

Mental Health in low-and middle income countries (LMICs): Going beyond the need for funding

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Abstract

Despite being globally recognised as an important public health issue, mental health is still less prioritised as a disease burden in many Low-and Middle-Income Countries (LMICs). More than 70% of the global mental health burden occurs in these countries. We discussed mental health issues in LMICs under themes such as abuse and mental illness, cultural influence on mental health, need for dignity in care, meeting financial and workforce gaps and the need for national health policy for the mental health sector. We highlighted that although mental health education and health care services in most LMICs are poorly resourced; there is an urgent need to address issues beyond funding that contribute to poor mental health. In order to meet the increasing challenge of mental health illness in LMICs, there is a need for effort to address cultural and professional challenges that contribute to poor mental health among individuals. We have a notion that mental health should be integrated into primary health care in LMICs. Creating awareness on the impact of some cultural attitudes/practices will encourage better uptake of mental health services and increase the ease when discussing mental health issues in these countries which can contribute to reducing the poor mental health in LMICs.

Keywords: stigma, developing countries, health funding, culture, abuse

Tweetable abstract: Addressing the high burden of mental disorders in LMICs requires going beyond funding to change in cultural attitude

Mental health in global context

Mental health needs have slowly come to the forefront of the global health improvement agenda over the last few years. Mental illness is, of course, a global issue, for example, World Health Organization (WHO) reported more than 450 million people are affected by mental illness [1]. The global burden of mental illness is under-estimated but recent research suggests that this burden accounts for 32.4% of years lived with disability and 13.0% of disability-adjusted life-years [2]. Depression is the most common mental illness, affects more than 300 million people globally. Depression significantly contributes to the overall global burden of disease and is the single largest contributor to global disability [1]. Several mental illnesses including depression are associated with an increased risk of suicide. The global increase in suicide rate is linked to untreated mental illnesses [3]. Currently, more than 800,000 people die due to suicide every year with suicide being the second highest cause of deaths among 15 to 29-year-olds [4]. This is a particular concern in Low and Middle-Income Countries (LMICs) where more than 70% of mental illnesses occur [5,6].

Poor access to mental health services has been highlighted, ranging from less than 50% to lower than 10% in many countries [7]. In LMICs, the gap between those in need of treatment and the availability of resources is almost 90% [8]. The need to prioritise mental health on the medical agenda has resulted in the mental health action plan 2013-2020 by the WHO [9]. This is to achieve the Sustainable Development Goals (SDGs) that aims to ensure healthy lives and promotion of well-being for all, at all ages, including mental health WHO [10]. Although mental health issues affect all countries, certain countries are more burdened by it. This is particularly true for countries facing natural disasters, war and conflict, economic recession, domestic and partner violence and poverty [11,12]. Countries affected by these challenges are generally LMICs which will make it difficult to meet their SDG targets by 2030 [13]. Consequently, it is important to make mental health a priority in these countries, addressing stigma and discrimination as well as factors surrounding care to increase access to and uptake of services. We need to ask the question why mental health care is a low priority in many LMICs especially since “There is no health without mental health” [14].

In this paper, we discuss factors that underline poor treatment and management of mental health in LMICs. These identified factors go beyond the need for adequate funding of mental health services. We have synthesized findings under the following headings: a) Abuse and mental ill-health; b) Widespread discrimination and stigma against mental health patients; c) cultural stereotypes: coercion and the “Man up” attitude; d) treating with care and dignity is ‘too far’; e) Poor human and financial resources in mental health services; f) Strategies to achieving cultural and attitudinal changes towards mental health in LMICs; g) integration of mental health into primary health care; and, h) need for national mental health policies and implementation.

Abuse and mental ill-health

The cultural tolerance of physical abuse affects women both physically and mentally. Women are likely to face punishment or other retributions from their partners if they do not submit to each of their whims. This has contributed to global levels of domestic violence against girls and women. In a study on women's autonomy in Nepal, a need for social strategies to enable women to access community and economic resources whilst challenging traditional norms has been highlighted [15]. In many countries domestic violence is a leading cause of mortality and morbidity for women of childbearing age, with the main contribution being from the mental health consequences of abuse [16]. This problem is a campaign issue for many, as evidenced by the recent 16 days of activism against gender-based violence (Nov-Dec 2017) with the theme "Leave No One Behind: End Violence against Women and Girls" [17]. However, actions are needed in LMICs where these practices are common. For example, more than 70% of women in Ethiopia have experienced physical/sexual violence by an intimate partner [18].

Sexual abuse in adults, particular among women, is a source of mental illness. Worldwide an estimated 1 in 3 women has been sexually assaulted [16]. The culture of keeping quiet among women is very common mainly due to avoiding shame and discrimination in the community. The recent sexual abuse allegations that surfaced in Hollywood highlight the far reach of the issue, particularly in the workplace, its deep-rooted nature and the long-suffering which victims have to endure, often in silence [19]. However, such events are rarely reported in LMICs partly because victims are still afraid to be labelled, shamed and discriminated and partly due to the patriarchal nature of the media, policy and judiciary system [20]. Women are not 'just' physically affected by violence, but also mentally resulting in depression, post-traumatic stress disorders, anxiety, suicide, and substance abuse [21]. Similarly, child disciplinary actions can result in abuse in some communities where it is normal to discipline children to such extent of abusing them. A study in Africa reported that most children (83%) had experienced psychological abuse, 64% psychological with moderate physical abuse and 43% psychological with severe physical abuse [22].

Widespread discrimination and stigma against mental health

An important contributing factor to mental health issues in LMICs is the discrimination against people with mental illnesses. They are labelled, exempted and even abused [23]. Although 70% of people affected by mental illness experience stigma and discrimination in the UK, this is even higher in LMICs where awareness of mental illness is low [24]. The ignorance of mental health and illness fosters the growth and spread of stereotypes in the population, which promotes discriminatory behaviour. Stereotypes such as an association of the mentally ill with danger, incompetence or blaming the individual for their illness are common and are exacerbated by communities lacking both knowledge of and empathy for the conditions. Discriminatory behaviour can include avoidance and withdrawal, coercion and segregation [25,26].

In some LMICs, some illnesses are seen as "karma" particularly psychiatric mental illnesses which are seen as the divine or universal punishment for past sins that individuals have committed in the past [27]. Not only do individuals with mental illness face discrimination but the stigma can also extend to their families. Hence the family members may try to hide the problems of mental illness from the community which may prevent extend from seeking support and treatment for their affected family member.

People recovering from mental illnesses are often also discriminated against communities. There is also evidence that people with mental illness experience stigma during their course of treatments, resulting in (a) poor care from healthcare workers; (b) delayed health-seeking behaviours; and (c) non-adherence to treatments. 'For example, 'it is a common view in South Western Nigeria that people with mental illness rarely recover [28].' There is also an assumption that people who have been treated for mental conditions will relapse. Accordingly, people may refuse to relate or interact with such individuals in the society. Ironically, such behaviour equals emotional abuse and could indeed cause relapse of the mental illness [29]. In addition, most people suffering from mental health illness are ashamed to discuss their condition and experiences. This hinders their recovery and is a barrier to accessing mental health services, hence increasing the risk of depression, anxiety or even suicidal thoughts.

Cultural stereotypes: Coercion and the "Man up" attitude

Culture influences all aspects of our life including health as such mental health can be adversely affected by cultural practices. Several cultural practices in LMICs have negatively impacted on the burden of mental illness. The need for population attitudinal change is embedded in the complexity of cultural influence on everyday practices and belief. Being told to "Man up", "Stop acting childish", "Such is life" or "Just face it" and other such stereotypical expressions are frequent forms of coercion contributing to the burden of mental illness in LMICs. We have used the term in recognition of the cultural beliefs associated with not talking about issues that trouble the mind in these countries. This attitude results in not allowing people to talk about their mental health challenges. Although there is lack of evidence particularly on how these cultural attitudes contribute to mental health burden within LMICs, it is inferred that due to this attitude, people are less likely to use mental health walk-in services [30]. In so doing, most cases of mental illness in these countries are left only identified when people show physical symptoms of mental distress (such as self-harm or attempted suicide).

Treating with care and dignity is 'too far'

Most people with psychiatric problems or serious mental illness who seek care and are able to access mental health services are hospitalised in LMICs, accounting for the high demand of a limited number of psychiatric hospital beds [31,32]. There have been reports of inhumane treatment of mental health service users particularly with isolation, detention [33]. Such treatment contributes to individuals and their

families' reluctance to seek psychiatric help [34]. The need to treat people suffering from mental illness with respect and dignity is of paramount importance in achieving adequate mental health care and increase access to mental health facilities. A WHO report on mental health suggested that family members feel left out of the care of individuals who are being treated for mental health conditions [33]. It is a necessity to include both the patient and their families in decision-making process concerning their health. This is a way to encourage people with mental illness to access professional support particularly at early stages of the condition instead of leaving it late and undiagnosed as commonly done currently.

Poor human and financial resources in mental health services

The literature shows that there is a shortage of mental health workers to support individuals with mental health needs in LMICs, a figure estimated at 1 per 100,000 people in LMICs in comparison to more than 50 staff per 100,000 people in High-Income Countries (HICs) [35]. A huge shortage of mental health workers exists and it is estimated that more than 239,000 workers are needed for adequate care in LMICs [36]. For example, Nigeria only has 150 psychiatrists (less than 1 per 1 million population), and only 5 psychiatric nurses per 100,000 population for the whole country's population of over 186 million people [37]. Similarly, in Nepal, mental health services are urban centred, with 0.22 psychiatrists and 0.06 psychologists per 100,000 population [38].

In addition to the shortage of mental health workers, there is also a shortage of funding for mental health care in general. In LMICs, less than 50% of mental conditions are treated with the majority of countries not having a dedicated budget for mental health [39]. Levels of mental health expenditure are often inadequate for the kind of care and treatment required in LMICs. It is estimated that, less than US \$2 is spent as expenditure per person with mental health illness per year which mostly goes to the funding of psychiatry hospital for patients on admission [35]. Since healthcare finance in most LMICs depends heavily on donor agencies and out-of-pocket payments, estimating total expenditure is very difficult. In HICs such as the UK, there is considerably more funding for mental health per person and as a proportion of all health care expenditure than in LMICs. In the UK, mental health expenditure is nearly £34 billion [40]. Thus, poor funding for mental health in LMICs places an even greater burden on already inadequate health systems. Since most people with mental illness present late to mental health services and often with more serious conditions, they will require more intensive and expensive hospital-based treatments as well as care from already inadequate numbers of mental health care providers.

With the increasing mental health burden globally and particularly in LMICs, more funds are currently needed. LMICs cannot meet the challenges of funding mental health services and employing more human resources. It is therefore important that we look into innovative ways to reduce mental illness burden with the limited resources available. One way to achieve this will be to create awareness for attitudinal change towards mental health. In doing so will facilitate discussions for and about mental health among all citizens, naturally increasing the number of persons seeking professional support at early stages of mental illness. Early diagnosis and treatment of people with mental illness can then reduce the demand on psychiatric hospitals and staff as the treatment in out-patient clinics reduces the need for admission. Moreover, in most LMICs, no separate inpatient care is available for children with mental illness. This requires urgent a reform as we aim to achieve universal access to health as guided by SDG.

Strategies to achieving cultural and attitudinal changes towards health in LMICs

One way to reducing mental health challenges will involve intervention on multiple aspects of mental health. A means of achieving this will be the use of protest, contact and education to reduce stigma [41,42]. These approaches have been suggested for the reduction of stigma, although protest has been reported as having disadvantages as it may increase rather than decrease stigma. Although protest is instructing community members to ignore or suppress negative thoughts about mental illness, individuals can have rebound effect as stigma will be augmented rather than reduced [41]. It is therefore essential that these approaches are adopted with care and modified to LMICs where it can be used. A method could be, to use education on mental illness and people living with mental illness. This allows people to learn and know about mental illness; and may bring empathy towards individuals that are suffering from the condition. Penn and Couture [41] reported on evidence that providing people with factual information through education is an effective way to change the cultural attitude and reduce stigma towards people living with mental illness. Although, Thornicroft et al. [43] reported social contact to be the most effective invention in reducing stigma on short-term but no effect was noted on long-term exposure for people living with mental illness. It is essential to look into the possible use of various strategies to reduce discrimination and stigma is highly recommended.

Concerning LMICs, we suggest that mental health information is made available to people using educational approach. This method is less expensive, have potential to change attitudes towards mental health, correct misinformation in the communities. This information can be channelled through community groups, local health workers, posters, fliers, educating children in schools. Many LMICs have great experience of using community radio or theatre, for example, to reduce stigma around HIV, change attitudes towards domestic violence, alcohol misuse. One less expensive way to disseminate this information can be through the channel of mobile phones (mHealth), telemedicine, and social media. This will be valuable as the number of people using mobile phones and internet is increasing with an estimated 84% of people in LMICs owning some type of cell phone [44,45].

Integration of mental health into primary health care

Until recently, healthcare services that are primarily focused on mental illness treatment in LMICs are very limited, with most facilities located in urban centres. Although limited healthcare facilities in LMICs are barely able to meet the demand for general health care, there are even further limited facilities for mental health care. This lack of priority for people with mental illness needs to be addressed. Mental

health impacts all physical health conditions which mean it can contribute to the successful treatment and management of other health problems [14]. For example, the impact of mental health in diabetes management has been highlighted as a double edge sword. Day-to-day diabetes management can lead to depression and suicidal thoughts while people living with diabetes have higher rates of mental illness [46]. In addition, mental illness as a complication in diabetes management results in poorer health outcome among individuals with both conditions [47]. Therefore, we need to prioritise mental health treatment and care; perhaps one way to do this is to encourage the integration of mental health services into primary healthcare in LMICs. A referral can be made to specialist mental healthcare facility if needed in countries where such specialists are available. This will allow a more effective early diagnosis and intervention for mental health problems before advancing to more critical stages requiring intensive interventions.

At the same time, we need to train existing community health workers, primary care providers on the range of issues around mental health and mental illness. For example, a recent project used UK healthcare workers that volunteered to train ANMs (auxiliary nurse midwives) in Nawalparasi (southern Nepal) on a range of mental health issues [48,49]. Theory of change was used to integrate mental health into primary health care services by training healthcare workers, finding volunteers for community champion on mental health within the community in Nigeria [50]. These have shown possible ways of integrating mental health into primary healthcare to reduce the burden of mental health worker shortages in LMICs.

Need for national health policy on mental health

A national policy with strategies to sustain the effort on mental health requiring the active involvement of policymakers is needed. More than 68% of WHO member states have a distinct mental health policy or plan and 51% of these member states have mental health legislation. However, in many countries, policies and laws are poorly implemented. Furthermore, these policies and laws are not fully in line with human rights. Family member's involvement is not fully included in the treatment process of people with mental illness particularly in LMICs [35]. Countries like Nepal have a national health plan for mental health but this is poorly implemented [38]. In Nigeria, the most populous nation in Africa, mental health is not included in the general health strategy and plan. Furthermore, Nigeria has no specific mental health budget, with less than 4% of health budget going to neuropsychiatric facilities. The existing mental health policies have not been properly implemented [51].

The way forward

We argue that although adequate funding and resource allocation is an essential part of providing the much-needed mental health services in LMICs. However, the need for attitudinal change in the wider society is equally urgent. Advocating for cultural attitudinal changes is as important as, if not even more important than increasing funding to help reduce the burden of mental illness. Certain social behaviours and attitudes towards mental illness in the community such as stigma, discrimination and lack of empathy seem to contribute social practices that in themselves increase the burden of mental illness. It is only after we have been able to achieve cultural attitudinal changes. Where community members are more empathic, accommodating and no stigma or discrimination is directed towards individuals with mental illness can discussions and accessing mental health services be prioritised.

Conflict of interest

The authors have no conflict of interest.

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