
ADDRESSING MENTAL ILLNESS IN AFRICA: GLOBAL HEALTH CHALLENGES AND LOCAL OPPORTUNITIES


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Mental illness is considered a silent epidemic throughout Africa due to substantial financial and systemic challenges. In this conceptual paper, I discuss the multiple individual and community level challenges that contribute to mental health care disparities in Africa. These challenges include: low priority/lack of clear mental health policy; poor health infrastructure and lack of funding; insufficient number of trained specialists; poor legal protection and lack of equity; lack of evidence-based and culturally aligned assessment and treatment; and stigma, discrimination and human rights abuses. I propose extending the biopsychosocial model of clinical and research practice in psychiatry to focus on the socio-cultural-spiritual factors that are the basis of many traditional explanatory models of mental illness in Africa and are also important determinants of illness, health, and wellbeing. Strategies for contextualizing mental health care approaches in Africa include: understanding explanatory and treatment models in Africa; recognizing multidimensional protective factors; strengthening community mental health and exploring parallel health systems; and incorporating global health best practices. Implications for making current treatment more culturally responsive and improving mental health systems are discussed.

Keywords: *Africa, biopsychosocial model, global mental health, mental illness, health disparities, culture, spirituality*

A Case of Mental Illness in Africa

27-year-old Fatim lives in a rural village in the eastern region of Guinea and has 3 small children. For almost 2 years, she has experienced debilitating symptoms of depression and anxiety that interfere with her ability to work, function on a day-to-day basis and care for her children. Fatim has suffered without receiving proper help or care because of the lack of personnel with mental health training in her village and surrounding community. In the past, she has visited a traditional healer from a nearby village to rid her of the “bad spirits” that she believed were causing her illness. Although she sometimes felt better after visiting the healer, she became discouraged by the amount of money she had to pay him and the only temporary relief she experienced. Fatim tried hard to hide her symptoms from friends and family members

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because she feared people would avoid and shun her due to the widely held negative attitudes about mental illness in her community.

1. Introduction

Mental illness is considered a silent epidemic throughout most parts of Africa. Owing to structural and systemic barriers such as inadequate health care infrastructure, insufficient number of mental health specialists, and lack of access to all levels of care, (Collins et al., 2011; Becker & Kleinman, 2013) mental illness has been characterized as a neglected and increasingly burdensome problem affecting all segments of the population throughout Africa. Prioritizing mental health has also been difficult due to lack of resources, limited funding and no or ineffective mental health policies. Most governments, health policy-makers and funders historically have focused on communicable diseases that plague the continent, such as malaria, tuberculosis, HIV/AIDS (Group, Lancet Global Mental Health [L.G.M.H.], 2007). In addition, due to stigma and discrimination, many people suffer in silence and fail to reach their full potential (Patel, 2007; Collins et al., 2011). Furthermore, a considerable segment of the population in African countries is vulnerable to mental illness due to psychosocial and socioeconomic stressors such as poverty, migration, war, conflict and disasters (Okasha, 2002).

Researchers, international health and policy bodies, and advocacy groups have launched various calls to action to address the mental health crisis, not only in Africa, but globally. Much of the focus has been on the disproportionate burden of mental illness in developing countries in terms of loss of life and productivity and stunted development in health, education, and economic growth, as highlighted by the United Nations' (U.N.) Millennium Goals (Miranda & Patel, 2005; Sachs & McArthur, 2005). Proposed solutions articulated in these calls include: integrating mental health into primary health care; developing clear national mental health policies and focusing on practical implementation of those policies; training mental health paraprofessionals; expanding community health care; and making links with traditional healers, among others (Alem, Jacobsson & Hanlon, 2008; Atilola, 2015). However, the societal burden of mental illness continues to rise internationally and in Africa and ongoing work to document the prevalence and severity of mental illness and improve access to appropriate care is necessary.

In this paper, I discuss strategies to improve mental health care for people suffering from mental illness, as well as approaches for promotion of mental health. The strategies encompass both professional health care and community-based care.

While the African continent is large and diverse, mental health care disparities are a problem throughout the continent. Typically, the term "Sub-Saharan Africa" is used when discussing health problems on the continent; however, in this paper I use the general term Africa and refer to findings for the regions of North, South, East and West Africa.

2. Global Mental Health and Mental Illness in Africa

Global mental health is a subfield of global health that is concerned with the worldwide prevalence of mental illness, the impact of mental illness on multiple quality of life and development outcomes, and the social and other determinants of mental health (Eaton & Patel,

2009; Patel & Prince, 2010). Organizations and bodies such as the Movement for Global Mental Health, the Lancet Mental Health Group, the World Health Organization's (WHO) MIND Program, the World Psychiatric Association (WPA) and the WHO Regional Office for Africa have been working for greater awareness internationally of the toll exacted on individuals and communities by mental illness. Mental illness is a general term describing a range of disorders that affect thinking, behavior and mood. Mental disorder is a more specific term that describes a condition characterized by clinically significant disruption in various aspects of mental functioning (American Psychiatric Association, 2013).

In series dedicated to Global Mental Health, *The Lancet* and *PLoS Medicine* journals published articles that revealed the significant drain of mental illness on national economies, the negative impact of mental health care funding gaps, and the international and local commitment needed to improve services and treatment effectiveness. In addition, the *Grand Challenges in Global Mental Health* series (Collins et al., 2011) outlined recommended research and funding priorities that include investments in research and training.

Research findings indicate that 30 percent of the global population each year has a mental disorder and up to 2/3 of them will not get adequate treatment (Group, L.G.M.H., 2007). Mental disorders are associated with marginalization, social vulnerability and a range of social problems, such as homelessness, imprisonment and drug use (Lund et al., 2011; Raviola et al., 2011; Becker & Kleinman, 2013). There is substantial evidence that mental health is an essential component of overall health and linked to progress on other indicators such as the U.N. Millennium Development Goals (Collins et al., 2011; Group, L.G.M.H., 2007). The eight MDGs are by 2015 to: eradicate extreme hunger and poverty; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; Combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability; develop a global partnership for development (U.N., 2006a). While, arguably, all of the goals are at least indirectly related to health, researchers (Sachs, 2004; Miranda & Patel, 2005) have highlighted the link between mental health and specific MDGs (see Table 1).

Table 1. MDG Goals Related to Mental Health.

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| Reduce population living in extreme poverty by 1/2 | Reduce maternal mortality by 3/4 & Reduce child mortality by 2/3 |
| Reduce impact of HIV, malaria and tuberculosis | Reduce people who suffer from extreme hunger/malnutrition by 1/2 |

Findings also show that practical, cost effective treatments for anxiety, depression, substance abuse and schizophrenia can be implemented in low-resource developing countries (Patel, 2007; Raviola et al., 2011). The cost of scaling up services is as little as an additional \$2 per person in low income countries and \$3-\$4 per person in middle income countries - as cost effective as treatments to eradicate communicable diseases (Group, L.G.M.H., 2007).

Statistics specific to the burden of mental illness in Africa shed further light on the disparities in suffering and mental health care. "Mental disorders account for 5 per cent of the total burden of disease and 19 per cent of all disability in Africa" (Amuyunzu-Nyamongo, 2013, p.59). Approximately one out of four people in Africa may experience what the WHO refers to as common mental disorders such as anxiety or depression, with depression having the second highest disease burden on the continent (WHO Regional Office for Africa, 2000). This means

that the loss of productivity (disability-adjusted life years) and risk for physical disease continue to increase due to depression, anxiety and other neuropsychiatric disorders (e.g., schizophrenia, bipolar and substance-use disorders) (Becker & Kleinman, 2013; WHO, 2003). These problems impact individuals on a day-to-day basis, especially vulnerable groups such as women, children and the poor.

In addition to mental health care disparities, populations in many African countries face increased susceptibility to mental illness due to a number of socioeconomic risk factors such as poverty, social inequality, war and conflict, disaster, urbanization and migration (Fekadu et al., 2014; WHO, 2014). These social determinants of mental health contribute to a cycle where the mentally ill have limited access to treatment and therefore become increasingly marginalized. Some reasons that they do not receive care include poor access to health services, too few trained mental health professionals, inability to afford available treatment, limited awareness of mental illness symptoms, and community stigma.

3. Problems, Challenges and Barriers to Treatment in Africa

Research findings indicate that 30 percent of the global population each year has a mental disorder and up to 2/3 of them will not get adequate treatment (Group, L.G.M.H., 2007). Mental disorders are associated with marginalization, social vulnerability and a range of social problems, such as homelessness, imprisonment and drug use (Lund et al., 2011; Raviola et al., 2011; Becker & Kleinman, 2013). There is substantial evidence that mental health is an essential component of overall health and linked to progress on other indicators such as the U.N. Millennium Development Goals (Collins et al., 2011; Group, L.G.M.H., 2007). The eight MDGs are by 2015 to: eradicate extreme hunger and poverty; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; Combat HIV/AIDS, malaria and other diseases; ensure environmental sustainability; develop a global partnership for development (U.N., 2006a). While, arguably, all of the goals are at least indirectly related to health, researchers (Sachs, 2004; Miranda & Patel, 2005) have highlighted the link between mental health and specific MDGs.

A number of challenges have been identified as significant contributors to the problem of mental health care disparities. Some challenges are related to the economic and development inequalities that are common to low and middle-income countries, while others are more specific to the social and cultural contexts in Africa. They simultaneously include multiple individual and community level factors, such as infrastructure, resource, psychosocial and socioeconomic problems. These challenges present as interrelated legislative, policy-making, institutional, organizational, community and professional problems. For example, one of the most significant problems, the lack of mental health policy, is both an infrastructure and planning problem; poor legal protection and lack of equity for people with mental illness are also caused by a lack of effective legislation; solutions to psychosocial problems would be improved with better epidemiological studies and culturally sensitive research; and stigma, discrimination and human rights abuses should also be addressed with laws and policies to enhance community-based interventions. Finally, all of these problems require comprehensive approaches and multi-level solutions in order to decrease the morbidity, disability and life disruption that can result from mental disorders and to improve individuals' well being throughout the continent.

Six key challenges are described below.

3.1 Low Priority/Lack of Clear Mental Health Policy

Prioritizing mental health is as important to improving patient care as adequate spending and infrastructure. Without practical mental health policies, gaps in treatment provision are likely to persist. Such policies are needed to formulate and coordinate comprehensive and integrated care in local communities (Jacob et al., 2007).

Despite mental health being mentioned in the general health policy of most African countries (80%), almost half (44%) of African countries do not have an approved or updated mental health policy (Jacob et al., 2007). It is not unusual to either not have a policy specific to mental health care or to have a policy that is not practical or has not been implemented at all levels of care or throughout the entire country – particularly in remote rural areas. This means that structures and strategies for implementing services and developing health worker training are lacking at multiple levels.

One of the important recommendations for improving healthcare globally is integrating mental health into primary care settings by having mental health care incorporated into the basic primary medical care, including screening, assessment and treatment by general health workers (WHO, World Organization of National Colleges, Academies, & Academic Associations of General Practitioners/Family Physicians [WONCA]), 2008). Researchers have found that health workers in Africa also generally support efforts to integrate mental health to help address mental illness in all communities (Alem et al., 2008; Hanlon et al., 2010; Monteiro et al., 2014). Like other aspects of planning services to combat mental illness, treat mental disorders and improve care, policies must also include stipulations for how to implement integrated mental health care. However, one considerable challenge to policy development in Africa is that policy-makers are often unconvinced of data on the negative economic impact of mental illness and the urgency of attending to mental health policy (Saxena et al., 2007).

Traditional methods of treating mental disorders were used throughout Africa up through the 19th century, at which time the use of asylums and other isolating methods were imposed during colonialism (Keita, 1996; Alem, 2002; Seloilwe & Thupayagale-Tshweneagae, 2007). However, because there were no formal policies, there has been limited widespread mental health care reform in Africa (Alem, 2002).

3.2 Poor Health Infrastructure and Lack of Funding

Mental health spending figures in Africa are dismal. Consistent with mental health care spending figures in low and middle-income countries (LMICs), health care infrastructure is still developing and spending is often wanting in most African countries. For example, in Nigeria, the most populous country in Africa, the national spending on mental health is just 4 percent of government expenditures, according to most recently available data (WHO and Ministry of Health Nigeria, 2006). On average, most countries in Africa spend less than 1% of their limited health budgets on mental health care (Daar et al., 2014). The most recent WHO Mental Health Atlas shows that average mental health care spending is approximately \$.25 per person, per year

as compared to approximately \$2.00 in high-income countries (WHO, 2011). These figures are telling, especially since outcomes such as life expectancy and individual earnings are significantly negatively impacted by mental disorders (Group, L.G.M.H., 2007; Esan et al., 2012).

The levels of care in many African countries are structured as follows: (a) health posts that serve small village areas; (b) health centers for larger towns; and (c) district or regional hospitals that provide specialist level of care upon referral (Alem et al., 2008). Most of the time, specialists are primarily available at the regional or district level, so specialized expert care is only available to patients who can find their way to the district hospital.

Part of the problem of poor infrastructure and inaccessible care is that there are very few facilities equipped to treat the severely mentally ill who may need acute or higher level of care — e.g., the average number of psychiatric hospital beds per 1000 people in Africa is .034 (Saxena et al., 2007). Those that do exist often are located in urban centers and are poorly staffed and equipped. For example, in Ethiopia, there is only one psychiatric hospital in the capital, Addis Ababa (Alem et al., 2008). Other countries such as Botswana, South Africa and Egypt may have more hospital capacity that are slightly better equipped and staffed (WHO, 2011), but these are still not sufficient to cover the entire population.

Another related challenge is that prevention and primary and secondary interventions are often lacking (Becker & Kleinman, 2013) as a result of poor infrastructure and systems. This means that many symptoms escalate and become worse due to under- or mistreatment or not being detected. Limited infrastructure and funding impact systemic issues such as, communication, policy development, training, intra-country mobility, documentation, and policy implementation (Monteiro et al., 2014; Saxena et al., 2007).

3.3 Insufficient Number of Trained Specialists

Also linked to the issues of weak infrastructure and low priority is the dearth of mental health personnel throughout Africa, which means that specialists are usually not available to diagnose, assess and treat most patients suffering from mental disorders. According to the WHO Mental Health Atlas (WHO, 2011), the mean number of psychiatrists per capita in Africa is 5 per 100,000 people and the number of psychologists is similarly low.

A number of factors contribute to the scarcity, including low numbers of medical professionals, brain drain to Western countries or from low-income countries to other countries within Africa, and lack of familiarity and stigma toward mental illness, which prevent students from choosing those professions. While there tend to be more nurses and social workers in many countries (WHO, 2011), the scope of multi-disciplinary mental health services provided to patients and families (i.e., evaluation, medication, case management, counseling, placement, monitoring, follow-up) remains limited. Moreover, understaffing and low pay creates a cycle of low morale and motivation among health workers who treat mental illness, as noted by a number of researchers (Mathauer & Imhoff, 2006; van der Doef et al., 2012; Monteiro et al., 2014).

3.4 Poor Legal Protection and Lack of Equity

A number of conventions and other ratified documents have recently focused on the legal and human rights of patients and people suffering from mental disorders. This emphasis includes several basic rights as outlined by The U.N. Convention on the Rights of Persons with Disabilities (U.N., 2006b) and also protection of family members of individuals who are mentally ill. One of the concerns raised regarding care throughout Africa is the lack of individual rights for patients, which puts them at high risk for stigma. This is partially due to collectivist cultural orientation in most African societies where the boundaries between individual and group are less rigid and mean that individual confidentiality is not a paramount concern (Alem, 2002; Ae-Ngibise et al., 2010). But it is also a function of guidelines and policies that do not reflect the social, cultural and economic realities in Africa. Such policies may fail to take into account less stringent boundaries between patients and their families and, therefore, do not address ways to protect rights while upholding family and social support that are often part of a collectivist orientation.

Furthermore, the way that many of the centralized psychiatric hospitals in parts of Africa operate has come under criticism for being inhumane and abusive at times. That is, in some hospitals, patients are still kept in chains and report neglect and abuse by hospital personnel (Drew et al., 2011; Maj, 2011).

Related to lack of equity is the issue of mental health care disparities in rural versus urban areas. As many studies and reports reveal, the few psychiatrists that are in-country tend to be centered in urban areas and typically have to supplement any government medical work with private practice on the side - up to 50% or more of psychiatrists in some countries (WHO and Department of Psychiatry and Mental Health, University of Cape Town, 2007; Akyeampong et al., 2015). This means only people who can afford it pay for treatment themselves; however, people in remote areas have little or no access to this level of specialized service and treatment. The situation is similar for psychologists. Social workers may be more available (WHO, 2011), but their work capacity is typically not focused on directly treating mental illness symptoms.

3.5 Lack of Evidence-Based and Culturally Aligned Assessment and Treatment

Research and field experience show that training for health workers or other paraprofessional training is helpful; however, this has not been implemented on a large scale in many African countries. If implemented, paraprofessional training could address the lack of specialists. There are various models, including: task-sharing or task-shifting - where non-specialists are trained to deliver mental health services (Mendenhall et al., 2014); use of health surveillance assistants (HSAs) to address psychosocial distress (Wright et al., 2014); the apprenticeship model for training and supervising lay counselors (Murray et al., 2011); the stepped-care model that advocates integrating pharmacological and psychological treatments for mental disorders (Patel et al., 2007); as well as teaching specific psychological interventions such as Cognitive Behavioral Therapy (Rahman et al., 2008) and Interpersonal Psychotherapy (Bolton et al., 2007).

Along with implementing evidence-based care, concerns about the cultural context of interpreting, diagnosing and treating mental disorders and understanding local perceptions of mental illness have been raised. Some researchers and practitioners have critiqued of the use of Western developed screening instruments, such as Self-Reporting Questionnaire (SRQ) and WHO instruments (e.g., Kortman, 1990). Other studies have found that indigenous concepts and symptoms match those of formal instruments and diagnostic systems (Beiser et al., 1972). So, the

issue may be more about tailoring existing assessment tools to the specific cultural, local context. A number of researchers (Kortman, 1990; Alem et al., 1999; Mulatu, 1999; Monteiro & Balogun, 2014a) have noted the importance of investigating and integrating traditional conceptual beliefs of illness into formal diagnostic practices in order to localize various evidence-based approaches.

While historically most mental disorders have been dealt with first by families and then treated by traditional healers in Africa, various factors, such as colonialism, segregation of healthcare and destruction of health care systems has weakened the capacity of traditional health care infrastructure (Alem, 2002; Seloilwe & Thupayagale-Tshweneagae, 2007; Alem et al., 2008). The fact that traditional treatments do not have the capacity to meet all the needs and contemporary socioeconomic problems of patients facing mental illness means that comprehensive care is not accessible to all patients.

3.6 *Stigma, Discrimination and Human Rights Abuses*

Social beliefs that include lack of knowledge, negative attitudes and perceived stigma about mental illness, may keep those who suffer from mental illness away from treatment. Mental illness stigma is a serious concern, due to its impact on patients' willingness to seek treatment, their quality of life and the discrimination that mentally ill individuals face (Sartorius, 1998, 2007). By activating uninformed and negative responses from members of society and threatening individuals' self-esteem and self-efficacy, stigma thwarts the growth and potential of individuals and families suffering from mental illness (Corrigan, 1998; Corrigan, Larson & Ruesch, 2009). Sartorius (2007) noted that stigma extends to the institutions, health care workers and even mental health specialists who provide treatment. One result is that "stigma makes community and health decision-makers see people with mental illness with low regard, resulting in reluctance to invest resources into mental health care" (Sartorius, 2007, p. 810).

Numerous empirical and narrative accounts look at the negative impact of stigma on help-seeking intentions, help-seeking behavior, self-esteem and discrimination (Pheko et al., 2013; Corrigan et al., 2014; Link et al., 2014; Monteiro, 2014; Oshodi et al., 2014). Specifically, stigma has been found to contribute to discrimination from others and internalized negative self-perceptions in the form of self-stigma, both of which make people avoid treatment and hide their symptoms. Particular beliefs about the cause of mental illness often include the entire family, who may also suffer stigma, prompting them to hide their family member's illness. Also, many investigators have criticized some traditional treatment approaches that are harmful and perpetuate stigma, including chaining, whipping and burning patients (Drew et al., 2011).

4. Framework for Solutions – Localizing and Contextualizing Mental Health Care

Developing sustainable solutions to the devastating impact of mental illness in Africa requires comprehensive and holistic planning and program development, as highlighted by advocates, stakeholders, researchers and practitioners. Overarching concerns are how to adapt services to local social and cultural contexts and how to capitalize on the multiple social strengths

throughout Africa to help promote culturally responsive prevention and intervention approaches. Or, better yet, how can the enormous human resource potential throughout Africa be harnessed to offset some of the challenges related to poor financial resources?

There is growing consensus is that every country must develop mental health policies and procedures that are guided by and consistent with its own social and cultural – i.e., contextual - realities (Gureje & Alem, 2000; Ae-Ngibise et al., 2010; Ventevogel et al., 2013; Monteiro et al., 2014; Oshodi et al., 2014; Atilola, 2015). Trickett and colleagues (2011) highlighted the complexity of community health interventions and the importance of developing “collaborative, multilevel, culturally situated community interventions” (Trickett et al., 2011, p. 1410). That means that a close investigation of the local setting and context in which mental health problems are experienced and interventions will take place must inform specific mental health care solutions. Part of such investigations must explore intra-country differences and disparities, such as differences in access, usage and health beliefs between rich and poor, educated and uneducated, urban and rural and other groups. Below I describe a multi-faceted framework that consists of both policy and socio-cultural approaches and actions.

The biopsychosocial model (Engel, 1977) of clinical and research practice in psychiatry encompasses multiple determinants of illness, health, and wellbeing that extend beyond a narrow biomedical paradigm of disease. Furthermore, the importance of social determinants of illness and health has also been established in the research literature (Marmot & Wilkinson, 2005; Thornicroft, 2011; WHO, 2014b). Many traditional African explanatory beliefs of mental illness are similarly multidimensional. The importance of social, cultural and spiritual understandings of illness in many African societies has been recognized and discussed as being related to the collectivist orientation of many African cultures. (Monteiro & Wall, 2011; Amuyunzu-Nyamongo, 2013; Akyeampong et al., 2015). Many of the explanations of mental illness are spiritual, meaning they focus on forces that are outside the material realm, but which have significant impact on human affairs.

Therefore, in order to represent the unique cultural explanatory models for understanding mental illness in Africa to localize and contextualize mental health services, I propose an extension of the biopsychosocial model to include a focus on socio-cultural-spiritual dimensions of conceptualizing illness and treatment. Emphasizing these aspects supports holistic and culturally responsive approaches to the mental health care gap in Africa. For example, a number of studies have explored the efficacy of traditional healers in treating mental illness - in Ghana (Aniah, 2015), Sudan (Sorketti et al., 2013), Uganda (Abbo, 2011), Kenya (Mbwayo et al., 2013), Tanzania (Ngoma et al., 2003) and other countries. Furthermore, the use of parallel health systems - where patients consult with traditional and formal medical professionals simultaneously – is common throughout Africa (Kale, 1995). Extending the biopsychosocial model would allow researchers and practitioners to examine how spiritual beliefs and cultural practices influence individuals’ help-seeking behaviors and community responses to individuals suffering from mental illness.

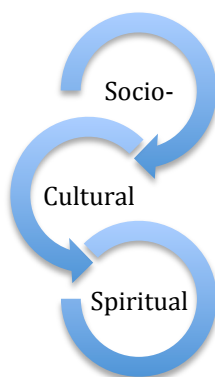


Figure 1. Socio-Cultural-Spiritual Extension of the Biopsychosocial Model.

4.1 Guidelines for Contextualizing Mental Health Care

While each country’s social and cultural realities are different, there are a number of underlying themes and evidence-based methods for using these actualities to contextualize service. It is important for researchers, policy-makers and practitioners to document the prevalence of common and severe mental disorders and the number of patients who present in primary care settings with symptoms of mental illness. But they also need to survey the social components (which include psycho-cultural-spiritual aspects) that influence behaviors such as use of traditional healers and parallel health systems and the pathways leading patients to traditional healers and formal medical facilities.

A guide for contextualizing should also include the following, which are described below:

1. Understanding explanatory and treatment models in Africa
2. Recognizing multidimensional protective factors
3. Strengthening community mental health and exploring parallel health systems
4. Incorporating global health best practices

Some aspects of these guidelines have been implemented in different countries; albeit, not always deliberately or holistically. One important contribution of the socio-cultural-spiritual extended model is that it provides a broad paradigm for contextualizing mental health care and improving collaborations between professional health care and community-based intervention systems in Africa.

4.1.1 Understanding Explanatory and Treatment Models in Africa

The World Health Organization defines mental health as “a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community” (WHO, 2014a). However, there often is a disconnect between the biomedical disease model that guides formal medical practice and socio-cultural-spiritual beliefs that influence patients’ interpretation of symptoms and help-seeking behaviors. There are a number of ways in which the socio-

cultural context in many African countries distinguishes on-the-ground mental health care from the biomedical approaches that predominate in Western countries. Findings from all over the continent indicate that patients have complex and nuanced understandings of mental illness, but a prominent feature of their conceptualization is the perception that supernatural factors are prominent among the multiple causes of mental illness (e.g., Haugum, 2011; Monteiro & Balogun, 2014b; Patel et al., 1995; Sorsdahl et al., 2010). Additionally, patients tend to seek treatment from traditional healers – either initially or simultaneously (Patel, 1995; Sorketti et al., 2011).

Much has been written about the social and cultural causal beliefs in African societies. Each society has its own specific beliefs, but there is commonality in that many beliefs relate to underlying supernatural causes or social causality of mental illness symptoms. This may mean that certain beliefs or cultural lore lead to stigma or prevent people from seeking or receiving help, even for severe problems. However, help-seeking behavior research indicates that there are a number of other factors that prevent people from seeking mental health treatment, including lack of access, and alternative pathways to seeking and receiving help, including using traditional healers. Moreover, many African explanatory models distinguish between common mental disorders, which are attributed to psychosocial causes, and severe mental disorders, which may incur more stigma and result in different help-seeking behavior (Alem, 2002; Assefa et al., 2012).

Studies have found that for psychosocial problems, traditional healers can be effective in decreasing patient distress (Abbo, 2011; Sorketti et al., 2013), at least temporarily, supporting the case for collaboration between traditional healers and medical professionals in order to reach more patients. There are also mixed findings on the protective function of rural environments and village life as compared to urban environments for mental health (Fekadu et al., 2014; Habtamu et al., 2015), indicating that environmental factors are important to understanding patients' vulnerability to mental illness.

4.1.2 Recognizing Multidimensional Protective Factors

There are a number of indigenous socio-cultural-spiritual values and practices that can be utilized to develop and implement culturally responsive mental health interventions and treatment in Africa. They include collectivistic sense of group belonging that can buffer against isolation, inclusion of the family in decision-making for greater social support, holistic perceptions of health, use of rituals that facilitate group cohesion and community support, and culturally congruent explanatory models of disease that reinforce community care and support. Of course, these are generalizations and do not apply to all societies in Africa, but they represent social and cultural dynamics that are common throughout many segments of the African continent.

4.1.3 Strengthening Community Mental Health Care and Exploring Parallel Health Systems

Recently, there has been a shift in parts of Africa that mirror de-institutionalization that started to take place in many of Western countries decades ago. In Ethiopia, in a deliberate effort to expand community mental health instead of hospital care, at least 36 community mental health

units have been established across the country. They were set up so that two psychiatric nurses would run each of the units and a referral system for severe symptoms is in place (Alem, 2002). However, there are numerous examples of community mental health care not operating optimally in many countries. For example, in Botswana in the past there have not been enough training personnel to run a national community mental health nursing program (Seloilwe & Thupayagale-Tshweneagae, 2007). Similar situations exist in other African countries (Bhana et al., 2010). Adequate mental health care, in the form of initial screening, primary treatment, referral structures and prevention efforts, at the local community level is essential for comprehensive health care. Policy-makers have also emphasized the value of integrating mental health care into primary care facilities.

Relatedly, there are parallel health systems in most countries, where people go to traditional healers before or at the same time that they go to formal health care. Anywhere from 20% to 85% of patients in Africa who experience symptoms of mental disorders seek treatment with a traditional healer initially or at the same time as formal health services (Gureje & Lasebikan, 2006; Seloilwe & Thupayagale-Tshweneagae, 2007; Ae-Ngibise et al., 2010; Abbo, 2011; Sorketti et al., 2011). However, there is some research that patients often prefer formal medical care for severe problems (Monteiro & Balogun, 2014b), which begs the question, how much choice do patients have in addressing the range of mental disorders?

Investigating the extent of parallel systems use in local contexts is necessary to improve care. In a review of key strategies and findings from different countries in Africa, researchers highlighted health workers' perceptions and cited the importance of integrating mental health into primary care and partnering with traditional healers (Hanlon et al., 2010). It was concluded that WHO and other global bodies need to develop services and initiatives specific to Africa's socioeconomic and cultural context (Hanlon et al., 2010). Calls for partnerships between formal healthcare systems and networks of traditional healers are not new. Developing viable partnerships and optimizing traditional healers' tremendous social capital require realistic assessments of the challenges and barriers to greater understanding and cooperation between the two sectors (Ae-Ngibise et al., 2010).

4.1.4 Incorporating Global Health Best Practices

Research has highlighted a number of global health best practices that can be applied to locally throughout Africa to improve mental health care. They include task-sharing (use of paraprofessionals to support specialists), training community health workers to be front-line advocates, peer counselor training, integrating mental health into primary care and psychosocial treatments for post-conflict recovery. Initiatives by the WPA, WHO (Okasha, 2002) and Mental Health Gap (MhGAP) program (WHO, 2010) have provided blueprints for developing these practices and to help implement the various calls and declarations to address Africa's silent epidemic of untreated mental illness. Health care policy-makers need to have an understanding of the current global mental health best practices and to collaborate with local community leaders (i.e., village chiefs, religious leaders, local officials) to assess which practices it could be successfully utilized and implemented.

4.2 Recommendations

Using a socio-cultural-spiritual paradigm to extend the biopsychosocial model of mental illness can help to guide policy-makers, practitioners and researchers develop initiatives and effective approaches to decrease the burden of mental illness in Africa. This holistic framework can be used to inform large- and small-scale strategies for improving mental health care. Specific recommendations are listed in Table 2.

Table 2. Recommendations for Contextualizing and Localizing Approaches to Improve Mental Health Care in Africa.

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- Sustained advocacy to international, national and local stakeholders about the importance of addressing mental health care disparities.
 - Funding and research to develop and assess interventions that can be delivered by non-professionals and delivered as part of routine care.
 - Prevention and intervention through improved general health services, such as routine mental health screening, outreach services, and comprehensive community health care.
 - Better understanding of local explanatory models in order to improve utilization of services
 - Culturally-informed solutions – in addition to infrastructure and policy improvement – that capitalize on existing local beliefs and practices.
 - Collaboration, where feasible, among formal health care providers, traditional healers and spiritual/religious leaders.
 - Evidence-based psychosocial treatment models tailored to the specific socio-cultural and spiritual strengths found in many segments of African societies.
 - Increased research into the local dynamics and functioning of parallel health systems
 - Ongoing training for local community health workers to build mental health care capacity and develop sustainability.
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Addressing the global mental health challenges in Africa requires a focus on locally-driven and culturally responsive solutions. Integrating global best practices with community-based interventions can lead to policy, research and treatment improvements.

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