Mental health in Zimbabwe: a health systems analysis

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There has been little external analysis of Zimbabwe's mental health system. We did a systems analysis to identify bottlenecks and opportunities for mental health service improvement in Zimbabwe and to generate cost-effective, policy-relevant solutions. We combined in-depth interviews with a range of key stakeholders in health and mental health, analysis of mental health laws and policies, and publicly available data about mental health. Five themes are key to mental health service delivery in Zimbabwe: policy and law; financing and resources; criminal justice; workforce, training, and research; and beliefs about mental illness. We identified human resources, rehabilitation facilities, psychotropic medication, and community mental health as funding priorities. Moreover, we found that researchers should prioritise measuring the economic impact of mental health and exploring substance use, forensic care, and mental health integration. Our study highlights forensic services as a central component of the mental health system, which has been a neglected concept. We also describe a tailored process for mental health systems that is transferable to other low-income settings and that garners political will, builds capacity, and raises the profile of mental health.

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Introduction

Mental, neurological, and substance use disorders account for between 7·4% and 13% of disability-adjusted life-years and are the leading global cause of years lived with disability.[1,2] However, mental health receives less than 1% of health-care funding in many low-income and middle-income countries (LMICs),[3] in which up to 98% of patients with mental illness can go untreated.[4] Challenges to maintaining mental health services in LMICs include funding and workforce shortages,[5,6] supply chain issues with psychotropic medications,[7] stigma,[8] outdated or inadequate mental health policies,[9] and controversy over culturally appropriate diagnosis and treatment.[10]

Strong health systems are needed to tackle the burden of mental illness.[11] A health system is "the sum total of all the organizations, institutions, and resources whose primary purpose is to improve health".[12] According to WHO, health systems strengthening is a priority for global health, and systems analysis is a key first step.[13] Health systems analysis identifies bottlenecks and weaknesses in health-care delivery to generate cost-effective, policy-relevant solutions that build on existing structures.[14]

There are countless examples in global health where health systems research has fundamentally changed the delivery of health care. Researchers in Zimbabwe, for instance, identified suboptimal uptake of provider-initiated testing and counselling for HIV in children.[15] By use of mixed methods, they identified several system-level barriers to uptake: children were often brought to the hospital without an appropriate caregiver; health-care workers were uncertain about consent requirements for testing; and long waiting times and lack of stock of testing kits created logistical barriers. In response to these findings, the team worked with the government to implement programmatic changes, including switching to a strategy of routine opt-out testing, training health workers about who can consent for children to be tested, and updating guidelines on consent. With these changes, uptake improved from 71% to 95%.[16]

WHO has proposed several frameworks for assessing health systems, such as Building Blocks[13,17] and the Innovative Care for Chronic Conditions Framework.[18] Additionally, several large research and capacity building consortia, in collaboration with WHO, have used a health systems approach to analyse and strengthen mental health services in LMICs.[19–22] Broadly, all these frameworks examined common health system building blocks, including services, workforce, information systems, resources, financing, and governance.[13] These groups concluded that the most robust mental health systems were those that were effectively integrated into primary care and other services and used broad, system-level analyses to structure transitions to a more integrated model of service provision.[19]

Zimbabwe is a country with a historically vibrant community of mental health researchers who helped kindle the broader global mental health movement.[23,24] On this basis, with increased mental health funding opportunities in recent times, Zimbabwean researchers have been able to make substantial progress. Their studies have explored interventions for depression in people living with HIV/AIDS,[25,26] task shifting (ie, delegating health-care duties usually done by specialised staff to less specialised or non-specialised staff) for common mental disorders,[27,28] traditional healing,[29] and training and capacity building.[30] However, there has been no system-wide research on mental health services in Zimbabwe since the 1980s.[31] During the past decade, the strain of a hyperinflationary economy has had negative consequences on health services in the form of decimation of infrastructure, supply chain challenges, worsening access to services, and the so-called brain drain of health-care professionals (ie, skilled health workers seeking opportunities outside the country, in other fields, or in the private sector).[30,32,33] Furthermore, major economic turmoil and the resulting social stress might increase the burden of mental illness.[34,35] In a recent subanalysis, we found that mental health advocacy was a crucial and desired component for Zimbabwean stakeholders.[36] Despite this

finding, the broader evidence base for advocacy has been inadequate. This study aimed to address this gap by providing an overview of public mental health in Zimbabwe, with emphasis on understanding what structures and services exist, how they are interrelated, key challenges, and opportunities and priorities for future action. These system-level findings could inform the work of researchers, policy makers, and advocates in Zimbabwe and other low-income settings where similar challenges and opportunities exist.

Methods

Setting

Zimbabwe is a landlocked country in sub-Saharan Africa with a population of 15 million.[37] The broader health system has been decimated by economic and political turmoil[38,39] and the major focus is on HIV treatment and prevention. No comprehensive studies have examined the burden of mental illness; however, small studies on depression estimate a prevalence of 15–30%, with a particularly high burden in women.[24,40] Although these estimates are high, similarly high rates (eg, 21% in Uganda[41]) have been reported in other LMICs. WHO reports an alcohol consumption rate of 5·7 litres per person per year[42] (similar to the average in the WHO African region of 6·0 litres per person per year) and a suicide rate of 16·6 per 100 000 people compared with 3·0 per 100 000 people in neighbouring South Africa.[3]

Study design

For more on **Emerald** see https://www.emerald-project.eu/the-group/consortium

Emerald is a mental health system strengthening consortium working in six LMICs. We chose to adapt their national-level needs assessment methods for our study because these tools, created by experts from leading institutions including WHO, generate in-depth system-level data about mental health services. Our team's contextual understanding and experience in iterative qualitative methods allowed us to adapt these instruments to the Zimbabwean setting and make them amenable to generating open-ended, novel data. We collected data between Jan 5, 2013, and Nov 30, 2015, and analysed only data that were available during this period.

Contextual information about mental health services

Through meetings with officials, practitioners, and other key stakeholders, we collected publicly available background information about public mental health care in Zimbabwe. We documented the numbers and types of health-care workers in the mental health workforce, cross-checked these lists with other local sources, and compiled a list of currently operating mental health facilities (appendix pp 6–7).

See **Online** for appendix

Policy analysis

Although several policy analysis tools exist,[43] we used the Emerald policy checklists because they had been used in other sub-Saharan African countries;[21] were tailored for mental health; and were designed to be used in concert with other Emerald tools, allowing us to maintain uniformity and completeness across our data. One member of the research team (KK or HJ) read each document and completed the checklists. Other members of the team reviewed the checklists to ensure that they were completed correctly. The wider policy environment was examined via qualitative interviews.

Qualitative interviews

We adapted an interview guide for national-level policy makers and planners from the Emerald Consortium.[21] The interview guide included open-ended questions about the following areas of the mental health system: law and policy, coordination and consultation, financing, integration, human resources, monitoring and evaluation, and quality assurance and ethics. These methods have been described elsewhere[36] and are further detailed in the appendix (pp 1–4).

Before the study, we obtained ethical approval from the Medical Research Council of Zimbabwe, the Joint Research Ethics Committee, and the Icahn School of Medicine Institutional Review Board. Before each interview, the interviewer described the study to the participant in plain English or Shona and obtained written consent.

Results

Study sample

We interviewed a range of leaders and national-level stakeholders in mental health, including policy makers, administrators, providers, and researchers (30 participants; appendix p 5), between Jan 5, 2013, and Nov 30, 2015. The interviews revealed five themes that are key to mental health service delivery in Zimbabwe: policy and law; financing and resources; criminal justice and forensic services; workforce, training, and research; and beliefs about mental illness. Illustrative quotations are provided in panel 1. The following sections are structured on the basis of information from the qualitative interviews and enriched with publicly available data and policy analysis if available.

Policy and law

We have summarised documents governing mental health care by use of criteria adapted from checklists used by Emerald for assessing mental health policies in other LMICs (table). Most interviewees were aware of the existing policies and laws. Three ideas emerged in their discussions: lack of implementation, a need to update the older policies, and minimal consultation of stakeholders in policy formation. The overwhelming concern of all participants was that policies were never fully implemented, generally because of human and material resource constraints. Participants also highlighted that policy creation and revision was not a resource-neutral

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