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An Evidence-Based Policy Brief

Strengthening the health system for mental health in Zambia

+ **Included:**

- *Description of a health system problem*
- *Viable options for addressing this problem*
- *Strategies for implementing these options*

✗ **Not included: recommendations**

This policy brief does not make recommendations regarding which policy option to choose

Who is this policy brief for?

Policymakers, their support staff, and other stakeholders with an interest in the problem addressed by this policy brief

Why was this policy brief prepared?

To **inform deliberations** about health policies and programmes by **summarizing the best available evidence** about the problem and viable solutions

What is an evidence-based policy brief?

Evidence-based policy briefs bring together **global research evidence** (from systematic reviews*) and **local evidence** to inform deliberations about health policies and programmes

***Systematic Review:** A summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise the relevant research, and to collect and analyse data from this research

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This policy brief was prepared by the Zambia Forum for Health Research

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Key messages

The problem:

Although mental illness constitutes a large proportion of the burden of disease in Zambia, it receives inadequate attention.

- Mental health was not among the twelve priority areas in the National Health development plan and was not provided for in the basic package of services defined by the Ministry of Health.
- Only 0.38% of health care funding was directed towards mental illness in 2008.
- *Mental health services are lacking in general in general health care, including secondary and primary care levels.*

Policy options:

An incremental versus a comprehensive option for integrating mental health into primary care

An incremental option

This option would start with a pilot project introducing mental health services into primary care with a well-designed evaluation prior to scaling up. Key advantages of this option are:

- *It is possible to make improvements in the plan, if needed, prior to scaling up.*
- *The pilot would help ensure that full implementation of the plan achieves its intended objectives and could provide better data for estimating the costs of scaling up.*
- *It may be more feasible than rapidly scaling up throughout the country.*

A comprehensive option

This option would entail implementation of a comprehensive plan to introduce mental health services into primary care in all nine provinces of Zambia. Key advantages of this option are:

- *Scaling up could occur more rapidly.*
- *Monitoring and evaluation could be used to ensure that the implementation of the plan is working as intended.*
- *It may be less likely to stall and than an incremental approach.*

Implementation strategies:

Strategies to implement either option must address a number of barriers, including:

- *Insufficient funding for mental health services due to inadequate advocacy, inadequate mental health indicators, inadequate public awareness of mental illnesses, social stigma attached to mental illnesses, mental health care not being perceived as cost-effective or affordable, and resources that are allocated to mental health at the district level not being earmarked*
- *A lack collaborative efforts between mental health workers in the tertiary care hospital and provincial units, primary care workers and community health workers and organizations*

- *Primary care workers already being overburdened due to low numbers and limited types of health workers trained and supervised in mental health care, poor working conditions in the public health service, lack of incentives to work in rural areas, and inadequate training of the general health workforce in mental health*
- *Insufficient funding for mental health services due to inadequate advocacy, inadequate mental health indicators, inadequate public awareness of mental illnesses, social stigma attached to mental illnesses, mental health care not being perceived*

Executive summary

The problem

Mental illness constitutes a large proportion of the burden of disease in Zambia. Although data regarding the burden of mental disorders in the country are lacking, there are some indicators of the magnitude of the problem. For example, Mayeya et al (2004) found a prevalence of 36 and 18 per 100 000 for acute psychotic states and schizophrenia respectively, based on hospital figures. Acute psychotic states refer to mental illnesses which present in an acute state and do not normally exceed a period two weeks for resolution while schizophrenia refers to a chronic state of psychotic illness. Further, according to the Mental Health and Poverty Project (MHaPP) Country Report of 2008, about 2667 patients per 100,000 population are admitted annually to the only tertiary referral psychiatric hospital and units around the country. It is expected that mental health problems in general will increase, taking into account the extent of predisposing factors like HIV/AIDS, poverty and unemployment. It is recognised that this is a very high incidence when compared to expected prevalence of about 3 percent for severe mental disorders and 19 percent for mild to moderate disorders. This observation would support the proposition that there is lack of provision for mental health at the primary and secondary level and that mental health services mostly accessed at tertiary level.

By contrast, mental health care services have continued to receive inadequate attention: mental health was not among the twelve priority areas in the National Health development plan; mental health was not provided for in the basic package of services defined by the ministry of Health; and only 0.38% of health care funding was directed towards mental illness in 2008. Moreover, legislation related to mental health care, not updated since 1951, fails to mention basic human rights related to the mentally ill.

The current system of mental health care is based largely on secondary and tertiary health institutions. Mental health services at the primary health care level are either inadequate or lacking due to several factors, the main one being the low level and misplacement of mental health professionals.

Policy options

In considering the way forward the government was confronted with two options for improving mental health services. The first is strengthening of the status quo by making the “vertical” system work more efficiently. This would imply investment in secondary and tertiary institutions to increase the number and competencies of human resources as well as the physical structures and logistics. Secondly, there was the option of investing in integrating mental health in primary health care services. The government decided on the latter.

Integrating mental health into primary health care: strategic options

The two strategic options that are considered here focus on integration of mental health into primary health care using (1) an incremental approach or (2) a comprehensive approach. In the incremental system, it is envisaged that a few centres will be selected for implementation with a view to scaling up at a later stage. In the comprehensive system an effort is made to initiate a process widely across the country without a need for extending to other centres at a later date. The important distinction between these two options is the implication for resource allocation in specific context of Zambia. It is important to take into account the country’s ability to fulfil the resource allocation implications of these options before adopting one or the other or both. The two options, how they would differ and their advantages and disadvantages are summarized in Table 1 in relation to the ten WHO/WONCA principles for integrating mental health into primary care.

Table 1. Key characteristics of two options for integrating mental health into primary care

Principles	The status quo	Option 1 Incremental implementation starting with a pilot project	Option 2 A comprehensive plan for scaling up
1. Policy and plans need to incorporate primary care for mental health	The Ministry of Health is committed to integrating mental health in primary care. Implementation of this policy has been slow, nonsystematic and uncoordinated	A systematic and coordinated plan for integrating mental health in primary care The plan will initially be implemented in a small number of districts	A comprehensive plan for scaling up the integration of mental health in primary care will be implemented throughout the country
2. Advocacy is required to shift attitudes and behaviour	Several independent organizations (e.g. MUHNZA, MHAZ) are working largely independently	A voluntary coalition of organizations will collaborate in advocating for change	A mental health advisory board will be established to ensure input into the plan and its implementation and to help monitor and coordinate implementation of the plan, as well as to advocate for change
3. Adequate training of primary care workers is required	Limited training for specialised skills at the only tertiary care mental health hospital, limited mental health training in the curricula for general health workers, and limited efforts and resources for in service training	A pilot project in a small number of districts including systematically planned and coordinated training and supportive supervision for primary care workers	A cascade approach for training relevant cadre of primary care workers throughout the country
4. Primary care tasks must be limited and doable	Treatable mental health problems commonly go unrecognised, minimal mental health services provided in primary care, lack of follow-up for discharged psychiatric patients	Improved recognition of high priority mental illnesses, diagnosing and treating high priority conditions that are optimally managed in primary care, improving referrals and communication with specialized mental health workers, and follow-up of discharged psychiatric patients Implemented initially in a small number of districts focusing on a minimal number of high priority conditions and tasks	Implemented throughout the country and the prioritised conditions and tasks may be expanded to include all priorities that are best provided in primary care
5. Specialist mental health professionals and facilities must be available to support primary care	Inadequate specialist mental health professionals, they do not have responsibility or time to provide adequate support, and the referral process is ineffective and inefficient	Increased supply of mental health professionals, posts providing support as a key component of the job description, and an effective and efficient referral process Implemented initially in a small number of districts with a minimal sufficient increase in capacity	Implemented throughout the country and may include additional expansion of the specialist mental health service to increase its capacity to handle referrals as well as to provide outreach, supervision and support for primary care workers

Principles	The status quo	Option 1	Option 2
6. Patients must have access to essential psychotropic and other mental health medications in primary care	No psychotropic drugs included in the primary health care kit or available in private pharmacies, and inappropriate drugs are being used	Include appropriate psychotropic and other drugs for mental health problems (e.g. depression) in the primary health care drug kit Implemented initially in a small number of districts for a minimal number of high priority conditions	Implemented throughout the country and the prioritised conditions may be expanded to include all priorities for which drugs are needed in primary care
7. Integration is a process, not an event	The process of integrating mental health into primary care does not have a timeline and is uncoordinated	Stage by stage changes building on experience, beginning with a pilot project, including rigorous evaluation of both impacts and processes	A plan for achieving comprehensive mental health care over a defined period of time with ongoing monitoring, evaluation and adaptation
8. A mental health service coordinator is crucial	Currently there is a National Mental Health Services Unit with a small number of staff	Strengthen the National Mental Health Services Unit and ensure that it has a clear mandate and capacity for coordinating the integration of mental health into primary care Initially focusing on ensuring a clear mandate and capacity for coordinating the pilot project	In addition establishing establish coordinators at the provincial level and focal point persons at the district level
9. Collaboration with key stakeholders is required	Not currently coordinated	The National Mental Health Services Unit will be responsible for indentifying key stakeholders and working with them	An advisory board with key stakeholders will be established (see 2 above)
10. Financial resources are needed	No earmarked funds allocated to integrating mental health in primary care	Earmarked funds for the pilot project and other elements of this option outlined above, including for training, drugs, mental health professionals to support primary care workers, evaluation, and strengthening coordination	Earmarked funds for mental health professionals to support an advisory board, training, additional tasks undertaken by primary care workers, drugs, mental health professionals to support primary care workers and to manage increases in referrals, and coordination

Implementation considerations

There will be several barriers to the implementation of either option. Inconsistent and unclear advocacy may result in unclear messages. It will be necessary to establish mechanisms for common approaches among stakeholders for either approach. It will also be necessary to devise comprehensive indicators that do not give a skewed view of the burden of mental illness.

Lack of general public awareness of mental illnesses and the social stigma that is attached to mental illnesses are bound to undermine efforts to provide mental health services in primary care. Moreover, mental health care and provision of psychotropic drugs may not be perceived as cost-effective or affordable. Finally, and most importantly, allocation of resources earmarked for mental health may continue to be scarce despite the adoption of either policy option for integrating mental health care in primary care.

MAIN REPORT

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Preface

“The problem of under-diagnosis and under-treatment of mental health problems cannot be remedied by simple provision of guidelines and protocols, no matter how elegant; it will require a reordering of the actual structure and process of primary care” (deGruy, 1997).

The purpose of this report

The purpose of this report is to inform deliberations among policymakers and stakeholders. It summarises the best available evidence regarding integration of mental health into primary health care. It was prepared as a background document to be discussed at meetings of those engaged in developing mental health and primary health care policies and stakeholders. In addition, it is intended to inform other stakeholders and to engage them in deliberations about those policies. It is not intended to prescribe specific options or implementation strategies. Rather, its purpose is to introduce systematic and transparent consideration of the available evidence of the likely impacts of different options into deliberations about mental health care.

How this report is structured

This policy brief has a list of key messages, an executive summary, and a full report to present policy-relevant research evidence about the impacts of integrating mental health into primary health care. Although this entails some replication of information, the key messages and summary address the concern that not everyone for whom the report is intended will have time to read the full report.

How this report was prepared

We searched for relevant evidence describing the problem, the impacts of options for addressing the problem, barriers to implementing those options, and implementation strategies to address those barriers. We searched particularly for systematic reviews describing the effects of policy options and implementation strategies. Reviews that we assessed as being most relevant were used to extract key findings and information that facilitates interpretation of those findings in the Zambian context. We supplemented information extracted from the included systematic reviews with information from other relevant studies and documents. The report was revised iteratively based on feedback from the Mental Health Research to Action Group, key informants and external reviewers.

Limitations of this report

Because this policy brief is based largely on previously completed systematic reviews and research, there may be important gaps in addressing options for which we did not find relevant evidence. We have attempted to address this limitation in three ways: by relying on other documents to fill in the gaps, through personal contact with experts, and through external review of the report.

The problem

Background

A large proportion of the burden of disease in Zambia and around the world is due to mental illness (WHO 2005). The common mental disorders are depression (42%) and schizophrenia (21%) while the diagnosis of acute transient psychoses is rare. The majority of people with mental illness do not have access to mental health services in Zambia [Mental Health Atlas, 2005]. The World Health Organization (WHO) and the Ministry of Health, along with non-governmental organizations dealing with mental health advocate integrating mental health into primary care to address this problem. In a survey conducted to explore attitude of health workers towards integrating mental health into primary health care in Zambia revealed that over 98.2 percent of the health workers were of the view that such integration was either extremely important (71.2%) or just important (27.0%) and this ranged from a high of 88.5 percent among Zambian Registered Nurses to 25.1 percent among Environmental Health Technologist who indicated that it was extremely important (Mwape, et. Al., 2010). Although the Ministry of Health has made some strides towards integrating mental health into primary health care, the process of integration to address the inadequacy of mental health service provision has been slow and has not been systematically planned or implemented.

The decision to focus this policy brief on mental health care was influenced by the Mental Health and Poverty Project conducted in four African countries (Ghana, South Africa, Uganda and Zambia) to investigate policy level interventions required to break the vicious cycle of human poverty and mental illness. This project was undertaken in order to generate lessons for a range of low and middle-income countries. Subsequently, discussions with key policymakers in the Ministry of Health, mental health professionals and mental health organizations' staff revealed that integration of mental health into primary health care is a priority of current policy interest. Further, it was evident that there was need for research evidence to inform decisions about how to effectively integrate mental health into primary health care.

Over the past two decades the focus of care in mental health has been through the provision of curative care, situated in big third level provincial hospitals (Petersen 1999). However, in the Mental Health Policy document (2005), the Ministry of Health has committed to integrating mental health into primary care. This integration is expected to address a full range of services so that continuity of care and a balanced mix of community and inpatient services are ensured. The process was also planned to be sensitive to prevailing cultural beliefs and practices. Further, the Ministry of Health has included mental health in the current National Health Services Strategic Plan which is as part of the Fifth National Development Plan (2006 – 2010) and has integrated it in Clinical Technical Guidelines, as they pave the way to integrating mental health at primary health care level (Mental Health Unit, MoH, 2008).

Reasons for integrating mental health into primary health care, as outlined by the World Health Organization (WHO 2008), include:

- The burden of mental disorders is great.
- Mental and physical health problems are interwoven.

- The treatment gap for mental disorders is enormous.
- Primary care for mental health enhances access.
- Primary care for mental health promotes respect of human rights.
- Primary care for mental health is affordable and cost effective.
- Primary care for mental health generates good health outcomes.

Size of the problem

Treatment for mental illness is either lacking or provided in a fragmented manner at the primary health care level for an estimated 200 000 people with mental disorders (of an adult population of 5 million) in Zambia [WHO, 2004; MHaPP, 2008; Mental Health Atlas, 2005]. It is cause for concern that mental health at the primary care level has been largely overlooked in Zambia [Mayeya et al., 2004]. It is not one of the top ten priorities and has not been included within the Zambian Basic Health Care Package. Consequently, psychotropic medications are not included in the primary care health kit and are generally unavailable in primary care.

Because mental health is omitted from the health package, mental health care services are unavailable throughout most of Zambia. There is currently only one mental care specialist in each of the nine provinces. There are only three psychiatrists in the country, for a population of 12 million, and none working in public health care (MHaPP, 2008; Mental Health Atlas, 2005). Mental health services are mainly hospital based with Chainama Hills Hospital, located in the capital city of Lusaka, as the only third level inpatient, long-term care facility in Zambia. It is supported by a network of psychiatric units in seven provincial general hospitals and three general psychiatric rehabilitation units (Mental Health Policy Document, 2005). However, the Mental Health Policy Document (2005) reports that the rehabilitation centres are not funded by the Ministry of Health, are inadequate, and are located far away from patients. The document further notes that there are scant mental health services for vulnerable groups such as children, young people, women, single parents, terminally ill, unemployed, prisoners, retrechees, widows, divorcees and the homeless.

Although data regarding the burden of mental disorders in Zambia are lacking, some indicators are available. Mayeya et al (2004), for example, found a prevalence rate based on hospital figures of 36 and 18 per 100 000 population for acute psychotic states and schizophrenia respectively, with alcohol and drug misuse cases accounting for 10 percent of acute psychotic states. This prevalence is slightly higher than global burden which when measured by years lived with disability and years lost as a result of premature death in disability-adjusted life years, accounted for 13% of the global disease burden in 2002 (WHO, 2002). However both the global and the Zambian prevalence do not capture other types of burden associated with mental disorders, including the burden of care giving for family members, financial costs, stigma, and human rights violations (Saxena, 2007). In addition, and mentioned earlier, it is recognised that this is a very high incidence when compared to expected prevalence of about 3 percent for severe mental disorders and 19 percent for mild to moderate disorders. This observation would support the proposition that there is lack of provision for mental health at the primary and secondary level and that mental health services mostly accessed at tertiary level.

Further, the burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions (Prince, Patel, Saxena, Maj, Maselko, Phillips, & Rahman, 2007). The WHO's 2005 (Mental Health Atlas, 2005) estimates of the global burden of disease provide evidence on the relative effect of health problems worldwide. WHO's 2005 report attributed 31.7% of all years lived-with-disability to neuropsychiatric conditions: the five major contributors to this total were unipolar depression (11.8%), alcohol-use disorder (3.3%), schizophrenia (2.8%), bipolar depression (2.4%), and dementia (1.6%).

According to the Mental Health and Poverty Project (MHaPP) Country Report [2008], about 2667 patients per 100 000 population are admitted to Chainama and psychiatric units around the country. The total number of beds at Chainama is 210, excluding 167 (floor beds) which are not officially recognised by the Ministry of Health. Primary health care units (health centres) form the first level in terms of the structure of health care provision. They are expected to refer complex cases to district hospitals (second level) and the district hospitals are expected to refer to third level (tertiary) hospitals. However, neither health centres nor district hospitals have mental health plans. Both are fragmented and uncoordinated in their provision of mental health services [Mental Health Policy Document, 2005; Gleisner, 2001; Gleisner, 2002].

Mental health care providers at the primary care level are generally clinical officers who have undergone three years of training. They are able to diagnose mental illness and they illegally provide prescriptions for psychotropic drugs, meanwhile medical officers are generally not available at the primary care level, especially in rural areas, yet they are the ones that have the legal provision to prescribe drugs for mental illness (MHaPP, 2008). Training of nurses and general practitioners about mental illness is limited. This may be attributed to the lack of knowledgeable trainers for mental illness and care (MHaPP, 2008). Generally, research in mental health in Zambia is scarce, with no research, apart from the MHaPP project, having been conducted on issues around integration of mental health within primary health care [MHaPP, 2008; Mayeya et al., 2004; Gleisner, 2001; Gleisner, 2002].

Factors underlying the problem

Key factors underlying the failure to integrate mental health into primary care are a lack of legislation, inadequate financing and an inadequate mental health information system.

Legislative challenges

Legislation related to mental health care in Zambia is an appendage of a colonial legacy. Created in 1951 the policy discusses how the general population needs to be protected from the mentally ill but fails to mention basic human rights related to those living with mental illness (MHaPP, 2008). Zambia is still under the guidance of this legislation, which does not recognize nor provide for the protection of the human rights of mentally ill patients or involvement of communities in the provision of mental health care. The National Mental Health Bill, which will repeal the Mental Health Ordinance of 1951 has been in under review for about 10 years. This has delayed repealing the Mental Health Ordinance of 1951 and enacting the new bill. The Mental Health Policy was ratified in 2005, still based on the Mental Health Ordinance of 1951, and has not been fully implemented. This has perpetuated

the slow pace at which integration of mental health services into primary health care is progressing, despite the good intentions of the Ministry of Health's vision of 'providing equity of access to quality health care as close to the family as possible'.

Inadequate financing

Only 0.38% of health care funding is directed towards mental illness (MHaPP, 2008). The Zambia Mental Health Policy (2005) makes it clear that this is insufficient. The Ministry of Health's Annual Action Plan (2010) with a total of K756 billion (app. \$151 million) shows Mental Health as having been allocated only K889 million (app. \$178 000) under six activities: strengthening coordination of mental health services in the provinces; support to tobacco control activities; training and research in mental health; creation of public awareness in mental health; the prevention of alcohol and drug abuse and facilitation of the provision of community mental health services in provinces. In comparison, STI/HIV was allocated K8.6 billion (app. \$1.7 million) and K2.4 billion (app. \$478 000) was allocated for tuberculosis and leprosy activities. This situation is similar to other states in the world despite the huge burden of mental illness and the availability of effective interventions; few resources are directed toward mental health care. Mental health spending in many countries in the world is less than 1% of health expenditures (which are already very low in most middle- and low-income countries), 31% percent of countries have no separate mental health budget, and the number of mental health professionals is grossly deficient (Mental Health Atlas, 2005; Saxena, Sharan, Saraceno, 2003).

Inadequate mental health information system

The Zambian Ministry of Health collects health information from health facilities in the country through a data capture form that clinicians complete by tallying conditions of patients seen each day. The data capture form has a list of conditions from which clinicians select. However, there are only two categories (psychosis and neurosis) through which mental health problems are captured leaving all others unrecorded. This has significantly contributed to under reporting of mental health disorders. It has further contributed to patients being referred to the only tertiary level hospital without being treated at the primary care level. The Mental Health and Poverty Project survey (2008) reports that patients with mental disorders are sent to a tertiary level hospital right away without being screened and in most cases, without a provisional diagnosis. This is done regardless of the distance the patient should cover to the hospital or the cost of transportation.

Other factors underlying the need for improving the integration of mental health into primary care can be summarised in relationship to the reasons for integrating mental health into primary health care listed above.

The burden of mental health problems is immense

Mental health problems are increasing in the Zambian population, mostly arising from the socio-economic difficulties that exist in the country. These include: HIV/AIDS, poverty, and joblessness. With the population of 12 million people, an HIV prevalence of 17 percent and only about 400 000 formal jobs, over 68 percent of the population live on one US Dollar per day or less (CSO, 2007). Amid all the mental health problems arising from socio-economic difficulties, the health system in Zambia considers a disease as a priority if it represents a

large burden (in terms of mortality, morbidity or disability), has high economic costs, or is associated with violations of human rights (Mental Health and Poverty Project, 2008). Although WHO has identified depression, schizophrenia and other psychotic disorders, suicide, epilepsy, dementia, disorders due to use of alcohol, disorders due to use of illicit drugs, and mental disorders in children as priority conditions, these did not fit the criteria that were used to prioritize conditions in Zambia. Disability and the economic burden imposed by these disorders includes loss of gainful employment, with the attendant loss of family income; the requirement for care giving, with further potential loss of wages; the cost of medicines; and the need for other medical and social services. These costs are particularly devastating for poor populations [Mweemba, et al, 2009; WHO/WONCA, 2008].

However there have been almost no epidemiological studies conducted in Zambia to determine the exact burden of mental health problems. Few isolated studies have been undertaken and the findings have indicated prevalence rates among various groups. A study that was undertaken to determine mental distress among primary care attendees reported a prevalence rate of 12.4 percent and 15.4 percent in men and women respectively (Chipimo & Fylkesnes, 2009). Another study which was conducted to explore psychological distress among women in the perinatal period reported a prevalence rate of 48 percent during the antenatal period and 37 percent during the postnatal period (Mwape, 2010)

Mental and physical problems are interlinked

Consistent associations have been reported between physical conditions and mental health problems in both low and high-income countries (Chipimo & Fylkesnes, 2009). Further, an association has been found between mental health problems and epilepsy (Lee & No, 2010; Gilliam, 2006); pregnancy (Mwape, 2010) and HIV/AIDS (Chipimo & Fylkesnes, 2009). The WHO in the 2010 world report shows that between 11% and 63% of HIV-positive people in low- and middle-income countries have depression. People with the condition also are prone to anxiety due to the unpredictable nature of AIDS progression. Stress has been reported to impair immunity, and depression is likely to affect adherence to antiretroviral therapy. A study conducted in Tanzania revealed that 57 percent of HIV-positive women experienced depression and that depression was associated with disease progression and death. Further, in both the general population and in general medical-care settings, at least, a third of all somatic symptoms (commonly pain, fatigue, and dizziness) remain medically unexplained. although, at least a third of those with somatisation have no comorbid mental disorder medically unexplained somatic symptoms and syndromes are strongly associated with common mental disorders (Prince, Patel, Saxena, Maj, Maselko, Phillips, & Rahman, 2007). In recognition of the relationship between mental health problems and physical conditions, some international agencies have supported mental health through programmes that support physical health problems. Mental health was integrated in round four and eight of the Global Fund with a component on mental health and Anti Retroviral Treatment, and mental health and alcohol and substance abuse in the context of HIV/AIDS included respectively. In addition, the United Nations Office for Drugs and Crime has provided support capacity building for service delivery in relation to substance abuse.

The treatment gap for mental health is enormous and respect of human rights is lacking

Mental Health did not qualify to be one of the six main health thrusts, and subsequently was left out in the first (1995-1998) and second (1998-2000) National Health Strategic Plans (Ministry of Health, 2005). Table 2 shows the priority area ranking in Zambia in what forms the Basic Health Care Package.

The Basic Health Care Package consists of interventions for the prevention and management for each of the priority conditions, on the basis of evidence about the effectiveness and feasibility of scaling up these interventions. An intervention has been defined as an agent or action (biological, psychological, or social) that is intended to reduce morbidity or mortality (Mental Health and Poverty Project, 2008), and could be directed at individuals or communities. The interventions were identified on the basis of their effectiveness, cost effectiveness, equity, ethical considerations including human rights, feasibility or deliverability, and acceptability.

As a consequence of not including mental health in the basic health care package, psychotropic drugs are not included in the primary care drug kit. (Mental Health and Poverty Project, 2008; Ministry of Health Strategic Plan 2005-2011). This was confirmed by the Mental Health and Poverty Project survey that was conducted in 2009, which found that out of the twenty three health centres in Lusaka, only two had psychotropic drugs in stock. Further, although the process of integration is slowly commencing, there has not yet been an attempt made to review the basic health care package in order to incorporate mental health. Yet mental health services delivered in primary care minimise stigma and discrimination. They also remove the risk of human rights violation (WHO/WONCA, 2008).

If the gaps in mental health services, resources, and policies are not addressed, the basic human rights of the mentally ill (including the right to treatment) will continue to be neglected, and the mentally ill will continue to suffer.

Table 2: National Health Priorities (Basic Health Care Package)

No	Priority Area/Condition	Strategic Intervention
1	Child health and nutrition	To reduce the mortality rate among children under five
2	Integrated reproductive Health	To reduce the maternal mortality ratio
3	HIV/AIDS, TB, and STIs	To halt and begin to reduce the spread of HIV, TB, STIs
4	Malaria	To reduce incidence and mortality due to malaria
5	Epidemics	To improve public health surveillance and control of epidemics
6	Hygiene, sanitation and Safer water	To promote and implement appropriate interventions aimed at improving hygiene and access to acceptable sanitation and safer water
7	Human resources	To train, recruit, and retain appropriate and adequate staff at all levels
8	Essential drugs and medical supplies	To ensure availability of essential drugs and medical supplies at all levels
9	Infrastructure and equipment	To ensure availability of appropriate infrastructure and equipment at all levels
10	Systems strengthening.	To strengthen existing operational systems, financing mechanisms, and governance arrangements for effective delivery of health services

Source: Mental Health Poverty Project Country Report (2008).

Primary health care for mental health enhances access

Mental health services at the primary health care level are either inadequate or lacking due to several factors, including low levels and misplacement of mental health professionals.

Human resources for mental health in Zambia have been declining over the past years. This has been largely attributed to low numbers of health care providers being trained in mental health, retirement, death due to HIV/AIDS, and migration. As of 2001, Zambia had a total of about 132 mental health workers for an estimated population of 12 million people. After the reintroduction of the Registered Mental Health Nursing and the Clinical Medicine Psychiatry programmes in 2006, the numbers are slowly increasing.

In addition to being scarce, mental health workers are often misplaced and end up being assigned duties in the provision of general health care. For example, none of the mental health workers in the urban clinics within the capital city were providing mental health care because they had been placed outside the mental health care system (Mental Health and Poverty Project, 2008).

Primary care for mental health is affordable, cost effective, and generates good health outcomes

Evidence shows that mental health services at the primary health care level are less expensive than psychiatric hospitals for both patients and government [Mwape, et, al, 2010; Mweemba, et al, 2009]. In Zambia, due lack of integration of mental health services at the primary health care level, patients are neither screened nor treated for mental illness. Generally, patients with mental illness are referred to the only tertiary hospital in the country without being screened (Mwape et al, 2010). This imposes a financial burden on patients, most of whom are living in poverty, which is perpetuated by their mental disability (Flisher, 2007). Integrating mental health services that are affordable and cost effective into primary care can lead to improvements in health seeking behaviour that ultimately lead to better health outcomes (Chisholm et al, 2007).

Policy options

Globally, mental health has been integrated into primary health care across a range of circumstances, including difficult economic and political circumstances. The specific models of integration vary due to differences in socioeconomic situations, health care systems and health care resources. Generally, success is achieved through leadership, commitment, and clear policies (WHO/WONCA, 2008). As has been highlighted earlier, in Zambia integration of mental health into primary health care has been slow and there is therefore, a need to carefully select an option that will be compatible and that will yield the intended results within a short period of time. The two policy options that are discussed in this section focus on integration of mental health into primary health care using WHO/WONCA's (2008) ten principles for integrating mental health into primary health care: (1) an incremental approach and (2) a comprehensive approach. We describe the current situation of mental health in primary health care before describing two options for addressing challenges to integrating mental health into primary care.

The Current Zambian Mental Health and Primary Health Care Situation

According to MHaPP (2008) access to basic health services was affirmed as a fundamental human right by the Declaration of Alma-Ata in 1978. The goal of the Alma Ata declaration was to enable people to receive a basic health care package as close to their residence as possible. However, this goal has not been realised, especially in low-income countries (MHaPP, 2008). In the Zambian context, as stated earlier the integration of mental health into primary health care has been slow. There is a critical shortage of human resources at the primary care level. Frontline mental health care workers are inadequate. According to Mental Health Policy (2005) there were less than 260 mental health workers working in mental institutions. Gleisner (2001) revealed that apart from declining numbers, there is misplacement of mental health workers into areas where they are unable to provide mental health services.

There are a number of challenges that must be addressed in order to effectively integrate mental health into primary care. These are described in relationship to WHO/WONCA's (2008) ten principles for integrating mental health into primary care.

1. Policy and plans need to incorporate primary care for mental health

The current mental health policy, which commits the Ministry of Health to integrating mental health into primary care, came into effect in 2005. However, it has taken over ten years to review the mental health bill needed to repeal the Mental Disorders Act, Cap 305 enacted in 1951. Further, there is not yet a coordinated plan or efforts to implement the policy.

2. Advocacy is required to shift attitudes and behaviour

There are several non-governmental organisations (NGOs) working in the area of mental health. These organizations will play an important role in shifting the attitude and behaviour for scaling up of mental health services in primary care.

3. Adequate training of primary care workers is required

The government recently re-introduced the training of specialist mental health workers in primary care - the Clinical Officer Psychiatry (COP) and Registered Mental Health Nurse (RMN). It will take a long time to produce required numbers of staff for all primary health care facilities. Currently, the Ministry of Health has been undertaking capacity building workshops for general health workers from primary health care facilities in identification and management of mental health problems. However, there is no systematic plan to scale up training and it is not clear who or how many should be trained over a specific period of time.

4. Primary care tasks must be limited and doable

Currently there is lack of integration of mental health into primary health care and as such tasks have not been specified.

5. Availability of Specialist mental health professionals and facilities to support primary care

As described above, there is a critical shortage of mental health specialists in Zambia. Specialised mental health care is concentrated at the one tertiary hospital (Chainama Hills College Hospital) and there is a scarcity of specialist mental health workers in primary care facilities. Hence, those requiring mental health services are referred to the tertiary hospital and there is no provision of mental health care at primary care level.

6. Access to essential psychotropic medications in primary care

There is a central procurement unit that ensures regulation of dangerous drugs, including psychotropic medications to allow for easy accountability and tracking of consumption patterns. However, psychotropic medications are not included in the essential drug kit and are in limited amounts at the tertiary hospital (Mwape, et al., 2010).

7. Integration is a process, not an event

Important steps that have been taken towards integrating mental health in primary care include the development and launch of the mental health policy in Zambia. The mental health bill is currently undergoing review.

8. A mental health service coordinator is crucial

The directorate of Public Health and Research at the Ministry of Health is responsible for the mental health unit. The mental health unit has a coordinator and an officer responsible for policy development, implementation and coordination of mental health services in Zambia. There is inadequate coordination of mental health services at primary care level.

9. Collaboration with key stakeholders

Due to lack of integration of mental health into primary health care, collaborative activities have not been implemented.

10. Financial resources

As earlier stated, financial resources for mental health services are inadequate.

Incremental and Comprehensive Options

1) An incremental option for integrating mental health into primary care

The first option for addressing the challenges to integrating mental health into primary care (described above) is incremental implementation of a plan for integrating mental health into primary care. It will start with a pilot project introducing mental health services into primary care with a well-designed evaluation prior to scaling up.

2) A comprehensive option for scaling up the integration of mental health into primary care

The second option is comprehensive implementation of a plan for scaling up the integration of mental health into primary care. It will introduce mental health services into primary care in all nine provinces of Zambia.

These two options are summarized in Table 1 in the Executive Summary and described here using the same ten principles for integrating mental health into primary health that were used above to describe the current situation.

1. Policy and plans need to incorporate primary care for mental health

Both options build on having a systematic and coordinated plan for implementing the current policy of integrating mental health into primary care. The need for a plan is based largely on lessons from other countries where mental health has been successfully integrated into primary care [WHO 2008; WHO, 2007; Prince, Patel, Saxena, Maj, Maselko, Phillips, & Rahman, 2007]. Other lessons learned from case studies of experiences in other countries include:

- National directives can be fundamental in encouraging and to shaping local activities and improvements
- It may be essential to ensure that all stakeholders are involved in local identification of needs and possible solutions, planning and implementation of the identified solutions
- The policy and plan must be embraced by local-level health managers, not only those involved in mental health. This includes both health and local authority managers

The incremental option will initially implement the plan in a small number of districts; e.g. two rural and two urban districts. The impacts of integrating mental health into primary care in these districts will be evaluated in comparison to similar districts in which the plan is not implemented. Lessons learned from the pilot project will guide any necessary revisions to the plan and inform strategies for scaling up. In addition, success in a small number of districts may encourage other districts to implement changes [WHO 2008].

The comprehensive option will begin with a comprehensive plan for scaling up the integration of mental health in primary care that will be implemented throughout the country.

2. Advocacy is required to shift attitudes and behaviour

Both options would use information in deliberate and strategic ways. This is likely to be important to change attitudes and behaviour [WHO 2008, Prince, Patel, Saxena, Maj, Maselko, Phillips, & Rahman, 2007]. Estimates of the prevalence of mental disorders, the

burden they impose if left untreated, the existence of effective primary care-based treatments, and lack of access to those treatments are important arguments to persuade health authorities and stakeholders. Time and effort is required to sensitize government and health system leaders, mental health specialists, primary care workers and the public about the importance of mental health integration. Lessons learned from case studies in other countries include [WHO 2008]:

- Discussions with policy makers and others in advance of major changes are likely to be important
- Advocacy may be required to overcome initial resistance and shift attitudes of mental health specialists and general health workers

The incremental option will involve civil society and other stakeholders in mental health through collaborative efforts together in their advocacy for integrating mental health into primary health care. A voluntary coalition of these organisations will also serve to strengthen community participation in the integration process.

The comprehensive option will establish an advisory board that will engage key stakeholders, including community representatives and leaders from other sectors. In addition to providing a formal forum for coordinating and helping to ensure effective advocacy for change, the advisory board will

- Ensure input into the plan and its implementation and
- Help monitor and coordinate implementation of the plan

In addition, a team will be organising at the district level to work with the advisory board and help to ensure that there is coordinated and effective advocacy locally as well as nationally.

3. Adequate training of primary health care workers is required

Both options need to address challenges due to limited

- Training for specialised skills at the only tertiary care mental health hospital ()
- Mental health training in the curricula for general health workers
- Efforts and resources for in service training in mental health for general health workers

Appropriate and adequate training of primary health care workers is essential to effectively integrate mental health into primary care [WHO 2008, Mental Health Policy, 2005, Mwape, et al, 2010]. Other lessons learned from case studies of experiences in other countries include:

- Improvements in pre-service and in-service training of primary care workers on mental health issues is often needed
- Training should provide
 - Basic education on the epidemiology, identification, and treatment of major mental disorders
 - Relationships between mental and physical health and illness
 - Communication skills, including active listening, showing empathy, using open and closed questioning techniques, and manage nonverbal communication
 - Knowledge and skills to discuss information with patients and families in a patient-centred and positive manner, to negotiate treatment plans, and to motivate and prepare patients to self-manage and follow their treatment plans at home

- In-service training is essential to
 - Provide basic education to health workers that have not been exposed previously to mental health care
 - Consolidate existing knowledge
 - Ensure that changes in practice based on new research are disseminated and implemented
- Ongoing support and supervision from mental health specialists are essential
- Collaborative or shared care models, in which joint consultations and interventions take place between primary care workers and mental health specialists are especially promising [Patel, Flisher, Hetrick, & McGorry, 2007]

The incremental option will start with systematically planned and coordinated training in a pilot project in a small number of districts. It will also include supportive supervision for primary care workers. The training will be targeted at nurses and clinical officers who are already working in primary care. Initially, they will be trained to identify and manage common mental health problems at this level of care and to recognise other mental health problems that should be referred to mental health specialists. Additional training will be targeted at

- Mental health specialists to provide supportive supervision
- Traditional healers and community health workers to recognize and refer people with mental health problems
- District managers to recognise
 - The burden of disease from mental illnesses
 - The existence and importance of cost-effective treatments
 - Organisational changes that are needed to enable primary care workers to provide mental health care and collaboration among general health care and specialist mental health care workers

The comprehensive option will use a cascade approach for training the same cadre of primary care workers throughout the country [Chisholm D, Lund C, Saxena S., 2007]. In addition, it will implement a plan for expanding the capacity of specialist mental health workers throughout the country to provide supportive supervision to primary care health workers. It will also include and implement a plan for strengthening mental health in the pre-service curricula of general health workers, and for strengthening training for providing supportive supervision in the curricula of specialized mental health workers.

4. Primary care tasks must be limited and doable

Both options will focus on

- Improved recognition of high priority mental illnesses
- Diagnosing and treating high priority conditions that are optimally managed in primary care
- recognition and referral of patients with other mental health problems
- Follow-up of discharged psychiatric patients

It is essential that the focus is on a limited number of additional tasks that is doable by already overburdened primary care workers. Caution is needed to ensure that primary care tasks for mental health do not impede the delivery of other prioritized tasks. Primary care providers, mental health specialists, policy makers and stakeholders need to agree on which

conditions are best managed in primary care and which specific tasks should be undertaken in primary care [WHO 2008; Patel, Flisher, Hetrick, & McGorry, 2007]. Other lessons learned from case studies of experiences in other countries include:

- Decisions about which mental health conditions and tasks to prioritize in primary care must be taken after careful consideration of local circumstances
- This requires consultation with policy-makers and health care workers, as well as users of mental health services and their families
- Functions may be expanded as practitioners gain confidence. In Chile, practitioners progressed
- It may be cost-effective to develop specialized primary care services for mental health that target particular population subgroups such as children

The incremental option will be implemented initially in a small number of districts focusing on a minimal number of high priority conditions and tasks.

The comprehensive option will be implemented throughout the country and the prioritised conditions and tasks may be expanded to include all priorities that are best provided in primary care.

5. Specialist mental health professionals and facilities must be available to support primary care

Both options need to address

- The inadequate capacity of specialist mental health professionals
- Their lack of responsibility and time to provide adequate support
- Ineffective and inefficient referral arrangements

To address these challenges they will both

- Increase the supply of mental health professionals
- Create mental health posts that include the provision of support to general health workers as a key component of the job description
- Develop and implement effective and efficient referral processes

Specialist mental health professionals and facilities must be available to support primary health care [WHO 2008]. Making mental health services accessible at primary health care level will have a multiplier effect on the demand for services. Therefore, supply of mental health professionals should be accelerated to meet the demand. According to WHO [2008] other lessons learned from case studies of experiences in other countries include:

- Providing support to mental health workers in form of resources and supervision is a vital component of the job description of specialist mental health professionals
- An effective and efficient referral process is needed
- Specialized mental health professionals may interact in a variety of ways, including
 - Referral and backreferral
 - Telephone consultation
 - Outreach visits that include supportive supervision
 - Regular meetings
 - Collaborative or shared care models
 - Onsite mental health workers

Primary care providers, mental health specialists, policy makers and stakeholders need to agree on how best to ensure adequate support from specialist mental health professionals and facilities, and how to ensure effective and efficient referral arrangements. Decisions about how best to do this must be taken after careful consideration of current arrangements and circumstances.

The incremental option will be implemented initially in a small number of districts with a minimal sufficient increase in capacity.

The comprehensive option will be implemented throughout the country and may include additional expansion of the specialist mental health service to increase its capacity to handle referrals as well as to provide outreach, supervision and support for primary care workers.

6. Patients must have access to essential psychotropic medications in primary care

Both options need to address the following challenges:

- Psychotropic drugs are not included in the primary health care kit or available in private pharmacies
- Inappropriate drugs are being used

To address these challenges both will include appropriate psychotropic and other drugs for mental health problems (e.g. depression) in the primary health care drug kit. For both options, after appropriate training, regulations will need to be modified to authorize primary care workers to prescribe medications for the agreed upon range of conditions [WHO 2008]. Primary care providers, mental health specialists, policy makers and stakeholders need to agree on which drugs should be available and prescribed in primary care. Problems are likely to exist in procuring and distributing these medications and these will need to be identified and addressed.

The incremental option will be implemented initially in a small number of districts for a minimal number of high priority conditions.

The comprehensive option will be implemented throughout the country and the prioritised conditions may be expanded to include all priorities for which drugs are needed in primary care.

7. Integration is a process, not an event

Both options need to address the lack of a timeline and coordination of developing and implementing the current government policy, which supports integration of mental health into primary care. Integration is not a single or one-off event. It is a gradual process [WHO 2008]. Other lessons learned from case studies of experiences in other countries include:

- Meetings with a range of concerned parties are likely to be essential
- There may be considerable scepticism or resistance that must be overcome
- Training manuals and clinical guidelines are likely to be needed and implemented [National Health Policy, 2005]
- Health workers will need training and additional staff will likely need to be employed
- For any of this to occur, budgets typically will require agreement and allocation
- Problems inevitably arise that must be addressed

The incremental option will use a process that can be characterised as a stage by stage approach to changes that builds on experience. It will begin with a pilot project and might include subsequent pilot projects. To maximise the ability to learn from experience pilot projects should include rigorous evaluations of both desirable and undesirable impacts of the changes that are being implemented and costs. In addition, process evaluations should examine how and why the strategies that are used worked or did not work as intended.

The comprehensive option will develop and implement a plan for achieving comprehensive mental health care over a defined period of time (e.g. 5 to 10 years) with ongoing monitoring, evaluation and adaptation.

8. A mental health service coordinator is crucial

Both options will strengthen the National Mental Health Services Unit and ensure that it has a clear mandate and capacity for coordinating the integration of mental health into primary care. Case studies have found that primary care for mental health is usually most effective where a coordinator is responsible for overseeing integration [WHO 2008]. Other lessons learned from case studies of experiences in other countries include:

- Both anticipated and unexpected problems can sometimes threaten the success of efforts to integrate mental health into primary care
- Coordinators may be crucial in steering programmes around these challenges and driving forward the integration process
- Coordinators are important at both national and local levels

The incremental option will initially strengthen the National Mental Health Services Unit and ensure that it has a clear mandate and capacity for coordinating the pilot project.

The comprehensive option, in addition to strengthening the National Mental Health Services Unit, will establish coordinators at the provincial level and focal point persons at the district level. This will help to ensure coordination at the provincial and local levels as well as at the national level.

9. Collaboration with key stakeholders is required

Both options will address the current lack of ongoing collaboration among the Ministry of Health, other sectors of the government, NGOs, community health workers and volunteers. Government sectors outside health can work effectively with primary care to help patients with mental disorders access the educational, social and employment initiatives required for their recovery and full integration into the community [WHO 2008]. NGOs, community health workers and volunteers also often play an important role in supporting primary care for mental health.

The incremental option will ensure that the National Mental Health Services Unit has a clear responsibility for identifying key stakeholders and working with them.

The comprehensive option will establish an advisory board with representatives from key sectors of the government and other stakeholders.

10. Financial resources are needed

Both options will require earmarked funds allocated to integrating mental health into primary care. For the success of the integration process, financial resources need to be made available to support training and other activities. The additional time required to address mental health issues means that more primary care workers might be needed and incentives may be needed to motivate primary care workers. Mental health specialists who provide support and supervision also must be employed or paid for these activities. [WHO 2008; Ducharme, Knudsen, & Roman, 2006]. Other lessons learned from case studies of experiences in other countries include:

The incremental option will require earmarked funds for the pilot project and other elements of this option outlined above, including for training, drugs, mental health professionals to support primary care workers, evaluation, and strengthening coordination.

The comprehensive option will require earmarked funds for mental health professionals to support an advisory board, training, additional tasks undertaken by primary care workers, drugs, mental health professionals to support primary care workers and to manage increases in referrals, and coordination

Costs

The key costs for each option and rough estimates of those costs are summarised in Table 3. Chisholm D, Lund C, Saxena S [2007] have estimated that the cost per capita of providing a core package at target coverage levels ranged from \$1.85 to \$2.60 (USD) per year in low-income countries. Although significant new resources need to be invested, the absolute amount is not large when considered at the population level and against other health investment strategies. These estimates included training costs, but may not have included all of the costs of scaling up that are listed in Table 3. Nonetheless, they provide a good indication of the likely recurrent costs once target levels of coverage have been achieved. Since the cost of coverage would be less while scaling up, the total cost while scaling up is likely to be less, or at least no greater than the yearly costs once target levels of coverage have been reached. In Zambia, with a population of 12 million, this corresponds to a total yearly cost of \$22.2 to 31.2 million (USD) (K114 to 161 billion), or roughly 15 to 21% of the Ministry of Health's Annual Action Plan for 2010. There is need to to adjust the core package to make it affordable and gradually increase the core package to include latest psychotropic medications. The ministry of health will need to identify additional sources of funds during a transition phase.

Equity considerations

Epidemiologic research over the last 20 years indicates that the social and economic conditions of poverty are linked with common mental disorders in low and middle-income countries [Lund C, Breen A, Flisher AJ, et al., 2010]. The mechanisms by which the cycle of poverty and common mental disorders is maintained are complex and multi-dimensional. An important conclusion that can be drawn for a systematic review of this is that efforts to address the burden of common mental disorders will be limited if they only target individual-level interventions. The relatively consistent association between common mental disorders and poverty, in addition to the large burden of disease caused by mental illness, strengthens

the case for the inclusion of mental health as a priority. Improving recognition and treatment of mental illness by integrating mental health in primary care is likely to reduce inequalities.

Monitoring and evaluation

Although there is high quality evidence of the effectiveness of many clinical interventions for mental disorders, evidence of the effects of strategies for integrating mental health into primary care is limited and, to a large extent, comes from case studies. Consequently, the impacts and costs of both options are uncertain.

The incremental option addresses this uncertainty primarily by piloting implementation of the plan for integration and evaluating the impacts (both desired and undesired) and costs. It also incorporates process evaluations to examine how and why the strategies used to integrate mental health into primary care worked or did not work as intended. The key advantage of this approach - in terms of evaluation - is that it makes it possible to make improvements in the plan, if needed, prior to scaling up [Supporting the Use of Research Evidence (SURE) Guides, 2010]. The key disadvantage is that, to the extent that the plan is effective and works as intended, it delays scaling up and the anticipated benefits of integrating mental health into primary care.

The comprehensive option addresses uncertainty about the impacts and costs of integrating mental health into primary care through monitoring and evaluation. Monitoring of financial, material and human resources as inputs can address uncertainties about the magnitude of the resources that are required and allow for adjustments to the budget, if needed [SURE) Guides, 2010]. Monitoring of impacts is unlikely to provide strong evidence that any changes in outcomes such as changes in the burden of disease from mental illness are attributable to integrating mental health into primary care. It can, however, inform decisions about whether changes are needed in the services that are provided or how they are provided. More rigorous evaluation of the impacts of integration could be incorporated into the comprehensive option by, for example, randomising the order in which it is scaled up in different districts (using the districts where integration occurs later for comparison), or sequentially introducing integration in different districts.

Advantages and disadvantages of the two options

Possible advantages of both options for integrating mental health into primary health care are that they will:

- Bring mental health services closer to the community in line with the Ministry of Health vision (1991)
- Help reduced travel costs for the patients and relatives who travel to Chainama hospital in their effort to access mental health services
- Reduce stigma and discrimination considering that people with mental health problems will be seen within the same setting as other patients
- Reduce the number of patients accessing the service at tertiary level, thus decongesting tertiary and provincial level hospitals

Possible disadvantages of both options for integrating mental health into primary care are that they will:

- Increase the workload for already overburdened primary health workers
- Compromise quality of care being provided due increase in workload
- Require deployment of more health care providers
- Increase the need for supervision
- Increase the need for financial resources.
- Waste of resources if integration is found not to be feasible
- Reduce the time available for primary care workers to attend to their usual patients

Possible advantages and disadvantages of the two options where compared to each other are summarised in Table 3.

Table 3. Advantages and disadvantages of the two options

Favours Option 1	Favours Option 2
Incremental implementation starting with a pilot project	A comprehensive plan for scaling up
It is possible to make improvements in the plan, if needed, prior to scaling up and the pilot would help ensure that full implementation of the plan achieves its intended objectives	To the extent that the plan is effective and works as intended, it delays scaling up and the anticipated benefits of integrating mental health into primary care and monitoring and evaluation could be used to ensure that the implementation of the plan is working as intended
Lower costs initially and the pilot could provide better data for estimating the costs of scaling up	More coverage initially. The incremental option is likely to take longer to achieve target levels of coverage and may stall
<ul style="list-style-type: none"> • May be more feasible, affordable (initially) and acceptable to the government and others concerned about expanding the governments budget for health care • It may be difficult to rapidly meet needs for more mental health specialists. Inadequate support for general health workers and capacity for increased referrals could have undesirable effects on the quality of care 	An advisory board may provide a mechanism for ensuring better input into policy decisions, implementation of policies, and monitoring and evaluation. It might also strengthen engagement of stakeholders – provided there is a clear understanding of the role of the board and appropriate processes for involving stakeholders. An advisory board could also include community representatives and representatives from other sectors
A voluntary coalition would require less government resources, but may give less of a voice to organizations and their members	May provide better coordination in early phases and therefore more effective implementation, provided coordination is effective

Implementation considerations

Key barriers to integrating mental health into primary care and implementation strategies for addressing these are summarised in Table 4. The same strategies and barriers are relevant for both options.

Table 4. Barriers to implementing the policy options and implementation strategies

Barriers to implementing policy options	Implementation strategies
Insufficient funding for mental health services [MHaPP 2008] due to	
<ul style="list-style-type: none"> • Inconsistent and unclear advocacy • Inadequate mental health indicators in the HMIS which currently capture only neurosis and psychoses and leave out other mental illnesses (particularly depression and schizophrenia) • Lack of general public awareness of mental illnesses • Social stigma attached to mental illnesses 	<ul style="list-style-type: none"> • Establishment of a coalition (option 1) or an advisory board (option 2) with a mandate to coordinate advocacy efforts amongst key stakeholders • Include an appropriate spectrum of mental illnesses in HMIS so as to provide a better picture of the burden of disease due to mental illnesses • Mass media campaigns to increase awareness and understanding of mental illnesses, their recognition and treatment options, and to reduce the stigma attached to mental illnesses [Grilli 2002] • Include guidance on strategies for reducing the stigma attached to mental illness in training targeted at primary care workers [Clement 2010; Mak 2007]
<ul style="list-style-type: none"> • Mental health care, including psychotropic drugs, may not be perceived as cost-effective or affordable 	<ul style="list-style-type: none"> • Summarise and disseminate evidence of the cost-effectiveness of mental health care compared to other drugs and types of care currently included in primary care [Ducharme, Knudsen, & Roman, 2006] • Undertake a detailed cost analysis of including psychotropic and other appropriate medications and other key costs of each option (see 'Costs' in the description of the two options above) • Based on the detailed cost analysis develop a plan for increasing funds for mental health over the next five to ten years, including transitional costs of a pilot project and scaling up
<ul style="list-style-type: none"> • Resources that are allocated to mental health at the district level are not earmarked for mental health 	<ul style="list-style-type: none"> • Training for district managers to sensitize them to the need to prioritise mental health and use funds allocated for mental health for that purpose rather than other purposes • Regulations that make district managers accountable for using national funds that are earmarked for mental health for that purpose
<p>There is a lack collaborative efforts between mental health workers in the tertiary care hospital and provincial units, primary care workers and community health workers and organizations</p>	<ul style="list-style-type: none"> • Setting up or refurbishing mental health units at health centres and at the district level • Involve the community in the provision of mental health services [SURE 2010]

Barriers to implementing policy options	Implementation strategies
Primary care workers are already overburdened <ul style="list-style-type: none"> • Low numbers and limited types of health workers trained and supervised in mental health care • Poor working conditions in the public health service • Lack of incentives to work in rural areas • Inadequate training of the general health workforce in mental health 	<ul style="list-style-type: none"> • Strategies for recruiting, redeployment and retaining health workers in underseverd areas • Redeployment (some mental health specialists are curenly misplaced and not providing mental health services) • Use of community health workers [Lewin 2010] • Training, as a component of both options • Strengthen mental health as a component of core curriculum for general health workers
Lack of infrastructure to enable community-based supervision	<ul style="list-style-type: none"> • Incorporate strategies for implementing community-based supervision in plans, as described for both options [Bosch-Capblanch 2008]
Lack of continuous supply of psychotropic and other appropriate drugs in primary care	<ul style="list-style-type: none"> • Systematically review and improve the procurement and distribution of psychotropic drugs and include appropriate drugs in the primary care drug kit
Mental health leaders have limited public health skills and experience and public health leaders have limited mental health skills and experience	<ul style="list-style-type: none"> • Both options include coordinators to lead integration of mental health into primary care • Leadership recruitment and training [refs], training for district managers in mental health, and public health training for mental health specialists who will be providing supervision [Ducharme, Knudsen, & Roman, 2006] • Stengthen mental health in public health curriculum and public health in mental health curriculum

Next steps

The aim of this policy brief is to foster dialogue and judgements that are informed by the best available evidence. The intention is *not* to advocate specific options or close off discussion. Further actions will flow from the deliberations that the policy brief is intended to inform. These might include:

- Deliberation amongst policymakers and stakeholders regarding the two options described in this policy brief
- Refining the preferred option, for example by incorporating components of both options, removing or modifying components
- Establish a coordinator with authority and accountability to lead the development and implement of a plan and a team of people to work with that person in developing and implementing the plan within an acceptable time frame

Appendix

How this policy brief was prepared

The methods used to prepare this policy brief are briefly described in the preface. The problem that the policy brief addresses was clarified iteratively through discussion among the authors, review of relevant documents and research, discussion within the Zambia Forum for Health Research (Zamfohr) and external review of a preliminary description of the problem. Research describing the size and causes of the problem was identified by reviewing government documents, routinely collected data, searching PubMed and Google Scholar, through contact with key informants, and by reviewing the reference lists of relevant documents that were retrieved.

Strategies used to identify potential options to address the problem included considering interventions described in systematic reviews and other relevant documents, considering ways in which other jurisdictions have addressed the problem, consulting key informants and brainstorming.

We searched electronic databases of systematic reviews, including: the Health Systems Evidence database of systematic reviews of delivery, financial and governance arrangements, and implementation strategies (<http://www.healthsystemsevidence.org/>). This database include records of policy-relevant systematic reviews that were identified through electronic searches of MEDLINE, the Cochrane Database of Systematic Reviews (CDSR), the Database of Abstracts of Reviews of Effectiveness (DARE) and EMBASE.

Abbreviations

AIDS	- acquired immune deficiency syndrome
ART	- antiretroviral therapy
CHW	- community health workers
HIV	- human immunodeficiency virus
MCH	- maternal and child health
MHaPP	- Mental Health and Poverty Project
WHO	- World Health Organization

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