from private practice and other income-generating activities. More realistic remuneration will help partly to address this problem and reduce the brain drain, with professionals being attracted to work in high-income countries. This needs to be combined with attention to the training of students (the specialists of the future) for leadership roles.

It is relevant to include public mental health in the curricula of all health professionals, certainly of psychiatrists but also of general practitioners and public health physicians. It is particularly important to ensure that students undertaking Masters studies in public health or related sciences are trained in mental health policy, planning and financing. Public health specialists can develop and run a national mental health programme effectively if they work with psychiatrists, psychiatric nurses, primary care professionals and other stakeholders through a coordinating committee. In Uganda, for example, the National Mental Health Coordinator is a public health specialist, and not a psychiatrist; she has been very effective in developing, implementing and overseeing the mental health programme.

## Need for an improved global architecture for mental health

Despite compelling evidence on the adverse personal, social and economic impacts of mental illness and the potential benefits that could be gained from readily available cost-effective interventions, appropriate attention to mental health and mental disorders appears to be lacking in most low-income country contexts. The global architecture for mental health is ill-formed, with no effective financing instruments to support implementation of mental health interventions through national health or disease-specific plans. This has implications for the achievement of the Millennium Development Goals (MDGs), which are inextricably linked to mental health.

Recent global initiatives, such as the Global Health Workforce Alliance, which are focusing on strengthening the health workforce, including the training of psychiatrists and psychiatric nurses (and their integration into general health care), plus the training of community health workers, are providing much-needed resources for mental health training in some countries. However, there is no systematic attempt by the donor community to address health system constraints in relation to mental health.

International donors are discussed in detail in the third article in this series.<sup>2</sup> The UK Department for International Development (DFID) is an international donor which has invested in mental health interventions in low- and middle-income countries. The new DFID health strategy *Working Together for Better Health*<sup>37</sup> emphasises the need to strengthen health systems, and efforts such as the International Health Partnership,<sup>38</sup> which aim to better harmonise donor efforts, provide an opportunity to integrate mental health into health systems reform initiatives: recognising that mental disorders and other non-communicable disorders are on the increase in low- and middle-income countries, and that current health system approaches do not adequately ensure access to health care for these populations.

A new DFID mental health Research Programme Consortium (RPC),<sup>39</sup> led from South Africa, is now examining the inclusion of mental health in government policies and legislation in four countries. DFID-funded projects on the development of mental health policy in Kenya and Tanzania, as well as on mental health reforms in Russia to address situation appraisal, policy development and implementation, have provided much needed evidence on ways in which care delivery can be improved and mental health mainstreamed into health sector reform initiatives.<sup>34,40,41,42</sup>

Addressing mental health abuses in some low- and middle-income countries is essential to addressing human rights, as outlined in the recent UN Convention on the Rights of Persons with Disabilities.<sup>43</sup> People with serious mental illness in parts of Africa and Asia, in the absence of access to effective health interventions, may sometimes be kept chained to 'ensure their safety'; cut with razor blades or beaten out of a belief in spirit-possession; and shunned because of misconceptions about contagion. Serving these people and enabling them to actively participate in society is not only a question of need, but one of human dignity. A human rights approach, supported by the global mental health architecture, as a lever to mental health policy and implementation is addressed in more detail in the final section of this paper.

There is also an opportunity to extend international donor actions, such as DFID-supported general initiatives in relation to health systems, access to medicines (Medicines Transparency Alliance (MeTA))<sup>44</sup> and governance and human rights, to mental health. However, before resources are committed, it is critically important to delineate and understand the architecture for donor-supported global initiatives in relation to mental health, including those currently targeted at mental health and those targeted at physical health or social development but whose efficiency would be strengthened if they also simultaneously addressed mental health.

Meantime, in 2009 the World Health Assembly welcomed the *World Health Report 2008: Primary health care – now more than ever*, which strongly reaffirmed the Alma Ata principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, decentralisation and community participation as the basis for strengthening health systems.<sup>45</sup> Training was mentioned as including primary healthcare nurses, midwives, allied health professionals and family physicians working in a multidisciplinary context with community health workers. This is exactly what is needed for mental health, and there is an opportunity for a critical policy dialogue with the WHO to ensure that mental health is included in all these activities.

Mental health advocates also need to link with other sectors, health initiatives and programmes funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), as these three diseases have a considerable burden of associated mental illness. For example, Zambia has successfully integrated mental health into Global Fund proposals for training of health staff, and Tanzania, Kenya, Uganda and Malawi have integrated mental health into general health service delivery utilising

general health service budgets as set out in the national health sector strategic plans and annual operational plans. These provide good examples of systematic implementation of mental health service delivery within highly resource-constrained environments.

## Need to strengthen the links between mental health and social development

The contribution of better health goes well beyond the reduction of clinical symptoms and disability. While a renewed approach to mental health in the context of health sector reform is crucial, this needs to be complemented by a multisectoral and multi-level perspective on mental health, to ensure that factors which influence mental wellbeing and its relationship to physical wellbeing, empowerment at family and community levels, livelihoods, workplace productivity, human security and the development of human, social and economic capital are effectively addressed. An analysis recently explored for the UK in the Foresight project on mental capital and wellbeing shows the importance and benefits of a holistic approach to mental health.<sup>46</sup>

A societal perspective is not just an analytical point of view. It needs to be reflected in structures for planning and financing that can realise an integrative and synergistic role for mental health capacity and expertise across sectors. Appropriate financing, in line with burden, need and availability of effective interventions, should be allocated to mental health from government, multilateral and bilateral resources, including financing entities such as the Global Fund and philanthropic foundations, for example the mental health training programme for Kenya primary care staff funded by the UK-based Nuffield Trust.<sup>40</sup> The effectiveness of community based approaches and the cross-sectoral benefits of investing in mental health in development need to be better documented and communicated to policy makers.<sup>47</sup>

## The need to address asymmetry between donor and government priorities

Governments respond to what they perceive to be the core priorities of donors, who need to more

clearly communicate that given its burden, including increasing an increased risk of poor physical health, addressing mental illness should be a priority. The Paris and Accra principles of aid effectiveness commit donors to ensuring country ownership.<sup>48</sup> Although governments are said to be 'in the driver's seat' in most instances this is not the case as exemplified by the neglect of mental health, which is not a priority for donors focusing on the health MDGs. Mental health is all but absent in most key development plans, including Poverty Reduction Strategy Papers (PRSP) and subsequently in Poverty Reduction Strategy Credit (PRSC). Exceptions include Uganda, where despite some donor opposition, mental health was included in health policy<sup>49</sup> and in three Health Sector Strategic Plans.<sup>50-52</sup>

Significant health gains can be achieved by appropriate investment in mental health. While the focus on demonstrating how improved mental health positively impacts on the MDGs globally, DFID and other donors should stress evidence-based policies that foster better prioritisation of mental health. Country counterparts should be empowered to develop evidence and arguments for the inclusion of mental health in their country health strategies.

It is important to learn lessons from targeted communicable disease programmes which have successfully raised large financing and effectively scaled up services for AIDS, tuberculosis and malaria to reach MDGs in many countries.<sup>53</sup> Synergies should be sought with investments in AIDS, tuberculosis and malaria to strengthen health systems, especially the primary care level. For example, the Nuffield Trust-funded mental health-related continuing professional development of 3000 primary care workers in Kenya referred to above<sup>40,54</sup> is being delivered through the Kenya Medical Training College and the Ministry of Health. The training has a health and social welfare systems approach, with modules that integrate understanding of mental, child and reproductive health, malaria and HIV, health system issues such as health information systems, working with community health workers and traditional healers and annual operational planning.

## Human rights as a lever for mental health policy and implementation

This is an important lever, which has been effectively used in Western countries, where legal advice is accessible and affordable and where governments

have resources to improve services and expand access to mental health services. However, in low- and middle-income countries the effectiveness of the human rights approach in expanding access to mental health services is less evident, partly because of a relative lack of resources and in some countries less democratic systems. Further, in Western countries the human rights and mental health movement has focused on ending the inhumane incarceration of mentally ill patients in large institutions for long periods of time: a frequent problem in rich countries but not so in low-income countries where institutionalisation is uncommon, and indeed where one of the human rights issues is the lack of access to adequate care. Hence there is a difference in the focus of mental health rights activists in high- and middle-income countries and those in low-income countries, unlike other advocacy movements such as those for AIDS, which has clearly benefited from north-south partnerships.

Mental health legislation has an important role to play in clearly articulating human rights issues to governments and populations, especially if a person has to be admitted or treated against their will. However, mental health legislation is only effective if successfully implemented: requiring *inter alia* a code of practice and training for relevant sectors such as health, police, lawyers and prisons, and financial resources which low-income countries do not have. For example, Kenya still lacks a code of practice for the 1988 Mental Health Act, and the police are still operating according to the 1944 Act because their statutes and training have not been updated. Thus the human rights approach can only have an impact if there is major funding for training staff and developing a code of practice that can be implemented.

In many of the SSA countries mental health legislation is old, with most dating back to the late 1950s or early 1960s.<sup>55</sup> The process of enacting new laws will require financial and human resources which low-income countries lack. Even when new mental health legislation is enacted, implementation, as in Kenya, is likely to be slow until good practice guidelines are developed and used by the relevant sectors (health, social welfare, police and prisons), with professional training to ensure appropriate implementation. New and additional resources will be needed from both domestic and external sources. Donors have an important role to play in encouraging the adoption of good human rights practices; this has been the case with some European Commission-funded programmes.

In this regard, possible roles that donors can play include placing mental health at the heart of their policy dialogues with countries and integrating mental health with health system strengthening,

health management information systems, communicable diseases and NCDs; as well as education, social protection and criminal justice strengthening. This is especially important to sustain the successes of AIDS programmes supported by the Global Fund and the US President's Emergency Plan For AIDS Relief (PEPFAR), which are currently supporting more than six million AIDS patients to receive anti-retroviral therapy: individuals who will probably survive well into the next three decades and develop co-morbidities such as mental illness and cancer, but lack systems to manage AIDS as a long-term illness.<sup>56-58</sup> In addition, agriculture and environmental protection may be improved if attention is paid to population mental health.

Donors can make it clear to governments that they regard mental health an equivalent priority to the major communicable and other non-communicable diseases, stressing the inextricable links amongst these conditions that affect individuals. In addition, donors can place mental health at heart of dialogue about health systems strengthening, to ensure mental health is integrated into primary care and that any human resource strategy includes attention to psychiatric nurses, who are the mainstay of specialist mental health service delivery in Africa; and last but not least donors can explore how the international overseas aid community can help in the development of research capacity for mental health.

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## Conclusions

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We discuss the social and economic challenges to mental health, highlighting implementation issues at country level as well as on the global development agenda, demonstrating the obvious gaps in the global funding architecture for mental illness. Our analysis shows the clear need to provide increased international financing to address growing mental illness in low- and middle-income countries, and to integrate mental health into general health policy and the essential healthcare package at all levels of the health sector, especially at primary care level, to develop a holistic and client-centred approach to health care and to help better achieve MDGs. Such an integrated approach will ensure mental health has a budget line and will also allow entry points for mental health into other budgets and initiatives (e.g. the Global Fund and the International Health Partnership). Integration into the non-health sectors, especially education, social welfare, employment, social, agricultural and business development and the criminal justice system is also essential. Developing partnerships and effective use of existing



financial and human resources holds the key to the development of sustainable mental health care for the general population. The mental health sector needs to form partnerships, underpinned by collaborative training, research and mutual dialogue, with other health and non-health sectors to enhance the use of wider budgets and initiatives for mental health. The next article in this series will examine international and national policy challenges to the inclusion of mental health in the global development agenda.<sup>2</sup>

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#### CONFLICTS OF INTEREST

None.

#### ADDRESS FOR CORRESPONDENCE

Rachel Jenkins, WHO Collaborating Centre, Post Office Box, Institute of Psychiatry, King's College London, De Crespigny Park, London SE5 8AF, UK. Tel: +44 (0)20 7848 0668; fax: +44 (0)20 7848 5056; email: [Rachel.Jenkins@kcl.ac.uk](mailto:Rachel.Jenkins@kcl.ac.uk)

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